Nursing Homes and COVID-19: Medical, Legal, and Ethical Perspectives

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Abstract

The COVID-19 pandemic has had a disproportionately devastating effect on the residents and staff in nursing homes and long-term care facilities in the United States, as this demographic has accounted for about 25% of all deaths for COVID-19 in the US, currently totaling over 132,000 according to the CDC. The data illustrates that nursing homes and long-term care facilities across the country have failed to protect its vulnerable residents against this virus. The neglect that has existed in nursing homes for decades has been exacerbated by this pandemic, and the nation's most vulnerable residents have paid a heavy price. This paper analyzes several aspects of this crisis and provides recommendations to ensure that nursing home residents' rights are respected to the fullest extent. The current state of nursing homes in the midst of the pandemic is outlined, along with CDC guidelines and an analysis of the disproportionately devastating effect that the pandemic has had on nursing homes of minority ethnic backgrounds. The medical intricacies of the virus along with its long-term effects on major organs such as the heart and lungs are explored in great detail. The legal history and current shortcomings of the nursing home industry are explained to expose the neglect that has become increasingly fatal over time. The ethical implications of the crisis occurring in the nation's nursing homes are explored, and the severity of the issue is highlighted. Lastly, we make recommendations, such as stricter infection control policies, increased registered nursing hours, and higher wages for long-term care staff, needed to restore residents' rights and safety.

INTRODUCTION

As of March 14, 2020, over 1.2 million confirmed COVID-19 cases and over 132,000 deaths were reported among long-term care facility residents and staff members in the United States, accounting for about 25% of deaths nationwide.[1] This data is a result of the required reporting to the CMS from nursing homes and skilled nursing facilities. Until May 8, 2020, nursing homes were not required to report coronavirus outbreaks and COVID-19 deaths.

Residents of long-term care facilities are considered to be the most at risk for COVID-19. This is true because older adults are more susceptible to infections and serious illness from COVID-19, given the population density in these types of facilities, where a majority of people residing already have underlying health conditions. Eight out of ten COVID-19 deaths reported in the United States have been in adults ages sixty-five and older.[2] Residents with pre-existing health conditions are encouraged to continue their treatment plan as normal including taking prescribed medications, having at least a thirty day supply of prescribed and non-prescribed medications, and calling your healthcare provider with any concerns about the underlying medical condition.[2] According to the KFF data, as of 2017 more than 40% of long-term care facilities in the United States had infection control deficiencies which can be looked at as a cause for high numbers of coronavirus cases and also high death rates. Residents and staff of long-term care facilities in twenty states account for over 50% of all COVID-19 deaths.[3] Deaths in long-term care facilities account for about 25% of all COVID-19 related deaths in the United States.[3] The CDC explains that it is critical to have a strong infection prevention and control (IPC) program in order to protect both residents and healthcare personnel (HCP). The CDC explains that there should be at least one individual with training experience in IPC in order to provide on site management of the facilities COVID-19 prevention and response activities. According to the CDC, when necessary, quarantining is put into effect in order to keep someone who might have been in contact with or exposed to COVID-19

away from other healthy individuals. Quarantining helps prevent the spread of the disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. People in quarantine are advised to stay at home, separate themselves from others who live in their home, monitor their health, and follow directions from their state or local health department.[4] Close contact can be defined as being within six feet of someone who has COVID-19 for a total of fifteen minutes or more, providing care at home to someone who is sick with COVID-19, direct physical contact with the person infected such as hugging, eating and drinking utensils were shared, or respiratory droplets got onto skin after being sneezed or coughed on.[4]

It is important to note the difference between quarantine and isolation. Quarantine keeps someone who might have been exposed to the virus away from others. Isolation keeps someone who is infected with the virus away from others, even in their own home (CDC). The Occupational Safety and Health Administration, an agency of the United States Department of Labor specifically recommends that nursing homes and other long term care facilities follow certain quarantine guidelines in order to benefit the greatest number of people. The "OSHA" specifically recommends that nursing home staff are trained to protect themselves and residents during the pandemic. It is important to regularly clean and disinfect shared surfaces and equipment workers come in contact with in order to perform their jobs. Hospital grade cleaning chemicals approved by the "Environmental Protection Agency" should be used during quarantine and break periods should be staggered in order to avoid crowding in the break rooms (OSHA.gov). Specific recommendations for workers and patients of long-term care facilities in isolation include staying home until it is safe to be around other people. It is also important to separate yourself from other members in the same household and establish a specific room as "the sick room" and use a separate bathroom if possible (CDC). It is also important to monitor any symptoms, wear a mask when entering common territories throughout the household and do not share household items like towels, cups, and utensils (CDC).

