In this Industry Update you will discover:

1. *"About One-fourth of SNFs Reported False Positives from Antigen Tests, Industry Study Finds"*
   - McKNIGHT'S LONG TERM CARE NEWS, 9/21/2020; pg. 1
2. *"HHS Releases Additional Details on How Nursing Homes can Receive Infection Control Incentive Payments"*
   - McKNIGHT'S LONG TERM CARE NEWS, 9/21/2020; pg. 2
3. *"'Quality of Life is Medically Necessary': What Nursing Home Residents' Families Want in a Post-COVID World"*
   - SKILLED NURSING NEWS, 9/20/2020; pg. 3
4. *"CMS Updates Nursing Home Visitation Guidance with Eye Toward Indoor Reunions"*
   - SKILLED NURSING NEWS, 9/17/2020; pg. 9

McKnight's
LONG-TERM CARE NEWS

About One-fourth of SNFs Reported False Positives from Antigen Tests, Industry Study Finds

Questions are being raised after a report reveals that about one-fourth of COVID antigen tests are coming back with false positives. This brings to light the difficulties of keeping facilities and equipment sterile while performing the tests and how we can further prevent false results.

Written by: Danielle Brown

9/21/2020

About 20 to 25% of skilled nursing facilities have received false positive results from their COVID-19 point-of-care antigen testing devices, a joint survey conducted by the American Health Care Association and LeadingAge revealed.

Providers said those false positive results were later found to be incorrect after using polymerase chain reaction (PCR) testing. A vast majority of SNFs also reported that they only had one to three "potential false positives," while just 3% have experienced more than five potential false positive results.

"While any potential false positive results are concerning, this appears to be consistent with what you would expect to see with widespread testing of many people in communities with relative low rates of COVID-19," the organizations wrote in a blog post Thursday.

The groups collaborated on the survey to understand the use of the Becton Dickson Veritor and Quidel Sofia-2 point-of-care antigen systems among SNFs — which were sent to all nursing homes by the federal government to aid their testing efforts. It comes after reports that some antigen testing equipment was producing false positive results for some providers.

Both BD and Quidel are conducting investigations to ensure the quality of their equipment and preliminary results haven't revealed any abnormalities, according to the groups.

"It's important for all providers to double check they are following the manufacturer's protocols and have staff appropriately trained on the use of each analyzer," they wrote.

AHCA and LeadingAge encouraged providers to continue using the point-of-care testing systems, and reach out to BD Veritor or Quidel to report any potential false positives. They also encouraged providers to follow federal guidance on when to conduct confirmation testing with PCRs after receiving positive antigen results.

"Most important, the potential false positive reports emphasize the need for communication from HHS on how to handle these cases, which will happen even with PCR testing," AHCA and LeadingAge wrote.

"We are working aggressively with HHS to get written information out to address what to do in the case of potential false positives, whether from antigen or PCR tests. This includes recommendations for cohorting and isolation; reporting to the state and to the NHSN; not treating a potential false positive as an outbreak; implications for Provider Relief Fund performance incentive payments," they added.

Experts earlier this year stated that one of the benefits of antigen tests is the reliability of a positive result. It was thought that those who tested positive for COVID-19 with the point-of-care tests truly are, while those who test negative may want to double-check the results with the established polymerase chain reaction tests. The study's findings seem to contradict this earlier notion.

McKnight's
LONG-TERM CARE NEWS

HHS Releases Additional Details on How Nursing Homes can Receive Infection Control Incentive Payments

The HHS recently announced updated guidance on infection control incentive payments that nursing homes can take advantage of, providing that they meet the requirements laid out within. The payments will be based on a month to month basis to each compliant facility.

Written by: Danielle Brown

9/21/2020

The Department of Health and Human Services has released final details on how it will pay out $2 billion in COVID-19 relief funding through its incentive-based payment program.

Initial details for the program indicated that HHS would use two outcomes to measure a providers' performance to determine whether they qualify for the funding: how well they keep down both coronavirus infection rates and mortality.

