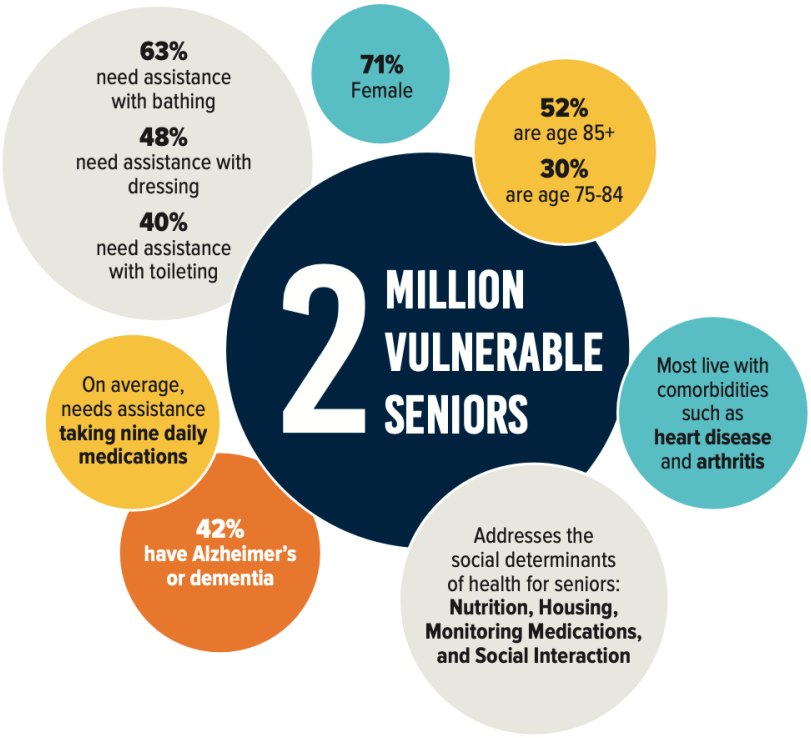
ARGENTUM
EXPANDING SENIOR LIVING

ARGENTUM-OMB TELECONFERENCE (2/2/23)
Documents submitted electronically

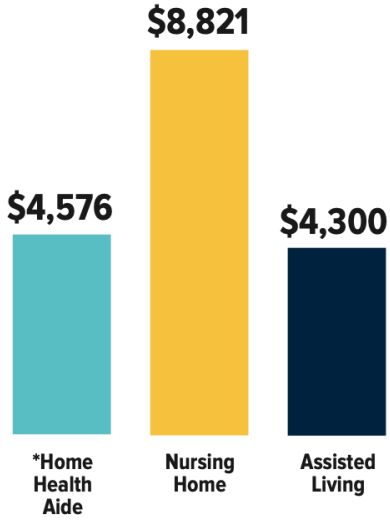
Attendees
James Balda, President & CEO, Argentum
Maggie Elehwany, Senior Vice President, Argentum
Paul Williams, Vice President, Argentum
John Schulte, Vice President, Argentum
Dan Samson, Director, Argentum
Kyle Loeber, Manager, Argentum
Alex Somodevilla, Associate, Foley-Hoag

Tentative Agenda
1. Introductions
2. Argentum's engagement during the rulemaking process
3. Overview of Assisted Living
4. CDC's guidance
5. Cost-benefit analysis
6. Impact of compliance on current workforce crisis
7. Senior resident and family testimonials
8. Open discussion

ASSISTED LIVING & MEMORY CARE FOR AMERICA'S SENIORS REMAIN IN JEOPARDY



WHO LIVES HERE?

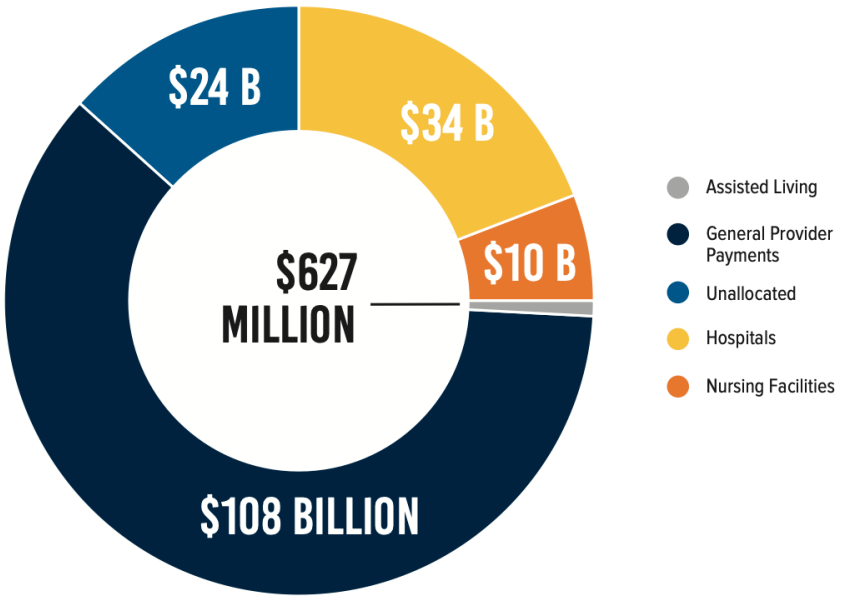


ASSISTED LIVING IS THE MOST AFFORDABLE CHOICE OF SENIOR CARE

based on only 44 hours of care per week

ASSISTED LIVING CAREGIVERS RECEIVED LESS RELIEF THAN ANY OTHER FRONTLINE WORKER

$30 billion in losses and expenses related to masks, gowns, gloves, hero pay, staffing, CDC compliance, and occupancy rate declines



