6 THE PERSPECTIVES OF ADMINISTRATORS AND MANAGERS

Providing Long-Term Care Throughout the Pandemic

Reflections on My Personal and Professional COVID Experiences, by Hayden Keziah

In early February 2020, I contracted COVID. Back then, it was still very much unknown, had no real treatment plan, and had not yet been declared a pandemic. I was the first patient diagnosed at the hospital in my town. I had accepted a new job at a nursing home in Charlotte, but had not yet started, and after two weeks in the ICU I wouldn't be cleared to work for almost two months. Those weeks in the hospital were some of the most horrifying, lonely, and uncertain times in my life.

When I was released from the hospital, I began Zoom calls with the team at my new facility to meet them while I waited to start, hoping to make up for lost time. I was nervous for this new venture, as I had just moved from out of town and hadn't worked in the industry since the pandemic began. The decision to change jobs was based on being close to my family, but the timing could not have been worse. I took on this challenge of COVID-19 in a new city, nursing home, and with a new company. Looking back, it seems even more eerie just how much I did not know what headed my way.

During the summer of 2020, once I had begun working, we completed our first round of testing and discovered over thirty positive cases among the residents. My supervisory team sprang into action and donned PPE to help move residents and create a COVID unit. These were our very first cases, so we had to set up barriers, move and clean rooms and beds, change information in our EHR [Electronic Health Records] system. There is so much involved beyond just isolating a patient. One day, the housekeepers all decided to walk out, all at once. They did not want to be around the COVID patients. I had just survived the virus, and I felt an obligation to help and reassure all the residents and staff. I went to the back

parking lot and there stood all six of my housekeepers, screaming about how unfair it was that they would have to do their jobs and help move residents. Family and friends had gathered in their cars. Across the parking lot, the entire team of department heads stood in full PPE, head to toe, ready to help. It was a stalemate like I had never encountered. I couldn't fathom the lack of dedication the housekeepers had to the residents they see each day, and the reckless abandon they showed by abandoning their post when they were needed the most. But more than anything, their attitude toward being around those residents with the virus worried me that it would make those residents feel diminished. If that was their attitude, I'd rather have them leave than stay and drag the team down.

After the police came to help disperse the employees who had resigned but refused to leave the property, I was standing in my gown, mask, goggles, in ninety-five-degree weather, sobbing. I could not believe this was my life. This was a pivotal moment in my career. I felt truly helpless, overwhelmed, and exhausted. It's important to note that the primary emotion was not fear, like some may think. It was a loss of control that sent me into a fight (or flight) reaction. I was determined to do whatever it would take to care for the residents I was legally responsible for. And I knew the residents were scared—scared of the unknown, scared of dying, and scared that they would be separated from everyone they know and love while they quarantined. But my core staff rallied around me, and we got everyone moved by the end of the day, picking up the slack created by the absent housekeepers. It was incredible to watch the teamwork that formed in the aftermath of a walkout that nobody expected.

I remember being the one who called family members and told them their loved one was positive for COVID, after I had just left the resident's room and delivered the same news. Again, this was in the very early days of the pandemic, and everything was uncertain and scary. Families cried, and pleaded for us to help their loved ones. And I promised them I would do just that. It was powerful to be able to provide to families of residents in my facility what the staff at the hospital was able to provide to my family just a few short months before. It was humbling to have everything come full circle. My empathy was specific to the situation and allowed me to lead without fear of the unknown. I did know what the virus was like, and I knew how to comfort those who were afraid.

Working past the outbreaks was difficult, including having to find supplies at local stores and borrowing from other facilities or using makeshift items since the supply chain was so disrupted and unclear. Giving staff every tool to work safely was of the utmost importance. However, the rules were constantly changing and it felt as though long-term care facilities were penalized for a phenomenon and disaster out of our control. It