The Centers for Medicare and Medicaid Services also recently issued nursing home reopening guidance for state and local officials. As stated by the CDC, when relaxing any restrictions, nursing homes must remain observant of COVID-19 symptoms among residents and health care professionals (HCP) in order to prevent the spread of disease and protect residents and HCP's from severe infections, hospitalizations, and death. As specified by the CDC, the person in charge of the IPC program at each long-term care facility is held accountable for reporting COVID-19 cases to the "National Healthcare Safety Network Long-term Care Facility COVID-19 Module" weekly. The CDC's "NHSN" provides long-term care facilities with systems to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF's COVID-19 module, which include resident impact and facility capacity, staff and personnel impact, supplies and personal protective equipment, and ventilator capacity and supplies. The CDC also advises staff of long-term care facilities to review the CDC "Infection Control Guidance for Healthcare Professionals about COVID-19" on a regular basis in order to be up to date on the current statistics and information about guideline changes. Staff should also be emphasizing hand hygiene, mask wearing, educating residents and families on what COVID-19 is and its symptoms, how to manage stress and anxiety, enforcing any visitation restrictions, and enforcing usage of proper personal protective equipment (PPE). Staff in charge of the IPC program should create a plan for testing residents and healthcare personnel for SARS-CoV-2. It is important that each long-term care facility has access to enough test kits for every resident incase of an outbreak, along with an available laboratory to receive results and conduct antibody tests. An inventory of staff members should also be taken in order to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission. All healthcare providers should be screened at the beginning of their shift for a fever and COVID-19 like symptoms. Temperatures should be actively taken and documented. Staff of long-term care facilities are also required to put alcohol-based hand sanitizer with 60-95% alcohol in every resident room and other resident care and common areas. A space in each long-term care facility should be dedicated to care for residents with confirmed COVID-19. This could be a designated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.

Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections. Testing practices should aim for rapid turnaround times in order to facilitate effective actions. Testing the same resident more than once in a twenty-four-hour period is not recommended. While the CDC guidance focuses on testing

in nursing homes, several of the recommendations such as testing residents with signs or symptoms of COVID-19 and testing asymptomatic close contacts should also be applied. The CDC recommends viral testing to be done of all previously negative residents, generally every three to seven days, until the testing identifies no new cases of SARS-CoV-2 infection among residents for a period of at least fourteen days since the most recent positive result.

Based on recommendations from the Advisory Committee on Immunization Practices (ACIP), an independent panel of medical and public health experts, the CDC recommends residents of long-term care facilities be included among those offered the first supply of COVID-19 vaccines.[1] All COVID-19 vaccines were tested in clinical trials involving more than tens of thousands of people to make sure they meet safety standards and protect adults of different races, ethnicities, and ages, including adults over the age of sixty five. The most common side effects due to the vaccination were pain at the injection site, fever and chills. The ACIP and CDC agreed that the lifesaving benefits of the COVID-19 vaccination for long-term care facility residents outweigh the risks of possible side effects.[1] For LTCF in particular, the CDC will work with pharmacies and other partners to report possible side effects to the "Vaccine Adverse Event Reporting System" (VAERS). Facility staff and residents' families are encouraged to also report any adverse effects immediately.[1] The CDC will also work with pharmacies and other partners to educate staff, residents families, and the residents about the vaccine and answer any questions. Consent for the vaccination should be obtained from the residents or the person appointed on their behalf to make medical decisions and documented in the residents chart per standard practice.[1]

While it is true that nursing home residents and elderly people in general are at much higher risk of infection and severe symptoms from COVID-19, residents living in predominantly black and Latino homes have experienced a substantially greater impact from the disease. A study by the KFF revealed that as of early October 2020, out of all homes that have reported at least one coronavirus case, homes whose residents are predominantly black and Hispanic have experienced more severe case outbreaks as a share of the homes' total beds than white nursing homes.[5] While there have been correlations to size and location of the nursing homes and the number of cases within the homes, nursing homes of predominantly black and Latino ethnic backgrounds have been twice as likely to experience a hit from the coronavirus.[6] One reason for this may be due to the pseudo-segregation in this nation's nursing homes, as smaller homes tend to be predominantly white, while the larger, urban homes tend to house predominantly black and Latino residents. However, there are other concerning phenomena that the data has revealed. Data has also shown that larger homes with few black and Latino members have had outbreaks at a lower rate than smaller homes composed of mostly black and Latino residents. In addition, primarily minority homes with a high CMS rating, which is based on a rating system that will be discussed in great length later, tended to have higher rates of cases than predominantly white homes with a lower CMS rating. Overall, while it is important to understand and interpret this data as worrisome for the nation's minority nursing home population, states are not required to report cases by ethnic group or race. So, while this data hints at a major problem related to protecting the nation's most vulnerable individuals, it is not the full story, and the situation may be much worse.

