Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY COULD BETTER ENSURE THAT NURSING HOMES COMPLY WITH FEDERAL REQUIREMENTS FOR LIFE SAFETY, EMERGENCY PREPAREDNESS, AND INFECTION CONTROL

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September 2023
A-02-22-01004

Office of Inspector General

https://oig.hhs.gov

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Report in Brief
Date: September 2023
Report No. A-02-22-01004

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

Why OIG Did This Audit

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all Medicare and Medicaid enrollees, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

Our objective was to determine whether New Jersey ensured that selected nursing homes in New Jersey that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

How OIG Did This Audit

Of the 356 nursing homes in New Jersey that participated in Medicare and Medicaid, we selected a nonstatistical sample of 20 nursing homes for our audit based on certain risk factors, including multiple high-risk deficiencies New Jersey reported to CMS.

We conducted unannounced site visits at the 20 nursing homes from March through May 2022. During the site visits, we checked for life safety, emergency preparedness, and infection control deficiencies based on requirements listed on CMS surveyor checklists.

What OIG Found

New Jersey could better ensure that nursing homes in New Jersey that participate in Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During our onsite inspections, we identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes we audited, totaling 363 deficiencies. Specifically, we found 148 deficiencies related to life safety, 152 deficiencies related to emergency preparedness, and 63 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes are at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, New Jersey had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, New Jersey does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey follow up with the 20 nursing homes we reviewed to ensure that they have taken corrective actions regarding the deficiencies identified in this report and instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements. We also make procedural recommendations for New Jersey to work with CMS to develop and implement a plan to identify and conduct more frequent surveys at nursing homes and to develop standardized training for nursing home staff.

New Jersey did not indicate concurrence or nonconcurrence with our recommendations and disagreed with some deficiencies and our conclusions. New Jersey provided information on actions that it has taken or plans to take to address our recommendations. We revised one recommendation based on New Jersey's comments and maintain that our findings and recommendations, as revised, are valid because they are based on the regulatory requirements contained in CMS surveyor checklists noted in our report.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/22201004.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its requirements related to health care facilities to improve protections for all Medicare and Medicaid enrollees, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems and smoke detector coverage to better protect residents, staff, and visitors from fire hazards. In addition, existing emergency preparedness plan requirements were expanded to include sheltering in place and evacuation provisions. Facilities were also required to update and test their emergency preparedness plans annually and train staff on them. Finally, facilities were required to develop an infection control program. CMS subsequently issued guidance to State survey agencies and nursing homes to help prevent the spread of COVID-19.

As part of our oversight activities, the Office of Inspector General (OIG) is reviewing this area because many residents of nursing homes have limited or no mobility and are particularly vulnerable in the event of a fire or other emergency. Nursing homes are also communal living environments; therefore, residents are susceptible to infectious diseases. In July 2022, we issued a report summarizing the results of a series of audits we previously conducted in eight States[1] to assess compliance with CMS's new life safety and emergency preparedness requirements.[2] This audit, which focuses on selected nursing homes in New Jersey, is one in a series of audits that also assesses compliance with CMS's infection control requirements.

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Health (State agency) ensured that selected nursing homes in New Jersey that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

BACKGROUND

Medicare and Medicaid Nursing Home Survey Requirements

Medicare and Medicaid programs cover care in nursing homes for eligible enrollees. Sections 1819 and 1919 of the Social Security Act (the Act) establish requirements for CMS and States to perform surveys of nursing homes to determine whether they meet Federal participation

[1] We conducted audits in New York, California, Texas, Florida, Missouri, Illinois, North Carolina, and Iowa. Appendix B contains a list of these audits.

[2] *Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety* (A-02-21-01010) July 15, 2022.

requirements. For Medicare and Medicaid, these statutory participation and survey requirements are implemented in Federal regulations at 42 CFR part 483, subpart B, and 42 CFR part 488, subpart E, respectively.

Requirements for Life Safety, Emergency Preparedness, and Infection Control

Nursing homes are required to comply with all Federal, State, and local laws, regulations, and codes, as well as accepted professional standards and principles (42 CFR § 483.70), including:

- *Life Safety Requirements*: Federal regulations for life safety (42 CFR § 483.90) require nursing homes to comply with standards set forth in the National Fire Protection Association's (NFPA) *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99).[3] CMS lists applicable requirements on Form CMS-2786R, Fire Safety Survey Report.[4]

- *Emergency Preparedness Requirements*: Federal regulations for emergency preparedness (42 CFR § 483.73) include specific requirements for nursing homes' emergency preparedness plans and reference the *Standard for Emergency and Standby Power Systems* (NFPA 110)[5] as part of these requirements. CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.[6]

- *Infection Control Requirements*: Federal regulations for infection control (42 CFR § 483.80) require nursing homes to comply with specific requirements for infection prevention and control programs (IPCPs) and with policies and procedures for influenza, pneumococcal, and COVID-19 immunizations. CMS lists applicable requirements on its *Infection Prevention, Control, and Immunizations Surveyor Checklist* and *COVID-19 Focused Survey Checklist* (Infection Control Surveyor Checklists).

[3] CMS adopted the 2012 edition of both publications in a final rule published in 81 Fed. Reg. 26872 (May 4, 2016).

[4] Form CMS-2786R is available online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009335.html. Accessed on Feb. 21, 2023.

[5] CMS adopted the 2010 edition of NFPA 110 in a final rule published in 81 Fed. Reg. 63860, 63929 (Sept. 16, 2016).

[6] CMS provides online guidance for emergency preparedness at https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/emergency-prep-rule.html and https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Surveyor-Tool-EP-Tags.xlsx. Accessed on Feb. 21, 2023.