More specifically, HHS explained that providers' non-admission COVID-19 infection rate must be below the rate of infection in their county. Additionally, a nursing home's rate of COVID-19 deaths among residents who acquired the virus within the nursing home must be below a nationally established performance threshold for mortality among nursing home residents infected with COVID-19.

"Failure to pass this gateway disqualifies a nursing home from receiving any incentive payment for that month," LeadingAge explained in a blog post Friday.

Nursing homes eligible for the funding will then have their performance based on the infection and mortality measures. The infection measure accounts for 80% of the incentive payment dollars and will be calculated by taking the total number of non-admission COVID-19 infections divided by their total number of resident-weeks as reported in National Healthcare Safety Network, the Centers for Disease Control and Prevention's tracking system that is receiving COVID-19 data from nursing homes. It will also be compared to the county infection rate.

The mortality measure will account for 20% of the incentive payment and will be assessed for facilities who have at least one non-admission COVID-19 infection. LeadingAge explained the measure will be risk-adjusted with relevant health and demographic data.

"It will also use NHSN data including: total number of COVID deaths resulting from in-facility infections [and] total number of non-admission infections," the group explained

"This will include infected residents from the performance period as well as several weeks prior to the performance period. HHS will reach out to nursing homes with at least one COVID death during the performance period and whose residents represent a mix of infection sources (e.g. nursing home acquired and admitted with COVID) to ascertain how many of the residents who died acquired COVID while in the nursing home," it added.

Skilled Nursing News

'Quality of Life is Medically Necessary': What Nursing Home Residents' Families Want in a Post-COVID World

Skilled Nursing News recently spent some time with Melody Taylor Stark to get a first-hand account of a family member depending on the care provided by a long-term facility during the pandemic. In her experience with her husband, the quality of life is the most important offering that any facility can provide.

Written by: Alex Spanko

9/20/2020

For Melody Taylor Stark, navigating life after her husband Bill required long-term nursing care hasn't always been easy, but with the help of some caring staffers and a little bit of creativity, the couple was able to settle into something like normalcy.

Friday nights out at a restaurant became takeout shared over a table that the facility's staff reserved just for them, off in a private room with a tablecloth and flowers. Sunday mornings at the kitchen table became coffee and newspaper time in the dining room, and thanks to wheelchair-accessible rideshare vans, the couple was even able to go out for movie and dinner dates.

Then COVID-19 shut all of that down.

After months of advocacy and evolving regulations in her home state of California, Stark was eventually able to conduct a scheduled window visit with her husband toward the end of August. But prior to that, their frustration with not being able to visit in person grew to the point where Bill's lung cancer treatments actually became a major bright spot in their lives — because Melody was able to spend time with him during his infusions.

"Here we are in the cancer infusion therapy center. This is not Disneyland. This is not our favorite restaurant. This is not our favorite beach," Stark told SNN. "And he's so happy to be able to see me in person. Even though we can't hug, we can't touch — for two hours, even in a cancer clinic, his mood is so elevated, and that glow lasts for a couple of days."

SNN spoke with Stark in late August for an in-depth discussion on her years of experience in long-term care alongside her husband, and how her struggles and victories could provide lasting lessons for operators across the country — key factors as the sector looks to regain the public's trust, and adapt their care models to a permanently changed landscape.

The conversation occurred before the Centers for Medicare & Medicaid Services (CMS) released updated visitation guidelines that acknowledged the psychosocial strain the ban had placed on residents on their families, though facilities can still shut down based on outbreaks and high rates of community spread.

Over their years in the system together, Stark and her husband have had many discussions about the differences between quality and quantity of life, she said: Would he rather spend five years in a nursing facility, receiving significant medical interventions but sacrificing a level of personal freedom, or ease off treatment and simply enjoy whatever natural time he has remaining?

Those discussions have now jumped into the mainstream, as policymakers, industry leaders, health officials, and resident advocates alike call for significant structural change after COVID-19 exposed a variety of simmering structural problems in long-term care.

