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**Ch. 932 Work Group Public Comment**

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Sam Kukich <skukich2002@yahoo.com>  
To: Rebekah Allen <rebekah.allen@vdh.virginia.gov>  
Cc: carole.pratt@vdh.virginia.gov

Wed, Sep 23, 2020 at 2:17 PM

Dr. Pratt and Ms. Allen: I asked Jennifer Tedmon to give me some feedback as to why she is no longer a CNA, these are her words, I hope you find them helpful in making recommendations.

My typical day as a CNA and why CNA's are quitting or leaving the field, from Jennifer Tedmon.

4 call lights going off.

3 people need toileted that use mechanical lifts and therefore two people.

1 of those 3 just went 15 mins ago but the nurse said take them again.

You have 9 full sets of vitals to get within 2 hours and breakfast is in the middle of that. On your way to meet your partner, the nurse stops you and says to change someone's shirt cuz its got food on it. This person is very demented and slaps and fights you. You finish getting the shirt on and the alarm goes off cuz a wanderer is trying to leave. You redirect them and head into the room to put someone on the toilet.

Still have 4 lights and now the administration is paging you to tell you that you have lights going. As you are wiping the residents poopy butt, the dining room pages you to help ambulate people out, but you can't answer cuz...poop. You and your partner finally wrap it up and you tell them you'll meet them in a second and to get the second resident hooked up. You stop and answer a light...resident can't reach the remote.

On your way to the dining room to quick grab someone, you see a resident on the floor. You now have to stop, call a nurse, get a full set of orthostatics (vitals laying, sitting, standing) and are now required to get a full set of vitals every 15 minutes on top of your other vitals. Your partner pages that they're ready so you run to help them transfer the second person, stop and answer a call light for a resident who forgot what they wanted, and as you enter the room, you get paged from the dining room again. People still need out and the kitchen wants their hall cart back. You rush to transfer resident two, run the hall cart downstairs, grab someone from the dining room while getting yelled at for taking too long and the nurse stops you on the way out.

Vitals are due and you're getting ripped for not having them. Your partner pages, number two is done. Still two lights going off and have to take a difficult resident to get a blood draw in twenty minutes. You apologize to the nurse for "slacking" and run to get two off the toilet. After, you run into the third resident room, get them on the toilet, grab 3 sets of vitals, get them off the toilet, answer two more call lights, get another 2 vitals, and as you are grabbing the resident for her blood draw, the first one you toileted hits her light. She needs to go again and swears you never took her. You assure her you'll be in as soon as you can cuz ur partner is giving a shower and you have to take someone to the lab. She calls you names and starts swearing at you as you run out to get resident to their now late lab draw. Nurse bugs you about vitals that aren't done.

You finally get back on the floor, run to make sure everyone is changed for lunch, and then get informed you never answered one of the original call lights and they had a full catheter bag that leaked and is now filing a complaint. You get lectured about neglect and told there is no excuse. Ready to cry, you look up and see 5 call lights and its lunch time. No time to cry. Take a deep breath and keep going.

I am not currently working as a CNA anymore... I was covering another noc shift after pulling a 17 hour shift earlier in the week and on our last rounds the patient tried to roll out of bed and I caught him, but blew 3 discs in my back. It took a year of physical therapy to even be cleared to work again and I had to go through a whole work comp case with a lawyer etc.

I can never be a CNA again 😞 I am working as an optical technician now. Still in scrubs and so happy to be working again, but I have chronic pain and there is a lot I can't do anymore

There is also the issue of everything that happens or goes wrong is automatically the CNAs fault. Administrators don't listen and see us as expendable. Underpaid, overworked, insufficient medical insurance for the injuries we receive while working... we never get time off, we are chastised heavily for being ill or injured or needing a mental health day, and the way the system works it pits CNAs against each other.

