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McKnight's LONG-TERM CARE NEWS

Providers Want Weekly Ongoing Pledge of 50,000 COVID Vaccines for LTC

Written by: Danielle Brown

3/15/2021

Nursing home, senior living and aging advocates are pushing the federal government to commit to allocating between 50,000 and 75,000 weekly COVID-19 doses to long-term care pharmacies enrolled in the Pharmacy Partnership for Long-Term Care in a push to keep their top vaccine priority.

The American Health Care Association, LeadingAge, Argentum and the American Seniors Housing Association issued the plea in a letter to President Joe Biden's COVID-19 response team last week. They also called on the administration to publicly prioritize vaccine allocations for all older adults who use long-term term services and supports. In addition, they wans provisions made for all providers, including those who serve homebound seniors.

"It is not enough to leave the allocation, access, and delivery decision-making to individual states. State health departments are understandably focused on more broad scale rollout of vaccines to all older people, and soon, all adults. We must not lose focus on the most vulnerable elders," they urged.

The groups also requested direct allocation of vaccine doses to long-term care and other pharmacies enrolled in the Retail Pharmacy Program that are willing to offer onsite clinics to residential communities, including independent living and adult day health.

They also want the administration to make a public statement about its commitment to connecting homebound seniors and their caregivers to vaccines and publicly prioritize those the aging workforce for future shot allocations.

"For all of these yet-to-be vaccinated individuals and the staff who serve them, we seek continued federal policies that focus on their unique situations and their greater need. The federal government made a lot of progress

with the Partnership. It's essential to keep up the progress with these vulnerable, prioritized individuals," the organizations wrote.

AHCA/National Center for Assisted Living also late last week called on U.S. governors to ensure their states keep long-term care pharmacies at the top of the list for the next phase of vaccinations.

"A steady, ongoing allocation of vaccines to long-term care will also help ensure we continue to build upon the progress we have already made in reducing COVID in long term care," AHCA/NCAL President and CEO Mark Parkinson said in a statement.

McKnight's LONG-TERM CARE NEWS

'Reverse the Narrative' on Bad Staff to Improve Nursing Home Accountability

Written by: Kimberly Marselas

3/15/2021

Healthcare leaders and policymakers must "reverse the narrative" around incompetent or neglectful nursing home staff and work collaboratively to ensure care teams meet regulatory requirements, according to the medical leader of a large skilled nursing chain.

Deep mistrust between frontline healthcare workers in nursing homes and industry overseers has led to an accusatory survey process that pits the sides against each other, said Arif Nazir, M.D., chief medical officer of Signature HealthCARE, during a presentation at AMDA's virtual annual conference Friday.

"There's no room for punitive and punishment approaches … in a complicated system like healthcare," Nazir said.

He called on surveyors to stop looking at mostly well-intentioned workers as if they are all out to do wrong. He compared the current survey approach to beating children who make an error because they don't know better.

"Nursing homes represent the same issue with all the regulatory issues and patients being sicker," he said. "You need me to improve, and you're going to take a million dollars away from me? That doesn't work anymore."

He also called on regulatory agencies to reduce the amount of required reporting and to streamline data collection processes.

Nazir is past president of AMDA and served on a survey task force that last year called for engaging geriatric experts in the survey process and recognizing high-performing and innovative facilities rather than assigning blame and focusing on punishments for providers. That group also included geriatrician Michael Wasserman, M.D., then-AMDA president-elect Karl Steinberg, M.D., Alan Horowitz, Esq., RN, and James Lett II, M.D.

In last week's wide-ranging talk on leadership, Nazir emphasized the importance of clinical expertise both during the pandemic and as the needs of the average nursing home patient increase.

He said engaging physicians on site more frequently and more cooperatively can help change the culture of nursing homes and improve patient outcomes. At Kentucky-based Signature, nurse practitioners lead a care hub model that assigns each patient a care path to assure coordination and transparency.

