

# THE DANGERS OF INSTITUTIONAL LIVING

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*COVID-19 in Utah's Long-term Care  
Facilities*



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# Introduction<sup>1</sup>

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The Disability Law Center (“DLC”), established in 1978, is a private, independent nonprofit organization designated by the governor as the federally mandated Protection and Advocacy (“P&A”) agency for the State of Utah. We engage in high-impact individual and class action legal representation, as well as investigation, outreach, public policy, and other nonlegal advocacy to advance our mission to enforce and strengthen laws that protect the opportunities, choices, and legal rights of people with disabilities in Utah.

At the heart of our mission as the P&A is community integration for people with disabilities across the lifespan. The DLC advocates for the full inclusion of people with disabilities into the larger community by promoting comprehensive, quality community-based services as an alternative to institutional residential and non-residential settings. The global COVID-19 pandemic has exposed the dangers of congregate long-term care facilities (LTCFs) for people with disabilities and people who are aging. To date, over 900,000 people have died from COVID-19 in the United States. People who are aging and people with disabilities, particularly those residing in congregate long-term care facilities, comprise a disproportionate number of these deaths.<sup>2</sup> **This report will examine the impact of the pandemic on people residing in long-term care facilities in Utah and will make recommendations to improve the safety of institutionalized individuals.**

## Methodology

At the outset of the pandemic in spring of 2020, the DLC was concerned about reports of mass infection and a lack of necessary resources to protect individuals in long-term care facilities from COVID-19. In response, the DLC created a remote monitoring plan to contact every long-term care facility in the state of Utah (this included skilled nursing facilities, nursing facilities, intermediate care facilities, and assisted living facilities) to determine the status of residents and gather information about what resources facilities needed to protect residents.

The first round of monitoring was conducted in the spring and summer of 2020. Each facility administrator was contacted by phone by a DLC staff member and was asked a series of questions regarding the infection status of residents and staff, staff and resident education relative to COVID-19, access to PPE, access to testing as well as a question regarding what providers needed to protect facility residents. With the help of the Kem Gardner institute, the DLC refined its survey questions (which continued to request information regarding the well-being of residents as well as questions regarding infection control and access to resources) and conducted a second round of surveys specific to long-term care facilities in Salt Lake County in the fall of 2020. The DLC also gathered data regarding care quality and COVID-19 infections and deaths from multiple other sources including data requests to the State of Utah and its state survey agency; records requested from individual long-term care facilities; and data collected by the Centers for Medicare and Medicaid Services (“CMS”). This report will rely on data collected from the outset of the pandemic in 2020 through December 31, 2021. Data regarding named facilities was gathered from publicly available sources in the media and from CMS. The

degree to which our analysis focuses solely on nursing facilities is due to lack of comparable publicly available data for assisted living and intermediate care facilities.

## Overview of Utah's Long-Term Care System

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Under the Utah Medicaid State Plan, an individual who meets the Medicaid income and level of care requirements is entitled to care in a nursing facility. Care in a nursing facility may include skilled nursing or medical care and related services, rehabilitation, and long-term care. Intermediate care facilities serve as nursing facilities for people with intellectual disabilities and are also an entitlement under the Utah State Medicaid Plan. Both nursing facilities and intermediate care facilities are institutional placements. Assisted living facilities are considered community placements but may share many of the characteristics of nursing facilities such as congregate living, onsite medical care, and limited community access.

An individual who instead wishes to receive supports in their home or community must apply for one of Utah's Home and Community-Based Services Waivers. Home and community-based services provide long-term care (including habilitative, nursing services, physical therapy, personal care, transportation, etc.), but help individuals to stay in their own homes without entering a congregate care facility. Some individuals receiving home and community-based care require residential care, but this is not facility-based care. Individuals in home and community-based residential services typically live in an apartment or home with a small number of roommates. Unlike institutional care, these programs are limited in the number of people they serve and require long wait times to access.<sup>3</sup>

Unfortunately, Utah lags far behind other states in its Medicaid funding of both institutional and community long-term care. According to the most recent AARP scorecard, Utah ranks 51<sup>st</sup> out of U.S. states and territories in Medicaid spending for long-term care for people who are aging and people with physical disabilities (for both nursing facilities and for HCBS services for these populations) and also ranks 51<sup>st</sup> out of U.S. states and territories for all Medicaid long-term care spending for people with all types of disabilities.<sup>4</sup> The most recent data from CMS shows that Utah has the lowest Medicaid expenditures for long-term care per state resident.<sup>5</sup> Utah ranks 39<sup>th</sup> for the percentage of home and community-based funding as a portion of the total long-term care spending for people who are aging or have physical disabilities; 75% of spending is given to institutional placements for people who are aging or have physical disabilities while only 25% of spending is allotted to home and community-based services.<sup>6</sup>

**With the emergence of COVID-19, the State's lopsided funding for institutional and home and community-based services has proven to have fatal consequences for Utahns in need of long-term care."**

This is problematic given the high demand for community services in Utah. People who are aging and who have disabilities often must wait for long periods of time to access supports they need to stay in their homes and communities. For example, there are currently 4,427 individuals on the Division of Services for People with Disabilities' waiting list (which operates 6 out of Utah's 10 waivers) with an average wait time of 5.7 years.<sup>7</sup> It is frequently the case that these individuals must choose institutional care when they can no longer wait for home and community-based care.

With the emergence of COVID-19, the State's lopsided funding for institutional and home and community-based services has proven to have fatal consequences for Utahns in need of long-term care. Nursing homes, assisted living facilities, and intermediate care facilities represent an outsized share of Utah's overall COVID-19 deaths, accounting for 22% of all COVID deaths even though residents in these facilities represent less than 1% of our state's population.

## Existing Dangers in Institutional Living

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Nursing facilities are subject to federal quality standards that govern all aspects of care.<sup>8</sup> These requirements are meant to ensure patients receive appropriate care and that facilities are meeting basic health and safety standards. These federal standards are set by CMS but monitoring for compliance is done by individual states through state survey agencies.<sup>9</sup> Because states can exercise discretion in monitoring and enforcement actions, these requirements are not uniformly applied, and some states hold facilities to less stringent standards. For example, Utah's state survey agency, the Bureau of Health Facility Licensing, Certification and Resident Assessment ("Licensing"), has not vigorously utilized monetary penalties for facilities that are out of compliance with federal quality standards<sup>10</sup> while other states are more aggressive when implementing fines and other penalties.

Despite the federal quality standards, nursing facilities nationally have shown a decline in quality of care that existed prior to the pandemic. Additionally, because nursing facilities provide congregate care—meaning communal living often with shared rooms for residents and staff caring for multiple individuals at a time—these facilities went into the pandemic with a high risk for COVID-19 outbreaks.<sup>11</sup>

### 2013-2017: An Increase in Abuse and Infection Control and Prevention Deficiencies in Nursing Homes

Federal standards require facilities to develop and implement effective infection control protocols to combat infectious disease outbreaks, however, this was the most cited deficiency for nursing homes between 2013 to 2017.<sup>12</sup> Deficiencies found by CMS surveyors have included violations such as failing to use proper hand hygiene and personal protective equipment

("PPE") and failing to isolate sick residents.<sup>13</sup> Yet, nationwide, enforcement actions for infection prevention and control deficiencies were rarely implemented.<sup>14</sup>

Data from the Government Accountability Office ("GAO") shows that in Utah 51.3% of nursing homes surveyed in 2017 were cited with an infection prevention and control deficiency.<sup>15</sup> From 2013 to 2017 only 17 out of 105 facilities in the state had no citation for infection prevention and control deficiencies, meaning 83% of facilities *were* cited for a deficiency.<sup>16</sup> Pine Creek Rehabilitation and Nursing ("Pine Creek") is a notable example of a local facility with repeated infection prevention and control deficiencies. (Pine Creek is also a facility that participates in the Upper Payment Level "UPL" program, an enhanced rate program administered by the Utah Department of Health ("UDOH") which will be further described below.) Pine Creek was the first nursing facility in the state to experience a COVID-19 outbreak and was cited for infection control deficiencies in June and October of 2020 and again in August of 2021.<sup>17</sup>

