ARGENTUM
EXPANDING SENIOR LIVING

August 19, 2021

VIA ELECTRONIC SUBMISSION

Edmund C. Baird
Associate Solicitor of Labor for Occupational Safety and Health
Office of the Solicitor
U.S. Department of Labor
Attention: OSHA-2020-0004

RE: Occupational Exposure to COVID-19; Emergency Temporary Standard (OSHA-2020-0004)

Dear Mr. Baird:

On behalf of our members, Argentum appreciates this opportunity to provide comments on the Occupational Exposure to COVID-19 Emergency Temporary Standard (ETS).[1] Argentum is the leading national association exclusively dedicated to supporting companies operating professionally managed, resident-centered senior living communities and the older adults and families they serve. Along with its state partners, Argentum's membership represents approximately 75 percent of the professionally managed communities in the senior and assisted living industry. Nearly one million older adults live in an estimated 28,000 assisted living facilities (ALFs) across the United States.

Despite being home to a highly vulnerable population to COVID-19, with an average resident age of 85, ALFs have had comparatively favorable outcomes in caring for this at-risk population. According to a survey from NORC at the University of Chicago, two-thirds of ALFs had no COVID-19 related fatalities and the fatality rate in ALFs was 1/3 of skilled nursing care facilities (SNFs) (19.3 fatalities per 1,000 residents in assisted living, compared to 59.6 per 1,000 in SNFs). Notably, these results are reflective of calendar year 2020, largely before vaccines became available to further protect residents and staff.

Vaccines are perhaps the most critical element in guarding against the virus, and ALFs have led efforts to vaccinate both residents and staff, with overall vaccination rates higher than 99% of all U.S. counties. A relatively high percentage of ALFs participated in the Pharmacy Partnerships program, leading to over 90% of residents and more than 7 out of 10 workers being vaccinated.[2] The high vaccination rates are a key metric, as the Centers for Disease Control and Prevention (CDC) estimates that less than 0.004 percent of people fully vaccinated in the United States face hospitalization after a breakthrough case and less than 0.001 percent have died from a breakthrough COVID-19 case.

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[1] 86 Fed. Reg. 32376 (June 21, 2021).
[2] *See* National Investment Center for Seniors Housing & Care, *Executive Survey Insights Wave 29: May 17 to June 13, 2021* (June 24, 2021), https://blog.nic.org/executive-survey-insights-wave-29-. (finding vaccination rates at long-term care facilities to be 9 out of 10 for residents, and 2 out of 3 for staff).

Additionally, it is important to recognize that unlike SNFs, ALFs provide only limited "healthcare services" (defined in part as services provided by "doctors and nurses"), and instead primarily assist residents with basic self-care or activities of daily living (ADLs) such as eating, dressing, bathing, and the management or administration of medication. Assisted living facilities are also a lower-risk environment than "hospital ambulatory care settings" and "non-hospital ambulatory care settings," which are exempt from this ETS in certain circumstances.

As explained in further detail below, we believe that this ETS should not be made permanent because it is: 1) duplicative of and at times conflicts with CDC-specific guidance and state-level regulations for long-term care facilities and assisted living facilities in particular; 2) overly burdensome on ALFs, many of which are experiencing severe financial difficulty as a result of the COVID-19 pandemic; 3) unnecessary given the assisted living community's substantial compliance with all relevant federal and state requirements and recommendations regarding COVID-19 infection control protocols, and its overwhelming success at containing COVID-19 in ALFs; 4) adds burdensome costs on the industry in having to pay sick time for employees even if their exposure was outside of work; 5) the sick pay provision discourages vaccinations; 5) OSHA does not have the statutory authority to dictate pay and benefits rules for employees; and 6) several provisions are vague. At a minimum, if OSHA makes the ETS a permanent standard, OSHA should exercise its enforcement discretion for providers who make good faith efforts to comply with the spirit of this ETS.

The OSHA ETS is duplicative of and at times conflicts with CDC-specific guidance and state-level regulations for long-term care facilities.

ALFs have complied with myriad federal and state level requirements and guidance regarding infection control protocols that have protected both staff and residents. In particular, facilities throughout the country have complied with CDC guidance related to the use of personal protective equipment (PPE), social distancing, sanitation procedures and other requirements to mitigate the spread of COVID-19. ALFs also comply with additional state-level requirements. Accordingly, for over a year, facilities have implemented comprehensive infection control protocols pursuant to an existing framework established by the CDC and state level agencies such as departments of health.