The model established a new on-call process focused on quality improvement and defined the role of the medical director as a mentor and coach. It also features weekly grand-rounds sessions for continued team training.

“We have to create an environment of learning,” Nazir said. “Gone are the days when the physician is the only clinical education leader on the team.”

The chain recently introduced an in-house app that “nudges” physicians to keep them more engaged with facility leadership. The mobile app provides routine educational refreshers, with three to five actionable recommendations related to topics such as pneumonia management.

Nazir also cautioned that not all innovation has to be “sexy” or high cost.

“We have so much we can change tomorrow by changing clinical workflows,” he said. “These are the heart of innovation that is required. It does not require policy change. It does not require millions of dollars.”

Opportunity for change

The pandemic has provided nursing homes a “unique opportunity” to change the perception that negatively impacted the industry over the past year, geriatrician Sharon Brangman, M.D., urged during AMDA’s opening keynote presentation on Thursday.

“It was okay if you died of COVID in a hospital but if you died of COVID in a nursing home that was sometimes perceived as being really bad and that means that facility was bad,” she explained. “That unequal perception based on all the negative connotations about nursing homes came into play.”

She added that “the time is now” to look at ways of improving long-term care and making it viable for seniors and providers, which includes reimagining long-term care from different perspectives (the people who live and work in facilities) and ensuring that providers have a seat at the table during decision-making time.

“This is what I think our call is now: To look at the system and decide how we improve it and build it,” she said. “We have a number of opportunities here.”

McKnight’s LONG-TERM CARE NEWS

ACHCA President and CEO Bill McGinley Calling it a Career

Written by: James M. Berklan

3/15/2021

Bill McGinley, the dynamic president and CEO of the American College of Health Care Administrators, has

announced his retirement. He will remain through the group's online annual convocation in April and is expected to "hand over the reins" near the end of May.
Since assuming ACHCA's top post in late 2017, he has boosted the organization with a firm hand, expanding its size and stature. He first joined the group when he became a licensed long-term care administrator in 1982 and plans to remain involved as the treasurer of its Massachusetts chapter.

Coaxed away from potential retirement a little over three years ago, McGinley has become well known as a candid industry spokesman and clear-eyed writer. His column for mcknights.com just after the start of the pandemic about nursing homes' "raw deal" set a readership record, garnering hundreds of thousands of views.

He notified ACHCA's board of directors Friday of his plans to step down. He was expected to make a public announcement Monday morning.

"It has been an honor and privilege to lead this association that I have belonged to for my entire career and that I love," he told *McKnight's* in an email. "I will miss the daily contact with our members, but I will stay a member and hope to see many at future convocations. I am most proud of the hundreds and hundreds of new members that joined during my tenure and that I was able to raise the profile of the association."

McGinley's career has included lengthy stints as a top executive for Greenery Rehabilitation Group, Whitney Place/Beaumont Rehabilitation and Skilled Nursing Center, and Brightview Senior Living. After 41 years in the workforce, however, the Massachusetts native said it is now time for him and his wife, Sue, who retired two years ago, to enjoy more leisure time.

"I look forward to the next chapter in my life, and hopefully some more travel," the 67-year-old noted.

The ACHCA board is conducting an open search for his replacement.

"Over the course of his three-year tenure, Bill has stabilized our operations, enhanced ACHCA's visibility in the post-acute community, and set us back on a successful course," ACHCA Board Chair Bob Lane said. "His relatability, level head and dedication to this association will be missed tremendously."

Among his favored accomplishments, McGinley lists combating ageism and enhancing relationships with industry partners such as the American Health Care Association, American Association of Post-Acute Care Nursing, National Association of Health Care Assistants and the American Medical Directors Association.

"I am happy that we were able to collaborate with our industry partners during the pandemic," he told *McKnight's*, "for the betterment of the profession and long-term care in general."

