

# “We Were Abandoned”

## How Connecticut Failed Nursing Home Workers and Residents During the COVID-19 Pandemic

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# Table of Contents

<b>Executive Summary and Key Findings</b> .....	<b>3</b>
<b>1. Background</b> .....	<b>7</b>
<b>A. Nursing Home Workers</b> .....	<b>8</b>
<b>B. Connecticut’s Nursing Home Industry</b> .....	<b>9</b>
<b>C. State Funding and Oversight of Nursing Homes</b> .....	<b>9</b>
<b>2. Timeline: COVID-19 in Nursing Homes</b> .....	<b>11</b>
<b>3. In Their Own Words: Nursing Home Workers Experience the Pandemic...</b>	<b>14</b>
<b>A. Relationships Between Workers &amp; Residents</b> .....	<b>15</b>
<b>B. Arrival of COVID-19</b> .....	<b>16</b>
<b>C. Lack of PPE</b> .....	<b>18</b>
<b>D. Lack of Testing</b> .....	<b>19</b>
<b>E. Lack of Transparency</b> .....	<b>20</b>
<b>F. Lack of Staff</b> .....	<b>21</b>
<b>G. Low Pay</b> .....	<b>23</b>
<b>H. Essential Workers, Left Behind</b> .....	<b>24</b>
<b>4. State Oversight: State Data Confirms Workers’ Experiences &amp; Agency Shortcomings</b> .....	<b>26</b>
<b>A. DPH Oversight Process</b> .....	<b>27</b>
<b>B. DPH Inspection Findings Confirm Nursing Home Workers’ Testimony</b> .....	<b>27</b>
<b>C. DPH oversight was insufficient to capture and address COVID-19 issues</b> .....	<b>32</b>
<b>5. Policy Recommendations</b> .....	<b>37</b>
<b>A. Enact S.B. 1030 and the reforms it proposes.</b> .....	<b>38</b>
<b>B. Provide adequate funding for nursing homes.</b> .....	<b>38</b>
<b>C. Increase worker pay and benefits</b> .....	<b>38</b>
<b>D. Establish medical loss ratios for nursing homes</b> .....	<b>39</b>
<b>E. Increase minimum staffing ratios.</b> .....	<b>39</b>
<b>F. Guarantee staff access to sick time.</b> .....	<b>40</b>
<b>G. Enhance Department of Public Health oversight of nursing homes.</b> .....	<b>40</b>
<b>6. Methodology</b> .....	<b>41</b>
<b>A. Interviews with workers</b> .....	<b>42</b>
<b>B. Analysis of DPH documents</b> .....	<b>42</b>
<b>C. Analysis of COVID-19 Nursing Home Dataset</b> .....	<b>43</b>
<b>7. Acknowledgments</b> .....	<b>44</b>

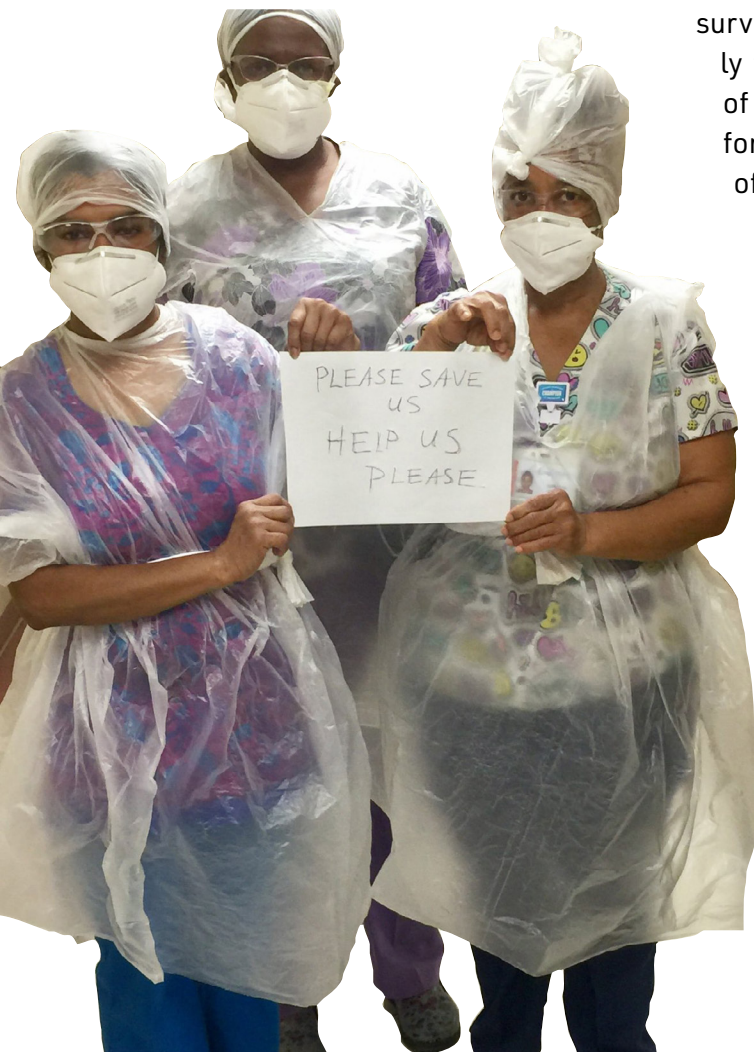
# Executive Summary and Key Findings

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This report is the first comprehensive study to center the voices of those who were on the front lines of Connecticut nursing homes throughout the pandemic: nursing home workers themselves. Released at a time with the potential for large work stoppages at a significant portion of nursing homes in the state, this report lays out the issues that have caused workers to consider such action. Their testimony reveals dangerous conditions and a lack of oversight and recognition. Workers were consistently unable to access personal protective equipment (“PPE”) and COVID-19 testing in their facilities. They worked long hours in unsafe conditions, in understaffed facilities, and often without sufficient compensation. The state has not adequately protected this workforce, which is predominantly comprised of working-class people of color, with a large proportion of women and immigrants. Further, worker testimony demonstrates that staffing, compensation, safety, and transparency problems predate the pandemic. These unresolved issues will continue to create perilous conditions for both workers and residents unless the state takes action.

A review of all publicly available Inspection Reports, Citations, and Statements of Deficiencies from the Connecticut Department of Public Health (“the DPH”) from March 2020 to February 2021 confirms these workers’ testimonies and exposes the deficiencies of state oversight under the administration of Gov. Ned Lamont. An overwhelming majority (94%) of publicly available Inspection Reports identified violations of multiple regulations.

These violations were not isolated incidents. DPH surveyors found that nursing homes repeatedly failed to conform to the recommendations of the Centers for Disease Control (“CDC”) for the proper distribution, use, and storage of PPE, often leaving workers with no choice but to share PPE or resort to using soiled or ineffective, makeshift PPE. Problems with PPE supplies persisted throughout the pandemic, not just in the beginning. Surveyors also routinely found deficiencies in testing practices, training on infection control, and cohorting and quarantine procedures, which put workers and residents at heightened risk. Furthermore, this report shows that Connecticut nursing homes continue to experience the severe staffing shortages that predated the pandemic, which exacerbated the COVID-19 crisis in nursing homes. This report finds that there is a sig-



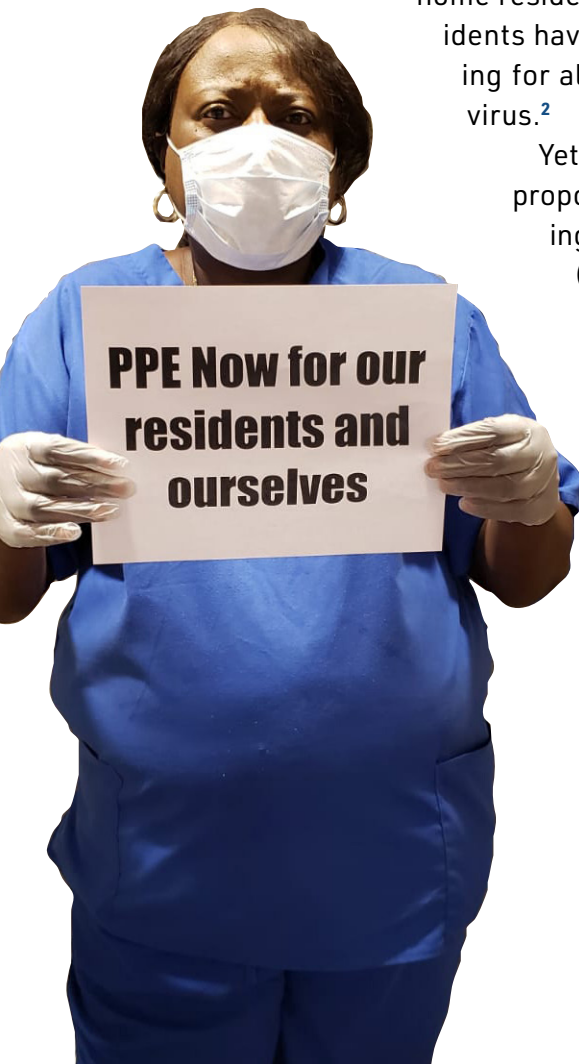
nificant association between staff shortages and risk of COVID-19 infection and deaths among residents.

Despite the DPH's own findings of flagrant violations of CDC guidelines in nursing homes, this report reveals that DPH leadership under the Lamont administration made little use of its primary enforcement tools: inspections and fines. Interviews with workers describe significant gaps in the distribution of supplies, training, and testing, resulting in staggering infection rates and deaths. A study of all oversight documents the DPH has made publicly available revealed that Citations were issued for only 34 incidents related to COVID-19 from March 2020 to February 2021, for a total of \$98,081 in fines across all nursing homes. The average fine for a violation related to COVID-19 was \$2,885, significantly below the statutory limit for class B violations, and strikingly lower than the average fine for class B violations unrelated to COVID-19 during the same period (\$6,023). At the same time that the Lamont administration did not meaningfully enforce CDC guidelines, DPH leadership said that nursing home workers who had to wear trash bags to protect themselves did so because they preferred them to other personal protective equipment.

The COVID-19 pandemic has ravaged nursing homes across the state and revealed the deadly consequences of long-term underfunding and understaffing.