State and local agencies have been very effective and proactive in providing guidance that reflects current and changing conditions in their regions and have closely monitored compliance. For the most part, the requirements set out in this ETS are duplicative of this existing framework, and only serve to add an additional layer of unnecessary complexity and confusion for facilities that have successfully implemented the existing framework to curb the spread of COVID-19 in their facilities, which have been tailored to regional and locality conditions. This framework also allows necessary flexibility based on the current conditions in a particular area, rather than a one-size-fits-all approach from federal OSHA. And with duplicative or contradictory guidance, employers would be forced to determine which set of guidance to follow, potentially leading to reputational harm if penalized for not adhering to guidance that may no longer be in line with current best practices.

Notably, ALFs were already subject to infection prevention and control training requirements even prior to COVID-19. As a result of the pandemic, additional training was imposed by state

regulators—including agencies that do not typically regulate ALFs—along with local or county departments of health. These duplicative layers of training and attendant paperwork create administrative burdens and divert important and increasingly scarce resources away from resident care, which would be further exacerbated by this ETS.

An example of the inconsistencies between the ETS and other guidance is that the ETS exempts fully vaccinated employees from wearing facemasks or maintaining physical distance from others "[i]n well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present." 29 C.F.R. § 1910.502(a)(4). In contrast, on July 27, 2021, the CDC recommended that all employees wear facemasks in indoor public settings in areas with substantial or high transmission of COVID-19, including all vaccinated individuals. On August 13, 2021, OSHA made the same recommendation. The ETS does not, however, include a requirement or recommendation to do the same. Thus, in that aspect, the ETS is less protective than OSHA guidance for non-healthcare workplaces. A static or slow-changing ETS will continually fall out of step from the developing science and best practices as the CDC continues to update its guidance.

The OSHA ETS's additional requirements and penalty framework are overly burdensome for long-term care facilities already under significant financial strain due to the COVID-19 pandemic and add duplicative expenses for seniors already under pressure to cover costs of living.

The ETS is a comprehensive and complex set of requirements that will require a significant amount of time and resources to review and ensure compliance. It contains references to many external sources and expects employers to both analyze those sources and determine which provisions are applicable. We are concerned that implementing an additional infection control regime will be overly burdensome for long term care providers and seniors and may ultimately divert time and resources away from resident care.

For example, the ETS requires removal of employees from the workplace who have tested positive for COVID-19, been told by their healthcare provider that they are suspected to have COVID-19 or is experiencing an elevated temperature, loss of taste or loss of smell. Included in this requirement is a complex timeline of monitoring and testing, most of which providers are already accomplishing through adherence to CDC guidelines and state regulations. The ETS then requires the employer to continue to pay these employee's normal earnings up to $1,400 a week for the first two weeks and the same or slightly reduced amount thereafter. This requirement can be overly burdensome for many providers that have already extended significant amount of paid leave throughout the pandemic, and that are already experiencing a significant workforce shortage. Notably, there is no maximum duration on the length of medical removal, meaning an employer's obligations to provide paid leave and to reinstate the employee are indefinite and may hit an ALF particularly hard if they must continue regular pay for an individual experiencing "Long COVID" while also paying for temporary workers.

Similarly, it is unclear how long an employer must provide paid leave for adverse effects associated with vaccination. OSHA does not have the necessary personnel, and its compliance safety and health officers may lack experience or resources to properly audit payroll records by individual employee to determine compliance with the requirement to provide continued

benefits and regular pay during medical removal periods. Finally, the "regular pay" requirement is unworkably vague, as it does not clarify other types of permissible employer-funded compensation, such as paid time off.

Many obligations related to paid leave are vague and ambiguous. The ETS requires employers to pay the "same regular pay and benefits the employee would have received had the employee not been absent from work." Although the preamble to the Final Rule states that employers are not required to provide "overtime pay," the standard makes no reference to overtime. It is unclear whether employers are obligated to pay straight time wages for all hours that would have been worked, or to pay only up to 40 hours per week. The ETS does not explain what is encompassed in "benefits" (i.e., health care, accrual of paid leave, etc.). It also fails to provide any guidance on how employers should compensate employees with irregular schedules.

We are also concerned that this requirement may incentivize employees to *not* get vaccinated – which undermines the national campaign surrounding the most effective way to curb the spread of COVID-19. The prospect of being forced to take unpaid leave due to COVID-19 infection or exposure might encourage some employees to get vaccinated. This requirement undermines that sentiment by ensuring employees have a steady stream of income if they are medically removed. At this stage of the pandemic, COVID-19 vaccines are readily available, and our members have implemented a variety of programs to encourage their employees to get vaccinated. We do not believe a paid leave policy that incentivizes employees to refuse the vaccine should be finalized or made permanent.