CMS uses these survey documents when CMS or a designated agency performs a nursing home survey. The results of each survey are reported and added to CMS's Automated Survey Processing Environment (ASPEN) system.[7]

In addition to the Federal requirements noted previously, New Jersey requires carbon monoxide detectors to be installed in nursing homes that contain a fuel-burning appliance or that have an attached garage (Title 5 § 70-4.9(d) of the New Jersey Administrative Code [NJAC]).

Responsibilities for Life Safety, Emergency Preparedness, and Infection Control

Federal law requires nursing homes to protect the health, safety, welfare, and rights of nursing home residents and to comply with requirements for participating in Medicare and Medicaid.[8] CMS is the Federal agency responsible for certifying and overseeing all of the Nation's 15,600 Medicare- and Medicaid-certified nursing homes. To monitor nursing home compliance with Medicare and Medicaid participation requirements, CMS enters into agreements with States under section 1864 of the Act (Section 1864 Agreements).[9, 10] Pursuant to these Section 1864 Agreements, State survey agencies are responsible for completing life safety, emergency preparedness, and infection control surveys (known as standard surveys) at least once every 15 months at nursing homes that participate in Medicare or Medicaid programs.[11] Nursing homes with repeat deficiencies can be surveyed more frequently. In New Jersey, the State agency is the State survey agency that oversees nursing homes and is responsible for ensuring that nursing homes comply with Federal, State, and local regulations.

Between 2016 and 2019 (prior to the COVID-19 pandemic), the State agency conducted standard surveys at least every 15 months at all 20 of the nursing homes we visited in New Jersey. In response to CMS's March 2020 COVID-19 guidance, the State agency shifted its oversight to infection control surveys and suspended standard surveys in nursing homes during the COVID-19 public health emergency. The State agency resumed standard surveys in September 2020. However, between 2020 and 2022, the State agency did not conduct standard surveys at least every 15 months at 17 of the 20 nursing homes we visited.

[7] ASPEN is a suite of software applications designed to help State survey agencies collect and manage health care provider data.

[8] The Act §§ 1819(f)(1) and 1919(f)(1); 42 CFR part 483, subpart B, including 42 CFR § 483.70.

[9] The Act §§ 1864(a) and 1902(a)(33); 42 CFR § 488.330; CMS's *State Operations Manual*, Pub. No. 100-07, Ch. 1- Program Background and Responsibilities, sections 1002 and 1004 (Rev. 123, Oct. 3, 2014).

[10] The Act §§ 1819(g) and 1919(g).

[11] State survey agencies oversee nursing homes in their respective States and are responsible for ensuring that nursing homes comply with Federal, State, and local regulations.

Management and staff at nursing homes are ultimately responsible for ensuring the safety and well-being of their residents and for complying with Federal, State, and local regulations. For example, management and staff are responsible for ensuring that facility systems (e.g., furnaces, water heaters, kitchen equipment, generators, sprinkler and alarm systems, and elevators) are properly installed, tested, and maintained. They are also responsible for ensuring that: (1) nursing homes are free from hazards, (2) emergency preparedness plans (e.g., fire evacuation and disaster preparedness plans) are updated and tested regularly, and (3) IPCPs are updated as necessary.

Nursing Home Surveys During the COVID-19 Public Health Emergency

In March 2020, CMS suspended standard surveys in nursing homes to reduce surveyors' time onsite and modified deadlines for completing surveys during the COVID-19 public health emergency. Consequently, State survey agencies (including New Jersey's) experienced a backlog of standard surveys. During this period, CMS shifted its oversight to infection control surveys, which are more limited in scope than standard surveys.[12] States, including New Jersey, also continued to conduct surveys for more serious nursing home complaints. In August 2020, CMS authorized States to resume standard surveys "as soon as they have the resources (e.g., staff and/or Personal Protective Equipment) to do so."[13]

HOW WE CONDUCTED THIS AUDIT

As of December 2021, 356 nursing homes in New Jersey participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on risk factors, including multiple high-risk deficiencies the State agency reported to CMS's ASPEN system for calendar years (CYs) 2016 through 2019.[14, 15]

We conducted unannounced site visits at each of the 20 nursing homes from March through May 2022. During each site visit, we checked for life safety violations, reviewed the nursing home's emergency preparedness plan, and reviewed the nursing home's policies and procedures for infection control and prevention. We considered noncompliance with a Federal requirement to be a deficiency, regardless of the number of instances of noncompliance we observed. For example, if we found three fire extinguishers at one nursing home to be in

[12] CMS, Prioritization of Survey Activities, Ref: QSO-20-20-ALL (Mar. 20, 2020).

[13] CMS, Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization, Ref: QSO-20-35-ALL (Aug. 17, 2020).

[14] The 20 nursing homes consisted of 9 with multiple high-risk deficiencies and 11 with at least one deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

[15] We defined deficiencies as high-risk if they: (1) were widespread and had the potential for more than minimal harm, (2) involved actual harm that was not immediate jeopardy, or (3) presented immediate jeopardy to resident health or safety.

noncompliance with the requirement for monthly testing, we considered it a single deficiency for reporting purposes.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency could better ensure that nursing homes in New Jersey that participate in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During our site visits, we identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that we audited, totaling 363 deficiencies. Specifically:

- We found 148 deficiencies with life safety requirements related to building exits, fire barriers, and smoke partitions (45); fire detection and suppression systems (41); carbon monoxide detectors (12); hazardous storage areas (24); smoking policies and fire drills (11); and elevator and electrical equipment testing and maintenance (15).