So much toxicity between CNAs is a direct result of pressure, favoritism, and no way to hold people accountable. I worked with a couple CNAs that treated residents horribly, violated state regulations, etc. and if you didn't get on their "don't tell on us" team you were singled out and tormented until you quit. Luckily, we had a new DON that was former military and I'm former military so we teamed up and got rid of them, but as soon as I was hurt and my DON resigned (the administrator thinks of CNAs like the bottom of her shoe and our DON was always in trouble for defending us) the troublemakers were hired right back despite being fired from two other facilities for abuse.

9/24/2020

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The system is so broken The nurses were pressured not to send residents to the ER because it lost the facility money. Once they were taken to the ER, the hospital got paid by insurance instead of the facility. So nurses were discouraged from sending patients I just feel like administration needs a higher accountability at the very least Exactly! And I was raised by a British family (grandparents migrated) and I was raised to revere the elderly. Not just respect but literally hold them on the highest pedestal. They are so precious, fragile, wise, and I was raised to protect and honor them. I see so little of that in facilities

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1 message

Sam Kukich <skukich2002@yahoo.com>  
To: Rebekah Allen <rebekah.allen@vdh.virginia.gov>  
Cc: carole.pratt@vdh.virginia.gov

Thu, Sep 24, 2020 at 9:23 AM

Dr Pratt and Ms Allen,

I would like to introduce my Mother In Law, Rose Kukich. She resided in 5 nursing homes and we were confused and angry at the staff as they did not change her, feed her, dress her, they gave her someone else's meds, she lost 65 lbs and fell 55 times. "Baba" was placed in 5 different homes in our search for proper care and she required two hospital stays due to neglect and abuse. She made the headlines on the front page of the Daily Press and Richmond Dispatch. If that picture does not tell the story and make it clear that Nursing Homes are understaffed nothing will.



COURTESY OF KUKICH

Sam Kukich's mother-in-law lost 65 pounds and had more than four dozen falls in less than 18 months at one nursing home.

## Frequent injuries, low staffing persist in area nursing homes

**By Dave Ress**  
Staff writer

Most Hampton Roads nursing homes have fewer nurses and aides and more violations of health standards than the national averages, putting patients at increased risk of injury or untreated illness, a Virginia-Pilot and Daily Press investigation found.

And many of the facilities where Hampton Roads' most vulnerable adults live — often unable to feed

themselves, move around or even speak — exceed national averages for resident injuries from falls and open wounds from lying too long in one position, hundreds of pages of state inspection reports and federal data show.

Residents of Hampton Roads nursing homes are more likely than those elsewhere in the country to lose their ability to move around and to manage daily tasks such as eating, dressing and going to the toilet.

Federal and state regulations say

little specific about staffing. Nursing homes argue Medicaid, which covers most residents' care, doesn't pay enough to cover the cost.

"Residents are drugged to keep them asleep. Residents are being yelled at and sworn at for falling down. Staff have given residents the wrong medications. People push their call buttons and no one answers, and they are left helpless and crying. Theft is rampant. Residents

Records show problems at Hampton Roads facilities exceed national averages

See **NURSING**/Page 8

During this experience we were made aware that abuse and neglect were happening everywhere and that the common cause was understaffing. 1 CNA was required to provide care for 20, 30 or more residents each day during their shift. "Baba" was awakened at 4am for her shower, then put back to bed because that was the only way her CNA could get all 20 residents showered, dressed and ready for breakfast. CNAs don't have the time to respond all the call lights, so residents relieve themselves in their briefs and sometimes have to wait hours to be changed.

"Baba" died last December and thankfully it was before COVID. I spent her last hours with her, cupping her hand in mine over her heart and listening to each labored breath. I had no idea that she would be talking to me even then, but she was.....

You see she was telling me to speak for those who have no voice. I sat with her until 2 am, and then I dozed off when her breathing seemed to become less labored, I thought she was sleeping.

I awoke at 2:15 and she was gone. I pushed the call light and when no one came I went to the nurse's station and found the nurse's badge on her desk, but the light was off, and no one was in sight. I walked the halls calling out to find a CNA, and there was no response. I went back to "Baba's" room and pushed the call button again, nothing, it was a helpless feeling. It took me 45 minutes to find the CNA, it was her first week on the job, she was in shock and did not know what to say to me.