Deficiencies included failing to ensure facility dishwashers were hot enough for the prevention of transmissible disease, using disinfectant on high touch surfaces that was not on the Environmental Protection Agency's list as effective against COVID, not cleaning vital sign equipment between resident use, and staff failing to perform proper hand hygiene and wearing face masks pulled down below the mouth while speaking in close proximity to residents.<sup>18</sup> Pine Creek was assessed a \$15,000 fine after a survey in August of 2021. In comparison, a facility in Minnesota with similar deficiencies was assessed a fine of over \$30,000, and the Life Care Center that had the first nursing facility outbreak in Washington was assessed a fine of over \$500,000 for its handling of COVID-19. It's also unclear how much of Pine Creek's fine can be attributed to infection control violations because the August 2021 survey included citations for failing to provide emergency electrical power and a functional fire suppression system during a power outage which were given substantially more weight than other cited deficiencies.<sup>19</sup>

The GAO also found that from 2013-2017 abuse deficiencies in nursing homes nationwide doubled.<sup>20</sup> The most cited deficiencies included physical and verbal abuse, followed by sexual abuse.<sup>21</sup> More often than not, staff were the perpetrators of the abuse.<sup>22</sup> Risk factors for abuse included infrequent visitors who could otherwise notice and report physical and mental changes in residents and a lack of staff which could lead to employees being overworked and exhausted resulting in a failure to notice signs of abuse or alternatively engaging in abusive behavior themselves.<sup>23</sup>

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This trend is particularly concerning for Utah's facilities because all long-term care facilities during the pandemic have had limits on visitors and experienced staffing shortages—leaving residents of these facilities at a high risk for abuse and neglect. The Omicron surge has

exacerbated staffing shortages and as a result the State has had to deploy the national guard in facilities across Utah to provide care to residents.<sup>24</sup> Unless Licensing does substantial work to uncover possible abuse and neglect that occurred over the last 2 years, the true impact of the pandemic's toll on residents in long-term care facilities may not be known.

## A Lack of Transparency in Oversight

State survey agencies and federal requirements for nursing homes are meant to serve as safeguards for residents, but these requirements rely on effective monitoring and enforcement. The public can view state survey information on the CMS CareCompare website and see how many stars a facility has been assigned based on inspection measures.<sup>25</sup> Yet, this metric does not always provide critical information the public needs to evaluate nursing facilities. Reporting from the New York Times has shown that facilities nationally have engaged in acts that significantly endanger residents' health and safety and are still able to maintain a 5 out of 5-star rating.<sup>26</sup>

There are several reasons for this discrepancy. One overarching reason is that state surveyors rarely categorize deficiencies as severe enough to hurt a nursing home's rating.<sup>27</sup> In other instances information is withheld while facilities challenge the results of an inspection through an appeal process.<sup>28</sup> For example, a nursing home in Minnesota has been able to maintain a 5 star rating even though it was cited by state surveyors in April of 2020 because employees did not follow basic infection protocols, such as failing to remove PPE after leaving a sick person's room, failing to screen staff for COVID-19, and moving a symptomatic resident into a shared room with a resident with no symptoms.<sup>29</sup> When nursing facilities lose an appeal process citations are supposed to be posted on the CareCompare website and factored into its overall star rating but this does not always occur.<sup>30</sup> The Life Care Center of Kirkland, Washington is just such an example. The facility had the first COVID-19 outbreak in the United States and was assessed with over a half a million-dollar fine that was upheld after an appeal but still maintains a 5-star rating.<sup>31</sup>

Utah's own state survey agency was shown to be insufficient in transparency and provider accountability in a November of 2017 audit by the Office of the Legislative Auditor General.<sup>32</sup> The audit primarily focused on Licensing's oversight of assisted living facilities but remains relevant to Licensing's approach to oversight of all long-term care facilities.

The audit found that Licensing could improve its process by "better holding providers accountable" and specifically recommended that survey findings and facility sanctions should be posted online in order to promote provider accountability and transparency.<sup>33</sup> At the time of the report Utah was among the 10 worst states for public availability to basic health information.<sup>34</sup> A review of Licensing's website shows the Bureau has failed to implement this recommendation, and it only provides links to CareCompare. However, CareCompare data may lack critical information about the facility and only provides information for nursing facilities and not assisted living. In Utah, assisted living facilities make up the vast majority of long-term



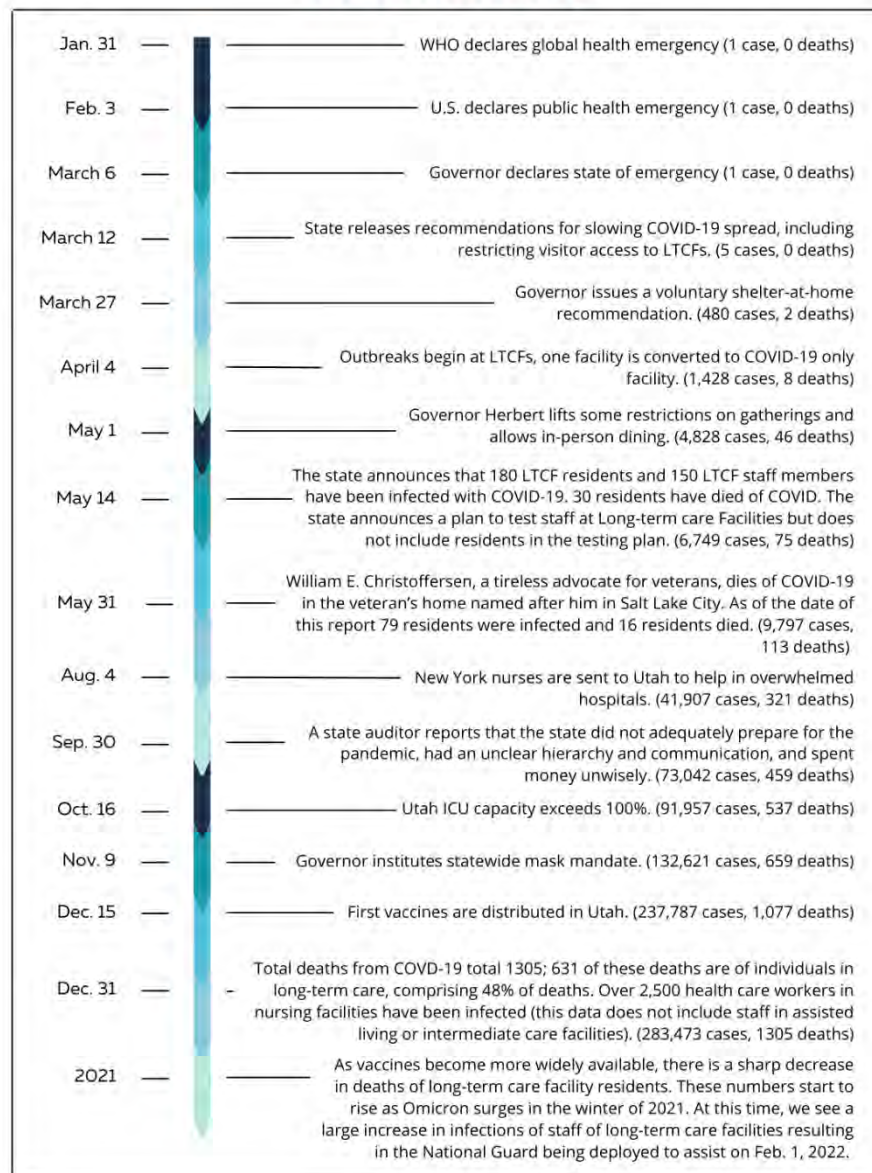
care facilities in the state and to review survey data a member of the public must make a public records request.<sup>35</sup> The audit also found that Licensing had not utilized many of the available enforcement tools, including monetary penalties.<sup>36</sup>

Like assisted living facilities, Utah’s use of monetary penalties in nursing homes could be improved. Over the past three years, Utah is ranked 39 out of 53 for penalties levied against nursing homes. Utah’s average number of penalties per nursing home is 2 and the average survey-based fine per nursing home is \$14,012.