(New article on next page)

Skilled Nursing News

Citing Vaccine Rollout, CMS Relaxes Nursing Home Visitation Rules

Written by: Alex Spanko

3/10/2021

The federal government on Wednesday issued updated guidance for nursing home visitations, calling on facilities to allow "responsible indoor visitation at all times and for all residents" — regardless of vaccination status — with a handful of situational exceptions.

"CMS recognizes the psychological, emotional, and physical toll that prolonged isolation and separation from family have taken on nursing home residents, and their families," CMS chief medical officer Dr. Lee Fleisher said in a Wednesday statement. "That is why, now that millions of vaccines have been administered to nursing home residents and staff, and the number of COVID cases in nursing homes has dropped significantly, CMS is updating its visitation guidance to bring more families together safely."

The news comes nearly a year to the day after the Centers for Medicare & Medicaid Services (CMS) shut down most non-emergency visits to nursing homes last March 13, at the very beginning of the COVID-19 crisis.

Calls for an overhaul to strict bans on visits, already loud given the heart-wrenching stories of residents' physical and mental health failing amid extended separation from loved ones, reached a crescendo this week after the Centers for Disease Control & Prevention (CDC) on Monday announced looser new guidance for gatherings of vaccinated and unvaccinated people.

CMS specifically pointed to the success of the federal vaccine rollout in nursing homes as a driver of the new policy.

"High vaccination rates among nursing home residents, and the diligence of committed nursing home staff to adhere to infection control protocols, which are enforced by CMS, have helped significantly reduce COVID-19 positivity rates and the risk of transmission in nursing homes," the agency noted in its announcement.

- Exceptions still remain, however. Operators will be required to limit indoor visits for three specific reasons:
- Unvaccinated residents will not be allowed visitors if the surrounding county COVID-19 positivity rate exceeds 10% and less than 70% of residents in a facility have been fully vaccinated
- Residents who have been confirmed COVID-positive will not be able to receive visitors until they meet criteria to discontinue transmission-based protocols

Quarantined residents cannot accept visitors until they meet the criteria to be released from quarantine.

Outdoor visits remain preferred, and CMS cautioned that physical distancing remains the safest option, especially in cases where one or both parties have not yet received a vaccine.

"However, we acknowledge the toll that separation and isolation has taken," CMS wrote in an updated memo to

states. “We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.”

Visitations can also continue during outbreaks, according to CMS, though only if the outbreak is contained within a specific wing or unit of a nursing home.

As was true prior to the new guidance, visits must always be allowed during end-of-life scenarios — as well as when residents are “in decline or distress.” Representatives of state long-term care ombudsman offices are also required access to residents at any time.

Additionally, operators cannot require visitors to provide proof of vaccination or submit to a coronavirus test as a prerequisite for entering a facility, though CMS is encouraging family and friends to roll up their sleeves when they have the opportunity. Federal and state surveyors also do not need to be vaccinated to perform their duties, though they can be denied access if they actively display COVID symptoms.

The two national trade groups that represent nursing homes and other long-term care settings welcomed the news late Wednesday.

“With today’s announcement, federal policy now reflects the real progress that has been made in vaccinating nursing home residents and staff,” Katie Smith Sloan, president and CEO of LeadingAge, said in a statement. “This is the right thing to do.”

Mark Parkinson, president and CEO of the American Health Care Association, called on federal officials to continue providing ongoing vaccine support for both nursing home residents and staff, as well as the general public to embrace the shots.

“Our dedicated staff members have done an extraordinary job filling in for loved ones and adapting visitations during this difficult time, but nothing can replace engaging with family members in person,” Parkinson said in a statement. “The health and wellbeing of our residents will improve thanks to this important guidance.”

Skilled Nursing News

He Won Praise for Keeping COVID Out of a Nursing Home. Here’s His Vision for the Future of Long-Term Care

Written by: Maggie Flynn

3/14/2021

COVID-19 cases in nursing homes have plummeted since the vaccination effort shifted into gear at the end of December, dropping by as much as much as 82% by the start of March.