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Activated Insights

The Value of Assisted Living in America

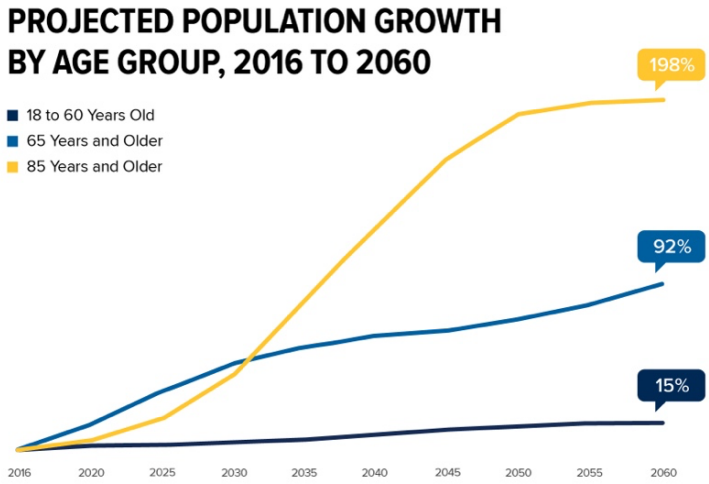
A Seismic Shift in National Demographics: 10,000 Americans turn age 70 each day and all Baby Boomers will be 65 or older by 2030. In less than 12 years, for the first time in our nation's history, there will be more seniors than children. The perfect storm is forming. With nearly 70% of the U.S. population needing some form of long-term care (LTC) as they age, a caregiver workforce shortage crisis already exists. Exacerbated by the pandemic, 96% of assisted living communities currently face workforce shortages. By 2030, there will be a shortage of nearly 8 million direct care workers (1.2 million for assisted living specifically). As our nation prepares for the seismic growth of our aging population, this analysis identifies the value of the assisted living model of LTC, and the importance of public policies that support LTC models of high value.

What is assisted living? *Assisted living is a private pay home and community-based residential setting for older adults combining housing, supportive health services, and personal care. There are currently 31,400 assisted living communities in the U.S. with 1.6 million residents calling assisted living home.*

PART 1: High Senior Satisfaction in Assisted Living Communities

Assisted Living Highly Approved by Residents: In numerous national surveys, both before and after the pandemic, over 90% of seniors in assisted living communities reported "good or great satisfaction" with their assisted living home. Over 85% of families of residents rated their satisfaction as "good or great."

Assisted Living, Health Care and Quality of Life: 96% of residents reported their assisted living communities provided sufficient health care and access to health care. Nearly 75% said assisted living improved their quality of life; 70% indicated their health outlook improved.



Assisted Living Value: Consumer surveys indicate that value is a major factor in choosing assisted living as a care option. A majority of residents and family members reported "satisfaction or strong satisfaction" with the value of care as correlated to the cost of care.

PART 2: Assisted Living Saves Safety Net Programs Billions

Medicaid as the Nation's Largest Payer of Long-Term-Care is Not Sustainable: Insolvency of both the Medicare and Social Security Trusts Funds are significant national concerns as our population ages; however, of equal concern is the projected escalation of Medicaid spending, which is by far the largest payer of LTC costs. **In 2020, Medicaid spent $130 billion for LTC and as population aging progresses after 2030, Medicaid's inflation-adjusted LTC expenditures are projected to grow even faster – at about 5% per year – reaching $466 billion by 2050.**

Assisted Living Saves Medicaid $43.4 Billion Each Year: According to estimates, if assisted living were not an option, as many as 61% of senior residents may be forced into skilled nursing facilities (SNF).

Because SNF care is double the average cost of assisted living, most seniors would be forced to pay down their savings and become Medicaid eligible. Using the 61% estimate, this additional burden would amount to $110.6 billion every year. **However, under a more conservative assumption of merely 25% of assisted living seniors being forced into SNFs, the added Medicaid costs would still total $43.4 billion per year.** This additional cost would cripple state and federal Medicaid budgets.

In a recent report to Congress, the Department of Veterans Affairs (VA) outlined federal savings achieved by providing the option of assisted living care instead of exclusively Community Nursing Homes (CNH). The annual cost of a CNH placement was $120,701 in FY 2020, compared to an average annual cost of $51,600 for assisted living. ***For Veterans who meet the criteria to choose assisted living, the VA would save $69,101 per placement per year.***

Assisted Living Will Heavily Contribute to Medicare Savings: The assisted living care model focuses on the social determinants of health, social interaction and often facilitates care coordination with other healthcare providers. Though no assisting living facility receives Medicare dollars, this coordinated care, including social and preventative care, keeps seniors healthier and saves Medicare dollars.