Furthermore, we are deeply concerned with the requirement that barriers be installed at each fixed work location outside of direct patient care areas where each employee is not separated from all other people by at least six feet of distance. According to OSHA, fixed locations where barriers may be required include entryways, lobbies, check-in desks, screening sites, and security guard stations. While we understand that physical barriers may provide some benefit in reducing COVID-19 spread, we believe this requirement is overly burdensome for many providers, as well as unnecessary considering other risk mitigation strategies already in place. Moreover, this requirement disregards the fact that our members' residents consider these facilities their homes. Erecting physical barriers throughout the facilities can be a cause of confusion and stress for the residents, especially those suffering from cognitive impairment.

Last, the requirement that employers must provide employees with facemasks and to ensure that employees change their facemask at least once per day is duplicative to state and local regulations already in place. Providers should not be placed in position to suffer penalty from one agency for complying with closely monitored state and local rules and inspections. The ETS' respirator requirement fails to consider ongoing respirator shortages and supply chain challenges. In particular, the requirement to provide a respirator to all employees who have exposure to a person with suspected or confirmed COVID-19 fails to include prioritized facemask use for selected activities recommended by CDC for Crisis Capacity Strategies. For example, employers facing respirator shortages must have the capacity to prioritize respiratory protection for nurses who perform aerosol-generating procedures on COVID-19 positive residents over maintenance workers who can enter a room briefly at a safe distance to empty a wastebasket.

These are just a few examples of the ETS requirements that are beyond the scope of current CDC and state-level requirements and recommendations. These requirements would be overly burdensome for ALFs that have already undergone significant financial distress due to the COVID-19 pandemic, and that have received relatively little federal support. For over a year, our member communities have been working tirelessly to keep safe and engaged the residents who call senior living home as well as the employees who tend to their personal care needs.

Despite caring for a highly vulnerable population, assisted living communities have not received anywhere near the same level of federal and state relief as other types of providers. ALFs have suffered over $30 billion in losses due to PPE, testing, cleaning, staffing needs and heroes pay, as well as record-low occupancy rates. Yet to date, assisted living caregivers have received only about $1 billion in relief from the Provider Relief Fund (PRF), which represents less than 1 percent of the overall fund. Many are still waiting for relief, and others have been inexplicably denied. As a result, nearly half are operating at a loss, and 56% report that closures are imminent.

Mandating these facilities to comply with the additional requirements laid out in the ETS will only exacerbate these concerns, especially given the penalties for noncompliance. OSHA states that the ETS will facilitate "determinations that are critical enforcement tools OSHA can use to adequately address violations…." With the ETS, OSHA seeks to utilize the "willful classification" and impose penalties of $136,532 per violation accordingly. Even violations that are not deemed "willful" can result in penalties of $13,653 per violation. Thus, many facilities that are already under significant financial strain will find it difficult to immediately comply with the ETS's comprehensive set of additional requirements, and may be subject to onerous penalties that will only make matters worse.

Long-term care facilities have successfully implemented existing infection control requirements and guidance to curb the spread of COVID-19 amongst staff and residents.

Throughout the course of the COVID-19 pandemic, the assisted living industry has complied with all relevant guidance and recommendations to keep employees and residents safe. Since the beginning of the COVID-19 pandemic in the U.S., ALFs have implemented enhanced protocols to prevent COVID-19 from entering the community, and to mitigate the spread of, and otherwise limit the harm from COVID-19. For example, properties implemented staff workflow changes and visitor restrictions to reduce disease spread.[3] Other steps have included enhanced infection control protocols; restrictions on or cessation of move-ins; conducting health screenings and COVID-19 testing as available and appropriate for employees and residents; and vaccinations administration.[4]

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[3] A. C. Pearson et al., *The Impact of COVID-19 on Seniors Housing*, NORC at the University of Chicago (June 3, 2021), p. 18, https://info.nic.org/hubfs/Outreach/2021_NORC/20210601NICFinalReportand20ExecutiveSummary20FINAL.pdf. (hereinafter "the NORC Report").

[4] *Id*.

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Argentum believes the protocols ALFs have had in place for over a year achieves the stated intent of the ETS, and that adding an additional layer of regulatory complexity on a community that has experienced severe financial distress will be to the detriment of the elderly population we are committed to serving. As such, we request that the ETS not become a final rule, and that OSHA exercise enforcement discretion for providers who make good faith efforts to comply with the general spirit of the ETS. However, if this ETS should become final, we request that assisted living providers be exempt similar to the exemptions already in place in this ETS.

Thank you for your consideration of these comments. Please contact me with any questions or requests for additional information.

Sincerely,

James Balda
President & CEO
Argentum