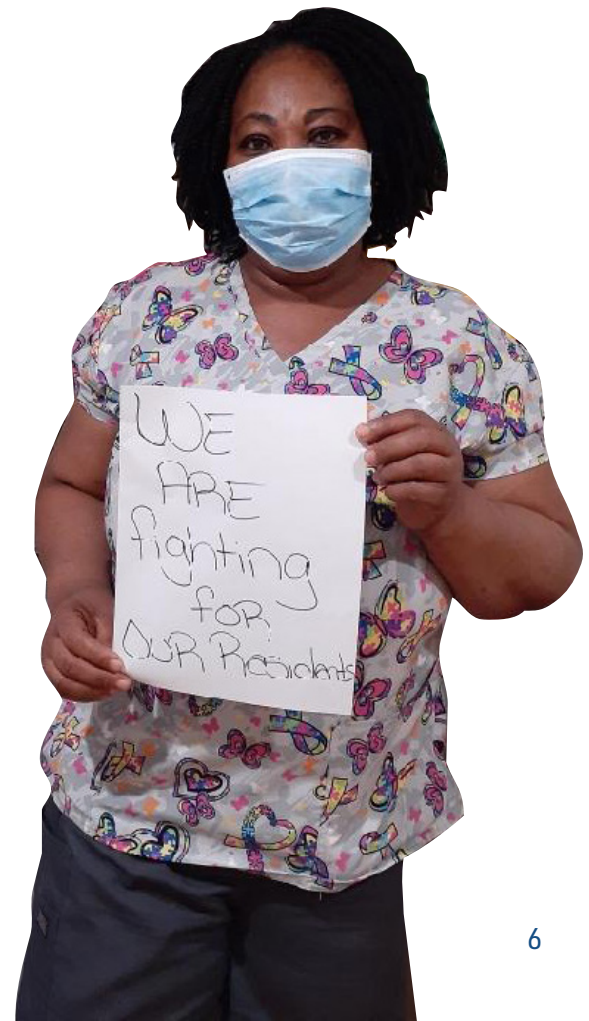
As a result, nursing home staff have been forced to work in hazardous conditions that jeopardized their lives, as well as their families and nursing home residents. In Connecticut, more than 3,800 nursing home residents have died from COVID-19-related complications,<sup>1</sup> accounting for almost half of the state's total recorded deaths from the virus.<sup>2</sup>

Yet Governor Lamont's FY 2022–FY 2023 biennial budget proposal included removing inflationary increases for nursing home costs in both years, resulting in total reductions (factoring in federal share) of \$22.2 million in FY 2022 and \$48.6 million in FY 2023.<sup>3</sup> And while Governor Lamont's proposed American Rescue Plan Act allocation plan includes \$12.5 million for one-time incentive payments for direct care staff and \$20 million for nursing home infrastructure, these funds are nowhere near enough to resolve the staffing crisis and modernize the industry.<sup>4</sup> Throughout the pandemic, Connecticut nursing home workers have bravely served as the primary line of protection for these vulnerable residents. But the state has not demonstrated a sufficient recognition of this sacrifice nor a genuine commitment to improving conditions in nursing homes.



In order to prevent similar recurrences of the COVID-19 tragedy in nursing homes and to protect workers and residents moving forward, this report recommends that Connecticut implement the following policies:

- Enact S.B. 1030, a proposed bill that would take a significant step toward applying the lessons learned from the pandemic.
- Provide adequate funding for nursing homes, without which genuine reform is impossible.
- Increase worker pay and benefits to recruit and retain essential frontline staff.
- Establish medical loss ratios for nursing homes—guaranteeing that a proportion of funding is used toward direct care of residents—to make sure government funding goes where it is most needed.
- Increase minimum staffing ratios, to make sure residents receive appropriate care.
- Guarantee staff access to sick time.
- Enhance the Department of Public Health oversight of nursing homes.



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**Background**

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## A. Nursing Home Workers

The Connecticut nursing home industry relies on the tireless, essential labor of professional health care personnel and support workers who provide direct care to nursing home residents. Nurses (including registered nurses, or RNs, and licensed practical nurses, or LPNs) ensure that residents' healthcare needs are met. RNs supervise staff and establish care plans for residents, while LPNs take responsibility for bedside care, monitor residents' health, and administer treatments and medications under RN and doctor supervision. Nursing home assistants (including certified nursing assistants, or CNAs; dietary aides; and housekeeping staff) provide day-to-day care. CNAs feed, bathe, dress, and help transport residents, as well as engage with residents in recreational activities. CNAs also take vital signs and assist nurses and doctors with certain medical procedures. Dietary aides maintain food inventories and prepare and deliver food. Housekeeping staff clean facilities and residents' rooms and launder bedsheets and clothes. Beyond the tasks included in their job descriptions, nursing home workers provide residents with crucial emotional support and daily human interaction.

Yet nursing home workers are not compensated with living wages for the essential care they provide. In Connecticut, the median hourly wage for CNAs in nursing homes is \$16.19, with entry level wages at \$13.71.<sup>5</sup> Median annual earnings in 2020 were \$33,693.<sup>6</sup> Nationally, more than a third of nursing home assistants rely on some form of public assistance, such as Medicaid, food and nutrition assistance programs, or cash assistance.<sup>7</sup> While LPNs and RNs earn higher wages in Connecticut (median wages are \$28.04 per hour and \$38.12, respectively), RNs in nursing homes are still paid 11% less nationally than the healthcare industry average.<sup>8</sup>

In a workforce that is largely made up of women and people of color, there are also gender- and race-based pay gaps for nursing home assistants: white women make on average 4% less per hour than white men and men of color, and women of color make on average 6% less per hour than white men and men of color.<sup>9</sup> Nationally, 57% of nursing home assistants are people of color,<sup>10</sup> and 92% are women.<sup>11</sup> More than half of nursing home assistants have not attended college.<sup>12</sup>

In addition to being severely underpaid, nursing home workers frequently face difficult working conditions caused by chronic understaffing. Although there is growing demand for direct care workers in the United States, the nursing home industry experiences high job turnover rates.<sup>13</sup> The median annual turnover rate for CNAs—who provide 80% to 90% of direct care—is 51.5%, while the annual turn-

**\$16.19**

Median hourly wage for  
CNAs in Connecticut  
nursing homes

**57%**

Percentage of nursing  
home assistants in the U.S.  
who are people of color

**51.5%**

Median annual turnover  
rate for CNAs in the U.S.



over rates for LPNs and RNs are 36.4% and 50%, respectively.<sup>14</sup>

Before the pandemic, CNAs and LPNs in Connecticut nursing homes had lower staffing hours per resident per day than the national average.<sup>15</sup> The Centers for Medicare and Medicaid Services give more than half of Connecticut nursing homes a three-star rating or lower (out of five stars) on staffing.<sup>16</sup> Both nursing home workers and residents suffer when facilities are understaffed because staffing levels correspond directly to quality of care.<sup>17</sup> As this report finds, there is a strong association between staffing shortages and COVID-19 incidences and deaths in nursing homes.<sup>18</sup> However, the staffing shortages experienced during the pandemic are not new. Instead, the pandemic has only exacerbated the existing staffing challenges in the industry.

## B. Connecticut’s Nursing Home Industry

There are currently 198 licensed nursing home facilities operating in Connecticut.<sup>19</sup> These facilities are home to 18,402 people, mostly elderly.<sup>20</sup> Nursing home residents are mostly white, women, and single.<sup>21</sup> Of these residents, 39% are 85 years and older, 45% are between 65 and 84 years old, and the remainder are under 65 years old.<sup>22</sup>

The overwhelming majority of nursing homes (83%) are for-profit, and the remaining 17% are non-profits.<sup>23</sup> More than half are part of a corporate chain.<sup>24</sup> Workers are unionized in 40% of nursing home facilities (as a percentage of total licensed beds). SEIU District 1199NE represents workers in nearly all unionized nursing home facilities, with 38% of total licensed beds. Although nursing homes are privately operated, the state has a primary role in determining the conditions inside facilities because it funds and regulates the industry.

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**198**

Number of licensed nursing home facilities in Connecticut

.....

**18,402**

Number of residents in Connecticut nursing home facilities

.....

## C. State Funding and Oversight of Nursing Homes

The vast majority of funding to nursing homes is controlled by the state. Only 8% of nursing home residents pay for their care out-of-pocket; 73% of residents are covered by Medicaid, and 15% are covered by Medicare.<sup>25</sup> Medicaid is a cooperative federal-state program administered by the state: Connecticut allocates federal funds and determines reimbursement rates for each facility.<sup>26</sup> To set rates,



the Connecticut Department of Social Services establishes the costs of direct care (including nursing home worker salaries), indirect care (including expenses for supplies such as food and laundry), administration (including administrative and maintenance staff salaries), property, and capital improvements.<sup>27</sup> Because state dollars provide most of the funding to nursing homes, the state, to a significant extent, determines wage levels in nursing homes.<sup>28</sup> But not all state funding goes to direct care for residents. In 2018, only half of Medicaid and Medicare reimbursements were used to pay for direct care for residents in Connecticut.<sup>29</sup>

The state is also responsible for ensuring nursing home compliance with health and safety laws. Nursing homes must be licensed by the state to provide resident care and must comply with state and federal regulations to qualify for Medicaid and Medicare funding.<sup>30</sup> The Connecticut Department of Public Health is responsible for inspecting facilities to ensure compliance and has authority to fine facilities for violations.<sup>31</sup>

# 2

## Timeline

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**COVID-19 in Nursing  
Homes**

- Mar. 8, 2020:** Lamont announced first CT resident COVID-19 case.<sup>32</sup>
- Mar. 13, 2020:** Executive Order No. 7A authorized Commissioner of Public Health to order restrictions on entering nursing homes.<sup>33</sup>
- Mar. 18, 2020:** First case of COVID-19 in a Connecticut nursing home was confirmed at Evergreen Health Center in Stafford Springs.<sup>34</sup>
- Apr. 3, 2020:** Lamont announced 10% increase in Medicaid funding to nursing homes.<sup>35</sup>
- Apr. 11, 2020:** Executive Order No. 7Y established dedicated recovery facilities to prevent COVID-19-positive patients from re-entering nursing homes.<sup>36</sup>
- Apr. 15, 2020:** Executive Order No. 7AA authorized approval of temporary additional nursing home beds for COVID-19 recovery.<sup>37</sup>
- Apr. 19, 2020:** Lamont announced additional 5% increase in Medicaid funding for nursing homes and physical, onsite visits by DPH staff in nursing homes to conduct infection control surveys.<sup>38</sup>
- Apr. 20, 2020:** Media reported that state health officials undercounted COVID-19 deaths in nursing homes; correction raised total COVID-19-related deaths of nursing home workers 76% higher than originally reported.<sup>39</sup>
- Apr. 22, 2020:** After reports of nursing home workers wearing garbage bags as a result of inadequate access to PPE, state officials issued statements that workers chose to wear garbage bags instead of PPE.<sup>40</sup>
- Apr. 23, 2020:** Executive Order No. 7EE required mandatory daily status reports for nursing homes.<sup>41</sup>
- May 14, 2020:** As of mid-May 2020, 1,627 nursing home residents in Connecticut—or roughly one in 13—had died from COVID-19 or related complications.<sup>42</sup> Combined deaths from nursing homes and assisted care facilities totaled 70% of COVID-19-related fatalities reported statewide.<sup>43</sup>
- May 22, 2020:** By late-May 2020, at least ten nursing homes had COVID-19 infection rates in the triple digits: Arden House in Hamden (170), Litchfield Woods in Torrington (121), Riverside Health and Rehabilitation Center in East Hartford (121), St. Joseph's enter in Trumbull (121), and Silver Springs Care in Meriden (120) had the highest infection rates. Riverside Health had the most COVID-19 related deaths, at 57.<sup>44</sup>
- May 27, 2020:** Executive Order No. 7SS established a Temporary Nursing Aide program through the end of the public health emergency.<sup>45</sup>