- We found 152 deficiencies with emergency preparedness requirements related to emergency preparedness plans (31); emergency supplies and power (31); plans for evacuations, sheltering in place, and tracking residents and staff during an emergency (29); emergency communications plans (42); and emergency preparedness plan training and testing (19).

- We found 63 deficiencies with infection control requirements or guidance related to IPCPs and antibiotic stewardship programs[16] (8), infection preventionists[17] (4), influenza and pneumococcal immunizations (4), COVID-19 immunizations (30), COVID-19 testing (9), COVID-19 case notifications (5), and COVID-19 facility visitation signage (3).

The identified deficiencies occurred because of frequent management and staff turnover at the nursing homes, which contributed to a lack of awareness of, or failure to address, Federal

[16] Antibiotic stewardship programs measure and improve how antibiotics are prescribed by clinicians and used by patients to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance.

[17] Infection preventionists are professionals who have completed specialized training in infection prevention and control and are responsible for the nursing home's infection prevention and control program.

requirements. In addition, the State agency had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than required by CMS (i.e., every 15 months). Finally, although not required by CMS, the State agency does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes are at an increased risk of injury or death during a fire or other emergency, or in the event of an infectious disease outbreak.

Appendix C summarizes the deficiencies that we identified at each nursing home.

SELECTED NURSING HOMES DID NOT COMPLY WITH LIFE SAFETY REQUIREMENTS

CMS's Fire Safety Survey Report form, described on page 2, lists the Federal regulations on life safety that nursing homes must comply with and references each with an identification number, known as a K-Tag (numbered K-100 through K-933). In addition, New Jersey requires carbon monoxide detectors to be installed in nursing homes that contain a fuel-burning appliance or have an attached garage (NJAC § 5:70-4.9(d)).

Building Exits, Fire Barriers, and Smoke Partitions

In case of fire or emergency, nursing homes are required to have unobstructed exits, self-closing doors in exit passageways that do not require tools or keys to open and are not manually propped open, discharges from exits that are free from hazards, illuminated exit signs, and fire-stopped smoke and fire barriers (K-Tags 211, 222, 223, 271, 293, 372).

All of the 20 nursing homes we visited had 1 or more deficiencies related to building exits, fire barriers, and smoke partitions, totaling 45 deficiencies. Specifically, we found deficiencies related to emergency exit doors that were inoperable and could not be opened (11 nursing homes), blocked or impeded pathways leading to exit doors (8 nursing homes), exit passageway self-closing doors that were propped open (6 nursing homes), and blocked or impeded exit door discharge areas (7 nursing homes). In addition, we found deficiencies related to missing or non-illuminated exit signs (seven nursing homes). Finally, we found deficiencies related to missing or damaged smoke and fire barriers (six nursing homes), including broken ceiling tiles and openings that could contribute to the spread of smoke and fire. The photographs on the next page depict some of the deficiencies we identified during our site visits.


Photograph 1 (left): Broken emergency exit door.
Photograph 2 (right): Discharge area impeded by mattress.

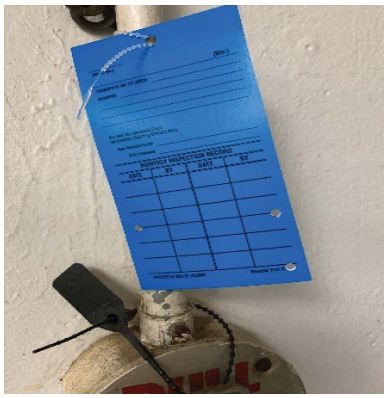

Photograph 3 (left): Pathway to exit blocked by storage and trash.
Photograph 4 (right): Missing and damaged ceiling tiles.

Fire Detection and Suppression Systems

Every nursing home is required to have a fire alarm system that has a backup power supply and is tested and maintained according to NFPA requirements. Sprinkler systems must be installed, inspected, and maintained according to NFPA requirements, and high-rise buildings must have sprinklers throughout. Cooking equipment and its related fire suppression systems must be maintained, and repairs must be performed on all components at intervals necessary to maintain good working condition. Nursing homes must also have fire watch policies and procedures for when fire alarms or sprinkler systems are out of service (or evacuate its residents if a fire watch is not instituted), and portable fire extinguishers must be inspected monthly. Smoke detectors are required in spaces open to corridors and other areas (K-Tags 324, 342, 344–347, 351–354, 355, 421).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to their fire detection and suppression systems, totaling 41 deficiencies. Specifically, we found one nursing home whose fire alarm system was not routinely tested and maintained. In addition, we found

deficiencies related to blocked or obstructed sprinkler heads (two nursing homes), and sprinkler systems that were not tested and maintained (three nursing homes). We also found deficiencies related to cooking equipment hoods that were not serviced or fire suppression systems that were not checked monthly (seven nursing homes). Finally, we found inadequate fire watch policies and procedures in effect during periods when the fire alarm or sprinkler system was out of service (17 nursing homes)[18] and deficiencies related to monthly portable fire extinguisher inspections (11 nursing homes). The photographs that follow depict some of the deficiencies we identified during our site visits.



Photograph 5 (left): Kitchen fire suppression system did not have monthly inspections.
Photograph 6 (center): Fire extinguisher did not have monthly inspections.
Photograph 7 (right): Sprinkler head obstructed by storage boxes.

Carbon Monoxide Detectors

CMS requires carbon monoxide detectors to be installed in nursing homes with solid fuel-burning fireplaces (K-Tag 525). CMS also requires nursing homes to follow applicable Federal, State, and local laws, regulations, and codes (42 CFR § 483.70).[19] New Jersey requires carbon monoxide detectors to be installed and maintained in nursing homes that contain a fuel-burning appliance or have an attached garage (NJAC § 5:70-4.9(d)).