MEDICAL PERSPECTIVES

Given the drastic effects that this disease has caused within nursing homes, it is vital to understand the science and medicine behind this disease and its behavior. Coronavirus disease 2019 (COVID-19) is caused by a positive-stranded RNA (ribonucleic acid) virus named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).[7] The overall burden of this disease is believed to be many times more as only a fraction of infections are diagnosed and reported.[8,9,10] COVID-19 is spread mainly through direct person-to-person transmission via respiratory droplets produced when an infected person coughs, sneezes, or talks. New infections happen when these droplets come into contact with a healthy individual's mucous membranes either directly or when they touch their eyes, nose, or mouth with their hands contaminated by these droplets. Another lesser-known mode of transmission in healthcare settings like hospitals and nursing homes is through direct inhalation of virus-containing aerosols suspended in the air produced by certain procedures like nebulization and suctioning of oral secretions.[11,12,13,14] The potential to transmit the SARS-CoV-2 in symptomatic patients exists mainly within the first 7-10 days of illness, especially in non-severe infections, and is highest during the early days of the disease course. Transmission from asymptomatic individuals can also happen and actually has been well documented.[15,16,17,18,19,20,21]

Symptoms usually start 4-5 days after infection, and the spectrum of clinical presentation ranges from mild to critical

disease, with most patients experiencing only mild to moderate symptoms. Advanced age and comorbid conditions like cardiovascular disease, diabetes mellitus, hypertension, etc., appear to be the most significant risk factors for developing critical disease. In a report published by the Chinese Center for Disease Control and Prevention, which included more than 72,000 patients from China, it was noted that nearly 81 percent of the patients had only mild symptoms (which includes upper respiratory tract symptoms, mild pneumonia, fever, myalgias, diarrhea, and smell or taste disorders), 14 percent had severe disease (like worsening fever, cough, dyspnea associated with worsening oxygen saturation in blood and chest imaging consistent with severe pneumonia) and 5 percent had critical illness with respiratory failure, septic shock, and/or multiple organ dysfunction.[22] Diagnosis of COVID-19 in suspected patients is achieved most commonly by detecting SARS-CoV-2 RNA in their upper respiratory tract. This is done by obtaining nasopharyngeal (inner nose) swabs from suspected patients and testing them for viral RNA by nucleic acid amplification tests like reverse-transcription polymerase chain reaction (RT-PCR).[23,24]

In addition to the acute infection, chronic COVID-19 infection is of great concern and is defined as the persistence of symptoms extending beyond 12 weeks from the initial onset of symptoms. Persistent fatigue and dyspnea are commonly reported after acute COVID-19 infection. Furthermore, specific organ dysfunction has also been reported, involving primarily the heart, lungs, and brain. The mechanism by which COVID-19 causes these long-term consequences is not clearly delineated; however, it could be related to direct tissue invasion by the virus, profound inflammation or cytokine storm, and hypercoagulable state described in association with severe COVID-19, or a combination of these factors.[25,26] From a cardiovascular standpoint, myocardial injury indicated by an increased troponin level, along with thromboembolic disease, has been described in patients with severe acute COVID-19. Myocardial inflammation, myocarditis, and cardiac arrhythmias have also been reported after SARS-CoV-2 infection. A decreased diffusion capacity for carbon monoxide and diminished respiratory muscle strength, along with pulmonary dysfunction from interstitial thickening and fibrosis, have been noted from a pulmonary standpoint.[25]

COVID-19 is also seen affecting the neurological system, as evidenced by the symptoms of anosmia caused by direct invasion of the olfactory nerve. A lesser stressed aspect of COVID-19 is its effect on cognitive function, directly or indirectly, by the SARS-CoV-2 virus. Severe hypoxia and cytokine-mediated damage are the presumed mechanisms leading to brain damage and cognitive impairment in patients who have developed acute respiratory distress syndrome (ARDS) due to COVID-19.[27] Additional contributing factors to cognitive impairment may be sepsis, sedating and anesthetic drugs, and mechanical ventilation. Other long-term neurologic symptoms after COVID-19 include headache, vertigo, chemosensory dysfunction, encephalitis, and seizures.[28] In addition to neurological symptoms, the psychological effects of long confinement periods, social isolation, and traumatic personal or familiar experiences associated with the disease should be considered when evaluating the potential cognitive effects in patients with COVID-19.[27,29]

Given the rising incidence of CNS involvement in COVID-19 cases, it remains to be seen if the COVID-19 pandemic will lead to a significant increase in the prevalence of longer-term cognitive dysfunction impacting the ability to return to everyday functioning.[30] The medical-scientific community needs to look beyond the current acute crisis and understand the links between coronavirus infection and long-term neurological sequelae. Knowing a patient's life and functioning before the virus can help physicians understand how much the illness has altered it. Thereby, depending upon the extent of the neurological and psychological effects, physicians can approach patients and talk to them about various management plans based on their life aspects they are most eager to regain.

There are no proven COVID-19 treatments available as of now, with multiple drugs currently under investigation. Patients with mild disease are encouraged to stay at home and self-isolate themselves until their health improves. However,, on November 21, 2020, the FDA issued an emergency use authorization (EUA) for use of a cocktail of two monoclonal antibodies- casirivimab and imdevimab (known as REGN-COV2) in non-hospitalized COVID-19 patients aged 12 years or older with mild to moderate symptoms and who are at high risk for progressing to severe disease. This includes patients who are 65 years of age or older or who have certain chronic comorbidities. This EUA is based on a clinical trial that reported administering casirivimab and imdevimab together through intravenous route reduced the hospitalizations and emergency room visits in high-risk patients to 3% on average compared to 9% in placebo-treated patients.[31] Administration of this cocktail

is not advised in hospitalized patients as it may be associated with worse clinical outcomes in them.