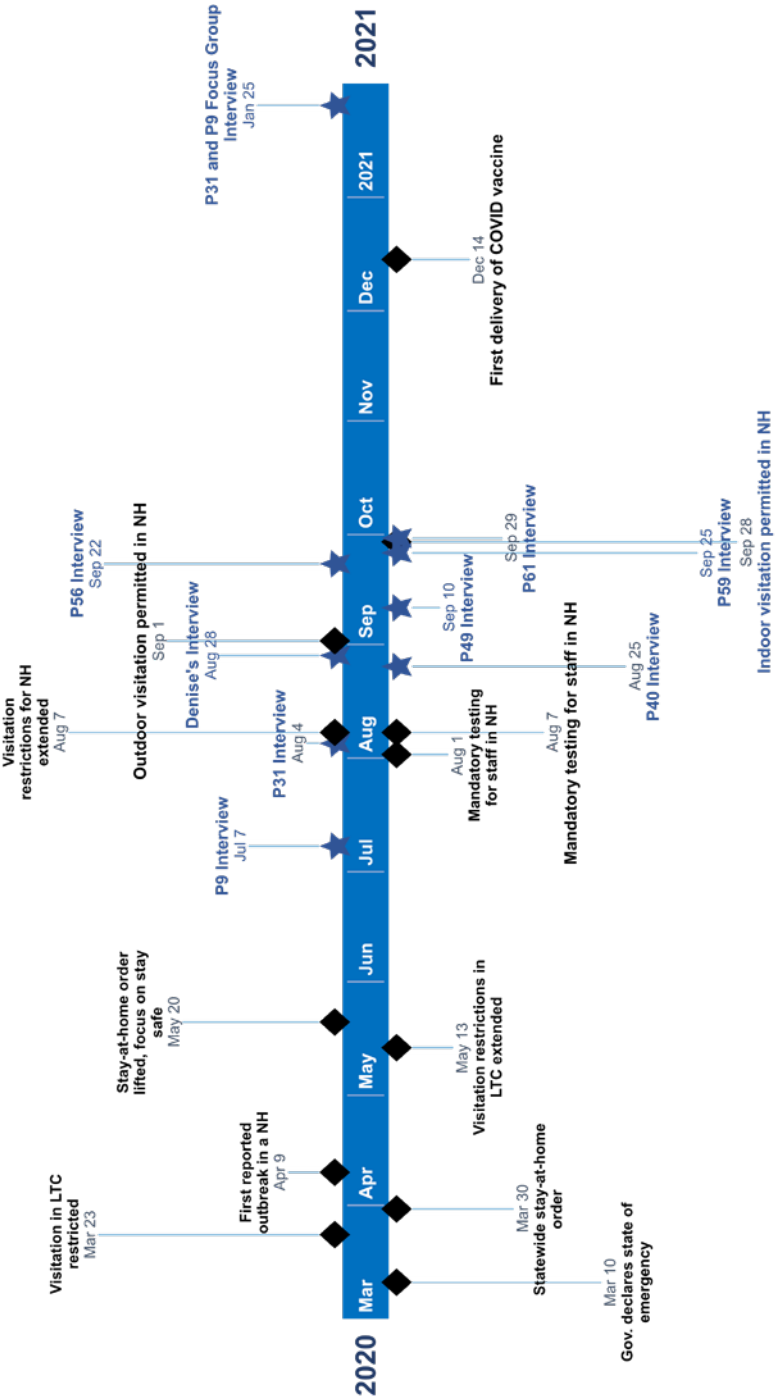

Figure 6.1. Timeline of Interviews Quoted in Chapter 6.

was infuriating to be villainized in the media and sometimes by your own organization, when you are the "boots on the ground" keeping things running, managing things most folks could not even imagine. It was up to us to do the best we could with what we had at our disposal. We did not have the option to "stay home and stop the spread." We had to step up for our residents.

I dried my tears and wiped my sweat and got back to work. And that's what I've been doing ever since.

> "I have felt it [mental stress]! There is so much on your shoulders. It is a lot of responsibility because you have to make sure everybody is doing what they are supposed to be doing." (P31)

This quotation is from an executive director at an assisted living community who we interviewed in August 2020 and January 2021. At the time of the first interview, she had successfully fended off COVID in the assisted living community while still maintaining some level of social engagement for the residents. She was stressed, anxious, at times overwhelmed, but also demonstrated great resolve and optimism regarding the care of her residents. She had been working with older Americans for over ten years and was able to draw on her experiences, her strong connections with residents and their families, as well as an engaged and highly responsive corporate infrastructure to navigate the pandemic in a way that seemed effective and manageable within an ever-shifting infectious disease landscape. Her optimism was well earned as the community was one of only a handful that had not experienced any outbreaks or COVID-related deaths at the time of our first interview during the summer of 2020. She was realistic, though, about this accomplishment, stating: "We take pride in what we have done here, but it can happen anywhere [an outbreak of COVID] and that's the scary part." She was foreshadowing a major outbreak that would occur in her community following the holiday break in 2020, which she would later deem a "super-spreader event" as residents went home to visit families for the holidays and brought back the virus. She described the outbreak to us:

> Well, uh, we went the entire pandemic up until Christmas, the week after Christmas, with no cases, not one case. Then we got hit hard. When I say we got hit hard, we got thirty-seven residents, which, we only have fifty-five residents, so that's a lot. Thirty-seven residents and fifteen staff. And we, to date, have six deaths. It's been hell. It really was hell." (P31)

They decided to move the residents who tested negative for COVID to hotels because they were at capacity and couldn't convert wings to COVID

units. It was costly, scary, and incredibly difficult for both residents and staff. Upon reflection, she stated plainly this was not a good plan for her community and that more thoughtful protocols, as well as preparations for future outbreaks, needed to be put into place. Below, we review how her responsibilities changed in response to the pandemic, as well as some of her lessons learned. We also draw insights from administrators across the long-term care continuum, including those providing home and community-based care, because they faced both similar and unique challenges.