Of the 20 nursing homes we visited, 12 had 1 deficiency related to New Jersey requirements for carbon monoxide detectors. Specifically, we found 11 nursing homes that failed to install carbon monoxide detectors in one or more required locations. In addition, we found one nursing home with three carbon monoxide detectors whose batteries needed to be replaced.

[18] When fire alarms or sprinkler systems are out of service, individuals are assigned areas to patrol to watch for fire or smoke until the systems are back in service. If a fire watch is not instituted, the building must be evacuated (K-Tags 346, 354).

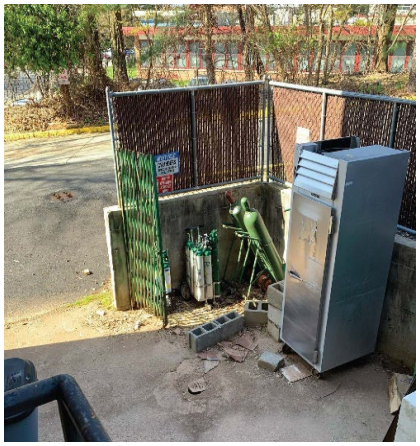
[19] Section 1864 Agreements do not require State survey agencies to survey for State and local requirements during a Federal survey; however, surveyors may cite such noncompliance if identified.

Hazardous Storage Areas

In hazardous storage areas, nursing homes must install a fire barrier or an automatic fire extinguishing system with smoke-resistant partitions and self-closing doors. Hazardous chemicals must be stored in a safe manner, and general upkeep should be maintained to limit unnecessarily large amounts of combustible materials that present a fire hazard. In addition, garbage and laundry containers must not occupy more than one-half gallon per square foot of floor space. Oxygen systems must be maintained and inspected, and rooms with oxygen cylinders must have proper signage. Oxygen cylinders must be stored in a safe manner (e.g., cylinders stored in the open must be protected from weather) (K-Tags 321, 322, 500, 541, 754, 905, 908, 923).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to hazardous storage areas, totaling 24 deficiencies. Specifically, we found deficiencies related to fire barriers, including self-closing doors to hazardous storage or laundry chute rooms that were propped open or unable to close, and doors that were hollow-core rather than fire-rated (six nursing homes). Additionally, we found deficiencies related to the storage of hazardous chemicals, including gasoline and paint not stored in approved safety storage cabinets (two nursing homes), and excessive garbage storage (one nursing home). We also found deficiencies related to oxygen cylinders, including the lack of testing and inspection records for oxygen systems (2 nursing homes), and unsafe storage and improper signage (13 nursing homes). The photographs that follow depict some of the deficiencies we identified during our site visits.

Photograph 8 (left): Door to laundry chute room containing combustible materials propped open.
Photograph 9 (right): Excessive garbage in storage room on patient wing.



Photograph 10 (left): Oxygen cylinders stored in unsafe manner, not protected from weather.
Photograph 11 (right): Gas not stored in an approved safety storage cabinet. (Stored in shed depicted in photograph 12 [next page].)

Smoking Policies and Fire Drills

Nursing homes are required to establish smoking policies for residents and staff. Smoking may be permitted only in authorized areas where ash receptacles are provided. Smoking is not allowed in hazardous storage areas. Further, no-smoking areas must include signage. Nursing homes are also required to conduct fire drills each calendar quarter that cover each work shift. Participation by staff members is required, and the drills must be planned and conducted by a qualified individual designated by the nursing home. The drills should be held at expected and unexpected times and include the transmission of a fire alarm signal and simulation of emergency fire conditions (K-Tags 712, 741, 925).

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to smoking policies or fire drills, totaling 11 deficiencies. Specifically, we found 10 nursing homes whose smoking policies were not being followed (e.g., smoking in banned areas). In addition, we found one nursing home whose fire drills were not conducted each calendar quarter covering all work shifts according to the facility's fire drill log. The photographs on the next page depict some of the deficiencies we identified during our site visits.

Photograph 12 (left): Inappropriately designated smoking area near shed depicted in photograph 11 containing improperly stored gas.

Photograph 13 (right): Cigarette butts in fire escape stairwell (not a designated smoking area).

Elevator and Electrical Equipment Testing and Maintenance

Nursing home elevators must be tested and maintained on a regular basis. Nursing homes must also keep a record of tests and repairs of other electrical equipment, such as patient beds and lifts. Power strips, extension cords, and portable space heaters must meet Underwriters Laboratories (UL) requirements and be used in a safe manner (e.g., extension cords are not used as a substitute for fixed wiring of a structure) (K-Tags 531, 781, 920, 921).

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to elevator or electrical equipment testing and maintenance, totaling 15 deficiencies. Specifically, we found seven nursing homes with inadequate documentation of elevator testing or maintenance, including failing to retain detailed testing reports from the elevator maintenance company. In addition, we found seven nursing homes that failed to maintain records of testing and repairs of patient beds and lifts and failed to maintain documentation of the inspection and maintenance of electrical receptacles at patient bed locations. Finally, we found one nursing home with unsafe connections of appliances to extension cords instead of fixed wiring.

Life Safety Training for Nursing Home Management and Staff

Under Section 1864 Agreements with CMS, State agencies agree to perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS's *State Operations Manual* § 1010). CMS has a publicly accessible online learning portal related to such life safety training.[20] Both CMS and State agency surveyors are required to receive standardized life safety training such as the training available through CMS's online learning

[20] Learning portal available online at https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLSCPR_WBT. Accessed on Apr. 24, 2023.

portal.[21] Also, as mandated by subsections 1819(g)(1)(B) and 1919(g)(1)(B) of the Act, States must conduct periodic educational programs for staff and residents of nursing homes to present current regulations, procedures, and policies.

