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Design Issues in Assisted Living Facilities in the Era of COVID-19



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Despite the negative impacts that the COVID-19 pandemic poses to the design and construction industry, there may be some opportunities to retrofit assisted living facilities and nursing homes to better protect residents, visitors, and staff from disease outbreaks, not only like the one we are currently experiencing but also those such as seasonal influenza and other communicable diseases that disproportionately affect the elderly.

In a letter to the National Fire Protection Association (NFPA) community, President Jim Pauley urged members to “protect it [the world] together.” The NFPA has grown from addressing just those building improvement features necessary to minimize danger to life from the effects of fire to considerations not related to fire which provide an on-going benefit in other conditions of use, including non-fire emergencies. In other words, its provisions will also aid life safety in similar emergencies.

The COVID-19 pandemic is one of those examples of a non-fire emergency. Governor Ron DeSantis issued an emergency order on March 15th, 2020, to “prohibit visitation to specific facilities for thirty (30) days from the date of the order in the State of Florida.” For purposes of this order, a facility includes: Group Home Facilities, Developmental Disabilities Centers, Long Term Care Hospitals, Transitional Living Facilities, Intermediate Care Facilities for the Developmentally Disabled, Assisted Living Facilities, Adult Mental Health and Treatment Facilities, Adult Family Care Homes, and some other health related specialty long term care facilities.

The threat of infectious disease spreading throughout a captive elderly population and the Governor’s emergency order restricting visitation in long term care facilities implies that some latent design and construction deficiencies could be responsible. Could this

be an overreaction to the Kirkland Nursing Home tragedy in Washington state, where there have been 25 deaths attributed to the disease? Subsequent similar episodes across the country point toward the building design contributing in whole or in part to the speed of the spread. So how can the rate of spread of infectious diseases best be slowed in long-term stay health care facilities?



I suspect that the limited presence or total absence of isolation rooms, clean rooms, and other effective forms of temporary quarantine holding areas could be contributory to both the number of infections and the velocity of the spread of the disease.

Unfortunately, the State of Florida's requirement to provide such isolation is somewhat unclear. Under the state's Agency for Health Care Administration (AHCA) such a requirement depends upon a resident risk assessment. According to the FGI Guidelines for Design and Construction of Residential Health, Care, and Support Facilities, "the risk assessment shall be initiated by the care provider during the functional programming phase of the health, care, or support facility project and continue through project construction and commissioning as applicable".

As an architect and forensic expert, this language appears somewhat discretionary and left up to sort of a "design committee" to determine the extent and number of isolation areas versus a clear cut life safety or building code requirement. It leaves the risk assessment to an "interdisciplinary team" to conduct the Infection Control Risk Assessment (ICRA) as part of the overall Resident Safety Risk Assessment (RSRA). What about making it an enforceable code requirement in all long term care facilities? I believe that the various building code congresses will do just that when reviewing lessons learned from the current outbreak.

That is what the new Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) seem to suggest. In CMS's recently released article, *Guidance for Limiting the Transmission of COVID -19 for Nursing Homes*, it states on page three under 9b, "if possible create dedicated visiting areas near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting". And more compelling than this, under CDC guidelines (Worksheet Number H.2), "prompt detection, triage, and isolation of potentially infected residents are essential to prevent unnecessary exposure among healthcare personnel and visitors at the facility." Confusing the issue though, is the CMS

guidance that states, "Facilities without an Airborne Infection Isolation Room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19." As a non-health care layman, these other practices seem to me to be extremely exhaustive and onerous. However, as an architect and forensic design expert, the existence of more and better isolation rooms will provide some level of fall back protection if the proverbial "crack in the dam" occurs in the other protective protocols.

Our colleagues in the legal profession are going to have a field day on interpreting what constitutes an acceptable level of risk when there were no or inadequate isolation rooms. There likely will be numerous wrongful death and premises liability suits filed against the owners and caregivers of these facilities.

To prevent further spread of infectious diseases in long-term health care facilities or at least mitigate it, I recommend the following:

1. Retain an experienced forensic architect or engineer to assess the facility and recommend if required, the placement or retrofit of suitable areas for isolation rooms.
2. Do not have the design professional issue any report that identifies suspected deficiencies because once conveyed to the premises owner or caregiver, it is potentially discoverable by a complainant.
3. If the facility is considered deficient by the expert with regard to adequate quarantine areas, then the owner may well decide to improve the facility in accordance with the design professional's recommendations.
4. Don't be overly concerned that the improvements or cures of alleged deficiencies can be construed as an admission of liability for any previous injury or death. According to our colleagues in the legal profession, building deficiency cures are not typically admissible in court after the fact.

If you are in the design or construction industry helping to institute the improvements described above, that could go a long way in preventing similar tragedies and the ensuing litigation that is likely an inevitable outcome.