## Utah’s COVID-19 Response

The first documented case of COVID-19 in Utah was announced on March 6, 2020.<sup>37</sup> Since then, COVID has continued to spread, infecting over 800,000 Utahns so far. Residents in long-term care facilities have been disproportionately affected by the spread of COVID-19 in Utah, both in terms of breakouts and in terms of deaths. The state of Utah failed to protect vulnerable residents of long-term care facilities in multiple ways, by (i) failing to communicate and provide transparency, (ii) failing to take important preventative measures, and (iii) neglecting memory units and intermediate care facilities.

### 2020 TIMELINE





### *i. Communication and Transparency Issues*

Outbreaks at long-term care facilities in Utah started in April when Pine Creek Rehabilitation and Nursing in Salt Lake County reported 6 positive residents, 2 positive staff members, and one resident death.<sup>38</sup>

During this outbreak, several family members of residents brought up concerning reports about not receiving communication from facilities or from the state about COVID outbreaks. One family found out about an outbreak at Pine Creek, where their loved one was a resident, from watching the news; they found out that their loved one was COVID-positive only after calling to inquire about the outbreak. Another family had a loved one pass away, only being told by staff that the resident died “peacefully in the night,” but they later found out from the news that their loved one actually died of COVID.<sup>39</sup>

**Throughout the pandemic, COVID has spread through long term care facilities at alarming rates. While the high numbers of hospitalization and deaths can be partly attributed to underlying factors in the population such as advanced age and pre-existing health conditions, the rate of disease spread cannot be excused."**

By May 2020, 180 long-term care residents in Utah and 150 staff members had contracted COVID, and 30 residents had died. The Utah Department of Health (UDOH) then finally announced that it would begin publishing the names of facilities with active COVID cases.<sup>40</sup> But family members of residents remained concerned that the state and individual facilities were not being transparent and communicative about the spread of COVID among residents.

### *ii. Lack of COVID Prevention Measures*

Throughout the pandemic, COVID has spread through long-term care facilities at alarming rates. While the high numbers of hospitalizations and deaths can be partly attributed to underlying factors in the population such as advanced age and pre-existing health conditions, the rate of disease spread cannot be excused. There have been multiple reports and complaints which demonstrate that long-term care facilities in Utah have failed to prevent disease spread among their residents, leaving vulnerable residents entirely exposed to a deadly virus.

One example of this failure was at Hillcrest Care Center, an intermediate care facility in Sandy, Utah, where a family member of a resident reported that basic disease prevention standards were not being met.<sup>41</sup> At this facility, a resident had a roommate test positive for COVID but continued to stay in their shared room.<sup>42</sup> When the family member of the COVID-negative resident asked if the COVID-positive roommate would be moved away from other residents, the facility said they had no plans to do so.<sup>43</sup> The family member then contacted the State to report a complaint about Hillcrest.<sup>44</sup> A complaint filed by the DLC to the Utah Department of Health alleged that State representatives told the concerned family member that quarantine procedures at intermediate care facilities were not being enforced because “due to the nature

of the facility, once an outbreak begins in an [intermediate care facility], the State assumes everyone in the facility will also contract the virus.”<sup>45</sup> This view was also expressed by a representative of the Utah Health Care Association (an organization that represents long-term care facilities) stating that intermediate care facilities have a hard time mitigating outbreaks because the residents “don’t understand and can’t really stay in their rooms and isolate.”<sup>46</sup>

Unfortunately, Hillcrest is not the only facility with substandard disease prevention protocols. The CDC recommends that all long-term care facilities have a designated location, as well as a staffing plan, for residents who have been infected with COVID.<sup>47</sup> This is a basic, essential disease prevention protocol. However, the DLC’s survey from between June and August 2020 found that 15% of long-term care facilities in Utah did not have any place to isolate infected individuals. When the same question was asked to Salt Lake County facilities in November and December 2020, nearly a year into the pandemic, 12% of these facilities still did not have a place to isolate infected individuals.

### *iii. Neglect in Memory and Cognitive Disability Care Units*

While all long-term care facilities are susceptible to COVID outbreaks, facilities with memory care or cognitive disability units have been found to be particularly susceptible. Residents with cognitive disabilities are susceptible to COVID because they are housed in groups and cannot maintain physical distance. A key defense

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against COVID transmission is physical distancing, but residents with cognitive disabilities may not remember directions they’ve been given to stay in their rooms or wear a mask. Facility staff members and state health officials have expressed indifference to this problem and did not create plans or guidelines sufficient to address it. Dr. Nakashima, the UDOH infection program manager, said about COVID spread in these units: “If one patient gets it, everybody in there gets it. It’s kind of the nature of these memory care units.”<sup>48</sup>

In May of 2020, UDOH began routine testing of staff in long-term care facilities in order to identify emerging COVID cases and try to prevent outbreaks but failed to include residents in the routine testing plan.<sup>49</sup> The State cited the estimated \$2.2 million price tag as its reason for not including residents, despite federal guidance recommending testing for staff *and* residents.<sup>50</sup> The state was able to spend \$6.7 billion in federal COVID relief money in 2020, however state auditors cited a “lack of monitoring or oversight...[resulting] in and may continue to result in material amounts of (coronavirus relief) funding paying for nonessential expenditures.”<sup>51</sup> Because the State had access to ample resources it is even more concerning routine testing was not implemented for residents at this time.

## Kem Gardner and DLC Survey Data

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Survey data collected directly from Utah’s long-term care facilities illustrates some of the challenges facilities faced during the first year of the pandemic and possible contributing factors to the high rate of infection and morbidity residents have faced.

*Inability to social distance or isolate infected residents:* The DLC’s first survey of long-term care facilities found that 15% of responding facilities did not have a place in their facility to isolate residents who were sick with COVID-19. This number was reduced slightly to 12% during the second round of surveys focused on Salt Lake County long-term care facilities. Without adequate access to personal protective equipment (“PPE”) or the ability to socially distance in congregate care settings, many of the responding facilities had to leave residents in their rooms to try to mitigate the spread. The Kem Gardner institute reported that during the first round of surveys when facilities were asked “are individuals confined to their room all day?” about a third of facilities said they were. The second round of surveys revealed even worse conditions; when analyzing the second round of surveys, Kem Gardner reports that almost half of responding facilities indicated individuals were “confined to their room all day.”

*Lack of access to PPE:* In the summer of 2020, 40% of responding facilities reported they needed help getting PPE and supplies. Concerningly, 6 facilities reported that they did not have enough cleaning and disinfectant supplies. These 6 facilities combined provide care to roughly 250 residents. One survey respondent who operated an assisted living facility stated “I feel like it is rather difficult to get PPE when we did have positive cases—the SLC health [department] said they would send out supplies but never did. We have been purchasing supplies where we can and luckily, we are a smaller facility.” One intermediate care facility operator stated that PPE was unavailable for intermediate care facilities at the time because companies would only sell PPE to hospitals or skilled nursing facilities.

*COVID testing access:* During the second round of surveys, half of all responding long-term care facilities reported that they had to pay out of pocket costs to meet COVID-19 testing requirements. Almost all facilities reported that these costs were some strain or a big strain on their budgets and they had to pay out of pocket to meet safety protocol requirements. About half indicated they had to do so to meet COVID-19 testing requirements. It was a “big strain” for about half of facilities paying out of pocket, and there were a range of possibilities mentioned in terms of how they were meeting those costs, including corporate funds to CARES funding, operating costs, or an interest-only loan. It should be noted that the survey responses represented financial costs facilities incurred at the time of the survey and are not reflective of current state and federal spending on testing.

*Staffing shortages and lack of backup plans:* One of the significant issues brought up by multiple facility operators was the problem of maintaining staff to support individuals residing in long-term care facilities during the pandemic. One facility reported that during the pandemic

many staff “walked out” of the job and the administrator’s entire extended family moved into the parking lot to provide direct care to residents. Another provider stated that if they had insufficient staff, they planned to have administrators or adult children of employees to help fill in shifts.