Health care administrators say there is no money to pay the CNAs however \$2.22 Billion is being considered in proposed legislation to protect seniors from abuse and neglect with the Reauthorization of the Elder Justice Act.

Unfortunately all of these monies are meant to address programs and agencies that provide programs and activities **AFTER** the elderly are abused, neglected or dead. Dignity members have provided documentation at every meeting to **substantiate the need for Establishing Ratios**. Profit is being put above human lives, nursing homes have become a front for Private Equity Firms to secure huge profits, politicians continue to protect these firms in return for campaign contributions. Owners will continue to use nursing homes as fronts to feed the Greed machine and CNAs will continue to be used as slave labor and set up for failure while the elderly die. It is criminal that residents have been dying and the Commonwealth of Virginia is unable or unwilling put forth and pass bill to establish ratios to protect our citizens. Health Officials of the Commonwealth are complicit in this failure as they continue to fail in their duty to put forth recommendations that will correct current abuse.

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Sam Kukich <skukich2002@yahoo.com>  
To: Rebekah Allen <rebekah.allen@vdh.virginia.gov>  
Cc: carole.pratt@vdh.virginia.gov

Thu, Sep 24, 2020 at 9:28 AM

Dr Pratt and Ms Allen,

Since our 1<sup>st</sup> workgroup meeting, I have found it challenging to prepare properly for any of our workgroup meetings as no minutes **have ever been provided** for any of the three-hour meetings. Taking Minutes forms an essential part of most meetings.

**Minutes are required in order to:**

- . confirm any decisions made
- . record any agreed actions to be taken
- . record who has been allocated any tasks or responsibilities
- . prompt action from any relevant attendees
- . provide details of the meeting to anyone unable to attend
- . serve as a record of the meeting's procedure and outcome

Members of this workgroup have requested minutes numerous times, as well as contact information for all participants. None have been provided. We had a scheduled meeting on September 15<sup>th</sup>. No phone call, email or notification was provided to workgroup participants concerning cancellation. Dignity Members and others were left to look at the schedule and find the date had been changed the morning before the 1 o'clock meeting.

Many individuals have taken time to provide written comments addressing concerns about Staffing Ratios. Some have provided survey results containing the top concerns for medical staff with regard to their inability to provide care due to understaffing and many are leaving the field. In our last meeting we were provided with Potential Recommendations. **None of the issues provided by written comments were incorporated into these recommendations. With No minutes, and no input from participants, why are we even having these 3 hours meetings? We don't discuss any of the submitted comments?**

Most of the following recommendations would require extensive planning, coordination, funding and 20 years to implement, never mind all the workgroups – a great way to spend more taxpayer money with little or no results. And the Elderly will keep being abused, neglected and dying. The crisis, not 20 years from now.

During these meetings we are continuously reminded that The mandate states:

**1. § 1. That the Department of Health shall convene a work group to review and make recommendations on increasing the availability of the clinical workforce for nursing homes in the Commonwealth.**

If we could just hang on to the current clinical workforce by paying them properly, providing adequate staff and treating them professionally that would be the obvious beginning solution.

- Permit, but not require, local school boards to offer graduation credit for service learning
- Statewide offering of optional graduation credit for service learning
- Implement Fairfax County Public Schools service learning project model statewide (i.e., required for students in grades 6, 8, and 12, with optional diploma seal)