Participation by all nursing home management and staff in State-conducted periodic education programs is not mandatory. In addition, although not required by CMS, the State agency does not require newly hired nursing home management and staff to receive standardized life safety training such as the training available through CMS's online learning portal. During our onsite inspections, we found that there was frequent nursing home management and staff turnover. Combined, these factors may have contributed to a lack of awareness of, or failure to address, Federal requirements, potentially resulting in deficiencies similar to those detailed in our report.

SELECTED NURSING HOMES DID NOT COMPLY WITH EMERGENCY PREPAREDNESS REQUIREMENTS

CMS's *Emergency Preparedness Surveyor Checklist*, described on page 2, lists the Federal regulations on emergency preparedness that nursing homes must comply with, and references each with an identification number, known as an E-Tag (numbered E-0001 through E-0042).

Emergency Preparedness Plans

Nursing homes are required to develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The emergency preparedness plan must: (1) include a facility and community all-hazards risk assessment; (2) address emergency events and resident population needs; (3) include a continuity of operations plan/succession plan; (4) address coordination with Federal, State, and local emergency management officials; and (5) have policies and procedures for emergency events based on the risk assessment. Additionally, a nursing home that is part of a group of affiliated but separately certified nursing homes electing to have a unified and integrated emergency preparedness program may elect to participate in the group's unified and integrated emergency preparedness program. If elected, the nursing home must be included in the group's unified and integrated emergency preparedness program and actively participate in the development of the group's emergency preparedness plan (E-Tags 0001, 0004, 0006, 0007, 0009, 0013, 0042).

Of the 20 nursing homes we visited, 14 had 1 or more deficiencies related to their emergency preparedness plan, totaling 31 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that were not updated at least annually (11 nursing homes), emergency preparedness plans that could not be accessed by the supervisor on duty (3 nursing homes), and an emergency preparedness plan that was missing pages (1 nursing home). In

[21] No State or Federal surveyor shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary of Health and Human Services (The Act §§ 1819(g)(2)(E)(iii) and 1919(g)(2)(E)(iii)).

addition, we found deficiencies related to all-hazard risk assessments that were not completed (three nursing homes) and risk assessments that did not address all risks (e.g., pandemic scenarios or active shooter events) (three nursing homes). We also found deficiencies related to emergency preparedness plans that did not address resident population needs (e.g., the emergency preparedness plan was not specific to the facility or its residents) or consider continuity of operations (four nursing homes), and emergency preparedness plans that did not include a delegation of authority/succession plan (five nursing homes). Finally, we found one nursing home whose emergency preparedness plan was not included in an affiliated group's unified emergency preparedness program.

Emergency Supplies and Power

Nursing homes' emergency preparedness plans must address emergency supplies and power, and nursing homes are required to have adequate, readily available supplies of emergency food, water, and pharmaceuticals. As a best practice, the Federal Emergency Management Agency considers 3 days of emergency supplies to be sufficient.[22] Nursing homes are also required to provide an alternate source of energy (usually a generator) to maintain temperatures to protect residents' health and safety, as well as for food storage, emergency lighting, fire protection, and sewage disposal (if applicable). Further, facilities must establish policies and procedures for heating and cooling their facility if they lose power during an emergency. Nursing homes with generators must have them installed in a safe location and are required to perform weekly maintenance checks, monthly load tests, and annual fuel quality tests if fueled with diesel.[23] Nursing homes should also have a plan to keep generators fueled "as necessary" and an evacuation plan if emergency power is lost (E-Tags 0015, 0041).

Of the 20 nursing homes we visited, 16 had 1 or more deficiencies related to emergency supplies and power, totaling 31 deficiencies. Specifically, we found seven nursing homes with deficiencies related to insufficient emergency food and/or water supplies. In addition, we found four nursing homes with deficiencies related to insufficient alternative energy sources (i.e., generators), including:

- two nursing homes that were unable to provide support for which circuits and appliances their generator powered; therefore, they were unable to determine if their emergency power supply was adequate and

[22] The 3-day standard is a best practice recommendation, as CMS does not require a specific standard. (We did not audit for compliance with this standard.) Our findings regarding a sufficient amount of generator fuel or other emergency supplies were based on a totality of the applicable criteria.

[23] Generators that operate on diesel fuel or propane gas are generally designed with a minimum fuel tank capacity to last for 3 days at half load, which factors in an emergency fuel stock and lead time for refueling.

- two nursing homes whose generator systems were not sufficient to power their heating, ventilation, and air conditioning system.[24]

Further, we found deficiencies related to generators that were not installed in a safe location (e.g., an area not susceptible to flooding) (two nursing homes)[25] and generators that were not properly tested and maintained (15 nursing homes). Finally, we found three deficiencies related to generator fuel levels, including:

- two nursing homes that did not have sufficient generator fuel on hand to last 3 days or sufficient plans to obtain emergency fuel or evacuate the facility when fuel levels reached a specified low level and

- one nursing home that was unable to determine the fuel level of its generator because of a broken fuel level gauge.

Plans for Evacuations, Sheltering in Place, and Tracking Residents and Staff During an Emergency

Nursing homes are required to have a plan for evacuations, sheltering in place, and tracking residents and staff during and after an emergency. Nursing homes must also have a plan for transferring medical records, utilizing volunteers, and transferring residents, along with procedures for their roles under a waiver to provide care at alternate sites during emergencies (E-Tags 0018, 0020, 0022–0026, 0033).