For example, Denise is the program manager of senior nutrition, with over twenty years of experience overseeing twenty nutrition sites in the county. She stressed the collaborative nature of their work in partnering with a variety of faith-based organizations, NGOs, and other service providers to ensure that a wide swath of services, beyond nutrition, were available to improve and sustain the quality of life of older county residents. These partnerships proved effective in enabling them to pivot and collaborate creatively in order to meet the needs of clients. She explained:

> It was very interesting how we kinda. . . 13 March, it was a Friday, I remember, and we heard the [congregate meal and senior center] sites would shut down. [Eighteen hundred people were enrolled at congregate sites.] In one day, it was teamwork, we started calling people, physical phone calls were made, asking people, "Do you feel you would benefit from nutritional support?" (P42)

Over those three days, they expanded from eleven hundred to sixteen hundred people receiving nutritional support at home. They effectively integrated these new clients into existing routes, increased and altered their use of six drivers and pulled in two more who were no longer transporting clients to and from a variety of appointments across the county, and shifted nutritional requirements because food vendors were overwhelmed due to skyrocketing demand and shortages in the supply chain. They also rented more storage space for food so they could stock up on meals and staples in case shortages continued. There was also an increased demand from pastors calling about members of their congregations and individuals in the community who didn't know where to turn when people were afraid to go to the store or family were afraid to visit and bring food. While the logistic challenges were daunting, because of long-standing community partnerships that were in place, most clients' needs were met in an efficient and effective manner. Denise was able to support her mission of providing resources to maintain older Americans in their homes and keep them safe.

While the primary focus of our research was to capture the narratives of those frontline workers who were providing hands-on care or delivering the actual services and supplies to older Americans during the first year of the pandemic, it is also essential to consider the actions and challenges that

decision-makers were confronting during the quickly evolving pandemic in both residential long-term care as well as home and community-based programs. These leaders are responsible for the quality and safety processes in long-term care that then influence the performance of the workforce, job satisfaction, and staff retention (Siegel and Young 2021).

In this chapter, we highlight the experiences and responsibilities of administrators and managers as they attempted to preserve the physical and mental health of residents and clients. Key themes include 1) the logistic challenges and successes administrators experienced; 2) emerging or changing bureaucratic demands related to infection control as well as work associated with the resources made available or unavailable; and 3) the role of communication in navigating the pandemic including between administrators and governing agencies (e.g., CDC, CMS, NCDHHS), corporate offices, with staff, and with clients, residents, and families. We also include administrator narratives that capture key lessons learned as well as the personal sacrifices many of these workers made to preserve the health of those under their care.

This chapter is based on our interviews with a sample of seven residential long-term care administrators and sixteen managers of home and community-based programs. As displayed in table 6.1, the residential long-term care administrators represent four different corporate groups: two are independently owned and one is church-affiliated.

The types of programs and positions of the home and community-based managers included in our sample are displayed in Table 6.2.

Table 6.1. Residential Long-Term Care Administrators.

Level of Care	Position	#	Date	Ownership	Funding
Nursing Home	Administrator	9	7/7/2020	Corporate*	Medicaid
Nursing Home	Administrator	56	9/22/2020	Corporate*	Private
Assisted Living	Administrator	15	7/20/2020	Church-Affiliated	Mixed
Assisted Living	Executive Director	31	8/4/2020	Corporate*	Private
Assisted Living	Administrator	44	9/2/2020	Corporate*	Private
Memory Care	Administrator/ Co-owner	60	9/25/2020	Independent	Private
Adult Care Homes	Administrator/ Owner	27	7/30/2020	Independent	Private

*Each is part of a different corporate group

Table 6.2. Home and Community-Based Directors and Managers.

Agency/Program	Position	Partici-pant #	Date	Funding
Medical (dementia)	Executive Director	36	8/24/202	Non-profit
Community Services	Executive Director	37	8/25/2020	Non-profit
Home-Delivered Meals	Executive Director	58	9/25/2020	Non-profit
County Adult Programs	Manager	40	8/25/2020	County
County Senior Nutrition	Manager	42	8/28/2020	County
County Transportation	Manager	59	9/25/2020	County
Senior Center	Director	50	9/11/2020	County
Senior Centers	Recreation Coordinator	57	9/23/2020	County
Senior Center	Program Director	61	9/29/2020	County
Adult Day and Healthcare Center	Program Director/ Owner	49	9/10/2020	Mixed
Adult Day Care Center	Executive Director/ Owner	54	9/17/2020	Mixed
Adult Day Health Center	Executive Director	66	10/6/2020	Mixed
Home Care	Agency Director/ Owner	73	11/10/2020	Mixed
Home Care	Co-Owner	75	11/17/2020	Mixed
Home Health	Director/Owner	63	10/1/2020	Mixed
Senior and Adult Programs	Director	52	9/16/2020	Mixed

Logistic Nightmares and Notable Successes

Shifting services and transitioning roles were themes discussed by all the administrators and managers we interviewed during the pandemic. The rapid onset of COVID-19 required the ability of leadership across all forms of home and community-based and residential long-term care to pivot quickly to meet the needs of the older adults they provide care for and to help keep them safe. This required creativity and flexibility on the part of administrators in the creation of new policies and guidelines. In all cases, administrators were forced to ask caregivers to adapt to new procedures or even request they change their roles entirely. This was es-

pecially the case with the shuttering of community services as well as residential long-term care communities that were facing increased tasks and staffing shortages.