- Require changes to nursing home regulations to permit volunteerism and service project learning in nursing homes, with appropriate supervision
- Expand eligibility of Nurse Loan Repayment Program to include CNAs
- Fund the Nursing Scholarship and Loan Repayment Fund
- Establish education and outreach programs for middle school and high school students to promote career pathways in long term care
- Funding for Advanced Certification for CNAs upon conclusion of pilot program
- Increase wages for CNAs proportional to regional living wage standards
- Increase funding of Medicaid nursing care services
- Establish financial incentives to support working parents in the areas of childcare and transportation costs
- Creating a workforce program similar to Virginia Values Veterans (V3) Program for people with disabilities to increase employment opportunities and promotes economic development by training and certifying organizations in disability workforce best practices
- Require changes to nursing home regulations to permit care by non-credentialed individuals in the MMAC program
- Civilian credentialing/licensing reciprocity so state regulatory bodies recognize civilian equivalency of certain military allied health specialties.
- Civilian educational credits for statewide standardized recognition of military medical education and awarding of equivalent credit hours
- Awareness Campaigns for MMAC Program and the healthcare employment opportunities provided by the program
- State income tax credit for CNAs, LPNs, and RNs working at licensed nursing homes and certified nursing facilities
- State income tax credit for private-sector businesses for hiring individuals from any of ten target groups who have consistently faced significant barriers to employment.
- State income tax credit for disabled access for for-profit nursing homes
- Tax relief program for not-for-profit nursing homes that would allow them to offset part of their payroll tax for expenditures aimed at providing access to employees with disabilities



Allen, Rebekah <rebekah.allen@vdh.virginia.gov>

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**Sam Kukich** <skukich2002@yahoo.com>  
To: Rebekah Allen <rebekah.allen@vdh.virginia.gov>  
Cc: carole.pratt@vdh.virginia.gov

Thu, Sep 24, 2020 at 10:15 AM

Dr. Pratt and Ms Allen,

I have had several people provide information with issues related to CNA crisis. Attached you will find a presentation that addresses many concerns.

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 **CNA NURSING JOBS A NATIONAL CRISIS.pdf**  
177K

LET'S TALK ABOUT  
NURSING HOMES & ASSISTED LIVING CENTERS

LET'S TALK ABOUT  
CNA JOBS IN PARTICULAR

ONE OF THE MOST CRITICAL HEALTHCARE JOBS

# WHAT DO CNA/AIDE JOBS LOOK LIKE?

- PART-TIME JOBS WITH LOW SALARIES \$8-12 PER HOUR
- AN ANNUAL INCOME UNDER \$20K PER YEAR – SOME AT THE POVERTY LEVEL
- NO PAID HEALTH BENEFITS/VACATION
- NO CAREER PATH FOR CNAs – WHO ARE NOT NURSES
- NO LIKELY SALARY INCREASES WHICH AMOUNT TO MUCH
- WORK SCHEDULES CONSTANTLY SHIFTING WORK HOURS – HARD TO JUGGLE CHANGING SCHEDULE & FAMILY
- EXPECTATION OF DEDICATION TO THE JOB
- RESPONSIBILITY TO CARE FOR 20-40 VERY ELDERLY/DISABLED PATIENTS/RESIDENTS AT A TIME
  - ASSIST THEM WITH STANDING, WALKING, TOILET, BATHING, EATING, MEDICINES
  - CLEAN THEIR BOTTOMS MUCH OF THE DAY
  - BRUSH THEIR HAIR, CLEAN THEIR TEETH
  - WHEEL THEM TO MEALS
  - ASSIST WITH MEDICINES
- EXPECTED TO WORK WITH EMERGENCY SITUATIONS ALL DAY LONG
- EXPECTED TO CARE FOR MORE VERY SICK PATIENTS THAN HUMANLY POSSIBLE DUE TO NURSING SHORTAGES
- HIGHER PERSONAL RISK BECAUSE OF OVERLOADS

# WHAT ABOUT CNA JOB TRAINING?

- ❑ MANY FACILITIES DON'T DO MUCH TRAINING – MINIMAL OR SKELETAL
  - NOT IN FIRST AID
  - NOT IN RIGOROUS OPERATIONAL PROCEDURES
  - NOT FOR DIFFERENT “PATIENT” HEALTH SITUATIONS – ILLNESS, DIET, MENTAL, MEDICINES
  - NOT FOR HOW TO HANDLE PATIENTS WITH DIFFERENT CONDITIONS: BROKEN BACK, DEMENTIA, PULMONARY ISSUES AND MUCH MORE
  - NOT IN THE WAY OF A “WARM AND DETAILED” INTRODUCTION TO EACH PATIENT
- ❑ HIGH TURNOVER PRECLUDES RIGOROUS ON-THE-JOB TRAINING
- ❑ SEVERE CNA STAFF SHORTAGES EXIST ALL THE TIME