The approach towards COVID-19 specific treatment in hospitalized patients depends on the severity of their illness. For non-severe hospitalized patients not requiring supplemental oxygen, the mainstay treatment is primarily supportive, while the use of steroids like Dexamethasone and antiviral medications like Remdesivir are reserved for patients with critical disease requiring high amounts of supplemental oxygen or mechanical ventilation. While studies have shown improved mortality risk with use of Dexamethasone in severe cases, no such benefit was evident with Remdesivir even though it improves the recovery time.[32,33] Convalescent plasma, the liquid portion of blood that contains high titers of COVID-19 neutralizing antibodies obtained from individuals who have recovered from COVID-19, was initially hypothesized to have clinical benefit when given to patients with severe disease, but later studies did not demonstrate any clear benefit.[34] Due to this lack of evidence, it is currently neither recommended nor advised against.

From a public health perspective, effective vaccination is an important tool in mitigating the rapidly growing pandemic. Vaccine development is being vigorously pursued worldwide stimulating alliances between different governments and multinational pharmaceutical companies.[35] The urgency to create a vaccine for COVID-19 has forced the developers to shorten the timeline of vaccine development by combining different clinical trial steps over months that usually take many years when done sequentially.[36] Many new novel technologies of vaccine development are being explored, one of which is mRNA (messenger RNA) developed by Pfizer-BioNTech and Moderna. They were the first COVID-19 vaccines to be granted EUA in the US and the European Union and carry an efficacy of 95% and 94.5% respectively.[37] As previously mentioned, many countries along with the US are implementing phased distribution plans prioritizing healthcare workers and high-risk elderly populations.[38] As of now we do not know how durable the protective responses of these vaccines are as new variants of the virus continue to emerge due to sequence variation in SARS- CoV-2 genetic material.

LEGAL STANDARDS OF SAFETY AND CARE

Given the increasing neglect that nursing home residents experience as time goes on, it is vital to understand first what the existing standards are. The Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act of 1987 set forth new regulations and standards for nursing homes throughout the country. This bill was passed in response to a growing concern for the health and welfare of countless nursing home residents leading up to 1987. It came as a result of a growing advocacy for improved nursing home conditions. First and foremost, the federal regulations require that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care".[39] This bill implemented large changes into the care regimen of residents in nursing facilities. Some of the new residents' rights established by the bill were the right to privacy, freedom from restraint, free communication, banking personal funds with the nursing facility, self-determination, and express grievances without discrimination.[40] Perhaps the most important of these new rights was the right to express grievances, as new federal regulations and inspection standards required conversations not only with staff but also with residents and their families.[41] These rights represent the improvements in the quality of care for individuals.

While the standards put forth by the 1987 bill seem promising, it is also important to look toward the current standards for nursing care to find answers for the national nursing home neglect issue. Current standards require a 24-hour licensed nursing service in all nursing homes with a registered professional nurse working at least eight hours per day, seven days per week.[42] Furthermore, nursing homes must maintain in-service education for nurse aides and provide daily staffing information pertaining to the professional and unprofessional employees available to residents each day. Finally, all residents' care must be provided under the supervision of a physician.[42]

The policy that has been focused on predominantly by advocates for nursing home residents has been the nursing staff requirement. According to a federal study done in 2001, the recommended minimum amount of time that nurses should spend per resident is 4.1 hours. However, this never became a federal mandate or industry regulation, so minimums in states remain much lower than that.[43] States who attempt to approach that 4.1 minimum requirement face backlash from the industry and from other states for raising the bar since increased staffing increases costs thereby decreasing profits.[43] According to NJ.com, in 2019, efforts to

establish a higher minimum staffing requirement for nursing homes were squashed by powerful lobbyists from the industry.[44] What has transpired during the pandemic in New Jersey has revealed the negative effects of the denial of that legislation.[44] This has led many states to exploit this lack of sufficient requirements. In April of 2018, federal regulators began tracking staffing records based on payroll, replacing the previous method of relying on homes' self-reporting two weeks prior to an inspection. This new method quickly found that 25% of long-term care facilities reported no registered nurse on staff at least one day within a three month period.[45] The new method resulted in 70% reporting lower staffing records compared with the self-reporting method, and those understaffed facilities tended to exhibit higher numbers of health code violations.[45]

According to the Kaiser Family Foundation, since 2015, 72% of facilities nationwide have lacked or have not followed an infection-control program.[43] This raises a serious accountability question for these homes. What are the existing enforcement standards and why are they not being enacted? According to US Code 42, if a state finds that a facility is not in compliance with a requirement, it may impose specific remedies based on severity and urgency of the noncompliance.[42] Remedies include the denial of government payments to the facility, the implementation of civil money penalties based on each day of noncompliance, and the appointment of temporary management within the deficient facility.[42] The denial of payments applies to all individuals within or being admitted to the facility during the period of noncompliance.[42] In addition, in order to ensure proper and prompt compliance of the requirements, if compliance is not implemented into facilities within three months of the findings, the denial of payment remedy is required for all those admitted to the home after the three month mark.[42] Also, if the state finds deficiencies in one or more requirements and this poses an immediate risk to the health and safety of residents, the state must immediately ensure compliance through remedies, or terminate the facility's participation in US Code 42, which would require the transfer of all residents to a compliant facility.[42]