Many faced impossible logistic scenarios when attempting to institute necessary changes to programming. As discussed in the opening paragraphs of this chapter, Denise, the program manager of senior nutrition for the county, explained the strain that logistics—including food supply, storage, assessment, delivery, and funding issues—placed on their ability to efficiently meet the nutrition needs of her clients. When congregate dining at the nutrition sites was shut down, she had to quickly enroll clients who would pivot to needing in-home delivery in order to support their nutritional needs. At this time, the country was experiencing food shortages and a plethora of supply chain issues. Denise felt this as the program manager of the county's nutrition program for older adults. She recalled:

> The food vendor . . . could not keep up with the demand, the production demand. But since we are a large customer, . . . they offered us what they had in store, which were not part of our regular meals, but I had to adjust [and] make sure that these meals still met the nutritional guidelines and for reimbursement for funding purposes. . . . And we accepted the meals that they had in. . . In the back of my mind, that was a worry that we were gonna have enough meals. . . . I actually had about seven or eight pallets of meals that we purchased. . . . We didn't have room in our own warehouse, and we had to get storage space, . . . [to] store extra meals just in case if the vendor was falling short of meals or on a delayed schedule. . . . So those are more like operational logistics. (P42)

An owner and program director of an adult day and healthcare center that remained open shared similar concerns with nutrition services regarding food shortages, which were compounded by income loss. She explained: "Despite the fact that we didn't have as many participants, so that's less income, and I couldn't find certain meats, I have to feed them. And it was like going to the grocery. . . You couldn't get ground beef and chicken, . . . Everything was coming at us. But when you're doing it, you're not realizing what you're doing." (P49)

Dealing with funding shortages as a result of COVID was noteworthy during the shutdown, which was the case even as CARES money was made available but was slow to access. One program director of a senior center spoke of these specific financial losses that occurred alongside the need to spend money to pivot services during the pandemic: "We've lost a lot of money. I'm sure that a lot of people have. We're sitting close to around a $350,000 loss, and it's just continuing to mount up" (P61). Even though slow to access, CARES funding was identified as an important resource to

enable flexibility as the environment changed. The same senior center program director explained:

> We are getting some CARES funding. . . . We attempted a Bingo outside, when you could have twenty-five people outside, and our patio has no shade, and we were sweating profusely. It was disgusting, actually, so part of the CARES funding we're requesting to have an awning put on outside to have some shaded area that we can also continue, if this should ever happen again, we can do more outdoor programming and not be so uncomfortable, but we can also extend programs outside to provide that social distance now that we're able to open. (P61)

Another major challenge was providing adequate staffing along the entire long-term care continuum. Most residential long-term care administrators requested their staff, who often work more than one job in order to earn a sufficient income, work only in their community to limit the potential spread of COVID. Similarly, in-home healthcare workers were limited in the number of clients they served. At the same time, some staff were unable to work because of their own illness or their fears of getting sick or endangering their families.

School closures as a result of COVID-19 were difficult for some staff to manage. A county program manager of services for adults along with the owners of in-home aide agencies pointed out that in-home aides are largely women who were now also responsible for caring for their own children. Administrators and managers discussed the need to accommodate these issues in scheduling staff.

The essay at the beginning of this chapter focuses on the example of the nursing home administrator who had numerous staff resign as soon as the COVID outbreak occurred. She discusses this difficult scene when they suddenly had a group of residents test positive and all the housekeepers walked out. Based on this traumatic experience, she explains her strategy to mitigate this potential mass exodus moving forward:

> *Now* I have a backup plan for the backup plan. Everybody is cross trained to do anything they need to do. . . . We've even thought about housekeeping knowing how to do dietary's job, you know, everybody knows how to do laundry so if something happens you can step in. . . you're not relying on people who are gonna fly the coop. (P9)

Facing excessive and constantly shifting challenges, the administrators and program managers reported on both the nightmares and successes as they looked back at the earlier phases of the pandemic. They also highlighted the new bureaucratic requirements that emerged alongside the pandemic.