# WHAT IS THE SCREENING TO HIRE CNAs?

- OFTEN NO CRIMINAL BACKGROUND CHECK
- NEVER ANY PSYCHOLOGICAL TESTS FOR “ABILITY TO CARE” CHARACTERISTICS
- NO TESTS FOR ABILITY TO FOLLOW DIRECTION
- NO TESTS TO INSURE COMMON SENSE AND CRITICAL THINKING
- NO TESTS TO INSURE SOUND ATTITUDES TOWARDS THE ELDERLY & DISABLED

# WHY IS THERE NO GREAT SCREENING?

- OWNER/OPERATORS DON'T CARE – THEIR FOCUS IS ON PROFIT
- FACILITIES ARE A MEANS TO AN END - MINIMIZATION OF CNA/NURSING STAFF IS REQUIRED
- THE CONSTANT CNA JOB TURNOVER (MUCH QUITTING) MEANS THAT FACILITIES  
DON'T HAVE THE TIME TO DO ALL OF THIS – OVER AND OVER.
- THEY ARE LOOKING FOR BODIES TO FILL JOBS – NO MATTER WHO MUCH OF THE TIME

NO TIME TO DO  
BACKGROUND/CRIMINAL/PSYCHOLOGICAL/APTITUDE SCREENING

**JUST HIRE ANYONE PART-TIME... AND PUT THEM TO WORK**

SOMETIMES THEY GET THE WRONG CNA  
ABUSIVE/VINDICTIVE  
NOT FIT FOR THE JOB

**CNA JOB**  
**A GREAT CAREER PATH FOR PEOPLE?**

**NOT AT ALL**

THERE ARE NO BENEFITS TO THE CNA POSITION  
MANAGEMENT DOES NOT REALLY VALUE THEM/THEIR JOB

THERE IS NO WAY TO PUT LIPSTICK ON THIS PIG OF A JOB  
ALL THE TALKING IS NOT GOING TO MAKE MAGIC HAPPEN

WHAT HAS JUST BEEN DESCRIBED  
IS ONE KEY REASON WHY THE SYSTEM OF CARE FAILS  
THE ELDERLY & DISABLED IN THESE FACILITIES

- THE CNAs ARE ILL PREPARED TO DO A GOOD JOB
- EXPECTATIONS ARE TOO HIGH FOR THE JOB
- DAY TO DAY DEMANDS ARE TOO HIGH – TO MANY TO CARE FOR; SO ALL RECEIVE MINIMAL/POOR CARE
- PAY IS TOO LOW FOR THE JOB
- STRESS IS TOO HIGH WITH UNREALISTIC, HIGH PATIENT LOADS

**WE ALL KNOW THIS BUT WE CHOOSE NOT TO FIX THE PROBLEM**

**FACILITY OWNER GREED IS THE OTHER MAJOR REASON FOR CARE FAILURE**

WHY IS CNA WORK SO CRITICAL?

THEY ARE THE FIRST MOST IMPORTANT LINE OF CARE  
FOR THE ELDERLY, DISABLED & SICK

**THESE PEOPLE TOUCH, BATHE, CARE FOR OUR LOVED ONES**  
THEY ARE WITH THEM THE MAJORITY OF THE TIME

THEY MAKE OR BREAK THE CARE SYSTEM

FAMILIES DEPEND ON THEM TO KEEP  
LOVED ONES WELL, HAPPY, SAFE

# THINK ABOUT THIS – FOR ONE MOMENT IN HUMAN TERMS

## **OUR ELDERLY WERE ALL OF US YEARS BACK**

DOCTORS, TEACHERS, NURSES, PROFESSORS, WORKERS, MOTHERS, FATHERS,  
JUGGLING WORK, HOME, WORKING TO MAKE A LIVING  
SOME RESIDENTS ARE YOUNG AND DISABLED WHICH IS TRAGIC

**THEY HAVE THE RIGHT– TO RECEIVE EXCELLENT CARE**

**NOW MANY HAVE VERY SERIOUS HEALTH & OLDER AGE PROBLEMS**

HEART PROBLEMS, BRITTLE BONES, DIABETES, DEMENTIA,  
**COMPLICATED ISSUES. OFTEN COMPLICATED MEDICAL & DRUG ISSUES**

**THIS IS THE CIRCLE OF LIFE**

NOW THINK AGAIN ABOUT CNAs

There is no “baby sitting” job

This is a most serious and demanding medical job

It is a Skilled Healthcare Job

Yet We Fail to Give it the Respect it Deserves

Why?