While there isn't a one-size-fits-all answer, Stark believes that any major shifts need to have the residents' autonomy and dignity at their center. She rattled off the life stories of some of the people in her husband's facility — a woman who raised three kids on her own at a time when that wasn't as common, another who was an early female field reporter in New York. For his part, Bill was a member of "the old guard in the dentistry field," teaching at the University of Southern California.

But while these stories are likely familiar for anyone who's spent time in senior care, Stark observed that our wider cultural attitude toward the elderly is that those stories stop once you enter a facility — even though there could be many more years of life ahead.

"Quality of life is medically necessary," she said.

Let's start out with some ideas you may have for changing the space based on your experience so far.

They need to go through what their clients are going to be going through, and experience it. I wish in places like nursing homes, that there would be something that would parallel that experience … new staff coming on board, I think, for two weeks, they're assigned a bed in the nursing home.

Of course there's some modifications to it, but they can't get up and go to the restroom by themselves. They have to wait until someone comes in, and they're eating the food everybody's eating. They are probably using like M&M's or something, but having to take meds, and having to manage being in a wheelchair and sit through bingo — not my favorite, but just experience what it's like there — and what it's like that when they say they have

to go to the bathroom, and they're calling and calling and it's an hour before somebody shows up.

Just to get a little bit of sense of what that change in quality of life [looks like], and that you're in half of a roughly 10-by-20 room with a roommate who's got people coming in and out and visiting, and maybe the roommate has got some issues. My husband had one roommate that would spend sometimes two hours just calling out "help me, help me, help me" — and he was not cognitively impaired. He was just a pain in the behind.

All of a sudden, your life changes quickly because most of the time with skilled nursing facilities, as opposed to independent living or assisted living, you don't always have time to shop them before you go in. You're like my husband: You were here at the house one day, and then you're in the emergency room. And while you're there, you may go right from the emergency room to a SNF, or you're in a hospital room for whatever length of time, and all of a sudden they're saying: "Oh, you need to choose a nursing home."

I had to do it at three o'clock in the morning in an emergency room one time, and your mind's not thinking about quality or going onto the internet and seeing who's got five stars and all those things. You need what you think is a safe place to have your loved one literally shipped off to in the middle of the night, where they don't know where they're going. They're being admitted in the middle of night. They're in an ambulance. There's this whole sense of disorientation — right from the get-go, it's a very traumatic experience.

That's really emblematic of the bigger issue we're seeing in long-term care more broadly: Nobody thinks about nursing home quality or resident experience until it's right in front of their faces — whether that's someone like you, trying to find placement for a loved one, or lawmakers now realizing the extent of the problems in the landscape amid COVID-19. I think that's also where a lot of the trouble, and a lot of the anger and a lot of the confusion, comes in — the fact that people's expectations of long-term care don't really match what the reality is.

Exactly. Exactly — like that night when it was three o'clock in the morning making a decision. I had a social worker; she actually worked for the insurance provider, with HealthCare Partners. And she's going, "Oh, you know, this facility and this facility is good, and they're close by and so forth." So she said, "You know, he needs to be safe." My husband has post-polio syndrome, and it had gotten to the point where he was falling a lot when he first went into the nursing home, and I just trusted what she said.

I come to find out part of her job was helping to fill the beds at that nursing home, and within four months, I had a 10-page letter chronicling and documenting horrible things that went on there that went to the Department of Public Health — who came back and said, "Oh, this is all unfounded." No, no, it wasn't. I was close to calling adult protective services a couple times.

There's all of those things that make it stressful, and for family support, I should have been the fun person coming in. I should have been the moral support and the cheerleader, and a lot of our visits back then started with business: "Let's take care of who did what, and what I need to address, and why I need to go to the nurse's station before I can come back and say: Okay, honey, let's watch television or hang out together."

So you were able to transfer him to a different facility?

Well, with that one, he was in a situation where he was able to be back at the house. But during the six weeks he was here, I just kept saying, "I still don't feel he's ready to be released to come back home."

We made arrangements; we thought he was going to be here long-term, and within about six or seven weeks after that, he was retaining a lot of fluid and … he went into ICU for about a little over a week, where they drained about 40 pounds of fluid in three and a half days from his body, and also from his lung lungs. That's where he

transitioned to the nursing home where he currently is, and that was in January 2016.