Bureaucratic Challenges

The issue of added paperwork surfaced in multiple interviews with owners, administrators, and program managers. These bureaucratic issues—including grant applications, financial forms, vendor agreements, new enrollment forms for individuals needing in-home services, and audits that required completion and compliance—inhibited the ability of caregivers to serve their clients quickly and efficiently. Denise, the county nutrition manager provided detail regarding this issue:

> So we really have state registration forms and for audit purposes and for reimbursement purposes. There is actually paperwork that needs to be done. . . . For homebound people, we normally do home visits, but we had to end up doing all telephone visits. Telephone assessments for everybody who was considered as new clients, and we had to make sure whether they were homebound, they met criteria. . . and really need home-delivered meals not just because of COVID. . . . And then we also had to do paperwork, a different type of packet for people who could be potential congregate. . . or it could be just people who did meet the homebound criteria. . . and so adding all those people is in itself a lot of work, but that gave duties to our staff. (P42)

Much like the reallocation of resources and reporting, infection control included an abundant array of new procedures and requirements for both residential and home and community-based care. Administrators reported having to procure as well as track the use of PPE by staff and, in the case of residential care, residents. As testing became more available, rigorous requirements were put in place. Simultaneously, there were evolving demands for testing both residents/clients and staff. All positive tests had to be reported to the CDC as well as the NCDHHS. In addition, quarantining had to be standardized and tracked for staff of both residential long-term care and home and community-based programs on exposure and actual infection. For congregate residential care, quarantining includes tracking residents' activities outside the residential community (i.e., trips to doctor's offices and hospitals) in addition to setting up spaces within the nursing home or assisted living community that allow for safe quarantine environments. As vaccines became available, administrators had to encourage, educate, document, and report the vaccination status of staff. In congregate residential long-term care, residents were also monitored regarding vaccination status. The administrator of a nursing home explained the stress she felt between the challenges of the new procedures she had to navigate every day that existed inside a "harsh regulatory environment" and news media eager to point fingers and even demonize the skilled nursing community:

> In a SNF [skilled nursing facility], it is a full time job, just the reporting. [We] did hire a new CNA to be a wellness coordinator to provide numbers for the reports. [There was] respiratory screening of all the residents, cross-referencing screening and testing of my staff and payroll. . . . We missed three staff being tested and the state came in and gave us a citation. It's such a harsh regulatory environment anyways and now they will use this with any headline they ever write about us—SNF has poor infection control, etc. It's ridiculous. (P9)

These bureaucratic challenges all added to the workload of the administrators and managers who are responsible for providing safe, effective care for residents and clients, as well as a safe working environment for their staff. In a media analysis we conducted, it was clear that the majority of coverage around COVID-19 outbreaks and high mortality among older Americans painted a negative picture of what was occurring in long-term care communities. The caustic media environment put the spotlight on the outbreaks and deaths that were occurring at a high rate, adding to the challenges and stress experienced by the administrators and managers who were navigating this nightmare.

Communicate, Communicate, Communicate

As the pandemic progressed, and knowledge about the virus increased, so too did policies and programmatic requirements. These changes were discussed, advised, and at times legislated at all levels from federal mandates and guidelines to state and local bodies. These policies did not always coincide and often emerged on different timeframes. This was a difficult landscape for all administrators and managers to navigate as they were often inundated with competing demands and guidelines. It is not surprising that throughout all our interviews, participants at every level of care in every type of care scenario discussed the value of good communication as well as frustration with poor or inadequate communication. Administrators and managers in residential long-term care and home and community-based services experienced both overlapping and unique communication demands.

Communication was especially critical in both home and community-based and residential long-term care when state-mandated lockdowns occurred. As programming and policies evolved quickly, administrators had to ensure consistent and clear communication with their residents and clients, as well as with their staff regarding infection control and shifting responsibilities (i.e., group activities changed to individual or pod activities), and families that could no longer visit their loved ones or whose loved

ones could no longer attend adult day care or senior centers or congregate nutrition sites. These efforts began with consideration of the government mandates and communication with professional organizations and corporate offices and advisory boards.

Communicating with Corporate Offices, Advisory Boards, Other Administrators, Vendors, and Professional Associations

Administrators and managers had to gather information and confer with various professional organizations and supervisory boards as they struggled to interpret federal, state, and local mandates and guidelines and make decisions about how to provide safe and effective care for the residents and clients. Participants working in residential long-term care discussed in detail how they navigated the evolving knowledge about the virus and instituted changes in procedures regarding infection control, quarantining, social (or physical) distancing, and vaccines. One administrator of a skilled nursing community that experienced a major outbreak in the early months of the pandemic explained:

> But it seems like we get one hundred [messages about COVID] per day. . . but when you get five different entities—your federal government, your state government, your local government, your corporate policies, and your facility policies—and they're all doing something different, that's really difficult to keep track of. It's difficult to figure out who's got the best way of doing things. (P56)