# IS THERE....

## A LACK OF RESPECT & DISCRIMINATION AGAINST THE PEOPLE WHO FILL THESE CNA JOBS?

IT BEARS SOME THINKING ABOUT THIS

- THEY ARE APT TO BE LESS EDUCATED
- THEY ARE MORE LIKELY TO COME INTO THE JOB WITH LESS SKILLS
- THEY ARE MORE LIKELY TO BE A MINORITY
- THEY ARE LESS LIKELY TO HAVE SOLID WORK EXPERIENCE
- THEY SHOULD BE “OK” WITH MINIMUM WAGES & DOG JOBS. NO?
- WE CAN TAKE ADVANTAGE OF THEM BECAUSE THEY NEED A JOB

# CNA JOBS ARE CRITICAL TO EXCELLENT CARE

**WE MUST ELEVATE THESE JOBS AND GIVE THEM THE RECOGNITION THEY DESERVE  
TO MAKE SURE WE HAVE OUTSTANDING CARE IN OUR NATION**

- CNA JOBS MUST BE RESPECTED
- WE MUST MAKE THEM FULL-TIME JOBS WITH BENEFITS AND GOOD PAY
- INSTITUTE A RIGOROUS SCREENING PROCESS WITH BACKGROUND/CRIMINAL CHECKS
- TAKE THE TIME FOR FORMALIZED TRAINING; GROUNDING IN OPERATIONAL PROCEDURES
- LEGISLATE OPTIMAL STAFF TO RESIDENT RATIOS

# HEART OF THE MATTER....

WE KNOW ALL OF THE REASONS FOR POOR CARE AND FAILURES

From:

Academic Research

Reports from Experts in the Field

Testimony before Congress, State Legislatures

Years Long - Local Inspections Done by Social Services

Claims filed with State/Federal Attorney Generals

Claims filed with State Nursing Licensure Depts

SO WHY NO CHANGE?

# PURE SELF-SERVING INTEREST & GREED

Looming  
In the  
Background  
MEDICARE  
MEDICAID  
FUNDS  
RUNNING OUT

**Greed of Rich  
Facility Operators  
Who Put  
PROFIT ABOVE CARE**

Lack of Financial  
reporting &  
transparency  
Especially for  
Webs of private  
Equity companies

Lax Law  
Enforcement  
Federal/States  
Operators Can  
Get Away with It

Looming in the  
Background  
Elderly/Disabled  
Neglected, Abused  
Dying from  
Poor Care

They have money &  
hire lawyers to  
intimidate families  
with complaints

No central  
System at HHS to track  
Financial penalties;  
many facilities just  
don't pay & No  
consequence.