While these enforcement standards are in US law, the actual action upon these enforcement standards has been insufficient. Early on in the pandemic, the Centers for Medicare and Medicaid Services deployed federal investigators to inspect if the 15,400 Medicare-certified homes were following regulation protocol. Yet, even as the pandemic worsened, nearly eight out of every ten homes inspected were given a clean bill of health from the inspectors.[46] In the midst of this deadly pandemic, homes cited for infection-control violations remained at about the same level.[46] According to the Kaiser Family Foundation in May 2020, out of all California nursing homes with at least one case of the coronavirus, 91% had infection-control violations in their history while only 24% had been fined by the federal government in the past.[47] Among federal and state regulatory oversights, infection-control is not viewed as the most serious concern for facilities. According to a study by ProPublica, out of the 509 homes in Pennsylvania with reported infection-control deficiencies, only 62 suffered payment suspensions.[48] This glaring discrepancy between the shortcomings of nursing homes and the subsequent consequences reveals an apparent lack of accountability. The current pandemic has only highlighted the devastating consequences of subpar enforcement of regulations.

The *Nursing Home Compare* Five-Star Rating system was created to establish a relative comparison of the quality of nursing homes within a state. Each home is given a rating from 1-5 based on three domains: Health Inspections, Staffing, and Quality Measures.[49] The Health Inspections section encompasses scope, severity, and frequency of facility deficiencies in addition to how many revisits are required to resolve the deficiencies. Each deficiency is classified into one of five categories of severity and one of three classifications of scope. More points are assigned to a facility in tandem with how many revisits are required and how severe or urgent the issue is. These points are then totaled up for each individual facility, and due to varying management, medicaid policy, and state licensing laws, homes are judged by state: top 10% receive 5-star health rating, middle 70% receive 2, 3, 4-star ratings, and the bottom 20% receive one-star. Notably absent from the Health Inspection section is an analysis of the facility's infection control programs or training. Also, an individual facility's rating remains the same until a new deficiency is found, which can arise by inspection or complaint.

The Staffing section consists of registered nurse hours per resident per day and total nurses hours per resident per day. That data is derived from the aforementioned payroll-based reporting of staffing. Higher stars are rewarded for increased RN hours and total nurse hours combined.

Lastly, the Quality Measures section rates quality of resident care based on 15 long/short stay measures. These 15 measures were compiled based on previous Medicare claims

that aptly encompass a resident's stay for different time intervals. Short-stay measures include improvements in function, re-hospitalization rates, and percentage of residents who received antipsychotic medication. Long-stay (residents who stay for more than 100 days) measures include the percentage of residents whose mobility has declined and the number of hospitalizations per 1000 residents or emergency room visits per 1000 residents. These ratings are released quarterly and only change in response to new complaints, inspections, changes in scope, or the aging of the deficiency into a previous period.

The pandemic, however, has exposed the shortcomings of this rating system, namely that there exists no significant statistical relationship between the facilities deemed to have the highest quality by the rating system and lower numbers of COVID-19 cases. According to a study published in the *Journal of the American Geriatrics Society*, the star rating, infection control violations, and ownership represent no indications of how well the facility has been able to avoid the virus.[50] Rather, the study reveals that facility size, location, and resident ethnic makeup significantly correlate to the probability of cases within a facility.[50] Several other studies have similarly concluded that facility size and location, namely the number of cases in the surrounding area of the facility, represent the most significant statistical relationship between a facility and its probability of having a case. Due to limitations on the data as a result of inconsistent case reporting, these correlations will need to be studied much more. However, these studies reveal that the crisis within nursing homes during this pandemic is a highly complex matter, the cause of which being extremely difficult to pinpoint. The likelihood of contracting an initial positive case may not have been in the control of nursing homes, but these studies display that there may be a need for a more detailed and advanced rating system, one that can more aptly recognize the facilities best-suited to protect its residents and employees.