This same administrator lauded their corporate office for their efforts to distill the information into tangible policies and procedures on an evolving basis. They also found the weekly check-ins with others in their corporate group to be helpful as staff at other residential long-term care communities were able to share their experiences and communicate back to corporate their failures and successes. They explained:

> She [their regional director] kept us all together and on the same page as best she could. So by having those weekly calls. . . we're able to bounce ideas off of each other, off of other administrators. Every administrator and every DON [director of nursing] on that call. We're able to go through different scenarios, we're able to hear experiences such as, "Hey guys, we just had a state team walk in and they gave us this tag for this infection control issue. Make sure you guys aren't making that same mistake." So I think we had knowledge and power because of the masses that we had of DONs and buildings and corporate structure. And if it weren't for that, it would be exhausting having to keep up with all that if we didn't have that. (P56)

This administrator alluded to the potential differential experiences faced by various residential long-term care communities. Our data indicate that corporate-owned congregate residential communities typically did have easier access to PPE and more support in determining effective approaches to combating the virus. On the other hand, owners and administrators of independent residential long-term care communities stressed their flexibility, creativity, and resourcefulness as they processed the incoming information and navigated the changing environment in order to keep their residents and staff safe.

In home and community-based programs, managers faced equally daunting challenges as the distribution of services fundamentally changed for all programs. The advisory boards of most programs directed the managers to shutter their programs but retain staff. County funding pivoted to allow programs to be reimbursed for adult day care participants, for example, as long as staff communicated with the clients by telephone to assess their needs and provide ongoing support. A senior center director explained how they determined participants' interest and ability to join virtual programming:

> So what we did is we split up the list and we started calling people to say we're closed. . . After a few weeks, it became apparent that we weren't gonna open again anytime soon. So we went back and started polling the seniors: "Do you have a computer? Do you have an iPad? Do you have a cell phone? . . . Do you use the internet? Do you use Zoom? Do you use FaceTime? What do you use? And then, are you interested in using Zoom if someone teaches you?" And once we did that, we started getting people onboarded to Zoom. . . We set up a Zoom test and we had a full screen and it was so cool because everybody hadn't seen each other. (P52)

They also delivered kosher meals to their regular participants who were no longer receiving that service since the program was closed: "The only thing that we had done from the beginning is we were delivering meals, so we started delivering meals every two weeks, and we tried to give them enough for at least a meal a day for two weeks and they could freeze things that they could freeze and things like that" (P52).

Denise, the county program manager of senior nutrition, was very effective in shifting from congregate dining to in-home delivery, which occurred essentially overnight between Friday and Monday. She was also able to continually add home-delivered meal recipients as the pandemic continued and more and more older community members needed nutritional support as the congregate nutrition sites and other community programs were closed and they were unable to go out grocery shopping. She highlighted the resilience and flexibility of staff as well as her ability to commu-

nicate with strong community partners who could expand their services. She explained:

> Of course, the entire operation of home deliveries was team-based, so people who manage the [congregate] site operations started helping the drivers. . . [I] realized to extend services on a much larger scale I had to leverage resources. . . We did get CARES funds. . . And one of the things that we kind of used part of those funds for nutrition support, and I think this has kind of helped me realize, in order for me to sort of extend the services on a much larger scale, and I have to leverage resources that are already available, like I have to work with community partners, so there are two nonprofit organizations that I thought about, and we were able to get funding in place. (P42)

Denise, the nutrition program manager, was noted by other program managers for her effectiveness in responding quickly to the expanding need as they increased their delivery of home-delivered meals. This was due in part to the strong ties and effective communication between community agencies. This decision-making at the administrative level also required strong communication with staff in order to be implemented effectively, to keep staff safe, and to provide safe care for their clients.

Communicating with Staff

These staffing challenges required communication with individual staff members to ascertain their changing availability and scheduling needs. The county program manager for programs for adults pointed out the need to better accommodate and communicate even more effectively with staff to ensure their continued engagement with evolving programming and assure staff that their safety was a priority. They described:

> Okay, so I'd say one thing that has worked well was the mobilizing for staff to work remotely, because they felt supported. . . because it's always better for people to be able to work with accommodations than to have to take FMLA [Family and Medical Leave Act] and have half of your workforce out. And it also gave the message that our health and our safety was a priority to the county, and I think that did wonders for morale. (P40)

Alternatively, Denise, the nutrition program manager, noted the communication breakdown that occurred when everyone left the office and worked remotely. She bemoaned the lack of communication that no longer happened as people did not talk or see each other every day, and she felt this had a negative impact on morale. She saw this as an important lesson learned that needs to be integrated into remote responses moving forward.