So [the nursing home] at that point became our home. We always say where I am right now is our house, and it's where I sleep and shower and have coffee before work in the morning — and home was with him. I'm working from my house right now, but my office is in a location where I was able to leave the house in the mornings and stop by and visit with him.

When he was at the house, we get a couple of print papers, and we always would just for fun read the horoscope. So that was part of stopping by in the morning, keeping that normalcy going, and then I would go to work and then at night I would come back and I'd be there around dinnertime, so I'd bring a sandwich or salad with me and we'd have dinner at the same time and do something in the evening — board game or watching television, just hanging out like we would if we were here at the house.

And then on Fridays I would pick up some kind of takeout — could be KFC, could be something more upscale, one of our favorite steakhouses or something like that. We had a table in the activity room that wasn't being used on Fridays, and staff are really sweet: They put a tablecloth and flowers and so forth. That was our Friday night date place.

Once in a while, through the miracle of Lyft having wheelchair vans — he doesn't transition out of the wheelchair — we were able to go out to the movies or a restaurant or something like that. Then Saturday morning, or Saturday during the day, was kind of my getting caught up on errands and grabbing a gulp there, and then I'd go back at night.

Sunday mornings at the house were big pots of coffee, and we get the L.A. Times and we get another local newspaper, and we'd sit here at the table. The whole morning was going through the Sunday papers — much bigger at that time — and then one of us would make brunch. So that transitioned into Sunday mornings of packing up coffee thermoses and bringing the papers, and we'd go to a table in the dining room, and that was our place.

We hung out, and then I'd get a guest tray, and I'd also bring some condiments that might make the lunch a little bit better. At the end of 2012, I had surgery — I was out, I wasn't there visiting for a few weeks, [the kitchen staff] wouldn't let anybody else use that table on Sundays. It was our place.

These things became normal. I developed friendships with some of the other residents who were there, even with the staff. It's a small facility — and not just the nursing staff, but admin, housekeeping, kitchen staff, the whole bit.

Anyway, during all of this journey and support, I was seeing a lot of things that like: This could just be so much better, you know? They have staff, but it seems like so much is what's expected of a nursing home. You get up when they tell you to get up, they get you dressed or somebody helps get you dressed, and then if you want to go play bingo, or you want to do arm circles, or you want to watch "Price is Right" — can we put some more life and energy into it?

I think in more recent times, the need for tech support is huge. My husband and I have been experiencing that — although we both use our cell phones, a lot of the time, it's something that [in normal times], I'd be there at night in order to problem-solve it. Where he is, once every 15 days, the passwords need to be updated, and usually he was very good with doing that. He also had a Roku stick, and so we would watch some of our favorite things on Netflix and so forth.

The password changing thing is wild to me — I'm 30 and healthy, and I have trouble remembering which passwords I've used with which account when it comes time to update them. I can't imagine having that burden as someone with cognitive or physical disabilities, on top of isolation.

Exactly. It's one thing if it's the visitors and so forth, but I think the WiFi should be [more permanent] if you're [living] there, and you're there long-term.

He used to read a lot — he was like a three-or-four-books-a-week person. Since he's been in the nursing home, he's more getting caught up on movies he hasn't seen, or he gets into some Netflix or Amazon Prime series. Some of them we'd watch together in the evening, and others might not be things I was interested in, so he'd watch it during the day in between PT and so forth.

This was our life for a long time, and then COVID showed up and that came to an abrupt halt. It's the tech part, and also in conjunction with … just the decline from the isolation and the loneliness. With one of the medical conditions my husband has, sometimes there's some numbness in his fingers, so putting those passwords in once every 15 days, remembering how to do it when you're really depressed — that could be a challenge. Something went wonky with the Roku stick, which I haven't been able to figure out yet. I was able to get it back home, but that's another thing. I wasn't able to be there to help to problem-solve that — so he's just been on the regular boring TV channels.

They really didn't bump up a lot of things for activities at that time, other than you can wheel yourself to the door of your room and have hallway bingo.