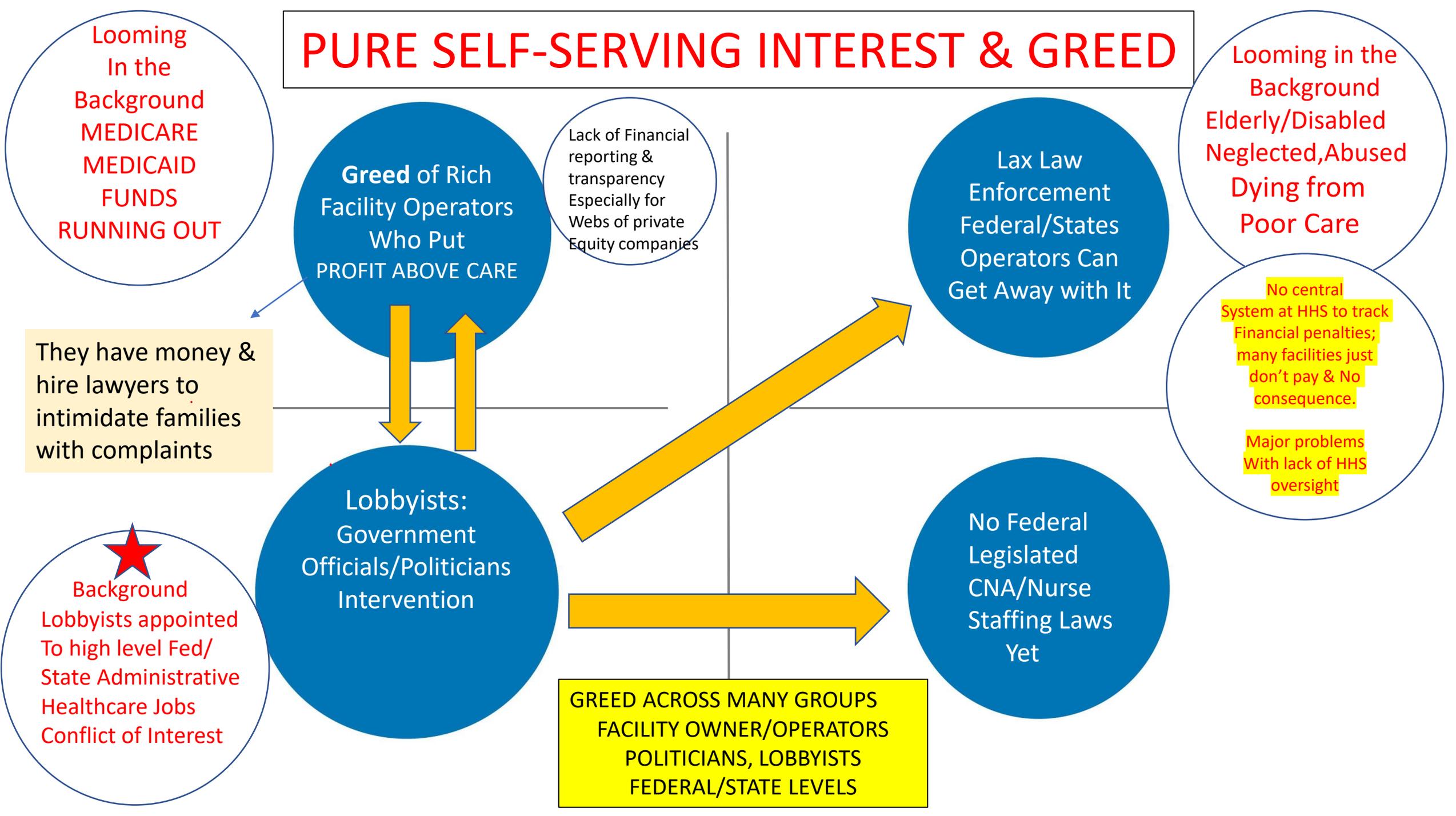
Major problems  
With lack of HHS  
oversight

**Lobbyists:  
Government  
Officials/Politicians  
Intervention**

No Federal  
Legislated  
CNA/Nurse  
Staffing Laws  
Yet

★  
Background  
Lobbyists appointed  
To high level Fed/  
State Administrative  
Healthcare Jobs  
Conflict of Interest

GREED ACROSS MANY GROUPS  
FACILITY OWNER/OPERATORS  
POLITICIANS, LOBBYISTS  
FEDERAL/STATE LEVELS





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Sam Kukich <skukich2002@yahoo.com>  
To: Rebekah Allen <rebekah.allen@vdh.virginia.gov>  
Cc: carole.pratt@vdh.virginia.gov

Thu, Sep 24, 2020 at 10:21 AM

Dr Pratt and Ms Allen,

On April 30, The Trump Administration announced the formation of a task force to develop recommendations to protect nursing home residents from the COVID-19 pandemic. The final report of that task force – the [Coronavirus Commission on Safety and Quality in Nursing Homes](#) .