ETHICAL ANALYSIS

The coronavirus pandemic has devastated nursing homes in the United States by infecting nursing home residents and staff members, which has contributed to about 25 percent of the nation's Covid-19 death toll. The United States is not an outlier. "A study by researchers at the International Long-Term Care Policy Network of fatalities in a range of high-income countries found that 46 percent of reported Covid-19 fatalities took place in nursing homes."[51] These numbers are problematic. However, what has made this pandemic even more devastating is how it has impacted on the African-America and Latino communities. "Nursing homes where those groups make up a significant portion of the residents-no matter their location, no matter their size, no matter their government rating-have been twice as likely to get hit by coronavirus as those where the population is overwhelmingly white." [6] According to the Centers for Disease Control and Prevention (CDC), poor quality care is the feature that stands out in the approximately 15,600 nursing homes in the United States with 1.7 million licensed beds, occupied by 1.4 million patients.52 It has become clear that the poor and the elderly, especially those living in nursing facilities, were in the greatest danger from Covid-19. The facts confirm this tragedy. The federal government has safety and quality standards for those homes certified under Medicare and Medicaid but the enforcement of these standards was lax and as a result innocent, vulnerable, elderly patients paid the price with their lives. Many in the healthcare industry believe this happened because regulators let the nursing home industry treat standards of care as a goal rather than as an actual requirement. Instead of protecting the residents of nursing homes, the industry protected the nursing homes. Nursing homes that were cited for violations and fined for substandard care were allowed to continue to operate. Profit became the guiding force not the sanctity of human life. Ethically, nursing home patients must be protected, existing standards need to be strictly enforced and stricter standards need to be developed and put in place to improve the quality of life and survival of nursing home patients. This is imperative for the elderly, their families and society as a whole. It will be argued that—according to the ethical principles of respect for persons, beneficence/nonmaleficence, and justice—action must be taken immediately to address the concerns surrounding the deaths of nursing home patients due to Covid-19 and the failed standards of care in these facilities. Such action will not only save lives, but will also do much to ensure the dignity and respect of our elderly citizens.

Respect for Persons

This principle incorporates two ethical convictions: first, that persons should be treated as autonomous agents; and second, that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.[53] Respect for human persons

refers to the right of a person to exercise self-determination and to be treated with dignity and respect. All people, no matter their race, creed, color, sexual orientation or health care condition, deserve autonomy and to be treated with dignity and respect. Failure to provide any person with adequate health care violates this basic right of respect for persons. The many examples of weaknesses in patient care and the lack of oversight in nursing homes led to the widespread death rate due to Covid-19 in nursing homes. This was a failure to provide adequate health care to our most vulnerable citizens. This is clearly a violation of the principle of respect for persons.

Second, as an autonomous agent an individual has the right of informed consent. The elements of informed consent include professional disclosure, patient comprehension of the information, patient voluntariness and competence to consent. This means that patients and their proxies have the right to know the quality of care in nursing homes, the staffing required by law, how quality standards are monitored and enforced and any failures in regulations. Unless this information is provided to patients and their proxies we are not providing these patients and families informed consent. In addition, "long before the pandemic, there was disparity in nursing homes. Those with more black and Latino residents tended to score worse than mostly white homes on quality metrics used by regulators." [6] These lack of quality standards led to the devastation we have seen in the nursing homes in the United States. As of May 2020, "the Centers for Disease Control and Prevention report that 2.1 million people live in nursing homes or residential care facilities, representing 0.6% of the U.S. population. And yet residents in such facilities account for 42% of all deaths from Covid-19 for states that report such statistics." [51] Patients and their proxies have a right, under informed consent, to know the basic facts concerning care of patients in nursing homes. It is clear from the Covid-19 crisis that there is poor quality of care and safety in U.S nursing homes. The reasons these issues have not surfaced before this pandemic is that the nursing home industry is being controlled by large and politically powerful multinational corporations. "These corporations have wide discretion over the spending of large amounts of public funds, but at the same time there is little financial accountability. Fraud and financial mismanagement are widespread throughout the industry as is poor quality care."[54] In addition, poor staffing, low wages and lack of benefits also has been a major issue in the nursing home industry. Unless state and federal agencies and healthcare advocacy groups work collaboratively and establish a national database that reflects accurately the standards of our nursing home facilities, patients and their proxies are being denied informed consent. Only when this criterion is met will true informed consent be assured.

The failure of state and federal authorities to be proactive in addressing the medical needs of this most vulnerable population in regards to accurate staffing, quality standards, safety standards, etc., is causing needless suffering and possibly even more deaths. To deny patients and their proxies the right to accurate quality standards data from an accessible national data base that may help them and others clearly violates the ethical principle of respect for persons and our responsibility to help others in society.

Beneficence/Nonmaleficence

The principle of beneficence involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim primum non nocere ("Above all, do no harm"). Patients and their proxies have the right to know the standards of quality and safety in nursing homes and data about these standards to make sure that patients are being protected in nursing homes. It is clear that due to weak standards of safety and quality in U.S. nursing homes and a lack of adequate oversight from state and federal agencies, patients did not receive the beneficial treatment and protection they required in the present Covid-19 pandemic. Data shows that state and federal regulators allowed nursing homes to treat the standards of care and quality as goals rather than as actual requirements. Violations were reported to state agencies and the Centers for Medicare and Medicaid Services, fines were assigned for these blatant violations, yet these nursing homes continued to operate at sub-standard levels. The Covid-19 pandemic only exacerbated these issues; however, the pandemic did force the public to become aware of these issues and as a result to demand corrective actions. One reason the public became more aware of these problems is that the pandemic forced improvements in state reporting of Covid-19 fatalities in long-term care facilities. In reality, the rising mortality rates within nursing homes relative to the general population also alerted the public to this problem. As of October 2020, data reported by nursing homes to the CDC's National Healthcare Safety Network (NHSN) system Covid-19 Long Term Care Facility Module, reported 60,491 deaths.[55] This clearly violates the principle of nonmaleficence. Many of

these deaths could have been avoided, however, profit margins for multinational corporations took the priority over sanctity of life and quality of life for these most vulnerable patients.