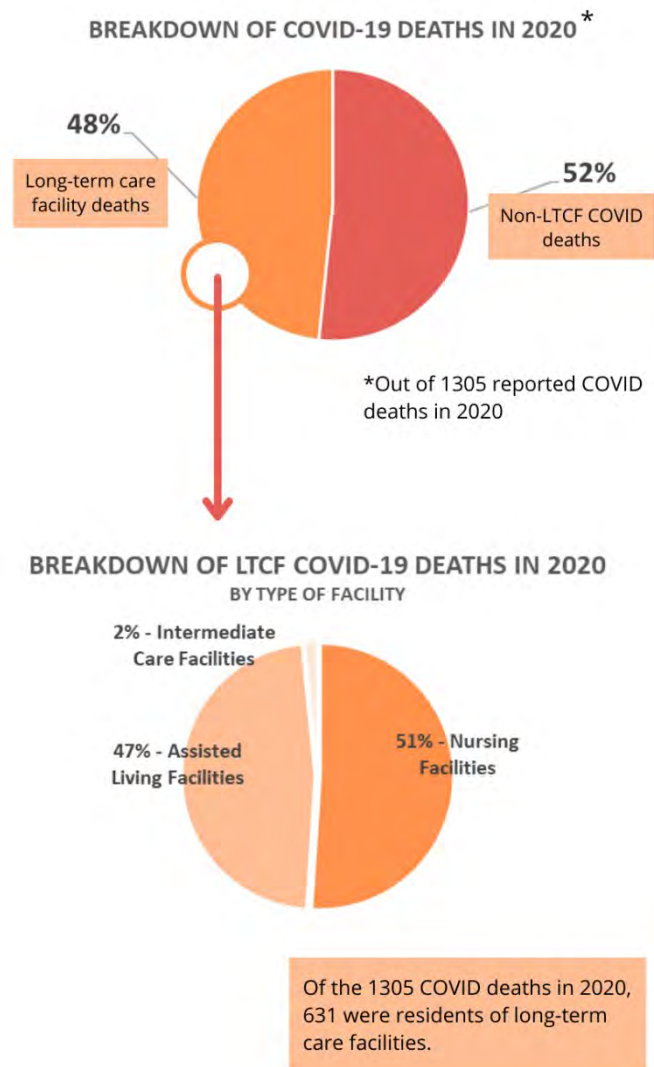
*Mental health of residents:* Some of the most troubling of the responses were the descriptions of the declining mental health and well-being of residents. One operator stated “residents need in person contact with family and loved ones. I am seeing many residents decline, self-isolate and even become very depressed because they cannot touch or hug their family members. My opinion is that this is violating the Utah residents’ rights. The right to interact with members of the community both inside and outside the facility. The right to leave the community at any time.” The nature of congregate care made it difficult for facilities to curb the risk of spread while also helping individuals to interact with others and spend time outside of their rooms. This forced facilities to choose to prioritize physical over mental health and left many residents stuck in their rooms. Smaller home and community-based services did not face this dilemma during the pandemic and individuals could interact with family and/or roommates within their homes because there was not a risk of large scale spread.

# The Impact of Utah's COVID-19 Response in Long-term Care Facilities

In 2020, 48% of Utah's COVID-19 deaths occurred in long-term care facilities. While the pandemic and its effects were new, it was predictable that long-term care facilities would face outbreaks. In fact, on April 6, 2020, the DLC sent a letter to Governor Herbert warning of the high risks for spread in long-term care facilities and setting out a series of recommendations including ongoing data collection, expanded licensing efforts, and a channel to report COVID-19 cases that was available to the public. It is unclear how many of these recommendations were adopted. However, during this same time frame the State was working to procure treatments of hydroxychloroquine for \$800,000<sup>52</sup>

Although some of the State's early missteps can be explained by the unknowns of the pandemic, a large majority of deaths in long-term care facilities occurred at the end of 2020. By the end of 2020 over 2,500 health care workers in nursing facilities (which does not account for staff in assisted living and intermediate care facilities) contracted COVID; approximately 631 individuals in long-term care facilities died from COVID; and the State missed an important window to protect those who were most vulnerable to the impact of the pandemic.

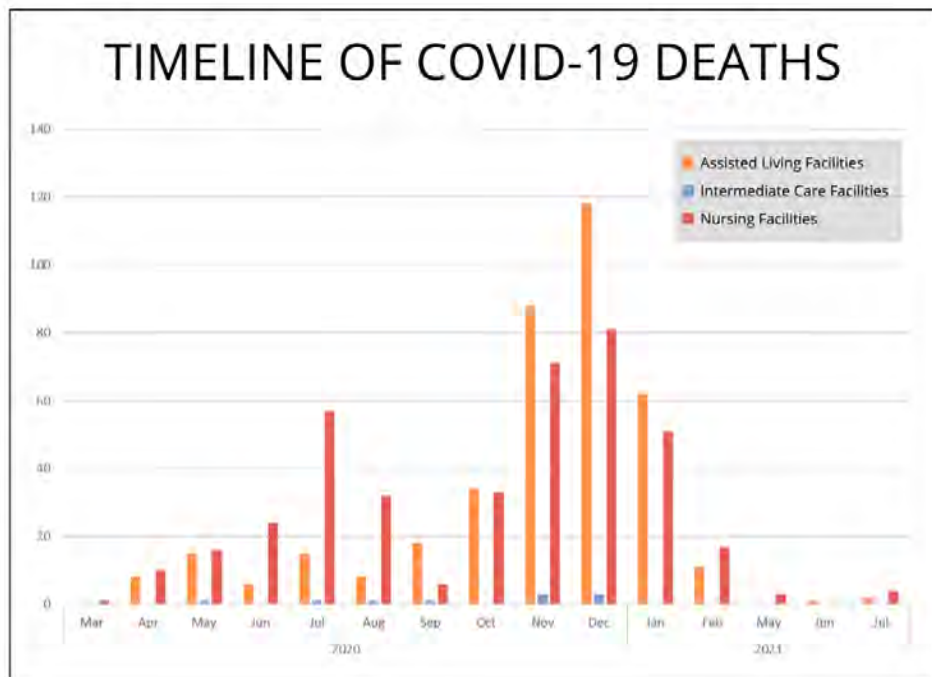
Utah was unlike Washington or New York; our state was not caught off guard by a novel virus but instead had time to plan and learn from those parts of the country that were first hit by the pandemic. Yet, the deadliest months of the pandemic in long-term care facilities in Utah would start seven months after the pandemic began.



## Contributing Factors

### Workforce issues

The pandemic has exacerbated staffing shortages that already existed in the long-term care system.<sup>53</sup> In the DLC's second survey of long-term care facilities, 85% of Salt Lake County facilities said hiring additional staff was either difficult or somewhat difficult. The Washington Post reports that nationally long-term care has lost 420,000



workers over the past two years.<sup>54</sup> "No other industry suffered anything close to those losses over the same period, according to the Bureau of Labor Statistics."<sup>55</sup> Several states, including Utah, have even deployed the national guard to help with shortages in these facilities.<sup>56</sup> This crisis-level shortage of staff is being compounded by staff who have become sick during the Omicron surge.<sup>57</sup> CMS data currently shows that Utah has the 17<sup>th</sup> highest rate of long-term care facility staffing shortages in the nation and 41.8% of nursing facilities in Utah report a shortage of nurses and/or aides.<sup>58</sup>

Experts cite low wages and challenging work as the primary causes of the shortage.<sup>59</sup> Nursing home workers are the lowest paid workers in the health care sector.<sup>60</sup> Long-term care workers experience high levels of poverty (15% live in poverty defined as living below 100 percent of the federal poverty level, while 44% live in low-income households, defined as below 200% of the federal poverty level.)<sup>61</sup> Forty-two percent of long-term care workers require some form of public assistance.<sup>62</sup> Susan Reinhard, Executive Director of the AARP's Public Policy Institute describes the challenges long-term care workers face "If you have too many people to care for, you're going to feel moral distress [...] Like 'I'm not doing my best.' 'I can't do the best job I've been trained to do, that I want to do.' 'I'm not meeting the needs of those that I'm supposed to be caring for.' That is really devastating personally, just day after day."<sup>63</sup> Working in long-term care is challenging during the best of times, but working in long-term care during the pandemic has been dangerous. In fact, during 2020, nursing home worker became one of the deadliest jobs, with more deaths than logging and rivaling fishing as the most dangerous profession.<sup>64</sup>



This trend has continued—deaths of nursing home workers hit an all-time high in January 2022 according to a report released by the American Health Care Association.<sup>65</sup> In Utah, there have been 15 staff deaths in nursing facilities alone.