With the immediate crisis starting to abate, SNF operators are now faced with a daunting task: determining what comes next, and what the new normal of operations looks like.

Whatever else it may be, it cannot go back to the old normal, which saw more than 170,000 deaths in long-term care facilities over the course of the pandemic.

For Rev. Dr. Derrick DeWitt, the director and chief financial officer of the Maryland Baptist Aged Home — who won national accolades for the measures he took to keep COVID-19 out of the 30-resident nursing home — this means that infection control needs to become completely integrated into the day-to-day practices of care.

But it also means turning the traditional nursing workplace hierarchy upside-down to focus on the frontline staff who work most closely with residents. It means keeping facilities small, no matter their overall ownership structure. And it means that nursing homes must own their place in the health care continuum as the place insurers want to send their patients to keep them from infection in the hospital setting.

“A hospital is an infection death trap,” DeWitt told Skilled Nursing News in a wide-ranging interview on March 2. “Unless you keep the person in the ICU [intensive care unit] and you keep them in a bubble, and you wear a gown, wear gloves, wear a mask every time you go in and out … you’re not going to control infection with that person. Why should we take that chance at the hospital? Send them to the nursing home, let them have the risk. We did the risk of the surgery, let them have the risk of getting the person back to health. It’s ludicrous.”

DeWitt spoke with Skilled Nursing News about his hiring of an infection control nurse, and some of the challenges he faced in implementing the programming and education that came with that hire earlier this month.

But he also shared his view of the operating landscape for skilled nursing facilities, a view forged by his status as a relative outsider — someone brought in to right the financial ship at the Maryland Baptist Aged Home.

Excerpts from that conversation, edited for length and clarity, are below.

You’ve talked about how, when you first took steps to hire an infection control and quality assurance nurse full-time, you faced some pushback. Can you go into what happened as you were making that hire?

For me, it was the criticism that normally, for a facility as small as ours, we wouldn’t have a quality assurance and infection control nurse as a full-time staff member. Normally, that would be somebody who comes in maybe a couple days a week, or would be an extra duty for one of the nurses that you already have on staff.

But in my estimation, it was very critical for us. When I was sent over to the nursing home try to figure out what the problems were financially and everything, I was saying: If there’s one thing that’s going to sink a small facility like ours, it’s going to be widespread infection. So that became one of the priorities in our business model.

When I looked at it, I said, “Listen, infection control is going to sink us, and low ratings [are] going to sink us, because we have to be able to compete with those conglomerate nursing homes that are already getting the Medicare patients and leaving the other uninsured and less insured to facilities like us. To compete, we need to make sure that we are a facility that is getting high ratings, and one of the things that’s going to help us get high ratings is the health of our residents — which means keeping out infection.”

To me, coming in knowing nothing about nursing care at all — I was a finance guy — I’m like: Well, if I’m in nursing, what’s going to kill us, what’s going to ruin our business? And infection was at the top of that list. If the demise of your business is going to be a slow leak, it’s probably going to be because you’re not making enough money, right? But if your business is just taken off the map, in one fell swoop, it’s going to be either a catastrophe or a pandemic.

So I began to think: We can't prevent the catastrophe, because that's an act of God, but we can prevent how a pandemic affects us if one should come, and that was keeping out infection. In nursing homes, every touch is an opportunity for infection, every single touch. You go from one room to another, don't wash your hands, you touch a patient, you can spread infection. You give a patient an inoculation without using the alcohol pad, when the skin breaks, it can put infection into the blood stream. Every touch was the possibility of infection. So how do we control that?

I said: We need to bring in somebody who can make sure that we're teaching on that regularly, we're training on that, and we're documenting what we do.

The criticism was: You're going to bring in a full-time person, pay them $80,000, $90,000 a year in a facility that's barely making money?

