Mr Chair, members of the working group, my name is Brian Splatt. I am a Registered Nurse working primarily on a Transitional Care Unit (TCU) at Minnesota Masonic Home, a Care Providers of Minnesota member. Here today with the Long-Term Care Imperative.

In March of 2020, we converted the wing I normally work on, to an isolation unit, for COVID-19. Due to the uncertainties surrounding COVID-19, staffing the isolation wing was challenging. My family didn't want me to work with COVID-19 positive patients. I understood their concerns, but also knew when I decided to get into nursing, there could be tough decisions like this, and ultimately, someone needed to care for these patients, so I volunteered.

In March of 2020, we started seeing COVID-19 patients. At first, just one-at-a-time. Then, eventually the whole 20-bed wing was nearly full. Fortunately, more staff volunteered to work the unit. Due to guidelines, visitation was limited. It was heart-wrenching telling patient family members that they could have one, one-hour, in-person visit, with their loved one (wearing N95 mask, face shield, disposable gown, and gloves - properly donned).

Because many of our patients were elderly and their code status was "Do Not Resuscitate"/"Do Not Intubate"/"Do No Hospitalize", we did see patients decline and die on our unit. There was one twelve-hour shift, where two patients died. We were there for these patients, caring for them, comforting them, communicating with families, and often holding their hand, while they took their last breath. It can be very difficult to prepare for shifts like these. We are emotional beings-but we kept things together for all of the other patients who needed us.

There were many concerns related to availability of proper Personal Protective Equipment (PPE). Due to shortages, we made N95 masks last about 60 hours. Our protective gowns were made of non-breathable plastic, and we would start to sweat five minutes after putting them on. We typically work 8-hour shifts, but on the COVID-19 unit we worked 12-hour shifts, to limit staff exposure. I worked the overnight-shift--7pm to 7am. When my shift was done, **I would shower, and then sleep on the unit, for four days, to try to reduce the risk of bringing the virus home to my family**. When I did leave the facility, I would shower and have all my dirty scrubs, double plastic-bagged to reduce the risk of viral spread into our home.

My family was aware of the highly infectious nature of COVID-19, so, I stayed socially distanced, as much as possible. The shifts were not my normal shift hours. The hours varied with COVID-19 spikes and dips. Many staff left. We are still struggling to find staff today. Our facility still requires mask-wearing for all staff. And gown/glove/face shields when caring for patients who aren't fully vaccinated. We are currently, not "back to normal". We haven't seen co-workers unmasked faces in nearly a year and-a-half! Our isolation wing has been idle since March, 2021 but sits ready to meet the needs of next COVID-19 wave.

As you and the working group members contemplate the distribution of the frontline worker fund I would ask that you recognize those of us in senior care who risked so much throughout the pandemic to care for Minnesota's elders.