Staffing shortages have a devastating effect on people residing in long-term care. Studies have shown that a lack of facility staffing results in higher rates of COVID-19 and deaths amongst facility residents.<sup>66</sup> Field experts cite this lack of staffing as a primary reason for an increase in psychotropic medication use and chemical restraint during the pandemic: “the worse a home’s staffing situation, the greater its use of antipsychotic drugs.”<sup>67</sup> The dangers of lack of staffing have been well-documented even prior to the pandemic; in particular, “higher [registered nurse] staffing levels are associated with better resident care quality in terms of fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse of antipsychotics; and lower mortality rate.”<sup>68</sup>

**During 2020, nursing home worker became one of the deadliest jobs, with more deaths than logging and rivaling fishing as the most dangerous profession.”**

## Upper Payment Limit Program

One surprising finding of this report was that facilities receiving extra funding under a program created by the Utah Department of Health called the Nursing Facility Non-State Government-Owned Upper Payment Limit Program (UPL Program) demonstrated alarmingly high rates of COVID-19 infection and death. The program is meant to ensure facilities can receive additional funds to reinvest in the facility and provide higher quality care. Concerningly, the COVID-19 data does not reflect that residents were better protected in these facilities. To date, of the 15 nursing homes with the highest rates of deaths in Utah due to Covid-19, 13 of these facilities were Upper Payment Limit facilities (of the 2 facilities not participating in the upper-payment limit program one is owned by Ensign and the other is a Veteran’s nursing home owned by Avalon). Of the top 15 nursing facilities with the highest number of deaths as a percentage of confirmed COVID-19 cases, 11 facilities participate in the Upper Payment Limit Program (of the facilities that do not participate in UPL: one facility is hospital-based with a very low number of overall COVID-19 infections, 2 are VA facilities managed by Avalon, and 1 is owned by Life Care Centers of America, the largest privately held long-term care company in the U.S. The Life Care Center of Kirkland in Washington state was fined over \$500,000 after 37 residents died from COVID-19 in 2020<sup>69</sup>).

Under the UPL Program, the state Medicaid plan allows local government Medicaid licensees to receive supplemental payments for Medicaid nursing home residents equal to the Medicare rate of \$339.69 per day rather than the Medicaid rate of \$203.04. These additional funds are substantial and are intended to improve the care at nursing facilities. Multiple local governments participate in this program in the state, including Beaver Valley Hospital (“BVH”),

which owns approximately 40 facilities, and Gunnison Valley Hospital (“GVH”), which owns approximately 7 facilities.<sup>70</sup> These make up approximately 48% of the nursing facilities in the State of Utah.

Under the UPL, local governments assume ownership of nursing facilities but continue to have the original nursing facility act as the operator. The operator provides an administrative fee to UDOH and “seed funding” to the local government licensee which is equal to 30% of the UPL payment and the remaining funds are given to the operator to be invested in the nursing facility.<sup>71</sup> In 2019, Beaver Valley and its nursing facilities received over \$57 million in UPL funds.<sup>72</sup> UDOH charges a sizable administrative fee to the local government licensee; in 2016 UDOH was given \$1 million in UPL administration fees.<sup>73</sup>

UPL programs are increasingly being scrutinized for the value they may or may not add to the care of residents in nursing facilities. In 2019, CMS proposed increased regulation of UPL programs stating “We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert the system.”<sup>74</sup> There have been concerns about the administration of the UPL program in Utah; an audit was conducted by the legislature in 2017 and a bill was

passed that same year, requiring additional reporting requirements for UDOH and restrictions on future UPL expansion.<sup>75</sup> In 2020, the Utah Investigative Journalism Project reviewed data from Beaver Valley homes and found “shocking incidences” of lack of care in these facilities. This series of articles note that “a history of poor health inspections and concerns of a lack of oversight [has] been present for years” and that 23 BVH facilities had health violations above the national average, including 10 facilities that had more than double the national average of health violations.<sup>76</sup> “Five facilities have been the subject of medical malpractice lawsuits since being acquired by Beaver Valley Hospital.”<sup>77</sup> News reports raised particular concern about the UPL facilities at the outset of the pandemic, citing issues with “inadequate sanitation supplies well before the pandemic” and “overworked staff.”<sup>78</sup>

**It is alarming that a program encompassing the majority of nursing facilities in the state which also generates substantial revenue for local governmental entities, as well as for UDOH, has not demonstrated improved care for residents of these facilities.”**

It is alarming that a program encompassing the majority of nursing facilities in the state, which also generates substantial revenue for local governmental entities, as well as for UDOH, has not demonstrated improved care for residents of these facilities. Rather, it seems that individuals who reside in a UPL facility are at an increased risk for being infected with or dying of COVID-19 and these facilities have persistent problems with patient care according to state licensing reviews.<sup>79</sup>

## For-Profit Status, Pandemic Profits, and Pandemic Relief Funds

In a review of 6 different studies, the Kaiser Family Foundation concluded that nursing homes owned by for-profit companies have higher rates of COVID-19 mortality when compared to non-profit counterparts.<sup>80</sup> There is evidence that for-profit nursing facilities run by private-equity firms may be at an even higher risk of death from COVID-19.<sup>81</sup> It is difficult to determine this correlation between COVID-19 deaths in nursing facilities with for-profit status in Utah as there are no nursing facilities owned by non-profit entities in the state. There are, however, a significant number of nursing facilities in Utah that are owned and operated by local governments and for-profit companies under the UPL enhanced rate program. As described above, 13 of the 15 facilities with the most deaths from COVID-19 and 11 out of 15 facilities with the highest percentage of deaths compared to COVID-19 infections participate in the UPL program.

**“ They’re trading at the highest level they’ve ever traded at, in the middle of a pandemic in which they’re supposed to be bleeding money.”**

Of the top 15 nursing facilities with the highest number of deaths and highest rates of deaths as a percentage of COVID-19 infections during the pandemic, 60% of these facilities reported a profit during 2020 (the most recently available data). The Ensign Group, a health care company that owns 18 nursing facilities, 1 assisted living facility, and 1 intermediate care facility in Utah, is estimated to have a cash flow growth of more than 18% over the past year. “They’re trading at the highest

level they’ve ever traded at, in the middle of a pandemic in which they’re supposed to be bleeding money.”<sup>82</sup> While reporting exponential profits, the Ensign group owns 5 of the facilities in Utah which have reported the top 15 most fatalities from COVID-19 during the pandemic and 2 of the facilities that report the most deaths as a percentage of total COVID-19 infections.<sup>83</sup> For example, the Ensign facility St. Joseph’s Villa showed a profit of 4.62 million dollars during 2020 while having the 10<sup>th</sup> highest number of nursing home COVID-19 deaths during the pandemic; Holladay Health Care Center showed a profit during 2020 of 1.26 million dollars and had 22.45% of COVID-19 infected patients die—the 10<sup>th</sup> highest rate in the state.