- **Jun. 1, 2020:** Executive Order No. 7UU ordered mandatory weekly testing for nursing home staff.<sup>46</sup>
- **Aug. 31, 2020:** In July and August of 2020, 2,000 nursing home employees were laid off or had their hours cut by 50% or more.<sup>47</sup>
- **Aug. 20–Sept. 16, 2020:** CT DPH made several announcements about COVID-19 outbreak at Three Rivers Nursing Home in Norwich and its non-compliance with regulations.<sup>48</sup> The DPH ultimately ordered that all residents be transferred out of Three Rivers and into other facilities.
- **Oct. 1, 2020:** Harrington Court Nursing Home in Colchester, a Genesis facility, reported an outbreak impacting over half of its population (46 positive cases among 76 residents), in addition to 11 staff cases.<sup>49</sup>
- **Oct. 30, 2020:** Lamont announced launch of Nursing Home and Assisted Living Oversight Working Group together with legislators.<sup>50</sup>
- **Nov. 19, 2020:** In Fall 2020, infection rates in nursing homes started to swell again. Mid-November saw 60% of Connecticut nursing homes recording at least one COVID-19 infection amongst residents or staff.<sup>51</sup>
- **Dec. 13, 2020:** Lamont announced first order of COVID-19 vaccines and long-term care facilities vaccination plan.<sup>52</sup>
- **Dec. 30, 2020:** Lamont announced additional \$31.2 million in funding for nursing homes.<sup>53</sup>
- **Jan. 13, 2021:** The Nursing Home and Assisted Living Oversight Work Group released its recommendations.<sup>54</sup>
- **Feb. 10, 2021:** Lamont released his biennial budget proposal, which eliminates inflationary increases in nursing home funding and cuts a total of \$11 million in FY 22 and \$24.3 million in FY 23.
- **Mar. 30, 2021:** As of March 30, 2021, the state reported 14,013 total confirmed cases of COVID-19 amongst nursing home residents in Connecticut, and 3,867 total COVID-19 related deaths.<sup>55</sup>
- **Apr. 13, 2021:** Lamont administration approved a temporary 5% Medicaid rate increase to nursing homes from April 1, 2021 to June 30, 2021.
- **Apr. 26, 2021:** Lamont released his American Rescue Plan Act allocation proposal, which includes \$12.5 million in incentive payments for direct care staff and \$20 million for nursing home infrastructure, but no funding for permanent Medicaid rate increases or wage or benefit improvements for staff.

# 3

## In Their Own Words

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Nursing Home  
Workers Experience  
the Pandemic

As the COVID-19 pandemic unfolded, nursing home workers persevered through extreme, unprecedented risks. At least 20 nursing home workers in the state have died from the virus. Despite inadequate support from both their employers and the state, they have continued to provide residents with quality care and love. This section spotlights the experience of nursing home workers in their own words.

## A. Relationships Between Workers & Residents

Nursing home workers prioritize the needs and wellbeing of residents and often provide care to residents as if they were caring for their own family—knowing that, in many instances, they are caring for someone whose family can no longer do so.

“We’re taking care of somebody’s mother, somebody’s grandmother, somebody’s dad. They’re depending on us to be the caregiver, to make sure their mom eats, their dad eats, to make sure they’re taken care of,” Tori,<sup>56</sup> a CNA, said.

Providing care to the same residents over time creates a familial bond, according to Tanya Beckford, a CNA. “Most of our residents, we’ve had for 10 years—they’re our family.”

For residents without living relatives, or whose relatives are unable to visit, nursing home workers are an especially important source of emotional support, listening to resident concerns, comforting them, and providing for their needs. “No matter how sick some of these patients are, they know when we’re giving them tender, loving care from one human being to another,” said Tori.

Because of this unique relationship, workers often view themselves as vital advocates for the residents in their care. Workers report that if a nursing home is not providing something residents need, they will speak up on the residents’ behalf, persisting until the residents receive what they need.

Direct care staff, in particular, spend significant amounts of time with individual residents, and often feel that their contributions are overlooked and undervalued. “People are always talking about nurses, doctors, nurses, doctors . . . [t]hey’re not the ones who give direct care. They depend on the CNAs, who are there 24/7, doing double shifts, . . . working so hard,” said Tori.

***We’re taking care  
of somebody’s  
mother, somebody’s  
grandmother,  
somebody’s dad.***

***We stuck around and stayed and [said] we are going to do everything that we have to do to protect our residents.***

As reports of COVID-19 infections spread, despite the enormous risk to themselves, nursing home workers showed up for work to care for their residents. “This is not just a job,” Tanya explained. “[W]e are so close and tight-knit with these residents—they are our family members. We stuck around and stayed and [said] we are going to do everything that we have to do to protect our residents.”

## **B. Arrival of COVID-19**

During the COVID-19 pandemic, nursing home workers risked their own lives to care for residents with whom they shared these close bonds. Many workers contracted COVID-19 and witnessed their colleagues and residents fall ill, even as nursing home operators were frequently unresponsive to the immense daily health and safety risks taken by workers.

According to Janet Sewell, a CNA, it was frustrating to see residents and co-workers become ill and die. “I felt like they were hiding [the fact that the facility had positive COVID-19 cases] from us and the next thing you know they’ll come out and say yes, we have COVID-19 [in the building],” she said.

Janet contracted COVID-19 after her mother, a nursing home resident, passed away from COVID-19. Janet spent a month in the hospital “fighting for [her] life,” and was subsequently out of work for five months.

Similarly, Hillary,<sup>57</sup> a CNA, and Tanya both reflected that administrators did not provide them with information on who was sick.

Other workers also reported getting sick themselves with COVID-19. A CNA who contracted COVID-19 in December 2020 had to stop work for fourteen days and quarantine away from their<sup>58</sup> family. As a result of their illness, they could not leave their basement, even when their father passed away. “I couldn’t bury [my father] because I ended up with COVID-19,” they said through tears. “COVID-19 was the worst thing that ever happened to us at that workplace.”

Oftentimes, staff who were sick with COVID-19 still felt compelled to come to work due to serious staffing shortages and pressure from administrators, as well as emotional bonds with residents.

***I couldn’t bury [my father] because I ended up with COVID-19. COVID-19 was the worst thing that ever happened to us at that workplace.***



When Tanya started developing COVID-19 symptoms, including a headache, fever, and hallucinations, she asked her employer for permission to go home sick on three consecutive days. Each day, she was denied. She ultimately made the decision to risk her job and call in sick.

"At that time, they were threatening you: 'if you go home, or if you call out, you could be risking your job because it [is] considered abandonment.' Because they didn't have enough staff. So even if you were sick you were ordered to come to work because they didn't have enough people working the unit," she noted. "But I just had to make the decision to call out of work."

Janet also noted that because the nursing home was understaffed, she was "working, working, working," even when she felt unwell. She later tested positive for COVID-19.

According to Hillary, sick employees were allowed only seven days off due to staff shortages, and she suspected that many employees were still sick when they came back to work.

Glenn Andrus, a dietary aide, reported that COVID-19 "spread like wildfire" in the nursing home; he contracted it three weeks after the first cases appeared. When he eventually came back to work, the resident population had dwindled significantly.

Some workers continue to suffer from lingering COVID-19 symptoms.

"Before, I couldn't [even] walk to my kitchen and make toast," remarked one LPN who had tested positive for COVID-19. "Now I'm able to do more things, but I get winded a lot."

Months after contracting COVID-19, Tanya still suffers every day from its consequences, including lung damage, post-traumatic stress disorder, and anxiety and panic attacks. "I didn't eat for eight straight days. [I had an] unbreakable fever for 15 days. [I lost] so much weight and muscle mass, [and I was] unable to walk. I had to learn how to walk again, literally had to crawl first. I was in that state for three months before I was able to stand up on my own," she said. Tanya was out of work for seven months.

Workers who contracted COVID-19 were fearful about returning to work even after they had recovered. "I didn't even want to come back, that's how scared I was," Janet shared, noting that the absence of coherent infection control protocols made her nervous about possibly contracting or spreading COVID-19 again. Nevertheless, Janet said she returned because of her sense of responsibility

***I didn't even want to come back, that's how scared I was.***



and duty to care for her residents.

Similarly, Glenn went back to work after recovering because he felt “a sense of guilt,” and Tanya did so because she could not abandon the residents whom she saw as part of her family.

## C. Lack of PPE

At the outset of the pandemic, nursing home workers also lacked sufficient access to PPE, which is critical to reducing the spread of COVID-19 and protecting both workers and residents.

***We were so scared to catch COVID-19, we would put on plastic bags.***

Tanya reported that in the beginning of the pandemic, the workers in her nursing home had one mask and one gown that they had to wear for three to five days at a time. The gowns were so thin that they would rip if someone even brushed by.

“That’s why, at that time [when] we were so scared to catch COVID-19, we would put on plastic bags,” Tanya said. There were also not enough gloves, so workers had to use hand sanitizer to

clean and reuse disposable gloves meant for single use.

Tori and Jocelyn,<sup>59</sup> an LPN, reported similar hazardous conditions. Tori noted that staff at her facility, at various points, lacked access to fresh masks, and often wore the same dirty masks “over and over,” spraying the masks with peroxide, a powerful bleaching agent that “messed up a lot of [the workers’] faces.”

Jocelyn added that workers caring for residents with COVID-19 were, at one point near the beginning of the pandemic, forced to share the same gown. “Every worker in that one eight-hour shift—everybody that went in the room . . . with the positive patient [had to] use [the same gown], which I thought was horrendous.”

Janet added that at the outset of the pandemic, workers at her facility were given cloth PPE items that were then washed and came back ripped.

Employers also discouraged or outright prevented workers from using their personal supply of PPE. “When it first happened, people had their own masks, and they would wear them, and the supervisor would tell them to take the mask off . . . a CNA went home because she refused to take her mask off,” said another LPN.

***When it first happened, people had their own masks, and they would wear them, and the supervisor would tell them to take the mask off.***

Nicole Ahima, a CNA, noted that near the beginning of the pandemic, she was ordered to remove her disposable mask because it was ineffective and was “sending the wrong message.” The director of the nurses even threatened to write people up if they refused to remove their masks.