Assisted Living Prevents Social Isolation: Recently, U.S. Surgeon General Dr. Vivek Murthy cited loneliness as "America's Invisible Epidemic." The analysis in this report utilizes the first large-scale survey of assisted living residents using the UCLA-3 Loneliness Assessment. Findings indicate that over 75% of SNF residents are "very lonely" and 29.9% of older adults who live alone are "very lonely." **However, 130,272 assisted living resident responses showed statistical significance: only one in seven (14.3%) residents reported being lonely.**

According to a Harvard-Stanford-AARP study quantifying the impact of social isolation on the healthcare system, Medicare spent an estimated $134 more per month ($1,608 annually) for each socially isolated older adult than it did for those who had more social contacts. As a result, this analysis **estimates $2.2 billion per year of savings accrued to Medicare for care needs being met by assisted living communities.**

Assisted Living Care Coordination Results in Fewer Hospitalizations: A rising trend in senior living communities is to provide coordinated care, which results in far fewer hospitalizations and Medicare spending. A 2017 study conducted by ATI (Anne Tumlinson Innovations) examined the Connect4Life Care Coordination at Juniper Senior Living Communities. The findings showed that care coordination decreased the hospitalization rate of residents by 52% and led to an 83% drop in rehospitalizations of Juniper residents compared to similarly frail Medicare seniors. Implying Medicare costs of $26,460 per hospitalization, **care coordination programs for just half of all assisted living residents would amount to $13.2 billion in national Medicare savings.**

Assisted Living Can Reduce Lost Work Productivity by Nearly $44 billion: Assisted living's contributions to the caregiving economy also increase productivity and economic output of families. Blue Cross Blue Shield estimates that family members caring for a senior led to the loss of 656,000 jobs and an additional 791,000 family caregivers suffering from absenteeism at work, which equals a direct economic impact of $43.9 billion. Additionally, the indirect effect that deteriorating family caregiver health has on economic outcomes is even more significant at $221 billion.

Conclusion

As our population rapidly ages, policymakers must look to care options that provide high value for seniors and protect limited public resources. Private pay options, such as assisted living, should be supported by federal and state policies because they provide high value to seniors and high value in protecting social safety net programs. Specifically, policymakers should: **(1)** Create workforce development programs to ensure a sufficient workforce to care for the nation's escalating aging population; **(2)** Ensure that assisted living communities have the financial sustainability to overcome the financial losses of the COVID-19 pandemic; and **(3)** empower more seniors to access high-value care models such as assisted living through options such as LTC insurance expansion, tax benefits, Medicaid waiver expansion, health savings account flexibility and other financial tools.

The research in this report was conducted by Argentum, the voice of America's assisted living communities, in collaboration with Activated Insights, a leading senior care analytics provider.

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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

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January 19, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Douglas L. Parker
Assistant Secretary of Labor
Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Attention: OSHA–2021–0007

Re: COVID–19 Vaccination and Testing; Emergency Temporary Standard

Dear Assistant Secretary Parker:

On behalf of our members, Argentum appreciates this opportunity to provide comments on the COVID-19 Vaccination and Testing Emergency Temporary Standard (ETS).[1] Argentum is a 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 living industry. Nearly 2 million older adults live in tens of thousands of senior living communities across the United States.

Argentum is supportive of efforts to promote vaccination and infection control to lower the risk of COVID-19 in workplaces. Argentum also appreciates the importance of policies that expand mitigation efforts and increase access to vaccinations and overall vaccination rates. Senior living facilities have successfully implemented policies to mitigate harm from COVID-19, and have implemented successful vaccination campaigns among both residents and staff. Since the start of the COVID-19 pandemic in the U.S., senior living communities have implemented enhanced protocols to prevent COVID-19 from entering the community, mitigate the spread of, and otherwise limit the harm from COVID-19. These steps led to a significant mitigation of harm - while 39 percent of skilled nursing facilities experienced no COVID-19-related deaths, about two-thirds of independent living (67 percent); assisted living (64 percent); and memory care (61 percent) properties have had no COVID-19-related deaths.[2]

However, requiring senior living communities to implement a mandatory vaccination or testing policy would be incredibly burdensome for a community that already has a relatively high workforce vaccination rate.[3] Communities around the country have successfully increased staff vaccination rates through a variety of approaches tailored to the specific needs of each community, and efforts to facilitate access to and administration of COVID-19 booster shots are currently underway. However, an across the board vaccination requirement would be untenable for many of our members, especially those in rural areas, who are experiencing historic workforce shortages. Such a

[1] 86 Fed. Reg. 61402 (Nov. 5, 2021).

[2] 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://www.norc.org/PDFs/COVID-19Executive20Summary20FINAL.pdf.

[3] 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).

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requirement would only exacerbate these issues, and impede access to care and services for the senior population.

Furthermore, the ETS's testing and masking option is simply not feasible for many of our members. While the ETS does not specify that the employer must pay for testing, some state laws prohibit the employer from requiring an employee to pay for medical testing or procedures. There may also be contracts in place that prohibit the employer from requiring the employee to pay for this type of testing. Notably, the test itself must be proctored (e.g. at a remote testing site or at the place of employment) – an employee cannot simply take the test and attest to a negative result.

Relatedly, the ETS requires the collection of proof of vaccination – not just an employee attestation that one has been vaccinated. This requires the collection of a substantial amount of documentation from employees, state and/or public health organizations. This documentation must then be examined for the appropriate information and retained. This would necessitate significant labor hours and implementation of costly systems. Meanwhile, the penalties for noncompliance can be severe. Any single violation may result in a penalty of $13,653 per day. Violations found to be repeated and willful may result in penalties of over $136,000.