That's been challenging. It might be: "Okay, who's your CNA on tonight? Oh, good. She's there. She knows. She's very tech-savvy. I can walk her through — put her or him on the phone and I can walk them through what to do with your phone to get it back on track. But we had several days where we were using a landline because something had gone wonky with his phone.

How would you redesign the post-acute and long-term care industry based on your experiences navigating the landscape with your husband?

You enter a SNF quickly, and when you get in there, there's no one to really help you navigate. You're sitting in your room, waiting sometimes for hours before anyone comes in, and it's oftentimes one of the nursing staff saying, "Hi, we're here to do a body check."

Some of them, what I call higher-quality nurses who I adore, will come in and introduce themselves and talk to the person for a second or so before they start getting down to what they need to do for documentation. But I've seen others come in and they're just: "Hi, I'm your nurse tonight, and this is what we're going to do."

It's very cold. So the patients themselves have you this very traumatic experience going on of being disoriented, and then the families — there's no explanation of navigating. I know here in California, and probably across the country, the primary care physician doesn't go into the nursing home. There's another team from the health care insurance that works out of the nursing home, but they're actually not part of the nursing home staff.

That makes a difference as well, because someone comes in one day and says, "Hi, I'm Dr. Taylor Stark," and they don't explain that Dr. Taylor Stark doesn't work for the facility, but works for UnitedHealthcare in managed care. All these things start coming — You don't know who or what's what. People are coming in and out of the room. They're having you sign papers without really going over them.

I think [having] a concierge on staff, or a liaison. In recent days, there's been no communication from the facility unless there was a problem. For example, my husband had some type of a lesion on his leg where they needed to bring a specialist in. So they called me about that. But there's no other communication as far as: "How's your husband doing?"

Bill and I have the advantage of at least being able to talk on the phone, where there's a lot of people there, that's not the case. I think also designating the essential family caregiver, so that should there be a situation where there's another lockdown moment, that you have someone who can come in and safely be able to have some good family contact. I think being mindful of the individual … [employing] more person-centered models, maybe trying to have one person in a room, letting it be less institutionalized.

Activities that are more than bingo. When Bill would get a new roommate, they'd come in and [say], "Oh, we offer this and this and this and this," without asking the person: What are some things you like to do? Because of the cultural mindset, people are not always likely to say: "I really enjoy playing golf," for example. They're not going to say that.

Whether it's a Wii, whether it's using VR, whether it's using the activity room or somewhere outside where they can do a wheelchair putting green — all of those ideas. I think people don't even respond to that because nursing homes just don't do those things, and they're not encouraged, and they're not offered.

It's thinking outside the box, and then also thinking creatively inside the box — because outside the box sometimes can mean budget constraints, and I get that. So I think a lot of those elements, plus the tech support, [and] someone to help navigate around the facility.

Mental wellness is huge. That's just a foreign concept at skilled nursing facilities. And I know here in California, it's supposed to be part of their milieu. For people who are in custodial care, it's supposed to be part of their milieu services, and they have no idea what that means. When even asking for a friend about a year ago, who was telling me she was depressed and so forth: It's like, well, we can have a psychiatrist see her, and then they can put her on some meds.

No, she needs somebody. She's here, she's estranged from her family, she's bedridden. She needs somebody — forgive the language — but somebody she can bitch to, and somebody who can help her emotionally navigate what she's going through. I get these [blank] stares back.

The same thing happened with my husband when I was seeing a lot of the impairments that he was dealing with, and the depression he was handling.

With my husband, thankfully — we say thankfully — he has lung cancer and thankfully he's in a wheelchair. The lung cancer treatment's going great, by the way, but because of that, he has a palliative care team that's been assigned to him, and on the palliative care team, there's a clinical social worker who started having sessions with him.

With that being said as well, I'm required to go with him — happily required to go with him — for his cancer immunotherapy treatments. Here we are in a cancer infusion therapy center. This is not Disneyland. This is not our favorite restaurant. This is not our favorite beach. And he's so happy to be able to see me in person. Even though we can't hug, and we can't touch — for two hours, even in a cancer clinic, his mood is so elevated, and that glow lasts for a couple of days. And then we're back again to seeing some more of the depression.