Of the 20 nursing homes we visited, 15 had 1 or more deficiencies related to their emergency preparedness plans for evacuations, sheltering in place, and tracking residents and staff during and after emergencies, totaling 29 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that did not address evacuations (10 nursing homes), sheltering in place (2 nursing homes), tracking residents and staff (2 nursing homes), a method for transferring medical records (1 nursing home), transferring residents during disasters (12 nursing homes), and obtaining waivers when providing care at alternate sites during emergencies (2 nursing homes).

Emergency Communications Plans

Nursing homes are required to have an emergency communications plan that includes names and contact information for staff, entities providing services, residents' physicians, other nearby nursing homes, volunteers, government emergency management offices, and the State survey

[24] The facilities did not have an alternate means of powering their heat and air conditioning systems or a plan that specified when they should be evacuated if they become too hot or cold.

[25] We note that the generators located in areas susceptible to flooding are not required to be moved to a safer location until a new generator system is installed (NFPA 110), although it would be a best practice to do so.

agency, among others. The emergency communications plan must be updated at least annually. Nursing homes are also required to have primary and alternate means of communication (e.g., landline and backup cell phones), a means to communicate residents' condition information and location in the event of an evacuation, and methods to share emergency preparedness plan information with residents and their families (E-Tags 0029–0032, 0034, 0035).

Of the 20 nursing homes we visited, 15 had 1 or more deficiencies related to the adequacy of their emergency communications plans, totaling 42 deficiencies. Specifically, we found deficiencies related to emergency communications plans that did not include various categories of required names and contact information[26] (28 nursing homes), emergency communications plans that were not updated annually (7 nursing homes), emergency communications plans that had insufficient alternate means of communication (3 nursing homes), and nursing homes that did not have procedures for sharing emergency preparedness plan information with residents and their families (2 nursing homes). In addition, one nursing home did not have a means to provide information about the facility to emergency management officials, and one nursing home did not have an emergency communications plan; however, it maintained required contact information in other locations.

Emergency Preparedness Plan Training and Testing

Nursing homes are required to have training and testing programs related to their emergency preparedness plans and to provide updated training at least annually. Initial training must be provided to new staff members, independent contractors (e.g., contracted cleaning staff), and volunteers. The training, as well as annual refresher training, is required for all staff, must be designed to demonstrate knowledge of emergency preparedness procedures, and must be documented. Nursing homes must also conduct an annual community-based, full-scale testing exercise.[27] In addition, a second training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise[28]) must be completed annually. An analysis of all training exercises (and actual events) must be completed and documented, and the emergency preparedness plan revised, if necessary (E-Tags 0036, 0037, 0039).

[26] The 28 deficiencies were related to nursing homes whose emergency communications plans did not include the following various categories of required names and contact information: staff (7), entities providing services (2), residents' physicians (8), other nearby nursing homes (3), volunteers (1), government emergency management offices (1), the state licensing agency (2), the ombudsman program (3), and other various required entities (1).

[27] The exercise can be facility-based if a community-based exercise is not possible. Nursing homes are exempt from this requirement if they activated their emergency preparedness plan during the year. QSO-20-41-ALL (Sept. 28, 2020) provides additional guidance related to the emergency preparedness exercise exemption based on the facility's activation of its emergency preparedness plan due to the COVID-19 public health emergency.

[28] A "tabletop" exercise includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency preparedness plan.

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to emergency preparedness plan training, totaling 19 deficiencies. Specifically, we found deficiencies related to nursing homes that did not update their training plan annually (two nursing homes), nursing homes that did not conduct a second annual training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise) (four nursing homes), nursing homes that did not conduct analyses of their training exercises (nine nursing homes), and nursing homes that did not document that the training covered all emergency preparedness plan elements (four nursing homes).

SELECTED NURSING HOMES DID NOT COMPLY WITH INFECTION CONTROL REQUIREMENTS

CMS's Infection Control Surveyor Checklists, described on page 2, list the Federal regulations on infection control that nursing homes must comply with, and references each with an identification number, known as an F-Tag (numbered F-880 through F-888).

Infection Prevention and Control and Antibiotic Stewardship Programs

Nursing homes are required to have a facilitywide IPCP for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and contractors. Written standards, policies, and procedures for the IPCP must include a surveillance system designed to identify possible communicable diseases or infections, when and to whom possible incidents should be reported, when and how to isolate individuals, hand-hygiene procedures, and the circumstances that would prohibit employees from direct contact with residents or their food. Nursing homes must also have a system for recording identified incidents and corrective actions taken and must conduct an annual review of their IPCP and update it as necessary. Nursing homes are also required to have an antibiotic stewardship program that includes protocols for using antibiotics and a system to monitor antibiotic use (F-Tags 880, 881).

Of the 20 nursing homes we visited, 6 had 1 or more deficiencies related to their IPCP and antibiotic stewardship program, totaling 8 deficiencies. Specifically, we found deficiencies related to IPCP policies and procedures that did not include the circumstances that would prohibit employees from direct contact with residents or their food (two nursing homes), when and to whom possible incidents should be reported (one nursing home), and when and how isolation should be used (one nursing home). Additionally, we found two deficiencies regarding the IPCP annual review: One nursing home did not complete an annual review, and another nursing home completed an annual review but did not update its IPCP as necessary.[29] We found one nursing home that did not have a system for recording identified incidents and corrective actions taken. Finally, we found one nursing home whose antibiotic stewardship program did not include all required elements.