These concerns are particularly salient given the precarious financial situation of many senior living facilities across the country due to the COVID-19 pandemic. For nearly two years, senior living communities have been serving on the front lines of the COVID-19 pandemic, working tirelessly to keep safe and engaged the residents who call senior living home, as well as the employees who care for them. Despite caring for a highly vulnerable population, senior living communities have not received anywhere near the same level of federal and state relief as other types of providers. Senior living communities 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, senior living caregivers have received only about $1 billion in relief from the Provider Relief Fund, which represents less than 1 percent of the overall fund. As a result, half of providers are operating at a loss and at risk of facility closures.

As a result of the Supreme Court's January 13, 2022 stay order, OSHA is currently prohibited from enforcing this ETS for the foreseeable future.[4] Given the above, should the agency withdraw this ETS and promulgate a new, more narrowly tailored ETS, we urge the agency to exclude the senior living community from that ETS's scope. These communities, many of which are experiencing severe workforce shortages, are in desperate need of relief. Mandatory compliance with any additional requirements would only exacerbate these ongoing issues.

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

[4] https://www.supremecourt.gov/opinions/21pdf/21a244_hgci.pdf.

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April 22, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Douglas L. Parker
Assistant Secretary of Labor
Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

RE: Occupational Exposure to COVID-19 in Healthcare Settings (OSHA-2020-0004)

Dear Mr. Parker:

On behalf of our members, Argentum appreciates this opportunity to provide comments regarding OSHA's proposed rulemaking.

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 living industry. Nearly one million older adults live in an estimated 28,000 assisted living facilities across the United States.

On June 21, 2021, the Occupational Safety and Health Administration ("OSHA") published an interim final rule establishing an emergency temporary standard (ETS) "to protect healthcare and healthcare support service workers from occupational exposure to COVID–19 in settings where people with COVID–19 are reasonably expected to be present."[1] The ETS took effect immediately but also served as a proposed rule on which OSHA requested comment. The requirements were in effect for 6 months, after which the ETS expired.

On December 27, 2021, OSHA announced its intention to issue "a final standard that will protect healthcare workers from COVID-19 hazards" in line with its earlier Healthcare ETS. On March 23, 2022, OSHA issued a notice announcing that, as part of the process of developing a permanent standard, the agency would be "partially reopening the comment period for the ETS to allow for additional comment" on specific topics.[2]

In this letter, we reiterate our opposition to OSHA's consideration of ALFs as a "healthcare setting." 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 were exempt from this ETS in certain circumstances. As such, it is our position that our members should not be considered "healthcare settings" and thus

[1] 86 Fed. Reg. 32376 (June 21, 2021).
[2] Occupational Safety and Health Administration (OSHA), Labor, Notice of limited reopening of comment period; notice of informal hearing (87 Fed. Reg. 16426).

should not be subject to any further requirements imposed by OSHA's rulemaking. We also reiterate other concerns expressed in our August 19, 2021 comments filed in response to the COVID-19 ETS.[3]

Below we provide additional comments in response to the specific potential modifications that would depart from the provisions of the ETS outlined by OSHA in its March 23, 2022 notice.

Extension of Comment Deadline

Argentum urges OSHA to extend the comment deadline by at least an additional 30 days. Argentum appreciates OSHA's consideration of additional modifications to the standards laid out in the now expired ETS, and is working diligently with its members to assess the potential changes and approaches specified in the notice, as well as OSHA's request for additional studies, information and data related to the delta and omicron variants since the close of OSHA's initial comment period in August 2021. An additional 30 days will allow for adequate time to solicit comprehensive feedback on these issues from our members, and thus a more comprehensive record for the agency to review as it proceeds with these proposals.

A. Potential Changes From the ETS

A.1—Alignment with CDC Recommendations for Healthcare Infection Control Practices

In the notice, OSHA states that it "is considering whether it is appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period." Argentum opposes this proposed modification. As written, OSHA's proposal would codify a permanent standard that aligns with *current* CDC recommendations. In practice, this will result in a static framework that does not account for future changes in CDC and other guidance and recommendations. Any future standard should remain flexible enough to account for changing circumstances and adapt with evolving COVID-19 recommendations.

A.2—Additional Flexibility for Employers

OSHA is also considering restating various provisions as broader requirements without the level of detail included in the Healthcare ETS and providing a "safe harbor" enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue.

Argentum supports OSHA's proposed change to restate various provisions as broader requirements without the prescriptive level of detail included in the Healthcare ETS. An overly prescriptive approach disregards the significant differences among the diverse types of entities covered by the ETS, and prevents employers from developing and applying standards and best practices that are most effective and least burdensome for their particular setting.

Argentum also supports OSHA's proposal to provide a safe harbor for entities in compliance with CDC guidance applicable during the relevant period at issue. This proposal creates a greater degree of uniformity and removes the burden associated with complying with multiple, and at times conflicting, standards. However, we urge OSHA to develop a safe harbor standard that limits the level of discretion given to compliance officers in determining whether an entity is in compliance with applicable CDC guidance, as an excessive level of discretion would contravene the proposal's intended benefit of uniformity and certainty.

[3] *See* https://www.regulations.gov/comment/OSHA-2020-0004-1311.