It is important to note that while many for-profit nursing home companies have reported financial losses during the pandemic, experts state that complicated ownership structures can make it difficult to determine accurate profits or losses for individual facilities.<sup>84</sup> For-profit nursing home owners often have separate but related ownership, management and real estate management companies, which can allow for-profit owned facilities to show that they are operating at a loss and ask for pandemic relief payments while hiding profits.<sup>85</sup> While the CARES act Provider Relief Fund infused \$21 billion of pandemic relief funds into nursing homes and other health care providers (in addition to the paycheck protection program), advocates have raised concerns that there was little monitoring of how these funds were spent to ensure that residents are protected.<sup>86</sup>

# Top Fifteen Facilities with COVID-19 Deaths

Top 15 Facilities with Highest COVID-19 Deaths										
Top 15 Facilities	Provider Name	Total Residents admitted with COVID-19*	Total Residents confirmed with COVID-19	Total COVID-19 Cases	Total Resident Deaths from COVID-19	Total Resident COVID-19 Deaths as a Percentage of Confirmed COVID-19 Cases	Total Staff Confirmed with COVID-19	Total Staff COVID-19 Deaths	Provider Profit in 2020	UPL Facility
1	Sandy Health And Rehab	120	104	224	73	32.59%	81	0	No	Yes
2	City Creek Post Acute	621	5	626	47	7.51%	31	0	Yes	Yes
3	Rocky Mountain Care - Willow Springs	24	99	123	39	31.71%	65	0	No	Yes
4	Canyon Rim Care Center	49	31	80	20	25.00%	35	1	No	Yes
5	Harrison Pointe Healthcare And Rehabilitation	267	146	413	18	4.36%	16	0	Yes	Yes
6	William E Christoffersen Salt Lake Veterans Home	3	79	82	16	19.51%	88	1	Yes	No-VA
7	Heritage Care Center	374	33	407	16	3.93%	40	0	No	Yes
8	Avalon West Health & Rehabilitation	0	55	55	14	25.45%	42	0	Yes	Yes
9	St Joseph Villa	35	137	172	13	7.56%	123	1	Yes	Yes
10	Coral Desert Rehabilitation And Care	191	31	222	13	5.86%	42	0	Yes	No
11	Rocky Mountain Care - Clearfield	139	83	222	12	5.41%	83	0	No	Yes
12	South Ogden Post Acute	126	28	154	12	7.79%	35	0	No	Yes
13	Woodland Park Rehabilitation And Care Center	347	42	389	11	2.83%	50	1	Yes	Yes
14	Holladay Healthcare Center	12	37	49	11	22.45%	83	0	Yes	Yes
15	Rocky Mountain Care - Cottage On Vine	8	31	39	9	23.08%	30	2	Yes	Yes

Top 15 Facilities with Highest COVID-19 Deaths as a Percentage of COVID-19 Cases										
Top 15 Facilities	Provider Name	Total Residents admitted with COVID-19*	Total Residents Confirmed with COVID-19	Total COVID-19 Cases	Total Resident Deaths from COVID-19	Total Resident COVID-19 Deaths as a Percentage of Confirmed COVID-19 Cases	Total Staff Confirmed with COVID-19	Total Staff COVID-19 Deaths	Provider Profit in 2020	UPL Facility
1	Logan Regional Hospital Transitional Care Unit	0	9	9	3	33.33%	15	0	Unavailable	No
2	Sandy Health And Rehab	120	104	224	73	32.59%	81	0	No	Yes
3	Rocky Mountain Care - Willow Springs	24	99	123	39	31.71%	65	0	No	Yes
4	Avalon West Health & Rehabilitation	0	55	55	14	25.45%	42	0	Yes	Yes
5	Uintah Health Care Special Service District	0	4	4	1	25.00%	26	0	Yes	Yes
6	Pine View Transitional Rehab	1	3	4	1	25.00%	11	0	No	Yes
7	St George Rehabilitation	11	17	28	7	25.00%	50	0	Yes	Yes
8	Canyon Rim Care Center	49	31	80	20	25.00%	35	1	No	Yes
9	Rocky Mountain Care - Cottage On Vine	8	31	39	9	23.08%	30	2	Yes	Yes
10	Holladay Healthcare Center	12	37	49	11	22.45%	83	0	Yes	Yes
11	Four Corners Regional Care Center	2	35	37	8	21.62%	30	0	No	Yes
12	George E Wahlen Ogden Veterans Home	0	24	24	5	20.83%	82	0	Yes	No-VA
13	Seasons Healthcare And Rehabilitation	4	21	25	5	20.00%	38	0	Yes	Yes
14	William E Christoffersen Salt Lake Veterans Home	3	79	82	16	19.51%	88	1	Yes	No-VA
15	Life Care Center Of Salt Lake City	13	24	37	7	18.92%	37	0	No	No

\*COVID-19 Admissions include individuals who are admitted to support post-acute care for hospitalized patients recovering from COVID as well as lateral transfers from long-term care facilities experiencing outbreaks as a containment strategy

## Spotlight Facilities

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### Canyon Rim<sup>87</sup>

*Ownership:* Canyon Rim is a 90-bed nursing facility in Salt Lake City. It is owned by Gunnison Valley Hospital as a part of the UPL program and is managed by Avalon Care, a for-profit company that owns and operates facilities in six western states. This means that Canyon Rim receives additional funding as it can bill at the Medicare instead of the Medicaid rate. Canyon Rim received \$305,819.27 in Provider Relief Fund payouts between September and December 2020.

*COVID-19 Statistics:* Canyon Rim has the 4<sup>th</sup> highest number of fatalities in the state—of the 80 confirmed cases of COVID-19 at the facility, 20 residents died. Canyon Rim had 35 staff members contract COVID-19 (a particularly high number) and even had one staff member die from COVID-19. Vaccination rates, including booster rates, are above state and national averages for both staff and residents. Canyon Rim has 96.55% of residents vaccinated; 88.6% of residents are vaccinated statewide and the national average is 97.69%. 91.67% of Canyon Rim staff are vaccinated, while the state average is 82.83% and the national average is 80.43%. 87.5% of residents have boosters, while the state average is 67.69% and the national average is 67.41%. 81.82% of staff have boosters compared to the state average of 36.57% and 29.67% nationally.

*Staffing:* Canyon Rim is well below the state and national averages for staffing. Nurse-to-resident and employee-to-resident ratios are calculated by dividing the average number of nursing staff or all employees by the number of patients. A higher nurse-to-resident or employee-to-resident ratio shows more staff to support residents and results in better patient care and outcomes. Its nurse-to-resident ratio is 45.65, while the state average is 57.02 and the national average is 57.41. Overall the employee ratio at Canyon Rim for employees to resident is 61.5, while the state average is 96.66 and the national average is 85.8. This facility reports 3.72 nursing hours per patient per day; the national average is 3.76 and the state average is 4.09.

*Survey and Quality Measure Issues:* Canyon Rim demonstrates some troubling quality rating issues according to CMS data. For short-stay residents, only 46.6% show functional improvement, compared to the state average of 70.47% and the national average of 73.12%. Short-stay use of antipsychotics is troubling—the facility averages 9.23% of short stay residents use antipsychotic medications while the state average is 1.26% and the national average is 1.85%. High rates of psychotropic medication use can indicate that chemical restraint is occurring in the facility or that perhaps individuals with mental health conditions are being inappropriately placed in the nursing facility. High antipsychotic use in combination with low rates of functional improvement can also indicate insufficient staff to meet the needs of residents.

Over the years, state survey has identified multiple incidents of abuse and neglect and poor infection control in Canyon Rim. However, a full survey of the facility has not been completed since February 2020, nearly 2 years ago as of the publication of this report. Despite an alarmingly high number of resident infections and deaths, as well as a high number of staff infections and one death, only one infection control survey found a single deficiency and no penalties were given of the 5 infection control surveys completed. Given the severity of the incidents occurring in the facility prior to the pandemic and the number of COVID-19 infections and deaths in this facility, it is very concerning that there has not been more regulatory oversight of this facility. Detailed explanations of survey findings are as follows:

*February 2020:* Canyon Rim was fined \$70,168 on February 25, 2020, based on abuse, neglect, exploitation and quality of life and care deficiencies. In this survey, surveyors found multiple incidents of physical and sexual assault that occurred at the facility. A full survey has not been conducted of this facility since this visit. Many incidents and deficiencies are listed in this report, a non-exhaustive list includes the following:

- a resident being dragged out of a peer's room by another resident
- a resident being pushed by another resident and striking their head on the floor
- a resident being struck in the eye and abdomen
- a resident being discovered on the floor in her room unresponsive after being pushed by another resident—staff assessment failed to include a neurological check and a femoral neck fracture went undetected
- a resident being hit and kicked by another resident
- a resident reporting that her roommate attempted to rape her or sexually assault her on 3 different occasions
- a resident was physically restrained by facility staff with no training, no investigation and no physician order or physician notification
- The survey team notes that the facility did not sufficiently investigate instances of alleged abuse, further abuse was not prevented while investigations were in progress, and investigation results were not reported to State Survey in a timely manner

*August 2020:* During an infection control survey on August 4, 2020, surveyors found the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, staff were observed without eye protection and gowns in patient care areas. In addition, PPE was not available for staff. No penalty was given at this time for the deficiency, but the facility was fined on August 3, 2020, due to a COVID-19 information reporting deficiency. Infection control surveys were also completed in May, July, and August of 2020 and again in January of 2021.