Alma,<sup>60</sup> an LPN, confirmed these reflections, recounting that housekeepers were not permitted to wear masks at the outset of the pandemic, and one worker who did was later forced to take it off. The employee ended up getting COVID-19 and was hospitalized for 21 days.

Eventually, when PPE distribution slowly began, workers were deprioritized. Chloe,<sup>61</sup> a CNA, said essential workers did not receive available face shields or the N95 masks donated by the Bloomfield Fire Department. According to Chloe, “It was the recreation, receptionist, or transportation guy [who received the PPE]. We saw this and were like, ‘Where did you get that?’ We who are taking care of the actual residents didn’t get that.”

## D. Lack of Testing

Nursing home workers had woefully inadequate access to COVID-19 testing, particularly at the start of the pandemic.

Especially in the beginning of the pandemic, nursing home administrators were secretive with how they handled testing. Administrators frequently did not provide workers with information about potential positive cases among the residents. Even when residents were tested, administrators withheld information about positive tests in a facility. Early on in the pandemic, many facilities completely failed to test workers.

“There was a time [early in the pandemic] when some of the residents had COVID-19, but we didn’t know it. We saw the nurses testing them, but they didn’t tell us they were testing them because they felt they had COVID-19,” Janet said. She added that she ended up getting COVID-19 herself because she was unaware that some of her residents were sick.

“We need to know [about positive tests] from the very beginning. Everything seemed like it was a secret,” Janet said.

According to Janet, administrators told workers in the beginning of the pandemic that testing was not necessary because COVID-19 was not in the building. Multiple workers reported that administrators in their facility denied that COVID-19 was present in their facilities in order to maintain an appearance of normalcy, recklessly putting resident health at risk.

“We, as the workers, were working with the residents. If [administrators] felt like something was going on with the residents, let us know, let us be aware of it

***Everything seemed like it was a secret.***

too," Janet said. "They [didn't] do that."

Janet's mother, who was a resident at Janet's facility, died from COVID-19.

"I told [administrators] I felt my mother had symptoms, since I had seen the same symptoms in some of the residents who had COVID-19. They said she didn't have it," Janet said.

Hillary also noted, "That was my question: were they going to let us know [who tested positive]? Especially someone like myself who has heart issues, if I'm going to be around [people who test positive for COVID-19], I'm going to want to know. And there was really no comment with that. I truly believe that we had active cases in the building, but they weren't telling us."

According to Tanya, "a resident died and workers did not even know he had contracted COVID-19 until they were informed by his family."

Administrators were very "hush, hush about this whole situation," said Tanya. "They were not telling us who had [contracted COVID-19], and they were definitely not running any tests on us." Tanya had to risk her job to go get herself tested after experiencing severe symptoms. She tested positive.

Later, when tests became more available to workers, results were often delayed and unreliable.

"Test results are not coming back in a timely manner; it is taking five to seven days for test results," said Regina,<sup>62</sup> an LPN. "[Our] test results are coming back negative, [but] we're sending residents out, and they're testing positive at the hospital."

## E. Lack of Transparency

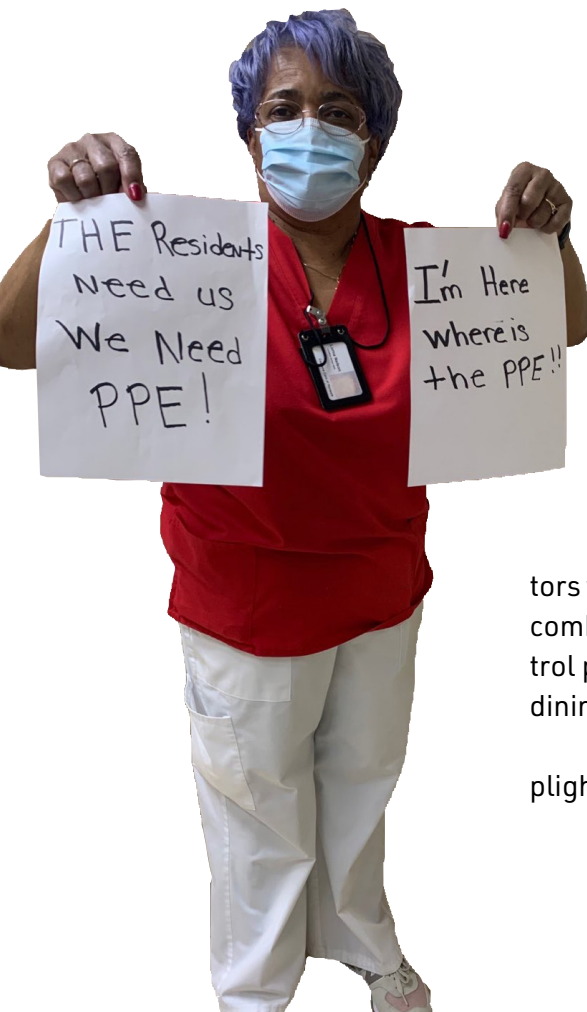
Many workers struggled with the lack of support from administrators and the overall lack of transparency in communication between the administration and workers.

"It was going [in] one ear and out the other when somebody [would] throw a question to them or something," Janet said. "It was just so terrible."

Another worker reported that talking to administrators felt like "talking to a brick."

Moreover, workers testified that administrators were unsupportive when workers tried to take initiative in combating the virus. Many workers had to take infection control precautions that administrators objected to, from closing dining rooms to simply wearing proper PPE.

Administrators were too often unsympathetic to the plight of the frontline workers.



One CNA felt that administrators abandoned workers on the third floor—which the worker called the “COVID-19 floor”—and “didn’t give a damn what happened to us.” The worker added that employees were not even offered water, and had to bring their own supplies.

***They make everything look good when the state is coming.***

Similarly, Tori said that administrators often refused to set foot on the floors that direct care providers worked on.

To make matters worse, workers reported that some administrators hid the reality of the employees’ appalling working conditions from the government during inspections.

“They make everything look good when the state is coming. When the state is downstairs, they make an announcement . . . then they run around and fill up all the [PPE] bins. That’s not protecting residents or staff,” Jocelyn said, adding that she felt administrators were just “sweep[ing] everything under the rug.”

According to Clara,<sup>63</sup> an LPN, administrators would ask workers to change what they were wearing if state officials were visiting.

“It’s like they’re playing games with our lives. If they’re not going to get in trouble and get caught, then they will go ahead and hide things from us. But when they know that the state’s coming in, or the National Guard is going in, that’s when they jump into action and decide to go ahead and act like they were doing something protective and helpful to the staff, when they were never really doing it,” said Claudia,<sup>64</sup> an LPN. “So it was all pretty much a front to the outside world.”

***It’s like they’re playing games with our lives. If they’re not going to get in trouble and get caught, then they will go ahead and hide things from us.***

## F. Lack of Staff

The short-staffing situation at nursing homes, already poor even before the pandemic, was further aggravated when COVID-19 hit.

One LPN noted that even before the pandemic, the staff was so overworked that they often considered quitting. A CNA could have up to 14 residents to care for in the morning, followed by four people to feed during mealtime, because the facility only had four CNAs on a floor of 60 residents, she said.

“In all honesty, the only time staffing wasn’t horrible was during the pandemic . . . only because half our people died. That’s the only reason staffing was halfway okay. Half of the residents passed away due to COVID-19,” the nurse said. “But now that they shut wings down and combined units, staffing is back to being horrible.”

Tanya noted that nursing home worker jobs became increasingly difficult during COVID-19 when many employees could no longer come to work because they were sick. Workers could find themselves responsible for 15 residents at a time, “which is really difficult because you have to get them up, get them dressed, toilet them, exercise them, entertain them, feed them lunch, toilet them again after lunch, put them down again, and then you have your paperwork,” she said.

***We are struggling. We are working so understaffed. We are so burnt out. We are so tired. And we just want the best for the residents.***

The problem, Tanya said, also stems from the fact that workers care deeply about the residents and want to do a good job caring for them.

“We are struggling. We are working so understaffed. We are so burnt out. We are so tired. And we just want the best for the residents. The residents are being abused. If we can’t care for them, if we can’t spend time with them . . . that’s abuse,” Tanya said.

Alma underscored the critical importance of hiring more staff.

“We definitely need staffing . . . I hope and pray [COVID-19] doesn’t come back because we won’t have the staff to run the facility,” she said.

As a direct result of understaffing, workers experienced extraordinarily long working hours and were often unable even to take proper breaks to rest during their shifts.

“I never really took any breaks because we were short on staff,” Janet said. “I just worked straight through [the breaks]. I didn’t have the appetite to sit down and eat anywhere anyways . . . I was constantly wiping down things . . . because we were afraid [of getting COVID-19].”

Glenn also said that he often chose not to take breaks, as he needed every minute he could get to finish his work at “breakneck speed” because of the understaffing.

Both Tanya and another worker said they had to work 16-hour shifts. In Tanya’s case, she had to work 16-hour days for two weeks straight, for a total of 80 hours a week. The other worker said that her breaks consisted of just five minutes to “grab something quick.”

***I never really took any breaks because we were short on staff.***



## G. Low Pay

The pay that nursing home workers receive does not reflect the grueling and indispensable work that they perform on a daily basis.

Some workers received state-funded hazard pay during the pandemic, but inconsistently, and eligibility for it was contingent on compliance with arbitrary rules determined by each facility.

***Two dollars an hour is nothing compared to our lives and the current situation that we're dealing with and working with.***

At Janet's nursing home, workers received between \$50 and \$80 per shift if they were on time for work, and \$100 for coming in on a day off. If they called out a shift or showed up late to work, they did not receive their bonus, "even if you were one minute late," according to Janet.

Rates of hazard pay varied widely between facilities and also by job title within a given facility. Regina's facility offered a \$2 bonus per hour to workers who arrived on time and did not give up shifts. "Two dollars an hour is *nothing* compared to our lives

and the current situation that we're dealing with and working with," Regina said. Certain categories of staff, including housekeeping, frequently received significantly lower hazard pay.

One LPN reported that administrators made stipulations as to how workers could receive their hazard pay. Workers could lose all their hazard pay for one week if they were late to work for one day, and they could lose their hazard pay for all shifts if they called out one shift—even if they picked up additional shifts to compensate.

"We were working in this pandemic, working hard. There are only two people I worked with that didn't test positive, but they could have had it too. Everybody else I worked with had COVID-19," the same LPN said. "A CNA was pregnant, she worked through COVID-19—she was late or called out, and they took all of her bonuses away. It is not fair that for the money the government gave to front line workers in nursing homes, the corporate people were able to dictate how it was handed out."

Alma, who is no longer receiving hazard pay herself, corroborated the other workers' testimony, noting that missing one day of work was sufficient cause for administrators to withhold the worker's entire hazard pay.