A.4—*Tailoring Controls to Address Interactions with People with Suspected or Confirmed COVID-19.*

OSHA is considering the need for COVID–19-specific infection control measures in areas where healthcare employees are not reasonably expected to encounter people with suspected or confirmed COVID–19. This could include eliminating certain requirements that were included in the Healthcare ETS and that applied to all areas of covered healthcare settings. Furthermore, OSHA notes that it is considering balancing the narrower scope of this proposal with a new "outbreak provision" to ensure that employers would still have a duty to address an outbreak quickly if an outbreak occurs among staff in the areas normally subject to fewer requirements.

Argentum supports OSHA's proposal to tailor COVID-19 specific infection control measures to patient care areas where employees are reasonably expected to encounter people with suspected or confirmed COVID-19. This proposal would scale back the broad and overly burdensome scope of the ETS, and would acknowledge the "new normal" in which entities are now operating.

Furthermore, Argentum recommends that any conception of "outbreak" adopted by OSHA account for the variation in size and resources of entities potentially covered by this proposal. For example, a percentage-based approach can penalize smaller employers, where outbreak provisions could be triggered if just 1 or 2 employees test positive for COVID-19. Furthermore, an approach by which the outbreak provisions are triggered by a fixed number of positive cases for all covered entities can penalize larger employers, as any such a number could be a very small percentage of that employer's employee population. Given the above, a viable middle ground may be a definition by which outbreak provisions are triggered where either a) 3 employees, or b) 5% of the workforce, *whichever is greater*, tests positive for COVID-19. This approach furthers the policy goal of the outbreak provisions and addresses the potential burden of a one-size-fits-all approach.

A.5—Vaccination

A.5.1—Booster Doses

OSHA is also considering how recent ACIP and CDC recommendations might impact the requirements in the ETS that take account of individuals' vaccination status (e.g., fully vaccinated, up to date).

Argentum opposes any proposal that provides for a more restrictive definition of fully vaccinated or up-to-date and imposes additional burdens on the long-term care community that is already experiencing severe workforce shortages. Furthermore, Argentum also opposes any approach that dismisses the efficacy of prior infection. According to the CDC, individuals with previous COVID-19 infection have protection against reinfection as well as severe illness leading to hospitalization.[4] As the pandemic has evolved, so has the science on this issue, and we urge OSHA to not narrowly focus on just one approach that provides protection from COVID-19 infection and severe illness, when it is clear that at this stage of the "new normal," additional vaccinations is not the only means by which individuals gain protection. Argentum supports vaccination efforts, particularly among our members' resident populations, but believes that it is time to move on from this limited and burdensome approach to conceptualizing protection from COVID-19.

[4] I. D. Plumb et al., *Effectiveness of COVID-19 mRNA Vaccination in Preventing COVID-19–Associated Hospitalization Among Adults with Previous SARS-CoV-2 Infection — United States, June 2021–February 2022*, CDC Morbidity and Mortality Weekly Report (MMWR) (April 15, 2022), https://www.cdc.gov/mmwr/volumes/71/wr/mm7115e2.htm.

A.5.2—Employer Support of Employee Vaccination

OSHA is considering requiring employer support for employees who wish to stay up to date on vaccination and boosters in accordance with ACIP and CDC recommendations. Argentum opposes this proposal and believes that it is outside the scope of OSHA's authority to require employers to provide employees with an additional paid time for the booster shot.

Argentum continues to believe that OSHA does not have the authority to require employers to provide employees "up to four hours of paid time at the employee's regular rate of pay," for employees who wish to take the COVID-19 booster or subsequent booster shots. Notably, OSHA does not require 4-hour paid time for Hepatitis B vaccinations in the agency's Bloodborne Pathogens standard.[5] Furthermore, given the strong evidence of widespread immunity to COVID-19, via either vaccination or prior infection, the status quo further weakens OSHA's position for authority in this space. According to the CDC, the number of cases, hospitalizations, new admissions, and deaths are close to pandemic lows.[6] There is also ample access to the vaccine through various venues, such as local pharmacies, allowing for employees to be vaccinated at times convenient to their schedule. As such, we urge OSHA to exclude this proposal from any final rulemaking.

Argentum supports COVID-19 vaccination efforts and assisted living providers have attained high rates of employee vaccination. However, at this stage of the "new normal," strong protection from severe illness and hospitalization via either vaccination, prior immunity, or a combination of the two, renders unnecessary a revised and more restrictive definition of fully vaccinated or up-to-date, as well as federal standards that have the effect of increasing the burden on long-term care facilities that are already experiencing unprecedented financial and workforce issues that preceded, but were exacerbated by, the pandemic. Mandating paid time off for the COVID-19 vaccination worsens staffing challenges for an already compromised workforce.

A.5.3—Requirements for Vaccinated Workers

OSHA is considering suggestions that certain requirements be relaxed for vaccinated employees and workplaces with high vaccination rates. Such requirements include masking, barriers and physical distancing. Argentum reiterates its opposition to policies that, in utilizing a limited conception of protection against COVID-19, impose additional burdens on long-term care facilities already experiencing significant losses due to the pandemic. Argentum believes this approach is overly prescriptive and does not reflect current pandemic conditions. Given the strong evidence of widespread protection against significant illness and hospitalization from COVID-19, via either vaccination, prior infection, or both, Argentum opposes a proposal that would tie relaxation of certain requirements, which would alleviate the significant burden of some of this rule's requirements, to a metric that only accounts for one method of protection from COVID-19.