I said, "Well, take some of my money, because it's that critical, it's that crucial to the survival of our facility and to the health of our residents."

When you talk about that criticism, who was it coming from?

Some of it was from the board of directors, and some of it was just from people within the industry. When we have these associations and affiliations with different health care agencies, and even with our accountants and those type of things, and they said: Listen, this to us don't really make a lot of economical sense.

But it wasn't about the economical sense; it was about the safety.

The criticism came from several different places, from within and without. People in the industry, just other nursing homes who we had communications with, just because it's a small industry, right? It's a small world. So when we talked to other partners, they were like, "You've got a what? An infection control person? How are you pulling that off? That's crazy to be spending that kind of money."

And now in hindsight, they're saying, "We wish we had spent that kind of money."

How did this affect operations at the facility — even outside COVID-19? How did it affect keeping the facility open, even outside out of the pandemic?

One of the things that drove the infection and the overall cleanliness and the sanitation of the facility — and if you visited the facility, it would help you understand — we have a one-story facility. We're a small facility, because the concept of our facility was that it was a nursing *home*, right? So if it's a nursing *home*, it should look like a home, versus a hospital or an institution.

We are a one-story facility. One of the major criticisms that you always hear about nursing homes is: the odor, or the smell. People say, "I don't go to nursing homes because of the way they smell, the odor."

So we always knew that we could not afford to have an odor or smell, because we're one-story. There's no way to mask or hide the odor or smell, you have to get rid of it. In having to do that, whenever we have an incontinence problem, or whatever, we have to remove that stuff from our facility right away. We don't have a bin that we can put it in until tomorrow; it's removed right away.

I tell you all that to say that plays an important part — us being a small, one-story played an important part in our sanitation methods and in our overall infection control, because we always have to be at a high state of cleanliness in that facility, because of the way we're situated.

That just rolled into COVID, but even before COVID, we realized because we were that type of facility, we had to make sure that we were at a high state of cleanliness. One of the other things that we prided ourselves on is not being a facility where you had to announce your visits; we were open for visits 24 hours a day.

Now, we have set visiting hours; we would prefer you to visit your family member from this hour to this hour. But if you came in at 2 in the morning and wanted to visit your family member, we let you visit at 2 in the morning, because we want you to know that we are not just putting on a good, clean face during visiting hours. We're always trying to be clean, at all times.

That type of practice, I think, prepared us to be able to handle the pandemic in the way that we've handled it.

Can you go into that infection control and quality assurance role — what it entailed, and what it's like now?

It's a part-time role now. Prior to COVID, we had reduced it to part-time. With the full-time person, the main objective was for them to put in the policies and the procedures and the programs, document that kind of stuff, train on it, and then from there, we can just maintain it without having to have a full-time person. So now, our infection control nurse is three days a week. [The full-time role] was about seven or eight years, I think.

We had to make some adjustments to our payroll; I myself took a pay cut in order to accommodate the role. I do know we had to prepare an office for the person, [and] we were very short on room. But we had to make sure that person had an office to be able to work in. It costs a lot of money, too, because of the training.

We had to do what they call in-service training, where you bring people in for training — you still have to pay them, right? You can't train on every shift, so sometimes when people were working night shifts, they may have to come in early for the training or come in on weekends for the infection control training. Eventually, we were able to put a lot of stuff on film and use tapes and that kind of stuff.

But still, there was a lot of in-service that we had to do, and always, when you bring people in for training, it always costs money.

We have a steady understanding of what it takes now, and we're able to do training of our new people in such a way that we can accomplish it with a part-time person. I think we will maintain that kind of structure unless we see a different need.

What does infection control look like when the focus is so much on incorporating every worker into the process? The way the Center for Medicare Advocacy described it on February 18 was "making every person an infection control officer."