Tessa,<sup>65</sup> a CNA, criticized administrators and argued that workers deserve more hazard pay because they are "putting [their] lives on the line." She added that workers "never signed up to say [they]'re willing to die at all costs."

***We never signed up to say we're willing to die at all costs.***

***It was too little for us, for the work that we do during COVID-19—it wasn't fair the money that they paid us, it wasn't right at all.***

only one job when administrators reduced hours. Danielle explained that she has two jobs for job security reasons, as she is worried about being laid off. "We just don't know where we're going to end up, so I have to keep another job, just for security. I have children, I have a household to run," she said.

According to Stella,<sup>67</sup> a CNA, administrators blamed resident deaths on staff who worked two jobs. Stella, who works 32 hours per week at one facility and 24 hours per week at the other, was criticized by her supervisor for spreading COVID-19. She explained that she is "forced" to work two jobs in order to take care of her family.

"If you give us a living wage, we wouldn't have to go to another facility," Stella said.

***If you give us a living wage, we wouldn't have to go to another facility.***



## H. Essential Workers, Left Behind

As the pandemic raged, the state publicly lauded health-care workers as heroes, while at the same time ignoring their everyday workplace struggles.

Despite public claims of unity, workers frequently experienced the pandemic alone and isolated, in unsupportive workplaces, with little to no help from the state.

"Everybody says we're in it together," Jocelyn explained, "But we're not. If you're not in a patient's room that has COVID-19 and they're coughing on you, we're not in it together."

Workers sought workplace improvements, not public recognition, so as to provide adequate care to residents and minimize infections during a frighten-



***They use the word, they say “heroes” . . . but we were abandoned.***

we were abandoned. We were in a place by ourselves trying to figure it all out on our own,” she said. Instead, Tanya said she just wants real substantive changes in working conditions for staff and living conditions for residents.

Workers want administrators to “[l]earn to listen to us about what we need to do the work,” she added.

Pandemic losses—of their residents and coworkers, in addition to exposed family and friends—took an irreparable emotional toll on nursing home workers.

Tessa said that many people experienced loss during the pandemic, including coworkers and residents. “You can see the fear in their faces.”

Chloe said she watched helplessly as residents died in their rooms, alone. “So many people just keep passing, passing, passing.”

ing and rapidly unfolding public health crisis.

Tanya testified that she feels gaslighted when people label her a hero but then treat her as worthless. “They use the word, they say ‘heroes’ . . . but



# 4

## State Oversight

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State Data

Confirms Workers'

Experiences & Agency

Shortcomings

As nursing home workers labored through unforgiving conditions made worse by a terrifying public health crisis, the Lamont administration—particularly the leadership of the DPH, the agency that licenses and oversees nursing homes—did too little to help. State oversight was particularly important during the COVID-19 crisis. The prohibition on nursing homes visitations, which barred even family members, meant that no one but workers and DPH surveyors could see what was happening inside these facilities.

As the pandemic wore on, the state announced that it would increase inspections of facilities to ensure compliance with CDC guidance for nursing homes. Publicly available reports from these inspections support worker claims about the dangerous conditions in which they labored. Yet the sanctions imposed for violations of state regulations were minimal.

## A. DPH Oversight Process

The state's DPH is responsible for ensuring nursing home compliance with both state and federal requirements. Nursing homes are licensed by the state to provide skilled nursing care, skilled rehabilitative services, and other health services.<sup>68</sup> To participate in Medicare or Medicaid programs, nursing homes must also comply with federal quality and performance standards.<sup>69</sup> The DPH inspects facilities on a regular basis, on average once a year, and also conducts complaint-driven inspections and more frequent inspections for nursing homes with particularly poor compliance.<sup>70</sup> In May 2020, in response to the pandemic, the DPH introduced specific COVID-19 compliance inspections.<sup>71</sup>

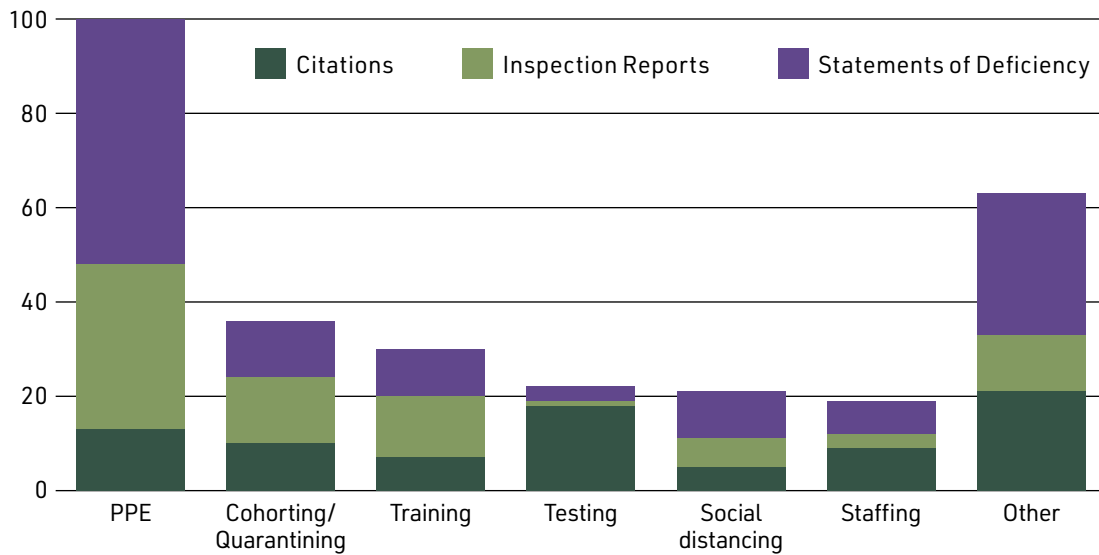
When the DPH finds violations in a facility, the nursing home must create a plan of correction and is given the opportunity to come into compliance with regulations.<sup>72</sup> In addition, the DPH has the authority to fine nursing homes, depending on the severity of a violation. For violations that “present an immediate danger of death or serious harm to any patient in the nursing home facility,” the DPH may fine up to \$20,000.<sup>73</sup> For violations that “present a potential for death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility,” the DPH may fine up to \$10,000.<sup>74</sup>

## B. DPH Inspection Findings Confirm Nursing Home Workers' Testimony

Publicly available information from DPH Inspection Reports and Citations validates the concerns that workers identified in their interviews. DPH inspectors frequently identified issues inside facilities related to PPE, social distancing, cohorting resi-

dents who tested positive or quarantining residents exposed to positive cases, understaffing, insufficient training, inadequate testing, and other practices that violated infection control guidelines. The DPH made findings that numerous facilities “failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection.”<sup>75</sup>

**Fig. 1: COVID-19 Infection Control Issues Identified by DPH**



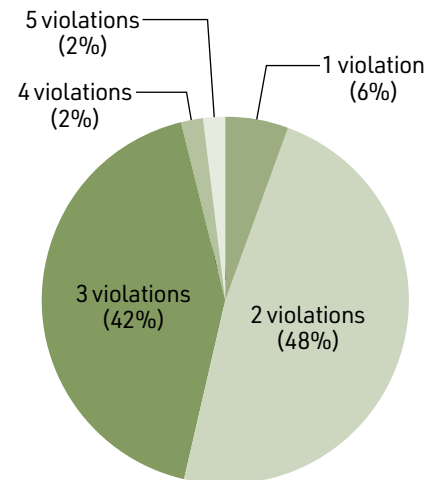
Source: CT DPH-CCNH eLicense Database Records, March 2020–February 2021

All of these violations combine to create an environment that is unsafe for both workers and residents. Notably, 94% of publicly available Inspection Reports (also known as Violation Letters) identified violations of *multiple* regulations. This suggests that violations of state regulations designed to protect nursing home workers and residents were not isolated incidents.

DPH inspection accounts of what went on inside nursing homes during the pandemic mirrors specific practices described by workers in their interviews.

One report indicated that “although enough supplies of PPE were available,” the director of nursing at Apple Rehab Cocomo required staff to continue wearing single-use protective Tyvek suits for “numerous days,”

**Fig. 2: Over 90% of Inspection Reports Cited Multiple Violations**



Source: CT DPH-CCNH eLicense Database Records, March 2020–February 2021

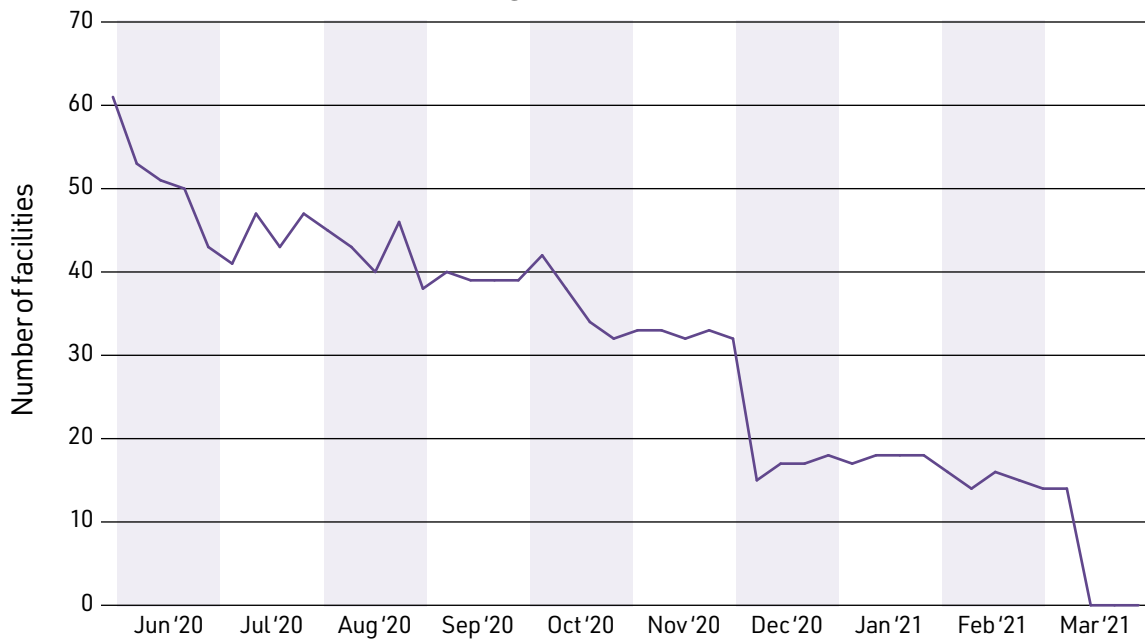
contrary to CDC recommendations that suits be discarded at the end of each shift.<sup>76</sup> At New London Sub-Acute and Nursing, staff were required to share gowns when entering COVID-19 positive and presumptive rooms: the inspection found that “[t]hese gowns are reused by all staff during a 24-hour time frame and are kept on a hook inside the [COVID-19] positive/suspected resident room.”<sup>77</sup> Workers at RegalCare at Greenwich were similarly put at risk when their facility “failed to ensure personal protective equipment (PPE) was utilized or stored per standard of care.”<sup>78</sup> An inspector’s interview with a nursing aide “identified s/he was provided one gown every seven days for resident care.”<sup>79</sup>