A.6—Limited Coverage of Construction Activities in Healthcare Settings

OSHA is considering the same coverage for workers engaged in construction work inside a hospital (e.g., installing new ventilation or new equipment or adding a new wall) as for workers engaged in maintenance work or custodial tasks in the same facility. Argentum opposes this proposal, and any proposal, that adds to the burden already placed on long-term care facilities. Consistent with the

[5] 29 CFR § 1910.1030.
[6] Centers for Disease Control and Prevention, COVID Data Tracker, https://covid.cdc.gov/covid-data-tracker/#new-hospital-admissions.

spirit of these standards, any needed protection for individuals engaged in construction or similar activities should remain the responsibility of their own employers.

A.7—Recordkeeping and Reporting: New Cap for COVID-19 Log Retention Period

OSHA proposes to cap the record retention period for the COVID–19 log at one year from the date of the last entry in the log, rather than the current approach in which that retention period is tied to the duration of the standard. Argentum is supportive of policies tailored to minimize the burden on long-term care facilities that continue to face the economic and other repercussions associated with the COVID-19 pandemic. That said, Argentum recommends that OSHA consider including a provision by which the record retention requirements can expire upon a qualifying event, such as the end of the public health emergency or other such objective metric that reflects the beginning of the endemic stage of COVID-19.

A.8—Triggering Requirements Based on the Level of Community Transmission

OSHA is considering linking regulatory requirements to measures of local risk, such as CDC's community transmission used in CDC's guidance for healthcare settings or the CDC's COVID–19 Community Levels used in CDC's guidance for prevention measures in community settings.

Argentum is supportive of standardized measures that facilitate an approach that accurately reflects the risk posed by current conditions. However, Argentum also urges OSHA to modify its conception of risk, given the evidence of widespread protection from COVID-19, via either vaccination, prior infection, or both. Although Argentum supports measures intended to prevent infection from COVID-19, we believe that given the decoupling of case counts from outcomes such as severe illness and hospitalization, OSHA should prioritize the latter when determining the level of risk in a community.

A.9—Evolution of SARS-CoV-2 into a Second Novel Strain

OSHA is considering specifying that this final standard would apply not only to COVID–19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects. Given the degree of burden and costs associated with this standard, Argentum opposes broadening its scope to also apply to different diseases. The OSHA permanent rulemaking process relies on a comprehensive record supported by the scientific and employer communities regarding the specific disease at issue. Any such standard applicable for a different disease must undergo a rulemaking process tailored to such disease, to ensure that the burdens associated with the standard reflect the circumstances of the particular disease at issue.

B. Additional Information/Data Requested

The standards set forth in the ETS were a comprehensive and complex set of requirements that necessitated a significant amount of time and resources to review and ensure compliance. It contained references to many external sources and expected employers to both analyze those sources and determine which provisions were applicable. Argentum is concerned that making these standards permanent will be overly burdensome for long term care providers and seniors and may ultimately divert time and resources away from resident care. These concerns are amplified by the workforce recruitment and retention issues plaguing the community. Overly prescriptive work rules place additional burdens on employees and restrict the pool of workers who are willing to endure these burdens. This further compromises the assisted living community's mission to care for the vulnerable senior population.

Argentum also reiterates that the measures laid out in the ETS that OSHA is considering in its permanent rulemaking are not just overly burdensome, but also unnecessary as applied to the

ARGENTUM
EXPANDING SENIOR LIVING

assisted living community. Since the beginning of the COVID-19 pandemic in the U.S., ALFs have implemented enhanced protocols in an effort to prevent COVID-19 from entering the community, and to mitigate the spread of, and otherwise limit the harm from COVID-19. Furthermore, ALFs are already subject to stringent infection control regulations issued by state and local health agencies that apply to employees. Properties have implemented staff workflow changes and visitor restrictions to reduce disease spread.[7] Other steps have included enhanced infection control protocols; restrictions on or cessation of move-ins; conducting health screenings for visitors and staff and COVID-19 testing as available and appropriate for employees and residents; and vaccinations administration.[8] Companies engaged in this business have already taken the steps necessary to protect the health, safety, and well-being of the residents they serve, and the health, safety, and well-being of the workers who serve them.

Argentum believes the protocols assisted living facilities have had in place for more than two years already fulfill the spirit of what the rule is trying to achieve. 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.

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

[7] 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").
[8] *Id*.

ARGENTUM
EXPANDING SENIOR LIVING

May 23, 2022

VIA ELECTRONIC SUBMISSION

The Honorable Douglas L. Parker
Assistant Secretary of Labor
Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

RE: Occupational Exposure to COVID-19 in Healthcare Settings (OSHA-2020-0004)

Dear Mr. Parker:

On behalf of our members, Argentum appreciates the decision by the Occupational Safety and Health Administration (OSHA) to reopen the docket for the agency's Rulemaking on Occupational Exposure to COVID-19 in Healthcare Settings to allow for the submission of post-hearing comments and briefs.[1]

In this letter, we would like to supplement our August 19, 2021 comments filed in response to the COVID-19 ETS,[2] our April 22, 2022 comments filed in response to OSHA's proposed rulemaking,[3] and our April 27, 2022 testimony provided at the informal public hearing on OSHA's Proposed Rule for Occupational Exposure to COVID-19 in Healthcare Settings.[4] Specifically, in this letter we would like to provide additional comments on the following: 1) the importance of senior living as a "home" for this nation's seniors, and 2) additional vaccination data.