In addition, Denise highlighted communication breakdowns with their vendors (including contracted agency staff), such as home health agencies, especially regarding policies vendors had in place concerning infection control for their staff but also for the recipients of care. She explained:

> Where I'll say I fell down is it would have been better if early on, I had gotten information from the vendors about their policies regarding infectious disease control. I think they were writing them as it went along as the CDC was giving guidance as the state was getting guidance, and that's a moving target, but probably earlier on it would have been good for me to have gotten that kind of information so I could share it. (P42)

In discussing this situation, she related a scenario whereby a client's family member tested positive for COVID but did not disclose this information to the social worker, agency, or staff person who visited their home to provide services. It was not until the adult day care center reported the occurrence of COVID to the county Department of Public Health that they were notified. She also explained that staff members themselves did not always disclose their exposure or infection:

> From the vendor side [the home health,] aides were not always, or haven't always been, forthcoming with their employer about having a family member who tested positive or going to get a test themselves. We kinda look at individuals who work with, I'll say a low-income job, need the money and make decisions for themselves, knowing that they may not be able to work if they disclose things so. . . that I'm not quite sure how we could do better, but that's something that did not go well. (P42)

As noted in chapters 2 and 3, some CNAs, housekeepers, and homecare aides felt supported by their supervisors. Others, however, felt administrators and managers were making decisions without listening to their concerns and utilizing input from their hands-on experiences.

Communicating with Residents and Clients

The administrators and managers all explained that many residents and clients were confused by mandates or frustrated with the substantive disruptions the pandemic caused. One residential long-term care administrator said plainly that the only way to address their anxieties, frustration, and anger was through constant communication and explanation of COVID mandates and policies. They said, "You cannot overcommunicate your commitment to residents. You just can't overcommunicate it. You have to show them that you're serious about it [COVID and prevention] in order for

them to feel safe. And that's our job, is to protect them and make them feel safe" (P44).

Administrators and managers stressed the importance of communicating the constantly changing rules and limitations to residents and clients. Residential long-term care residents were required to remain in their rooms for months with their only in-person interaction provided by staff. These lockdowns were generally reinstated whenever there was an outbreak in the long-term care residence. Enforcement of mask wearing and social distancing was exceedingly difficult—especially with regard to persons living with dementia, as discussed in chapter 5. Home and community-based providers struggled to provide essential services to clients while keeping the clients and themselves safe. This required extensive communication with clients to ascertain which services were essential and when clients were willing or unwilling to have workers in their homes (see chapter 3). This required consistent communication with clients and their families, as we discuss in the next section.

Communicating with Families of Residents and Clients

These communication demands also extended to family, many of whom were distressed because they could not be with their loved ones, including some living at home. Administrators in residential long-term care had to institute new forms of communication to connect families with residents, and several started sending regular email updates to residents' families (see the discussion in chapter 4 of innovations that allowed virtual and outdoor visits). Administrators emphasized that it was particularly important to have staff or themselves reach out to loved ones when residents, especially those with dementia, struggled to use new forms of communication and, of course, when residents were ill or declining. As one administrator explains in the essay at the beginning of this chapter, she was the one who called family to tell them of the COVID diagnosis during their early outbreak. She had experienced a severe case of COVID herself and was hospitalized back in February 2020 and felt she knew what the virus was like and how to comfort those who were afraid.

Extensive media and social media coverage has focused on the frustrations and complaints of residents' family members who were unable to visit with their loved ones and questioned the intent of administrators and staff. For example, an active Facebook group "North Carolina Caregivers for Compromise because isolation kills too!" was created in September 2020 as part of a nationwide reaction to lockdowns and limitations on visitation. This was especially disheartening to administrators and staff who were struggling to follow guidelines and keep residents safe from COVID.

In terms of home and community-based services, one manager lauded the ability to quickly communicate with clients and their families about their needs and make sure they were met. This is impressive as many services shifted overnight when adult day care and other home and community-based settings were closed. They explained:

> What we also did well at a micro level is I think my staff did a remarkable job assessing their individual clients and families to see who needed what, and to prioritize that and then to bring forward to me. "This is okay over here, but what this person really needs is a refrigerator. . . she's taking care of her elderly parents and her six-year-old grandchild, she doesn't have a functional refrigerator, can we get some money for it?" So just those. . . There's a micro level keeping people safe and just trying to help them out. (P40)

This shifting landscape proved stressful and demanding on staff at all levels. It is also important to acknowledge that beyond their best efforts to serve their clients and residents at this time, they also were experiencing an uncertain, risky environment and their commitment required managing personal stress and making personal sacrifices.