DPH leadership claimed that nursing home workers wore makeshift PPE, like garbage bags, by choice. Barbara Cass, Chief of the Healthcare Quality and Safety Branch at the DPH, insisted that doing so was at “the preference of the employee” and “has not been supported by the employer.”<sup>80</sup> However, the agency’s inspection documents confirm worker accounts that they had no choice because their facilities did not supply them with adequate PPE. In fact, DPH inspection documents reveal that some facilities had a formal practice of using makeshift PPE. An administrator at the Lutheran Home of Southbury, Inc. informed DPH inspectors that the facility was using plastic rain ponchos as PPE “in a conservation strategy due to the limited supply.”<sup>81</sup> A nurse aide at the facility indicated the poncho must be “re-used the next time he/she reports to work unless the poncho gets torn or ripped.”<sup>82</sup> Numerous other DPH surveys found that staff were instructed to reuse gowns, contrary to CDC recommendations.<sup>83</sup> An LPN at Regency House Nursing and Rehabilitation Center shared with DPH inspectors that “she was concerned with her safety reusing the same gown all shift.”<sup>84</sup>

DPH inspections revealed similar issues with other forms of PPE. Even when some facilities had access to N95 masks, they did not take the steps required to ensure workers benefited from their protection. An inspection of RegalCare at Greenwich revealed that “[t]he facility failed to ensure fit testing was conducted for staff wearing N95 masks according to standards of care.”<sup>85</sup> Other facilities did not make N95 masks available to workers at all.<sup>86</sup> DPH inspections found that some workers struggled to access any form of mask. DPH interviews with workers from RegalCare at Southport record a dietary aide indicating “that it is very difficult to get a surgical face mask and face shield from the facility” and a laundry aide sharing that “she brought the surgical mask from in home because it is difficult to get PPE from the facility.” Another laundry aide confirmed that “it is difficult to get a face mask from the facility despite asking [for] one. [She] indicated she was not provided with a face mask this morning.”<sup>87</sup> Though laundry aides’ work required them to come into contact with contaminated linens, washable PPE, and other potential vectors for disease transmission, the inspection found that the facility did not include laundry staff at that facility in their training on PPE usage.<sup>88</sup>

Data that Connecticut nursing homes self-reported to the Centers for Medicare & Medicaid Services (CMS) beginning in late May 2020<sup>89</sup> confirmed that nursing homes experienced PPE shortages throughout the duration of the pandemic, not only at its start.

**Fig. 3: Facilities Reported PPE Shortages Throughout the Pandemic**



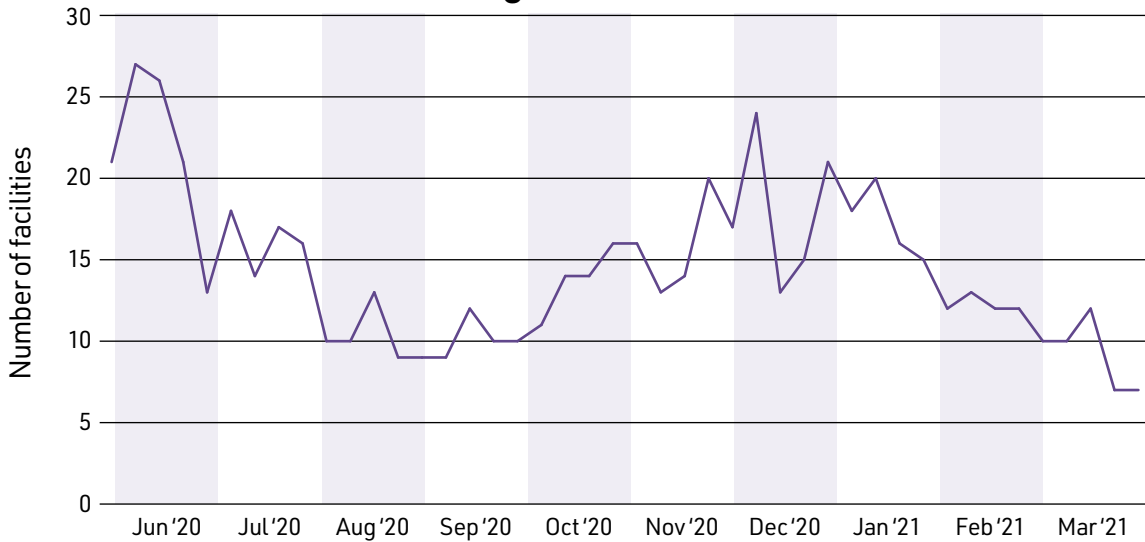
Source: Centers for Medicare & Medicaid Services data, self-reported by facilities. Workers believe PPE shortages have been underreported throughout the pandemic.

DPH findings also validated worker concerns about understaffing. At Orchard Grove Specialty Care Center, a DPH Citation found that just two nursing aides were responsible for providing care to the 50 residents on the dementia unit.<sup>90</sup> The facility's own guidelines required six nurse aides on duty that shift, for a staffing ratio of one aide for every eight residents—not one for every 25.<sup>91</sup> On another day at that same facility, a registered nurse was responsible for administering medications and providing care to more than 50 residents on the dementia unit at once because of nursing absences that could not be covered.<sup>92</sup> DPH documents found that, while the director of nursing services recognized it was unsafe for only one nurse to be on duty on the dementia unit, the registered nurse "informed the administrator . . . that the staffing levels were not safe and was told there was no one to help."<sup>93</sup>

Data self-reported by Connecticut nursing homes to CMS beginning in May 2020 underscore the continuing challenges of staffing shortages. Worker testimony suggests that this data is likely underinclusive. Even still, the data shows that staffing shortages persisted past the first peak of the pandemic in March-May 2020, continuing on throughout the rest of the year. In June 2020, 27 nursing

homes experienced staffing shortages of at least one type of worker (clinical staff, nursing staff, or aides).

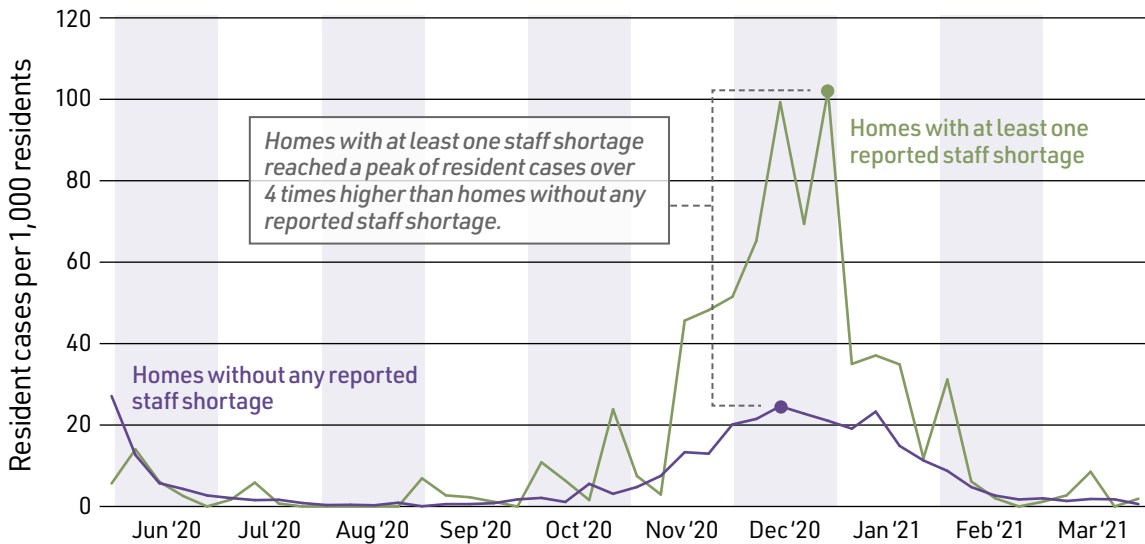
**Fig. 4: Facilities Reported Staff Shortages Throughout the Pandemic**



Source: Centers for Medicare & Medicaid Services data, self-reported by facilities. Workers believe staff shortages have been underreported throughout the pandemic.

Comparing the incidence of COVID-19 cases among residents of facilities with and without staffing shortages suggests a significant association between staff shortages and risk of COVID-19 infection among residents.

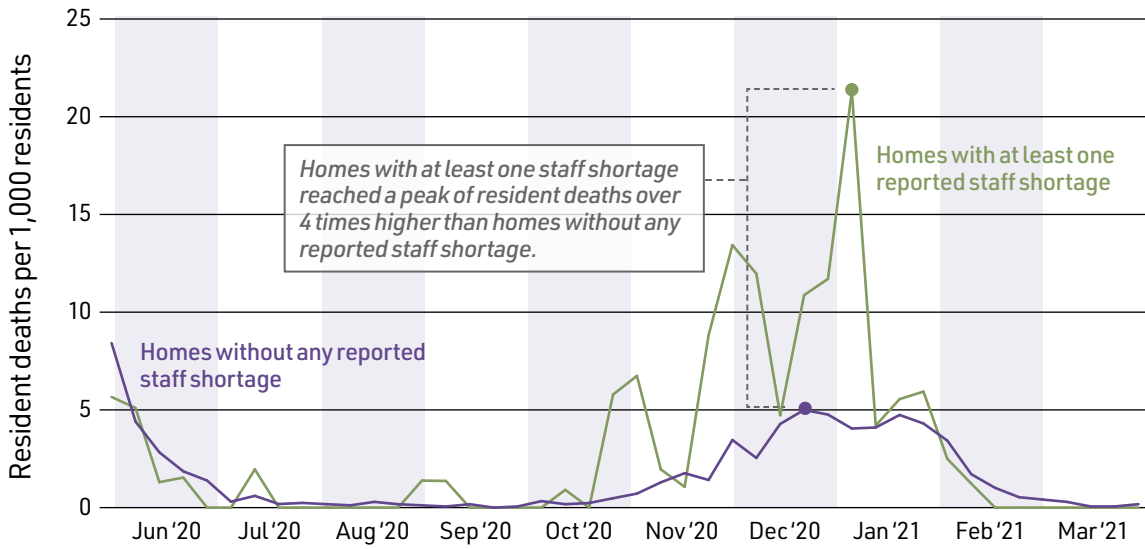
**Fig. 5: Facilities with Staff Shortages Had More COVID-19 Cases**



Source: Centers for Medicare & Medicaid Services data, self-reported by facilities.

A similar association exists between staffing shortages and resident deaths from COVID-19.