No deficiencies were noted during these surveys; this is concerning because there were a significant number of COVID-19 infections and deaths in the facility, for both residents and staff—which demonstrates the facility was seemingly unable to control COVID infections.

*December 2020:* Canyon Rim was fined a \$32,292 penalty on December 17, 2020, based on a complaint survey of the facility for inappropriate care for residents with a feeding tube. State surveyors found that feeding formulas were not appropriately administered for 2 residents which resulted in significant weight loss.

## **Sandy Health and Rehab<sup>88</sup>**

*Ownership:* Sandy Health and Rehab is a 120-bed facility located in Sandy, Utah. It is owned by Beaver Valley Hospital and participates in the UPL program to receive enhanced rates. Sandy Health is operated by the for-profit entity Cascades at Sandy Rehab, LLC. To our knowledge, Sandy Health and Rehab is a COVID-designated facility which contracted with the state of Utah to accept COVID-positive patients. Under this program, the state contracted with skilled nursing facilities in good standing that were willing to establish a designated COVID unit and could demonstrate the ability to safely isolate COVID-positive individuals from COVID-negative residents in the remainder of the facility.<sup>89</sup> Sandy Health and Rehab received \$137,646.18 in Provider Relief Fund Payouts between September and October 2020.

*COVID-19 Statistics:* Sandy Health and Rehab has had the most COVID-19 deaths out of any nursing facility in the state of Utah; to date, Sandy Health and Rehab had 73 COVID deaths out of 224 confirmed COVID cases. 78 staff members have had confirmed COVID-19 cases as well. The facility is not currently posting its vaccination and booster rates for residents and staff. It has received 8 fines totaling \$14,300 for failing to adequately report COVID-19 information between January and September of 2021.

*Staffing:* Staffing rates at the facility are troubling. Nurse to resident and employee to resident ratios are calculated by dividing the average number of nursing staff or all employees by the number of patients. A higher nurse to resident or employee to resident ratio shows more staff to support residents and results in better patient care and outcomes. The nurse to resident ratio at Sandy Health and Rehab is 52 while the state average is 55.01 and the national average is 56.81. The employee to resident ratio is 89.39 while the state average is 93.04 and the national average is 84.66. The reported nursing hours per patient per day is 3.17, which is below the national average of 3.76 and the state average of 4.09.

*Survey Issues and Quality Measure Issues:* CMS data regarding quality measures at Sandy Health and Rehab indicates that residents show higher ADL declines in this facility (activities of daily living like bathing and dressing oneself). 16.6% of long-stay residents in Sandy Health and Rehab experience an ADL decline, compared to the state average of 13.26% and the national average of 15.66%. Sandy's pressure ulcer rates are also considerably higher than state and national averages: 10.41% of long stay residents at the facility experience pressure ulcers, while

state rates are 5.79% and national averages are 8.33%. Data like a decline in ADLs and a high rate of pressure ulcers can indicate that there is insufficient staffing to meet resident needs.

Survey data of the facility shows a troubling pattern of understaffing and failure to meet quality care indicators. It is concerning that the state of Utah would choose to contract with Sandy Health and Rehab as a designated COVID facility given the repeated problems state survey has identified in this facility; particularly around inadequate staffing. Given the number of resident deaths at Sandy Health and Rehab, it is concerning that the facility would pass all infection control surveys with no deficiencies. More detailed information about Sandy Health and Rehab's survey history is as follows:

*May 2020:* Since May of 2020, Sandy Health and Rehab has had 6 infection control surveys completed. None of these surveys found any deficiencies, despite the outsized number of infections and deaths from COVID-19 when compared to other facilities in the state.

*July 2019:* A standard survey was completed in July of 2019 and cited 7 deficiencies and no fine was levied. Deficiencies included incidents such as a failure to investigate allegations of resident-on-resident abuse and a failure to consult with a resident's physician when treatment was altered by facility staff.

*December 2019:* A complaint survey was completed in December of 2019 and a fine of \$17,927 was incurred. In this case, a resident with diabetes had consistently elevated blood sugar levels and the physician was not contacted. The resident was found unresponsive at the facility and her medical record showed that her blood sugar had not been checked for 6 days. Her blood pressure, heart rate and oxygen saturations had not been checked for over a month. She was admitted to the hospital, emergently intubated, and then admitted to the ICU on a ventilator and feeding tube.

*July 2021:* A complaint survey was completed in July of 2021 and a fine of \$46,530 was incurred. Multiple residents list problems with staff responsiveness and a lack of staffing. In this survey, one resident complained that staff do not answer call lights and pass by rooms when residents call for help. The resident also reported falling when he needed to use the bathroom and could no longer wait, waiting from 10:00 pm to 6:00 am to have a brief changed, and stating that staff does not have time to change bed linens when they are soiled. Other resident reports included concerns that staffing shortages are a "nightmare", that wait times for assistance can be several hours, and that the wait time is the longest during the evenings. One resident stated that he must wait long periods of time when he is in pain. Another reported that staff put his call light and phone far away where he cannot reach it.

This survey also cites deficiencies in patient care. One resident reported that she was independent when she arrived at the facility but has developed a bad bed sore and while she was continent when she arrived, she has become incontinent. Another resident also reported a pressure sore. When staff were interviewed regarding this incident, multiple CNAs report that they are understaffed.

A standard survey and complaint survey was completed in October of 2021 and no fine was levied. Surveyors noted multiple resident rooms with debris on the floors as well as in the hallways and common areas. The facility was also cited for failure to adequately care plan or implement care plans. In one instance, a patient was missing a care plan related to his risk for aspiration pneumonia. Failure to implement a plan for this risk resulted in the resident being admitted to the ICU for aspiration. Additional complaints included multiple patients not being bathed in accordance with their care plan and a resident developing a pressure ulcer due to insufficient care by the facility.

## Conclusion and Recommendations

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The COVID-19 pandemic has been devastating for people residing in long-term care facilities. Pre-existing problems like staffing shortages, abuse and neglect, and infection control deficiencies were greatly exacerbated by the pandemic. However, the incredible loss of life that occurred in these facilities, both in Utah and nationwide, has been treated as a forgone conclusion rather than a warning sign for a model of care that puts people with disabilities and those who are aging at risk of harm. Simply put, it is inexcusable for residents to live in facilities where briefs go unchanged, patients are endangered because care plans are not followed, and residents are the victims of physical abuse. All while facilities like Sandy Health and Rehab and Canyon Rim are participating in the UPL program that is a benefit to state and local entities without improving patient care as intended.

Not all facilities experience the deficiencies noted above. But there is more than an insubstantial amount of nursing homes, assisted living facilities, and intermediate care facilities that have placed residents at risk. Now is the time to act to ensure facilities are receiving robust oversight that is transparent and responsive to real-time events and work toward implementing smaller, community-based models of care.

*Increase access to home and community-based care options:* National and state data sources demonstrate that people with disabilities and people who are aging were safer in community settings than in institutions during the public health emergency.<sup>90</sup> Utah should give these vulnerable groups increased access to community services through Medicaid waiver programs. In addition, Utah should transform existing nursing homes into smaller, more homelike environments.<sup>91</sup>

*Increase oversight from the Bureau of Health Facility Licensing, Certification and Resident Assessment:* The length of time in between surveys and the lack of robust enforcement by Licensing is especially concerning given the severity of the problems in long-term care facilities during the pandemic. Federal regulation requires a full survey of nursing facilities to be completed every 15 months—in many cases we observed more than 2 years since a full survey was completed. An audit of Licensing’s oversight of assisted living facilities in 2017 showed surveys were being conducted at the staggering rate of once every 72 months.