I guess the best way to describe it is: "If you see something, say something." It's up to you to make sure that these policies and procedures that we are training you on are followed by every member of the team. You don't have to have rank, if you will, or seniority to be able to correct anything that you see in violation of our infection control policies. It's your job to call that out immediately.

One of the reasons for that is because if you get two nurses in a room, you don't want to say, "Well, that was nurse so-and-so's fault because she didn't have on gloves." I want to be able to hold both nurses accountable, because the one that didn't have on gloves and the one that was watching her do the work without gloves — they both were just as culpable in whatever happened.

We empowered everyone to be an infection control officer, because you have the ability to correct anybody and to report anything that you see as a danger in the facility.

Jumping back to that hiring process of the infection control nurse, who is the primary competition for that kind of staff person? Is it a hospital or some other type of facility?

It probably would be primarily a hospital, yes, and maybe some of the larger nursing facilities can afford a full-time person. I would say I don't know how they don't have a full-time person; I would say if you're over an 80-bed facility, 50 to 80 beds, but if you're over 80, you definitely need a full-time person.

Infection is one of these things that is lurking around in your building that you cannot smell, taste, or hear. It's kind of like the carbon monoxide of nursing facilities, and your infection control person is kind of like the canary in the mining shaft. There's got to be a way of spotting or knowing that there's some danger lurking.

We've talked a lot about the infection control person, but what are the measures? One of the things we did during COVID is we made sure we hired additional sanitation staff. Just like we had three shifts of nurses, we had three shifts of environmental people in there sanitizing. And one of the residents said to me, "I'm so sick of smelling bleach, they're bleaching everything around here, everything!" And I said, "Baby, it's the bleach that's keeping you alive."

That was one of the necessary evils of it. It can't just be in a book, and it can't just be about wearing gloves all the time. That's certainly a big part of it, but it's got to be sanitizing the hands, because the residents are not wearing gloves. If they're walking down the hall to the bathroom and they're holding onto the rail, that's the possibility of infection, right? So you've got to be sanitizing the railings constantly. You've got to be wiping off the doorknobs constantly.

It's almost like if you could, you're posting somebody in the hallway, and they're watching everything somebody touches and then wiping it down. Of course, we didn't go to that extreme, but we had rotations. On this shift, you've got to make sure you wipe this down, this down, this down, and then the next shift comes in and they do the same thing. So it was a constant, 24-hour sanitation operation, just like we had 24 hours of nurses.

And we didn't have that before COVID. Before COVID, the environmental people were probably there from 6 until the shift came on at 7. We didn't have a person in the middle of the night. So anything happened in the middle of the night, there was the utility closet where the nurse or the CNA could mop up or clean up or whatever. But when COVID hit, we said: No, from 7 to 11, we've got to have a sanitation person here. And that sanitation person, while everybody is sleeping, is going to wipe down every railing, every door knob, every shower handle, every seat — just the whole facility.

It definitely took an increase in enhanced measures because of COVID.

You came into this world as a finance person, like you said. From that outsider's perspective, what would you say needs to change in how nursing homes prioritize their modes of operation around infection control, to be more successful? How does the general landscape of operations need to change in the wake of everything we've seen?

When you come in as a finance person, the two things are: How do we make more money? That was not a possibility for us. We're a 29-bed facility. If we have 29 residents, the only way to make more money is to get sicker people coming into the facility, and of course we're not going to make people sick to make more money, right? So making more money was virtually an impossibility.

The main thing was: We've got to keep the beds full. Hopefully we can get some Medicare, versus Medicaid-type people, but that's not realistic because of where we are and who were and the population that we serve, and so forth.

So my focus became: How do we stop losing money? Where are we losing money? That's where it caused me to turn the pyramid upside down and say: The folks who make money — there's a little bit of people at the top that make a lot of money, and then the people at the bottom, who are doing most of the work, they make a little bit of money.