**Fig. 6: Facilities with Staff Shortages Had More COVID-19 Deaths**



Source: Centers for Medicare & Medicaid Services data, self-reported by facilities.

According to publicly available DPH Citations, deficiencies in testing practices were the most common reason for the issuance of a fine (19/34 Citations). A Citation issued to Apple Rehab West Haven on September 17, 2020 indicated that 100% of the 117 total facility staff were not tested weekly for two consecutive weeks, as recommended by the CDC, CMS, and the DPH.<sup>94</sup> Hamden Rehabilitation & Health Care Center also failed to meet testing requirements, but according to a DPH Citation, the administrator reported that they “could not remove the staff who did not get tested from the schedule because they would not have enough staff to care for the residents.”<sup>95</sup> Given the importance of frequent, reliable testing to preventing infection amongst residents and workers alike, this widespread issue highlighted by workers and the DPH alike is particularly concerning.

### C. DPH oversight was insufficient to capture and address COVID-19 issues

The state’s management of the pandemic in nursing homes under the Lamont administration was inadequate to protect residents and staff. State oversight mechanisms were insufficient to meaningfully change conditions within nursing homes. The fines imposed by the DPH are low enough that they can be considered a cost of doing business, leaving nursing home workers and residents vulnerable to practices that expose them to elevated risks of infection. Stronger protections were necessary during this period of crisis.



As described in worker testimony above, some nursing home administrators changed their practices when they were under direct DPH observation. Workers consistently reported that PPE bins were filled and staff numbers were increased on days that DPH inspectors visited their facilities. These practices helped administrators hide PPE shortages, understaffing, and other dangerous conditions from DPH inspectors.

Even in facilities in which the DPH did identify issues, state oversight mechanisms were too weak to meaningfully change behavior. A study of all Citations the DPH has made available on the DPH-CCNH (Chronic & Convalescent Nursing Homes) eLicense database shows Citations were issued for only 34 incidents related to COVID-19 between March 2020 and February 2021. All were class B violations: conditions that the Commissioner of Public Health determines present a potential for death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility.<sup>96</sup> For each such violation, a civil penalty of not more than ten thousand dollars may be imposed.<sup>97</sup> Yet the average fine for COVID-19-related incidents was \$2,885, significantly below the statutory limit. The average fine for class B violations unrelated to COVID-19 during the same period was \$6,023.

According to publicly available DPH data, the total amount the DPH fines issued across all nursing homes for COVID-19-related incidents from March 2020 to February 2021 was \$98,081.

These fines are insufficient to disincentivize bad behavior. Their low amounts demonstrate a systemic failure to recognize the urgency and severity of the COVID-19 pandemic within nursing homes. For instance, when the DPH found that a facility failed to have multiple staff members complete weekly testing for two straight weeks following the positive test of a resident at the facility, the facility was fined just \$720.<sup>98</sup>

The eLicense database indicates that only 26 nursing home facilities in Connecticut have been cited and fined by the DPH for COVID-19-related violations. As the DPH has failed to keep its eLicense database updated, this is likely not the complete set of Citations or fines issued.<sup>99</sup> But for more than 170 facilities—in which a total of 3,398 residents and staff died of COVID-19<sup>100</sup>—there are no publicly available records of Citations or fines related to COVID-19 whatsoever. Furthermore, even if some of these facilities were cited or fined, the fact that none were posted publicly means that family members of residents were denied vital information about potentially dangerous life-threatening conditions in these facilities.

***Citations were issued for only 34 incidents related to COVID-19 between March 2020 and February 2021. For each such violation, a civil penalty of not more than \$10,000 dollars may be imposed. Yet the average fine for COVID-19-related incidents was \$2,885.***

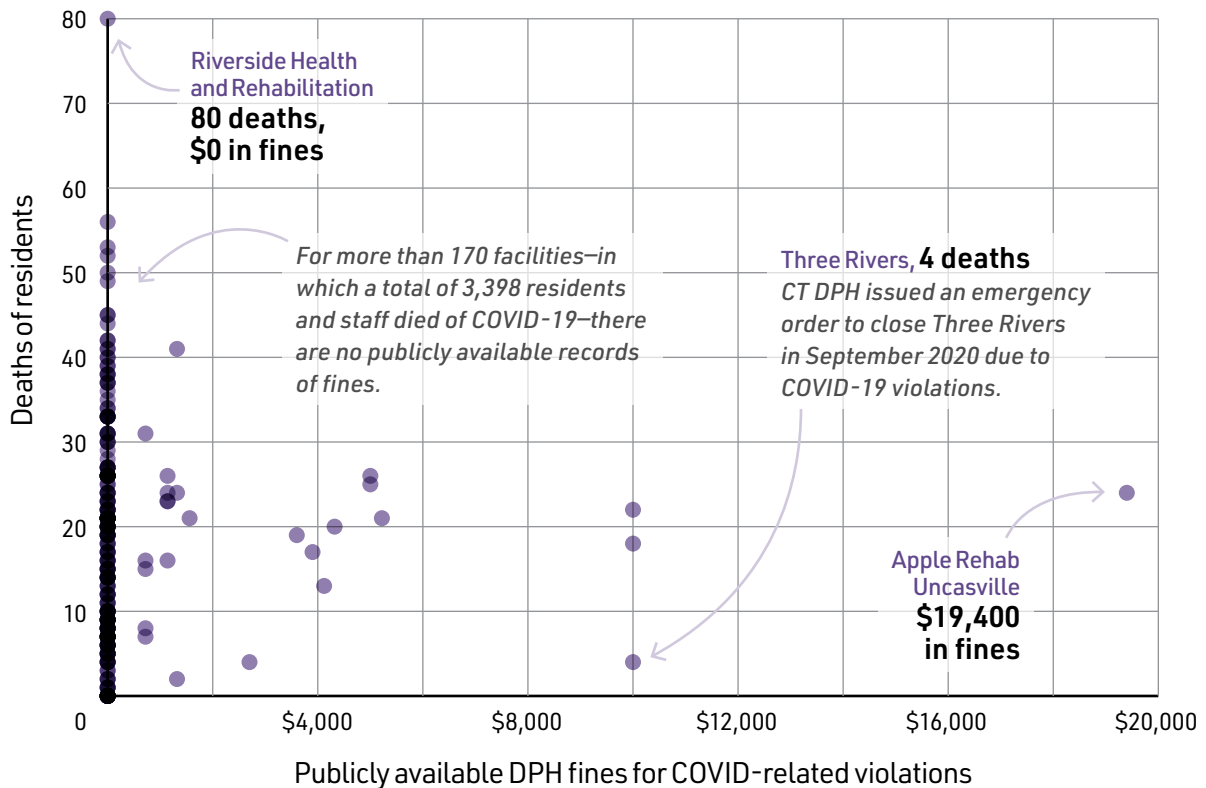
Facility	Publicly Available DPH Fines for COVID-Related Violations	Resident Deaths as of March 30, 2021
Sheriden Woods Health Care Center	\$1,320	41
Valerie Manor	\$720	31
Hamden Rehabilitation & Health Care Center	\$1,140	26
Whispering Pines Rehabilitation and Nursing Center	\$5,000	26
Bethel Health Care Center	\$5,000	25
Apple Rehab Uncasville	\$19,400	24
Autumn Lake Healthcare at Cromwell	\$1,320	24
Cassena Care at Stamford	\$1,140	24
Avery Nursing Home/Noble Building	\$1,140	23
Western Rehabilitation Care Center	\$1,140	23
Windsor Health and Rehabilitation Center, LLC	\$10,000	22
Salmon Brook Rehab and Nursing	\$4,320	21
Regalcare at Greenwich	\$5,220	21
St. Camillus Center	\$1,560	21
Regalcare at Southport	\$3,600	19
Waterbury Gardens Nursing and Rehab	\$10,001	18
Regalcare at Waterbury	\$3,900	17
Regalcare at West Haven	\$720	16
Westport Rehabilitation Complex	\$1,140	16
The Villa at Stamford	\$720	15
Apple Rehab West Haven	\$4,120	13
Essex Meadows Health Center	\$720	8
Wolcott Hall Nursing Center Inc.	\$720	7
Grove Manor Nursing Home Inc.	\$2,700	4
Three Rivers*	\$10,000	4
Pomperaug Woods Health Center	\$1,320	2

\*CT DPH issued an emergency order to close Three Rivers in September 2020 due to COVID-19 violations.

The ten facilities with the highest number of resident deaths from COVID-19 were not fined at all, according to publicly available data.

Facility	Publicly Available DPH Fines for COVID-Related Violations	Resident Deaths as of March 30, 2021
Riverside Health and Rehabilitation	\$0	80
Shady Knoll Health Center	\$0	56
Arden House	\$0	53
Abbott Terrace Health Center	\$0	52
Masonicare Health Center-LTC	\$0	50
Ludlowe Center for Health and Rehabilitation	\$0	49
St. Joseph's Center	\$0	45
Kimberly Hall North	\$0	45
St. Mary Home	\$0	44
Saint John Paul II Center	\$0	42

**Fig. 7: No Correlation Between DPH Fines and Resident Deaths at Facilities**



Source: CT DPH-CCNH eLicense Database Records, March 2020-February 2021 (fines) and CT COVID-19 Response, Nursing Homes Data, April 1, 2021 (deaths)

***The ten facilities with the highest number of resident deaths from COVID-19 were not fined at all, according to publicly available data.***

which DPH leadership structured and executed their oversight process prevented inspectors from capturing the full breadth of issues within nursing homes during the pandemic. Overall, the approach taken by DPH leadership to the pandemic resulted in minimal penalties of little consequence to nursing homes. As a result, resident and worker lives were placed at greater risk than necessary.

DPH inspectors found overwhelming evidence that nursing homes were not providing workers with sufficient protection. Rather than address these urgent threats to worker and resident safety, DPH assessed almost no fines. Instead, DPH leadership blamed workers, claiming that they “chose” to wear trash bags instead of PPE.<sup>101</sup> Moreover, as the prevalence of “No health deficiencies found” conclusions suggests, the manner in

# 5

## **Policy Recommendations**

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This report recommends that the following policies be adopted to address long-standing issues in the nursing home industry and to prevent the disastrous fallout of the COVID-19 pandemic from repeating in the future.

## A. Enact S.B. 1030<sup>102</sup> and the reforms it proposes.

The Connecticut General Assembly should enact legislation to implement the recommendations of the Nursing Home and Assisted Living Oversight Working Group regarding long-term care facilities, as well as make other revisions to long-term care facility statutes. S.B. 1030 mandates, among other things, that the DPH increase minimum staffing level requirements for nursing homes, that each long-term care facility employ a full-time infection prevention and control specialist, that the DPH maintain adequate stockpiles of PPE for nursing home use, and that nursing homes engage in regular testing during infectious disease outbreaks.