I think mental wellness is huge. The essential family caregiver, tech support, being mindful of the individual — I think if I could change it that each person could have their own room, and that the rooms could be much less clinical and institutional than they are.

Skilled Nursing News

CMS Updates Nursing Home Visitation Guidance with Eye Toward Indoor Reunions

With many families having been separated from their loved ones by the walls of a nursing facility since March, everyone has been looking forward to an update from CMS to let them know when they can schedule a time to visit the senior members of their family unit.

Written by: Alex Spanko

9/17/2020

The federal government on Thursday issued a new set of nursing home visitation guidelines, laying out a roadmap for resuming indoor visits based on community COVID-19 spread and emphasizing the importance of meeting residents' psychosocial needs.

The Centers for Medicare & Medicaid Services (CMS) unveiled the new recommendations in a memo to directors of State Survey Agencies, the groups responsible for performing routine nursing home inspections.

"CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends," CMS official David Wright wrote in the memo. "In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE [public health emergency]. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation."

Under the new framework, operators must conduct all visits based on a set of "core principles of COVID-19 infection prevention," listed as follows:

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h)

Outdoor visits remain preferred under the new rules — with CMS noting that they should be held "whenever practicable" — but the memo provides a blueprint for safe indoor visitation.

Operators should "accommodate and support" indoor visits as long as there have been no new COVID-19 cases in the last 14 days and visitors adhere to those core principles. The total number of visitors should be capped

both on a per-resident and overall basis, and operators should restrict visitors' movement around the facility, generally confining outsiders to residents' rooms or designated visitation areas.

Similar to a recent testing mandate, indoor visits will depend on the rate of COVID-19 infections in a given community, with CMS recommending they occur only in areas with positivity rates of 10% or lower; in counties with rates above 10%, only compassionate care visits should be conducted indoors.

In order to bolster facilities' ability to provide safe visitation areas, CMS is expanding the civil monetary penalty (CMP) reinvestment program; operators can now receive up to $3,000 for the purchase of tents and clear dividers, in addition to $3,000 for communication devices used in virtual visits.

CMS ordered the suspension of visits on March 14. The federal government until now has largely left the decision to reopen facilities up to individual states based on a framework released in May, resulting in a patchwork set of rules. CMS's Thursday memo makes clear that the federal guidance supersedes those state solutions, such as in areas that allowed residents to designate specific caregivers for visitation purposes.

"CMS does not distinguish between these types of visitors and other visitors," Wright wrote in the memo. "Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as 'essential caregivers.'"

Operators can still deny in-person visits based on a variety of factors, including their county's infection rates, the presence of COVID-19 cases in a given building, or visitor symptoms. But they will now face citations and enforcement actions for preventing visits without "a reasonable clinical or safety cause"; the memo included a list of specific tags that surveyors should investigate for non-compliance moving forward.

"For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home must facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above," CMS warned.

LeadingAge indicated late Thursday that it supports the new framework, but still called for greater access to vital supplies in order to maintain safe visitations.

"While today's memorandum helps to clarify the many elements providers must consider to ensure that indoor and outdoor meetings occur safely, it is clear that community positivity rates continue to be a significant consideration in determining the feasibility of in-person visits," LeadingAge vice president of regulatory affairs Janine Finck-Boyle said in a statement sent to SNN. "Mitigating the virus's spread is impossible without sufficient access to personal protective equipment, tests and supplies, and staff; without those things, providers face significant challenges."

The American Health Care Association, which represents primarily for-profit facilities, also welcomed the news.

"Providers are eager to welcome back family and friends to our facilities, but we must remain vigilant in preventing the spread of COVID-19," the organization said in a statement. "We appreciate CMS looking for ways to safely facilitate more indoor visits for residents, especially as we begin to head into the fall and winter. We also welcome the opportunity to use CMP funds for tents and barriers to help nursing homes adapt their facilities for this new normal."