[29] The IPCP had not been updated since 2018.

Following the conclusion of our site visits, mpox was declared a public health emergency from August 4, 2022, through January 31, 2023. We recontacted the 20 nursing homes to determine if they (1) received guidance from CMS or the State agency related to mpox, (2) updated their IPCP to mitigate mpox, and (3) experienced any cases of mpox among residents or staff.

Of the 20 nursing homes, 9 indicated that they received or accessed guidance related to mpox, 11 indicated that they updated their IPCP, and none reported experiencing any cases of mpox among residents or staff.

Infection Preventionists

Nursing homes are required to designate at least one individual as the infection preventionist responsible for the facility's IPCP. The infection preventionist must have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field; be qualified by education training, experience, or certification; work at least part time at the facility; and have completed specialized training in infection prevention and control. At least one infection preventionist must be a member of the facility's quality assessment and assurance committee and regularly report to the committee on the facility's IPCP (F-Tag 882).

Of the 20 nursing homes we visited, 4 had 1 deficiency related to infection preventionists. Specifically, we found deficiencies related to infection preventionists who had not completed specialized training in infection prevention and control (one nursing home) and infection preventionists who were not in attendance at the facility's most recent quality assessment and assurance committee meeting and therefore did not regularly report on the facility's IPCP (three nursing homes).

Influenza and Pneumococcal Immunizations

Nursing homes are required to develop policies and procedures so that each resident is offered influenza and pneumococcal immunizations unless an immunization is medically contraindicated or the resident has already been immunized. These policies and procedures must also ensure that, before offering the immunizations, each resident or resident's representative receives education regarding the benefits and potential side effects of the immunizations and has the opportunity to refuse them. Nursing homes are also required to ensure that the resident's medical record includes documentation that indicates whether education was provided and that the resident either received or did not receive these immunizations (F-Tag 883).

Of the 20 nursing homes we visited, 2 had 1 or more deficiencies related to medical records documentation of influenza and pneumococcal immunizations, totaling 4 deficiencies. Specifically, we found deficiencies related to medical records that lacked documentation that the facility provided required education regarding the influenza or pneumococcal immunizations (two nursing homes) and medical records that lacked documentation that a

resident did or did not receive an influenza or pneumococcal immunization (two nursing homes).

COVID-19 Immunizations

Nursing homes are required to develop policies and procedures to ensure that each resident and staff member is offered COVID-19 vaccination (unless the immunization is medically contraindicated, or the resident or staff member has already been immunized) and that staff (except exempt staff) are fully vaccinated for COVID-19.[30, 31, 32] These policies and procedures must also ensure that, before offering the immunizations, all staff and each resident or resident's representative receive education regarding the benefits and potential side effects of COVID-19 vaccination, and the facility documents this education and the immunization status of staff and residents. The policies and procedures must also provide each resident or resident's representative the opportunity to accept or refuse COVID-19 vaccination (F-Tag 887, 888).

Of the 20 nursing homes we visited, 12 had 1 or more deficiencies related to COVID-19 immunizations, totaling 30 deficiencies. Specifically, we found 28 deficiencies related to the lack of required elements in nursing homes' COVID-19 immunization policies and procedures. The nursing homes' policies and procedures did not:

- require staff and residents to be offered COVID-19 vaccination (two nursing homes);
- require students, trainees, and volunteers to be fully vaccinated (eight nursing homes);
- require licensed practitioners to be fully vaccinated (six nursing homes);
- require contractors to be fully vaccinated (five nursing homes);
- require staff and residents or residents' representatives to receive education regarding the benefits or potential side effects of immunization (four nursing homes);
- indicate that certain staff without direct contact with residents and other staff were exempt from the COVID-19 vaccination requirement (two nursing homes); or
- offer residents or residents' representatives the opportunity to accept or refuse COVID-19 vaccination (one nursing home).

[30] Staff are considered fully vaccinated if it has been 2 or more weeks since they completed a primary vaccine series for COVID-19 (i.e., a single-dose vaccine or all required doses of a multidose vaccine).

[31] The policies and procedures do not apply to staff who exclusively provide telehealth, telemedicine, or support services outside of the facility setting (exempt staff).

[32] The Final Rule published in 88 Fed. Reg. 36485 withdraws regulations pertaining to staff vaccination, effective Aug. 4, 2023.

We also found two deficiencies related to nursing homes' documentation of COVID-19 immunization requirements. Specifically, at one nursing home, one medical record did not include documentation that the resident or resident's representative was provided education regarding the benefits or potential risks of immunization, and at another nursing home, one medical record did not include documentation indicating whether the resident received or refused COVID-19 vaccination.

COVID-19 Testing

Nursing homes are required to test residents and staff, including contractors and volunteers, for COVID-19. The nursing home must, at a minimum, conduct testing based on parameters set forth by the Secretary of Health and Human Services, including testing frequency and response time for tests. Nursing homes are also required to document, in each resident's record, that testing was offered and completed, as well as the results of each test. Nursing homes must also establish policies and procedures for addressing individuals who refuse to be tested or are unable to be tested and for contacting State and local health departments to assist in testing efforts when necessary (F-Tag 886).

Of the 20 nursing homes we visited, 8 had 1 or more deficiencies related to COVID-19 testing, totaling 9 deficiencies. Specifically, we found deficiencies related to nursing homes' policies and procedures that did not address response times for COVID-19 tests (five nursing homes) or individuals who refused to be tested or were unable to be tested (two nursing homes). In addition, one nursing home did not have policies and procedures for contacting State and local health departments for testing assistance, and another did not have policies and procedures regarding testing frequency.