But it's the people at the bottom that are going to keep the residents safe, going to keep the residents clean, going to keep the residents healthy, right? So let's flip this pyramid upside down. Let's pay ourselves less money at the top and pay the people at the bottom more money, and get buy-in from them that they are the most important people in this facility. Not me as chief finance officer; anybody can count beans and bullets and hit the computer and print out reports and go to the board and lie about what we made, right?

But not everybody can do what [frontline staff] do, and when it comes to cleaning people and medicating people and rolling people over and physical therapy and occupational therapy and the stuff that really matters to them … all of that stuff you're doing at the bottom of the pay scale. We need to make those people and those functions the most important thing in this facility. And that's how we're going to keep people alive, safe, and well.

When you pay people a little bit of money, you're pretty much saying to them that what you're doing is not valuable. To me, that was important — to try to show them the value. And it's not just money and showing them the value but it's also the meaningful relationship that they develop with the residents. So we had to shift that culture, change that mindset; that is, "The people at the top are the most important," when it's not the people at the top, it's the people with their sleeves rolled up that's doing the work. That's the most important.

If we don't [shift that culture], we're going to have to have our next crisis. We had about 40%, maybe 45% of everybody who passed out of [roughly] 500,000 died in nursing homes. And why is that? Because you're paying people peanuts to keep people alive.

Unless they really have a heart for this work — you know, some people, unfortunately are working for money. But that's what we work for. We all work for money. How important is it for you to risk your life for a little bit of money? I will guarantee you, I will almost stake my reputation — and no nursing home is probably going to tell you, Maggie — they struggled to keep people alive because their employees walked out.

When COVID hit, I guarantee you employees walked out and never came back. Because: "I'm not going to risk my life for $12 an hour, $11 an hour, $7 and some change an hour in some states."

Those nurses who were making the big bucks at the top of the scale were left to do what they never were doing in the first place. They weren't the ones turning the people over and bathing the people and all of that. It was the GNAs [geriatric nursing assistants] and the CNAs [certified nursing assistants], and when those guys left them, they left them high and dry.

Now I don't want to say that they all just ran out on the nurses, but I'm telling you that there were a lot of staffing issues that happened before people were affected by COVID, before the staff was affected by COVID, left prior to getting infected by COVID.

We don't pay them enough. We simply don't pay them enough. So we've got to have the shift of that type of mindset within the culture, or we're going to have some catastrophic long-term care over the next five to 10 years.

What I'm pushing is that the model — I don't want to say "can't." I will say that it's very difficult to control infections in a mega-facility, so 300 beds. We are now getting people in our facilities post-acute care. We're no longer just nursing homes or rehab, we're post-acute care facilities. We're getting people two to three days after open-heart surgery.

You know why that is; one is because the insurance companies don't want to keep them in the hospital. One is because a hospital is an infection death trap, and unless you keep the person in the ICU and you keep them in a bubble, and you wear a gown, wear gloves, wear a mask every time you go in and out … you're not going to control infection with that person. Why should we take that chance at the hospital? Send them to the nursing home, let them have the risk. We did the risk of the surgery, let them have the risk of getting the person back to health. It's ludicrous.

What I'm saying is that we have to change the model where these conglomerates are buying up nursing homes and having these big, big conglomerates. That's okay, as long as the facilities are small, and we could have small, community-based long-term care rehab facilities that are easier to manage. So instead of having one 200-bed facility, why not have four 50-bed facilities? And why can't we put them in depressed communities or underserved communities that really need quality long-term care?

I hope that we learned a valuable lesson, that because you have a fountain and a serenity garden, doesn't make you a quality nursing home. What makes you a quality nursing home is that you have quality, comprehensive care. That's my soapbox. You come to my nursing home, I've got duct tape on the floor. Our building is old and it's unsettled, and every time we put down a wood floor, we get a crack here and a split here or something.

We've got duct tape on the floor, but we have no COVID cases. So how do you sell that? They want aesthetics. They want the beautiful scenery and all of that, and it's a tough sell.