Healthcare professionals and administrators have, as moral agents, an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately communicate and educate patients and families about accurate quality standards and safety standards in nursing homes and citations and fines for violations, is not in the best interest of the patient, their families or the society as a whole. Immediate changes must be enacted to protect the best interest of nursing home patients. Existing standards set by state and federal agencies need to be strictly enforced and more strict standards need to be implemented. A national database must be established to make this data accessible to all Americans. Federal minimum staffing standards need to be implemented immediately. At least one registered nurse must be in each facility 24-hours a day and there should be an infection preventionist in each facility at least part-time. Nursing homes must use best practices for testing and cleanliness. Realistic sanctions must be established and enforced for any violations. Finally, because greed is a major concern in the nursing home industry, federal regulations must be established to determine how much Medicare and Medicaid funds go to care and how much revenue nursing homes can siphon into profits, unrestricted administrative expenses or unaudited contracts with companies they control.[56] Patients and families have the right to expect the most beneficial treatment and care in nursing homes. Healthcare professionals and administrators have the responsibility to provide the best standards of care and safety to protect their patients. Failure to recognize this great need is a failure not only of the test of beneficence; it may also be a failure of the test of nonmaleficence.

Justice

This principle recognizes that each person should be treated fairly and equitably, and be given his or her due. The issue of government funding for enforcement of nursing home regulations also focuses on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reforming healthcare in this country has become a high priority, failure to initiate preventative measures that would save medical resources and possibly human lives in the long-run violates the principle of distributive justice.

The data that 42% of Covid-19 deaths have occurred in nursing homes and assisted living facilities in states reporting such statistics shows substantial flaws in how Covid-19 has been managed in these facilities. More attention must be focused on the infection control standards for these facilities. More funding must be put into testing, contact tracing and cleanliness in nursing homes. This is especially true in facilities with people of color. It is clear that people of color are dying at disproportionate rates in general and specifically in nursing homes. The Covid-19 pandemic brought to light the disparities in nursing homes, especially among the African-American and Latino populations. The elderly, and specifically, elderly people of color have experienced years of neglect in nursing homes, which has left them unprotected. This is a grave injustice that needs to be rectified immediately. Besides the reforms listed above and the recommendations that are being proposed in this paper, funding and enforcement of standards must be immediately implemented. This would also entail state-wide strike forces, composed of state and federal health department officials, local health care professionals and community members who would assess the safety of residents and staff in all nursing homes and assisted living facilities. The states of Maryland and Florida have enacted these strike teams. When they find nursing homes residents who are neglected or in medical distress, they are able to provide treatment and care or verify that these patients are transferred to hospitals or other appropriate facilities.[56] These strike teams will help confirm that all people are being treated with dignity and respect. To accomplish all of this there is a need for additional government funding, which will only be realized if the various agencies have the personnel and ability to enforce the standards that are already in place.

Americans espouse the belief that all men and women are created equal. Equality has also been a basic principle of the medical profession. If we truly believe in equality, we should insist that all men, women and children receive equal medical treatment and resources. Denying appropriate medical treatment to the elderly in nursing homes because of fraud and financial mismanagement by multinational corporations that control the nursing home industry and the unjust allocation of resources needed to enforce state and federal regulations on safety and quality standards violates a basic tenet of justice. The nursing home industry has lost valuable colleagues to Covid-19 due to lack of resources and failure to enforce standards of care. Our nursing home colleagues must stand together in solidarity to assure

healthcare professionals and patients in nursing homes are receiving the best care possible. Yes, to stand up may jeopardize your positions. Yes, you may not be supported by your administration. But as healthcare professionals who care about one another and their patients, you must have the courage to speak out with one voice. "Courage is not the absence of fear, but the willingness to carry on despite it, and that kind of courage is everywhere on display."[57] Healthcare professionals, nursing home administrators and the appropriate government agencies have an ethical obligation to use available resources fairly and to distribute them equitably. Failure to do so is ethically irresponsible and morally objectionable. To compromise the basic ethical foundations upon which medicine stands is destructive not just to the elderly but to society as a whole.

RECOMMENDATIONS/CONCLUSIONS

What has transpired in nursing homes and long-term care facilities since February 2020 has been nothing short of a healthcare crisis. Thus, several steps both immediate and long-term should be taken to restore health and safety in the nation's nursing homes and ensure complete care of residents for the future.