SENIOR LIVING AS HOME

Argentum reiterates our opposition to OSHA's consideration of senior living facilities as a "healthcare setting." It is important to recognize that although the senior living community facilitates the provision of healthcare services, senior living primarily assists residents with basic self-care or activities of daily living such as eating, dressing, bathing, and the management or administration of medication. Most importantly, as reflected in the more than one hundred comments submitted by residents, family members, caregivers, and other advocates, our members' residents consider these communities their homes.

For example, a caregiver at an assisted living facility in Oklahoma noted that it's imperative to be mindful that these residences are foremost seniors' homes, writing, "We work in their home, they don't live where we work." Adding to this, an operator based on the West Coast stressed that residences are not short-term placements, but in many cases the final home chosen by the senior or their loved one, writing, "Our residents are not in our communities for a temporary stay but are living out the remaining years of their lives. Over the last two years, our residents had to endure too much isolation and confinement. To restrict them further from physical contact from their friends,

[1] Memorandum to Reopen the Docket to Allow for the Submission of Post-Hearing Comments and Briefs Posted by the Occupational Safety and Health Administration on Apr 27, 2022, https://www.regulations.gov/document/OSHA-2020-0004-2135.
[2] *See* https://www.regulations.gov/comment/OSHA-2020-0004-1311.
[3] *See* https://www.regulations.gov/comment/OSHA-2020-0004-2097.
[4] *See* https://www.regulations.gov/document/OSHA-2020-0004-2153.

family, and staff who love them and care for them, with more masks, physical barriers, and plexiglass barriers, would be detrimental to their well-being."

Similarly, a rural operator based in Wyoming commented that restrictions "resulted in social isolation, increased (and unnecessary) fear, and decreased communication, especially for those persons who are hard of hearing, have an existing speech impairment, or have some age related or other dementia." And echoing these concerns, a commenter from Wisconsin wrote that restrictions are "the opposite from the care, love and support that assisted living providers strive to create in their environments" and added, "a smile can bring joy and wonder to a person in senior living, especially those with dementia," when describing the challenges of masking and barriers. These comments truly underscore why assisted living is unlike any other setting regulated by this rule, and why these restrictions are not appropriate.

The many requirements in OSHA's rulemaking that may be applicable to healthcare settings are inconsistent with this concept. As such, we request that our members should not be considered "healthcare settings" under OSHA's rulemaking and thus should not be subject to any further requirements imposed by such rulemaking.

ADDITIONAL INFORMATION/DATA REQUESTED

In its notice announcing the initial reopening of this comment period, OSHA solicits additional new data and information related to COVID-19 that were not available at the time of the ETS comment period, including data regarding vaccination rates. Notably, as of May 22, 2022, the Centers for Disease Control and Prevention (CDC) found that 91% of the U.S. population aged 65+ have been fully vaccinated (compared to 66.5% for the total U.S. population), and 69% of the U.S. population aged 65+ who have completed an initial vaccine series have had a first booster dose (compared to 47% for the total U.S. population).[5]

Based on these updated figures, along with additional information regarding senior living resident vaccination and staff vaccination mandates reflected in previous comments submitted by Argentum to this record, it is clear that senior living is among the most consistently vaccinated, best-protected populations in the country.

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

[5] *See* https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.

ARGENTUM
EXPANDING SENIOR LIVING

November 29, 2022

The Honorable Douglas L. Parker
Assistant Secretary of Labor
Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

RE: Occupational Exposure to COVID-19 in Healthcare Settings (OSHA-2020-0004)

Dear Mr. Parker,

In light of the Centers for Disease Control (CDC) updated guidance for infection prevention and control that recommended assisted living communities follow the same guidance as the general public, Argentum urges OSHA to maintain consistency across federal agencies in considering assisted living as a non-healthcare setting.

SENIOR LIVING AS HOME

On September 23, the CDC adjusted their guidance for assisted living communities to reflect guidance for the general public, distinguishing assisted living from a healthcare setting. The following is the new language from CDC, excerpted from Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (as of September 23, 2022):

> **Assisted Living, Group Homes, and Other Residential Care Settings (excluding nursing homes)**
>
> In general, long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care* similar to that provided by family members in the home (e.g., many assisted livings, group homes), should follow community prevention strategies based on COVID-19 Community Level, similar to independent living, retirement communities or other non-healthcare congregate settings. Residents should also be counseled about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease. CDC has information and resources for older adults and for people with disabilities.
>
> Visiting or shared healthcare personnel who enter the setting to provide healthcare to one or more residents (e.g., physical therapy, wound care, intravenous injections, or catheter care provided by home health agency nurses) should follow the healthcare IPC recommendations in this guidance. In addition, if staff in a residential care setting are providing in-person services for a resident with SARS-CoV-2 infection, they should be familiar with recommended IPC practices to protect themselves and others from potential exposures including the hand hygiene, personal protective equipment and cleaning and disinfection practices outlined in this guidance.
>
> *Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include the kind of health-related care that most people do themselves, like taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry.