## B. Provide adequate funding for nursing homes.

Connecticut should appropriate more funding to nursing homes to ensure that facilities have the money to implement necessary protocols protecting the health and safety of their residents and staff. Improvements in the quality of care in nursing homes will only be possible with increased ongoing funding—temporary aid is not enough. For example, providing a living wage and benefits to nursing home workers would require an additional \$200 million a year, and it would cost nursing homes at least an additional other \$200 million more annually to meet the staffing level requirements in S.B. 1030. Approximately half of these additional Medicaid costs would be reimbursed by the federal government. If Connecticut is to have sustainable nursing homes that provide quality care to all residents, it must make the necessary investments.

## C. Increase worker pay and benefits.

Connecticut faced a severe shortage of nursing home workers even before the COVID-19 pandemic, which left nursing homes unprepared to handle the devastating impacts of the virus.<sup>103</sup> In order to recruit and retain quality staff, the state

must ensure increased wages and improved benefits for nursing home workers, including a \$20/hour minimum wage for CNAs, \$30/hour minimum wage for LPNs, quality affordable health insurance, and the ability to retire with dignity. Essential care workers should not have to work two or three jobs be able to care for themselves and their families.<sup>104</sup> Raising standards will recognize the innumerable sacrifices nursing home staff made during the pandemic and will also help to ensure that every resident receives the individual care and attention they deserve.

## D. Establish medical loss ratios for nursing homes.

Connecticut must establish medical loss ratios for nursing homes. In 2018, only 51% of allowable costs went toward direct resident care.<sup>105</sup> To protect public dollars intended to fund care for elderly residents, the state should follow the example of New Jersey and pass a law requiring nursing homes to set aside 90 percent of a facility's revenue to be spent on the direct care of residents.<sup>106</sup> Medical loss ratios dictate the percentage of premium dollars that a health plan spends on medical claims and quality improvements versus administrative costs, thus capping profits and administrative expenses. Absent medical loss ratios, nursing home operators may improperly use state nursing home rate payments (including Medicaid and Medicare dollars) to cover administrative or non-direct care costs.

## E. Increase minimum staffing ratios.

Inadequate staffing in Connecticut nursing homes preceded COVID-19, but the pandemic has only made the problem worse. When a nursing home is short-staffed, quality of care suffers as workers are forced to spend less time with each resident. Facilities with higher staffing levels saw fewer infections and deaths during COVID-19.<sup>107</sup> Increasing minimum staffing ratios for Connecticut nursing homes will ensure that every resident receives sufficient, quality care; prevent future disease outbreaks within facilities; and make sure nursing homes are better prepared to withstand emergencies going forward. The state should raise minimum staffing levels from the current requirement of 1.9 hours of nursing staff care per resident per day to the federal Centers for Medicare & Medicaid Services-recommended 4.1 hours of care per resident per day, including 2.81 hours of CNA care, 0.75 hours of LPN care, and 0.54 hours of RN care.<sup>108</sup> In addition, the state should create minimum staffing standards of 1 social worker for every 75 residents and 1 recreational aide for every 25 residents.

## F. Guarantee staff access to sick time.

Connecticut should ensure that nursing home workers have access to sick time—and that they can use that sick time when they are sick. While the workers interviewed for this report were covered by state paid sick leave law and federal COVID-19 sick leave, workers who fell ill during the COVID-19 pandemic were subject to facility-specific restrictions on their use of sick time, which several workers say were intended to address staffing shortages. The state should require nursing homes to guarantee their staff access to both the paid sick leave they have earned and additional sick time, should circumstances so require. Requiring workers to come or return to work while sick endangers the health of both residents and staff.

## G. Enhance Department of Public Health oversight of nursing homes.

The DPH should increase its oversight and monitoring of nursing facilities by conducting more regular, unannounced, onsite inspections and levying heavier fines and other penalties for regulation violations. The state should allocate more funding to the DPH to boost staffing levels at the agency in order to perform this enhanced oversight. The DPH typically conducts annual inspections of each nursing home, but will inspect poorly performing facilities more frequently. The normal inspection schedule frequency should be increased from annually to quarterly. The state should also mandate that fines levied for infractions be drawn from nursing homes' management fees and profits, and ensure that these fees are not deducted from funding that the facilities allocate for PPE, staffing, and other direct care needs.



# 6

## Methodology

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This report is informed by both qualitative and quantitative primary research.

## A. Interviews with workers

A significant portion of the qualitative data for this report was gathered through semi-structured, in-depth interviews with nursing home workers. Each worker was interviewed individually, and all interviews were recorded for accuracy. An interview guide was used to facilitate comprehensive and systematic information collection on primary topics while allowing workers to express opinions on additional topics as they deemed important. The interview guide covered hours and breaks, COVID-19 testing, wages and hazard pay, PPE, communications with administrators, and COVID-19 exposure or infection. The interview subjects spanned a range of roles and nursing homes. Some interview subjects shared their experiences on the condition that they not be named in the report.

The research team conducted seven interviews directly and incorporated findings from group interviews conducted with a total of 20 nursing home workers by SEIU staff and Mathematica researchers during the development of Mathematica's report: *A Study of the COVID-19 Outbreak and Response in Connecticut Long-Term Care Facilities*.<sup>109</sup>

## B. Analysis of DPH documents

This study is also informed by a systemic review of DPH nursing home oversight documents. The DPH's regular practice is to upload the Inspection Reports (also known as Violations), Statements of Deficiencies, and Citations it issues to nursing homes to the eLicense website.<sup>110</sup> In March 2021, our research team downloaded all of the publicly available documents in each of these three categories from March 2020 to February 2021. Within this date range, the database identified 607 Statements of Deficiencies, 80 Inspection Reports, and 63 Citations.

The research team reviewed and coded this set of 750 documents, filtering out duplicate and mischaracterized documents. For each document, the research team identified the facility, the date of the relevant inspection, the date the oversight document was finalized, and collected a list of all regulations the document found violations of. The research team coded the documents to indicate the presence of issues relating to any of the following categories: PPE, social distancing, cohorting/quarantining, staffing, training, testing, other COVID-19 related issue(s), and non-COVID-19 issue(s). For documents that found violations, the research team entered a short qualitative description of the incident using the information contained within the document. For Citations specifically, the research team also recorded the class

of the Citation and the amount of the fine, as applicable. This dataset of documents formed the basis for all quantitative conclusions on DPH oversight in the report, including the distribution of types of issues identified and all conclusions about aggregate or average fines. The qualitative data collected through this research process guided the reports' use of specific oversight documents as examples.

In reviewing these documents, the research team identified a number of discrepancies that suggest the dataset of DPH documents on the eLicense website is missing entries. For example, the DPH issues Citations only after issuing an Inspection Report, but the dataset did not turn up Inspection Reports that corresponded with all Citation documents. Further, Medicare independently uploads Statements of Deficiencies to their Care Compare tool<sup>111</sup> and includes Statements of Deficiencies arising out of Infection Control Inspections conducted by the DPH that do not appear in the eLicense dataset. These missing documents are likely attributable to a lag in uploads and/or the DPH's inability to keep the database up to date during the pandemic. This limitation of the dataset impacts the certainty of this report's findings. For example, if Citations were missing from the dataset, those fines were not included in this report's conclusions about aggregate or average fines. However, the 750 documents that are available and were included in this study provide an important snapshot of DPH oversight. The missing documents speak to the need for better document management at DPH, so as to improve agency transparency and accountability.

## C. Analysis of COVID-19 Nursing Home Dataset

The data collected from worker interviews and Connecticut DPH inspection processes are supplemented by data reported by nursing homes to the CDC's National Healthcare Safety Network system COVID-19 Long Term Care Facility Module. Specifically, the research team focused on areas of data that overlapped with issues identified in DPH documents and worker testimony and were for the most part consistently reported by nursing homes: case incidence and deaths within nursing homes, staffing shortages, and shortages in one-week supplies of various forms of PPE. The research team calculated descriptive statistics from this dataset and plotted them over time.

The first deadline for nursing homes to report this data was 11:59 p.m. on Sunday, May 17, 2020, and facilities could opt to report cumulative data retrospectively back to January 1, 2020, for the week ending May 24, 2020. CMS cautions against using data reported for the week ending May 24, 2020 to perform trend analysis and longitudinal analyses, and therefore the analysis of this data in this report begins with data collected the week of May 31, 2020. Further information on the collection and limitations of this dataset is available on the CMS website.<sup>112</sup>

# 7

## Acknowledgments

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The report was reviewed and edited by staff of SEIU District 1199NE. We are grateful for the members of SEIU District 1199NE who shared their experiences working in Connecticut's nursing homes with us.

# Endnotes

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- 57** "Hillary" is a pseudonym.
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- 60** "Alma" is a pseudonym.
- 61** "Chloe" is a pseudonym.
- 62** "Regina" is a pseudonym.
- 63** "Clara" is a pseudonym.
- 64** "Claudia" is a pseudonym.
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- 89** Centers for Medicare & Medicaid Services data set, a collection of data reported by nursing homes on a weekly basis to the CDC's National Healthcare Safety Network (NHSN) system COVID-19 Long Term Care Facility Module. This reporting began in May 2020. As such, the data set excludes the early pandemic months of March and April 2020.
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## Figures

**Fig. 1** *DPH-CCNH Nursing Home Inspection Documents*, CT.gov (Mar. 1, 2020-Feb. 28, 2021), <https://elicense.ct.gov/Lookup/OnlineReportExecute.aspx?queryIdnt=25331>.

**Fig. 2** *DPH-CCNH Nursing Home Inspection Documents*, CT.gov (Mar. 1, 2020-Feb. 28, 2021), <https://elicense.ct.gov/Lookup/OnlineReportExecute.aspx?queryIdnt=25331>.

**Fig. 3** *CMS COVID-19 Nursing Home Dataset*, CT DATA (May 24, 2020-Mar. 28, 2021), <https://data.ct.gov/Health-and-Human-Services/CMS-COVID-19-Nursing-Home-Dataset/w8wc-65i5>.

**Fig. 4** *CMS COVID-19 Nursing Home Dataset*, CT DATA (May 24, 2020-Mar. 28, 2021), <https://data.ct.gov/Health-and-Human-Services/CMS-COVID-19-Nursing-Home-Dataset/w8wc-65i5>.

**Fig. 5** *CMS COVID-19 Nursing Home Dataset*, CT DATA (May 24, 2020-Mar. 28, 2021), <https://data.ct.gov/Health-and-Human-Services/CMS-COVID-19-Nursing-Home-Dataset/w8wc-65i5>.

**Fig. 6** *CMS COVID-19 Nursing Home Dataset*, CT DATA (May 24, 2020-Mar. 28, 2021), <https://data.ct.gov/Health-and-Human-Services/CMS-COVID-19-Nursing-Home-Dataset/w8wc-65i5>.

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