This Report has valuable information that our workgroup can use as insight. I have attached it for your review.

Justice in Aging Directing Attorney Eric Carlson was one of the Commission’s 25 members. He did **not** endorse the Final Report, because of its imbalance. The Final Report recommends dozens of obligations for the federal government **but does little to set higher standards for nursing homes, or to ensure nursing home accountability. A more balanced report would appropriately allocate responsibility to all parties – including nursing home operators – with a sense of urgency commensurate to the current crisis.**

#### [Eric Carlson’s Dissenting Statement](#)

The Commission’s Final Report makes 27 Principal Recommendations, with over 100 action steps. With limited exceptions, these recommendations and action steps do not address accountability of nursing homes and their operators. The result is an imbalanced report that gives a misleading impression of CMS’s role.

In the longstanding and appropriate model, CMS funds nursing home care (through Medicare and Medicaid payment) and enforces the quality of care standards of the federal Nursing Home Reform Law. **Nursing homes have responsibility for training their own staff**, with occasional assistance from federally funded Quality Improvement Organizations.

**For years, nursing home lobbyists have attempted to degrade this model. They characterize improved quality of care standards as “unfunded mandates,” even though Medicare and Medicaid payment rates are designed to be all-inclusive.** Also, they criticize the supposed “punitive” nature of CMS’s system to penalize violations of the Nursing Home Reform Law, and argue that surveyors should consult with and “assist” facilities **rather than enforce the federal requirements.** These types of arguments, unfortunately, have found their way into some of the Final Report’s recommendations.

#### [Principal Weaknesses in Final Report](#)

**The Final Report’s major weakness is its failure to address enforcement of federal quality of care standards. Deficient facility practices bear significant responsibility for the volume of COVID-19 infections and deaths; accordingly, any comprehensive report must acknowledge and address CMS’s role in enforcing quality of care standards. The Final Report, however, has nothing to say about surveys, complaint investigations, and enforcement remedies.**

**Similarly, the Final Report falls short in proposing improvements to facility infection prevention and control standards.** Under current regulations, facilities must contract with an infection preventionist on a part-time basis; in practice, most facilities simply add “infection preventionist” to the job duties of one of the facility’s nurses.

The Final Report recognizes this problem but is unwilling to require nursing homes to employ an infection preventionist on a more consequential basis. Instead, the Final Report calls on CMS to “[i]dentify and deploy infection-preventionist resources to provide immediate assistance to nursing homes without full-time infection prevention support,” through collaboration with various government agencies and private entities (p. 44). As a practical matter, this recommendation and the proposed collaboration are fanciful – **the federal government cannot and should not be responsible for pursuing ad hoc relationships to staff 15,000 nursing homes with full-time infection preventionists.**

Likewise, the Final Report recognizes the value of full-time Registered Nurses but is **unwilling** to make nursing homes responsible. **Instead, the Final Report calls on CMS to “provide 24/7 RN staff augmentation” by “[l]everag[ing] federal relief funds” and collaborating with state and local authorities** (p. 44). This again is unrealistic, as are other recommendations that call on CMS to identify funding that may be nonexistent, insufficient, or designated for other purposes (*see* pp. 39, 42, 43, 49).

The same unwillingness to make nursing homes responsible pervades the Final Report. **Instead of setting requirements, the Final Report recommends that CMS “urge” better staffing practices, and “reinforce” the role of medical directors** (p. 43). In a similar vein, the Final Report makes multiple recommendations that CMS be responsible for providing nursing homes with training, technical assistance, or management tools, **in conflict with CMS’s role as enforcer of nursing home standards (pp. 35, 45, 50, 54).**

Finally, it should be noted that the Final Report fails to address alternatives to nursing facilities. Although the Final Report appropriately discusses potential long-term changes to the nursing home model and nursing home buildings (pp. 56-59), it does not address policy changes that would enable greater numbers of people to live at home with supportive services, rather than in a nursing home.

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 FINAL-REPORT-of-NH-Commission-Public-Release-Case-20-2378 copy.pdf  
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