CMS data also shows that Utah ranks 39th for imposition of fines against nursing facilities with deficiencies. State regulation puts fines levied against assisted living facilities into the general fund—the state could invest these funds back into Licensing to increase the number of surveyors as recommended in the 2017 licensing audit.<sup>92</sup> The state of Utah needs to ensure that surveys are occurring in a timely manner, that deficiencies are adequately addressed, and that fines are appropriately levied.<sup>93</sup>

While consumers can look up nursing facility star ratings, as outlined above, studies have found that these ratings may not accurately reflect care concerns at facilities.<sup>94</sup> In addition, there is no comparable program for consumers to compare care in other long-term care facilities including intermediate care facilities and assisted living facilities. Utah should seek to provide more transparency about the quality of care at all long-term care facilities in the state.

*Increase state minimum staffing requirements, address staffing shortages:* There is no national minimum for patient care hours under federal regulations. Data from the public health emergency has demonstrated that increased staffing translates into better care and lower infection and mortality from COVID-19. Utah should join other states and set a state standard for minimum care hours in long-term care facilities.

*Increase oversight of for-profit ventures, enhanced rate programs:* It is concerning to observe that there are facilities with significant infection and death rates from COVID-19 that also participate in the UPL enhanced rate program. The state of Utah should ensure that facilities in the UPL program are reinvesting enhanced rates to benefit residents and demonstrating a minimum standard of care and safety.

*Increase access to vaccines and testing for LTCF residents and staff:* Utah currently has 55.9% of its nursing home residents fully vaccinated and boosted (22nd place nationally); 22.5% of health care staff are currently fully vaccinated and boosted (23rd nationally).<sup>95</sup> Vaccinations are required for staff among Medicare and Medicaid certified providers, which has been upheld despite court challenges. On January 14, 2022, CMS issued guidance directing 24 states, including Utah, to implement plans to ensure workers are vaccinated.<sup>96</sup> When vaccinations first became available in 2021, long-term care facilities saw a marked decline in infections and death. Utah should ensure that both workers in long-term care facilities and residents have easy access to vaccinations to continue to protect the health and safety of residents. To decrease spread in long-term care facilities, Utah must also provide ready access to testing for residents, employees, and visitors to long-term care facilities.

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- <sup>1</sup> The DLC would like to thank Hannah Pickett, who contributed to the research and drafting of this report and Spencer May who worked with facilities to gather information for the remote monitoring part of this project.
- <sup>2</sup> Priya Chidambaram, Over 200,000 Residents and Staff in Long-term Care Facilities Have Died from COVID-19, Kaiser Family Foundation (February 3, 2022), available at <https://www.kff.org/policy-watch/over-200000-residents-and-staff-in-long-term-care-facilities-have-died-from-covid-19/>.
- <sup>3</sup> In Utah, a person can access one of 9 waivers: Community Supports Waiver, Community Transitions Waiver, Acquired Brain Injury Waiver, Physical Disabilities Waiver, Medically Complex Children’s Waiver, Tech Dependent Waiver, Aging Waiver and the New Choices Waiver. Utah Department of Health Medicaid, Home and Community-Based Services (HCBS) Waiver Programs, available at <https://medicaid.utah.gov/ltc-2/>.
- <sup>4</sup> Across the States 2018: Profile of Long-Term Services and Supports in Utah, AARP, available at <https://www.aarp.org/content/dam/aarp/ppi/2018/08/utah-LTSS-profile.pdf>.
- <sup>5</sup> Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018, Centers for Medicare & Medicaid Services, p.36 (January 7, 2021), available at <https://www.medicare.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf>.
- <sup>6</sup> Across the States 2018: Profile of Long-Term Services and Supports in Utah, AARP, available at <https://www.aarp.org/content/dam/aarp/ppi/2018/08/utah-LTSS-profile.pdf>.
- <sup>7</sup> These figures were presented at the most recent legislative session in January 2022. Division of Services for People with Disabilities, Annual Report 2021, p.14, available at [https://dspd.utah.gov/wp-content/uploads/2022/01/Annual-Report-2021\\_final.pdf](https://dspd.utah.gov/wp-content/uploads/2022/01/Annual-Report-2021_final.pdf).
- <sup>8</sup> See Centers for Medicare & Medicaid Services, State Operations Manual, available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf).
- <sup>9</sup> United States Government Accountability Office, Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse, pg. 2 (June 2019), available at <https://www.gao.gov/assets/gao-19-433.pdf>.
- <sup>10</sup> Office of the Legislative Auditor General, A Performance Audit of the Division of Family Health and Preparedness, pg. 32 (November 2017), available at [https://le.utah.gov/audit/17\\_13rpt.pdf](https://le.utah.gov/audit/17_13rpt.pdf).
- <sup>11</sup> United States Government Accountability Office, COVID-19 In Nursing homes: Most Homes had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021, pg. 4 (May 2021), available at <https://www.gao.gov/assets/gao-21-367.pdf>.
- <sup>12</sup> United States Government Accountability Office, Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, pg. 4-5 (May 20, 2020), available at <https://www.gao.gov/assets/gao-20-576r.pdf>.
- <sup>13</sup> *Id.*
- <sup>14</sup> *Id.* Enforcement measures include actions such as transferring residents, a directed plan of correction, monitoring, and civil monetary penalties.
- <sup>15</sup> *Id.* at 9.
- <sup>16</sup> *Id.* at 10.
- <sup>17</sup> Centers for Medicare & Medicaid, Health Inspection Summary: Pine Creek Rehabilitation and Nursing, available at <https://www.medicare.gov/care-compare/inspections/nursing-home/46A064/health>.
- <sup>18</sup> *Id.*
- <sup>19</sup> *Id.*
- <sup>20</sup> United States Government Accountability Office, Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse (June 2019), available at <https://www.gao.gov/assets/gao-19-433.pdf>.
- <sup>21</sup> *Id.*
- <sup>22</sup> *Id.*
- <sup>23</sup> *Id.* at 28-30.
- <sup>24</sup> Scott McKane, Utah National Guard Troops Stepping in to Help Long-term Care Facilities Amid Omicron Surge, Fox13 (February 1, 2022), available at <https://www.fox13now.com/news/coronavirus/local-coronavirus-news/utah-national-guard-troops-stepping-in-to-help-long-term-care-facilities-amid-omicron-surge>.
- <sup>25</sup> See [www.medicare.gov/care-compare](http://www.medicare.gov/care-compare)

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<sup>26</sup> Robert Gebeloff, Katie Thomas and Jessica Silver-Greenberg, How Nursing Homes' Worst Offenses Are Hidden From the Public, *The New York Times* (December 10, 2021), available at <https://www.nytimes.com/2021/12/09/business/nursing-home-abuse-inspection.html>.

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> United States Department of Health and Human Services Departmental Appeals Board, *Life Care Center of Kirkland v. Centers for Medicare & Medicaid Services*, (November 9, 2021), available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5975/index.html>.

<sup>32</sup> Office of the Legislative Auditor General, *A Performance Audit of the Division of Family Health and Preparedness*, pg. 32-33 (November 2017), available at [https://le.utah.gov/audit/17\\_13rpt.pdf](https://le.utah.gov/audit/17_13rpt.pdf).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> Health Officials Announce First Case of COVID-19 in Utah, *Coronavirus Utah* (March 6, 2020), available at <https://coronavirus.utah.gov/health-officials-announce-first-case-of-covid-19-in-utah>.

<sup>38</sup> Sydney Glenn & Jonah Napoli, First Incident of COVID-19 Transmission in a Utah Care Facility Reported, *Fox13* (April 4, 2020) available at <https://www.fox13now.com/news/coronavirus/covid-19-outbreak-confirmed-at-salt-lake-city-nursing-facility>.

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## Our Mission

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*As Utah's federally designated Protection and Advocacy (P&A) Agency, the Disability Law Center works to enforce and strengthen laws that protect the opportunities, choices, and legal rights of people with disabilities in Utah.*



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