Personal Sacrifices and Personal Stress

Continuing to work and committing oneself to the care of particularly vulnerable older Americans during an uncertain, deadly global pandemic is heroic. Our interviewees discussed why they were willing to take on risk and continue serving clients and residents despite their own fear and anxiety. For example, one transportation manager used the isolation that they knew their clients were experiencing to motivate them to continue to show up and do their job and be available for the older adults needing the transportation services and human connection that they and their staff could provide:

> Well, what is the message here? And there's so much sadness right now and isolation, and how has that really impacted a lot of people, but then we're also thinking, "Well, okay, what can I think from a more positive side of it?" . . . So it kinda helps keep me a bit motivated, reminds me why I'm here. I have to remind myself, I have to tell myself, I'm not here just for my kids and bringing food home to the table, but there are people that really have a need for us, and there's a reason why our program exists to serve in your community. (P59)

Staffing issues are unfortunately common in long-term care, and staffing challenges were greatly exacerbated by COVID in several ways. For exam-

ple, workers were unable to work when they were sick or quarantining, and most programs tried to limit the number of residents or clients each worker served in an attempt to mitigate exposure. As stated above, staff were now dealing with personal challenges including keeping their children, grandchildren, parents, and others they live with safe. Many were not comfortable providing hands-on care and being exposed to COVID daily. All these issues added to the excessive challenges managers all faced in providing effective staffing in both residential long-term care and home and community-based settings including home care and home health aides going into peoples' homes. Discussing challenges associated with school closures as a result of COVID-19, one program manager of services for adults (P40) pointed out that in-home aides are largely women who were now responsible for caring for their own children who were no longer going to school each day.

At the same time, these administrators and managers also pointed to the great resilience and dedication of their staff, providing positive examples of staff who really stepped up and demonstrated their commitment to the people in their care. One participant stated:

> I know there's a silver lining in everything. So I think if anything, it's taught us to be resilient. It has definitely, you know, you always have sort of a sixth sense about some of your caregivers and what they're willing to do and able to do, and it has been astonishing to me how really awesome, so many people have just stepped up, and . . . they've taken risks to themselves and stayed with clients that can't be left alone. (P73)

Both professional and personal demands were described by each of the administrators and managers. Anxiety and depression were discussed by multiple participants who, while they were facing extreme challenges dealing with the pandemic at work, were coming to grips with their own isolation and fears surrounding the pandemic. A program manager of services for adults expressed these thoughts:

> I probably, like Michelle Obama [as described in her autobiography], have kind of felt that low depression. I haven't been to a restaurant, I think since February, other than getting takeout. But it really is an isolating experience and COVID, because it's what I see every day when I watch MSNBC, and because it's what I do in my job every day, there's just a whole lot of pandemic talk. . . and the world of my world revolves around that, and I'd say that's getting. . . That kind of gets to you. . . the fact that this is your world basically right now. (P40)

The administrator of a nursing home that had experienced a major outbreak early in the pandemic openly discussed their feelings and concerns as they thought back on that devastating period:

> There was probably four or five days in a row where I would sit back and no one would be around me, and I would blame a lot of it on myself. . . Not that I could have done anything or could have prevented it, I don't think, but I would say, "If I had done this or if I had done that or if I had. . ." A lot of second-guessing. And I would, I'd get very emotional. There was a day, I let three funeral home directors in because they had to pick up bodies and that, that's extremely difficult, and people didn't have to die. . . Now, for us we ran a high hospice volume of patients, and so these people were very compromised, and I tried to tell myself that, "Hey, [name], there's only so much you can do and that you could have done and so. . ." But yeah, there was probably a good week to two-week period where it was very difficult for me, and I didn't show it in front of anybody. . . but my [spouse]. But yeah, it was difficult. At the end of the day, as an administrator, we take full responsibility for everything that happens in this building. That's our role, and I took that to heart. (P56)

The combination of intense professional challenges along with the personal stressors they were experiencing at the same time was particularly difficult for the administrators and managers who had to make hard decisions in the constantly changing environment throughout the pandemic.

Discussion

A recent study of long-term care leaders in North Carolina and Pennsylvania reported:

> During the pandemic, long-term care administrators were expected to maintain infection control protective measures in an everchanging regulatory environment in order to maintain the highest level of safety and well-being for residents and staff. They were responsible for establishing isolation wings/hallways, ensuring that staff had personal protective equipment and knew how to properly use it, implementing work protocols to treat COVID positive residents and staff, and provide care and services when staff couldn't work due to exposure or testing positive themselves. (Lane and Liu 2022)

As discussed in this chapter, residential long-term care administrators and managers of home and community-based programs were faced with inordinate challenges as they engaged in constant decision-making throughout the pandemic. They had to implement safe care practices to protect their staff and residents/clients while following evolving federal, state, and local policies and guidelines.

One of the more common themes among administrators and managers is the need for a committed, flexible workforce. Adequate, effective staffing is currently at crisis levels for the many reasons we've discussed and

changes are necessary. As the nursing home administrator who had her entire housekeeping staff walk out as soon as the COVID outbreak began advised, it is essential to cross-train the staff so that they can step in to fulfill different roles when it becomes necessary. This is not necessarily common practice, although that was a lesson imparted to Shenk by a nursing home administrator in Denmark more than thirty years ago. That is one of the lessons learned and relearned during the COVID pandemic, and in the conclusion to this book we will continue to explore these lessons learned.