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Argentum reiterates our opposition to OSHA's consideration of senior living facilities as a "healthcare setting." It is important to recognize that although the senior living community facilitates the provision of healthcare services, senior living primarily assists residents with basic self-care or activities of daily living such as eating, dressing, bathing, and the management or administration of medication. Most importantly, as reflected in the more than one hundred comments submitted by residents, family members, caregivers, and other advocates, our members' residents consider these communities their homes.

The many requirements in OSHA's rulemaking that may be applicable to healthcare settings are inconsistent with this concept. As such, we request that our members should not be considered "healthcare settings" under OSHA's rulemaking and thus should not be subject to any further requirements imposed by such rulemaking.

ADDITIONAL INFORMATION/DATA REQUESTED

In its notice announcing the initial reopening of this comment period, OSHA solicits additional new data and information related to COVID-19 that were not available at the time of the ETS comment period, including data regarding vaccination rates. Notably, as of May 22, 2022, the CDC found that 91% of the U.S. population aged 65+ have been fully vaccinated (compared to 66.5% for the total U.S. population), and 69% of the U.S. population aged 65+ who have completed an initial vaccine series have had a first booster dose (compared to 47% for the total U.S. population). Based on these updated figures, along with additional information regarding senior living resident vaccination and staff vaccination mandates reflected in previous comments submitted by Argentum, it is clear that senior living is among the most consistently vaccinated, best-protected populations in the country.

Thank you for your consideration of comments.[1] Please contact me with any questions or requests for additional information.

Sincerely,

James Balda
President & CEO
Argentum

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1. **Additional Resources & Previous Comments**

Memorandum to Reopen the Docket to Allow for the Submission of Post-Hearing Comments and Briefs Posted by the Occupational Safety and Health Administration on Apr 27, 2022, https://www.regulations.gov/document/OSHA-2020-0004-2135.
See https://www.regulations.gov/comment/OSHA-2020-0004-1311.
See https://www.regulations.gov/comment/OSHA-2020-0004-2097.
See https://www.regulations.gov/document/OSHA-2020-0004-2153.
See https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.

ARGENTUM
EXPANDING SENIOR LIVING

January 17, 2023

The Honorable Douglas L. Parker
Assistant Secretary of Labor
Occupational Safety and Health
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

On behalf of Argentum, the leading national non-profit association representing the senior living industry, we ask for your consideration of the unique nature of assisted living communities regarding rules for occupational exposure. As we have repeatedly stated in public comments (dated August 19, 2021, April 22, 2022, May 23, 2022, November 29, 2022) as well as our April 27, 2022 testimony, senior living communities are not medical facilities and should not be regulated as such; rather, they are "home" for many of our nation's seniors.

Argentum remains opposed to OSHA's consideration of assisted living facilities (ALFs) as a "healthcare setting." 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. ALFs are also a lower-risk environment than "hospital ambulatory care settings" and "non-hospital ambulatory care settings," which were exempt from the emergency temporary standard in certain circumstances. As such, it is our position that ALFs should not be considered "healthcare settings" and should not be subject to any further requirements imposed by OSHA's rulemaking.

Our position is supported both by the Centers for Disease Control (CDC) and by more than one hundred public comments submitted last year by residents, family members, caregivers, and other advocates. Last September, the CDC adjusted guidance for assisted living communities to reflect guidance for the general public, distinguishing assisted living from a healthcare setting. That guidance noted that certain long-term care settings—including specifically assisted living—should follow community prevention strategies. The guidance specified that, "Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include the kind of health-related care that most people do themselves, like taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry."

Separately, and perhaps most importantly is the consideration of how ALFs should be categorized by the residents and their family members, as well as the dedicated staff who assist with their ADLs. In public comments submitted last Spring, a caregiver at an assisted living facility in Oklahoma noted that it's imperative to be mindful that these residences are foremost seniors' homes, writing, "We work in their home, they don't live where we work." Adding to this, an operator based on the West Coast stressed that residences are not short-term placements, but in many cases the final home chosen by the senior or their loved one, writing, "Our residents are not in our communities for a temporary stay but are living out the remaining years of their lives. Over the last two years, our residents had to endure too much isolation and confinement. To restrict them further from physical contact from their friends, family, and staff who love them and care for them, with more masks, physical barriers, and plexiglass barriers, would be detrimental to their well-being."

Similarly, a rural operator based in Wyoming commented that restrictions "resulted in social isolation, increased (and unnecessary) fear, and decreased communication, especially for those

ARGENTUM
EXPANDING SENIOR LIVING

persons who are hard of hearing, have an existing speech impairment, or have some age related or other dementia." And echoing these concerns, a commenter from Wisconsin wrote that restrictions are "the opposite from the care, love and support that assisted living providers strive to create in their environments" and added, "a smile can bring joy and wonder to a person in senior living, especially those with dementia," when describing the challenges of masking and barriers. These comments truly underscore why assisted living is unlike any other setting regulated by this rule, and why these restrictions are not appropriate.

The many requirements in OSHA's rulemaking that may be applicable to healthcare settings are inconsistent with this concept. As such, we request that our members should not be considered "healthcare settings" under OSHA's rulemaking and thus should not be subject to any further requirements imposed by such rulemaking.

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