1. Referring to the aforementioned racial disparity in the national data pertaining to Covid-19's effect on different racial groups, only four states, Iowa, Indiana, Louisiana, and Mississippi, are currently reporting coronavirus cases and deaths in long-term care facilities by ethnic group.[5] While trends within nursing homes can be observed based on the known resident makeup of each home, the ability of the states to report cases and deaths without disclosure of the racial breakdown prevents the legitimate effect that this pandemic is having on people and communities of color from being fully expressed in the data. Therefore, we recommend that states be required to report cases and deaths by ethnic group to more aptly understand and possibly pinpoint a cause for the staggering disparity.
2. According to a 2020 study released by the U.S. Government Accountability Office, from 2013 to 2017, about 82% of the over 16,000 nursing homes surveyed by the office had been cited for infection control deficiencies, while half of them had citations in multiple consecutive years.[58] However, almost 99% of all infection control citations were classified as "not severe" by the CMS, and the CMS only enforced punishment upon 1% of those non-severe citations.[58] This disturbing data demands a change to the severity classifications of infection control deficiencies.58 However, to further amplify this emphasis on infection control, inclusion of infection control programs must be implemented into the aforementioned CMS 5-star rating system of nursing homes. It is ethically imperative that prospective residents and their families fully understand the conditions and caliber of potential nursing homes before making the decision to live or house their loved ones there. The presence and quality of a home's infection control program is essential to a resident's quality of life especially during a pandemic, so we recommend that a tangible gauge of infection control ability be included in the rating system.
3. In response to the initial COVID-19 outbreak, CMS inspections were deployed to over 15,000 nursing homes across the country to determine compliance with longstanding safety requirements.[46] However, the inspections come as a result of a three-year push by political lobbyists at CMS to relax rules aimed at keeping nursing homes safe. As the October 2020 Washington Post article states, "Even before the coronavirus crisis, the [CMS] took steps to limit the use of some fines and strike an Obama-era mandate requiring nursing homes to bring on at least part-time infection preventionists."[5] This illustrates that while the government agency may appear to be doing its part in controlling the spread through the deployment of inspections, this may have been a too-little-too-late action. The limitations on government regulation in nursing homes over the past three years may have been an accelerator of the spread of the virus, as relaxed rules may have caused homes to be less vigilant over their infection control and daily safety practices. Therefore, in the first months of its term, the Biden administration should ensure that CMS and the Occupational Safety and Health Administration be given the resources needed to properly inspect, fine, and instill safe practices in the CMS-certified homes that are currently failing its residents.[59]
4. Another factor that plays into resident treatment in nursing homes is the quality of nursing care. As previously stated, the federal government has recommended raising the minimum nursing hours per resident per day in the past to 4.1 hours.[43] However, since 2001, the federal minimum has not moved due to lobbying powers of for-profit nursing home companies.[43] As a result, nursing home and long-term care facility residents throughout the country fail to receive the expert-recommended adequate care that they need to thrive as a human being. A bill, namely the Quality Care for Nursing Home Residents Act of 2019, has been introduced into Congress that would provide protections to whistleblowers and raise the minimum staffing requirements. Therefore, the federal government should work expeditiously to pass this essential requirement for residents of nursing homes, despite backlash from the for-profit homes.
5. The current reality for most staff within nursing homes and long-term care facilities includes low wages, little time off, and a diminished outlook on future promotions.[59] This has led to many of the nation's homes being shockingly understaffed.[60] Therefore, long term care nurses and staff should be paid a living wage of $20 per hour or more. To ensure that this happens, the $264 billion given to long term care providers from Medicaid and Medicare should be directed at caregiving expenses, such as the wages of staff.[59] Currently, this money comes with very little accountability on the part of care providers.[59] Healthcare leaders,

such as American Health Care Association president Mark Parkinson, have expressed a need to implement limitations and accountability in association with this funding.[59]

6. Lastly and perhaps most importantly, there is a desperate need for a shift in the narrative surrounding nursing homes and long-term care in general. As more and more homes have become for-profit in this country, more and more have nursing homes and long-term care facilities seemed to become more about "warehousing" the elderly residents as oppose to providing the healthcare the residents need to thrive as individuals.[59] A 2010 study compiling the narratives of long-term care providers at various career levels and positions revealed that legal and economic obligations many times take priority over the actual well-being of residents.[61] The subjects of the study revealed that certain routines and practices prioritized efficiency and financial performance over the care of residents.[61] This study is thus a small representation of the current general sentiment toward long-term care. In order to fully succeed in restoring proper care to residents, a transformation in attitude must be made. Long-term care must be thrust back into the forefront of our nation's medical system.

CONCLUSION

"This pandemic's death toll at nursing homes was not an inevitability."[46] Those are the words of Dean Lerner, enforcement consultant at CMS. Many factors have contributed to the high proportion of deaths occurring in the nation's nursing homes. Of course, most can agree that in general, a home's contraction of one or a few cases of coronavirus can be attributed to luck or other circumstances out of anyone's control. And, the older resident population within nursing homes makes them more susceptible to reporting deaths. However, the rate of spread throughout the homes across the country and the devastating toll it has had on this nation's elderly population as well as the nursing home staff is unacceptable. The many factors explored in this paper explain various ways in which the country has failed the residents of nursing homes and long-term care facilities. Medically, legally, and ethically, the government has failed to protect these residents and ensure that their rights as a human being are protected and fulfilled. As the pandemic rages on, we hope that changes laid out in this paper are implemented. And beyond that, more needs to be done at all levels of society to change the future of nursing home residents.

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