COVID-19 Case Notifications

Nursing homes are required to notify residents, their representatives, and families by 5 p.m. the calendar day following either a single confirmed COVID-19 infection or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other (F-Tag 885).

Of the 20 nursing homes we visited, 5 had 1 deficiency related to COVID-19 case notifications. Specifically, the five nursing homes did not notify residents, their representatives, and families in a timely manner of a confirmed COVID-19 infection or onset of respiratory symptoms by three or more residents or staff within 72 hours of each other.

COVID-19 Facility Visitation Signage

In addition to complying with Federal regulations on infection control (42 CFR § 483.80), nursing homes are required to follow supplementary guidance from CMS related to COVID-19,

including guidance related to posting signage at the facility entrances with visitation and screening procedures (QSO-20-20-ALL).

Of the 20 nursing homes we visited, 3 had 1 deficiency related to following CMS supplementary guidance on COVID-19 facility visitation signage. Specifically, the three nursing homes did not post appropriate signage at entrances.

CONCLUSION

At the conclusion of our inspections, we shared the deficiencies we identified with nursing home management and staff so that they could take immediate corrective action. We also shared the identified deficiencies with the State agency and CMS for followup, as appropriate.

Although nursing home management and staff are ultimately responsible for ensuring resident safety, the State agency could better ensure that nursing homes comply with Federal health and safety requirements if additional resources were available.

RECOMMENDATIONS

We recommend that the New Jersey Department of Health:

- follow up with the 20 nursing homes reviewed in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions;

- instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements;

- work with CMS to develop a risk-based approach to identify nursing homes where surveys should be conducted more frequently than once every 15 months, such as those with a history of multiple high-risk deficiencies or frequent management turnover;

- work with CMS to develop a plan to address the foundational issues preventing more frequent surveys at nursing homes with a history of multiple high-risk deficiencies; and

- work with CMS to develop standardized life safety training for nursing home staff.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations. The State agency provided information on actions that it has taken or plans to take to address our recommendations. In addition, the State agency acknowledged the thorough review we conducted and stated that it would typically cite several deficiencies identified in our draft report during its own surveys at nursing homes.

However, it disagreed with our characterization of some deficiencies identified in our draft report and disagreed with our conclusions that it could better ensure that nursing homes comply with Federal health and safety requirements if additional resources were available. Accordingly, we revised our fourth recommendation to indicate that the State agency should develop a plan with CMS to address the foundational issues preventing it from conducting more frequent surveys. The State agency's comments are included in their entirety as Appendix D.

STATE AGENCY COMMENTS

Regarding our first recommendation, the State agency indicated that it has followed up with the 20 nursing homes reviewed as part of our audit for any deficiencies identified in our report that are violations of the applicable regulations or code. The State agency's disagreement with our characterization of some of our inspection findings is based on its assertion that some of our findings and recommendations were too vague or not based on regulatory requirements, or requirements were misinterpreted. For example, regarding our "Building Exits, Fire Barriers, and Smoke Partitions" finding, the State agency noted that we cited several facilities for exit doors that were difficult to close. The State agency contended that, according to the requirements we cited, these doors are required to open for evacuation but are not required to close. Further, the State agency noted that we cited one facility for a smoke barrier door "hold-open mechanism" that was inoperable and contended that there is no requirement to hold the door open.

Regarding our second recommendation, the State agency indicated that there appears to be a misunderstanding on the applicable version of New Jersey regulations requiring the installation of carbon monoxide detectors; however, the State agency indicated that many of the deficiencies observed by OIG auditors were "indeed deficiencies" that would be cited during any State survey.

Regarding our third and fourth recommendations, the State agency noted that additional State resources would not automatically result in better compliance by nursing homes because the deficiencies we noted are attributed to factors that are beyond the control of the State agency. Additionally, the State agency indicated that it is not obligated to perform recertification surveys more frequently than the required minimum and is without the authority to require CMS to increase or alter its survey schedules. It also described CMS's Special Focus Facilities (SFF) program and stated that nursing homes enrolled in the program are provided with more frequent survey and certification oversight. The State agency indicated that it currently has the CMS maximum of two facilities enrolled in the SFF program and that these facilities receive more frequent surveys. The State agency also described its Mission Critical Team, initiated in 2022, that is separate from the State Survey Regulatory process and whose goal is to identify nursing homes that appear to need assistance.

Finally, regarding our fifth recommendation, the State agency said it has implemented a range of measures to improve emergency preparedness and infection control issues in nursing homes, including survey staff training programs. The State agency noted that although CMS

does not require nursing home providers or their staff to participate in CMS standardized life safety training programs, CMS and the State agency "highly recommend" that providers take full advantage of all trainings.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings, conclusions, and recommendations, as revised, are valid because our findings are based on the regulatory requirements contained in the CMS checklists noted in our report. We are pleased that the State agency has followed up with the 20 nursing homes; however, we continue to recommend that the State agency follow up on *all* of our findings and not just those it deems violations of applicable regulations or code. At the conclusion of each inspection, we shared our findings with nursing home management and staff, the State agency, and CMS. Only the State agency has expressed disagreement with the characterization of some of our inspection findings. We believe this disagreement is more a matter of interpretation of the requirements cited in our report rather than a lack of requirements, as the State agency asserts. The State agency's interpretation related to "Building Exits, Fire Barriers, and Smoke Partitions" mentioned in the example in the previous section fails to recognize that doors are intended to open *and close*. Doors serve not only an evacuation function but also function as a fire barrier and smoke partition. If doors do not properly open, they may hinder evacuation. If doors do not properly close, they may contribute to the spread of smoke and fire. Both situations endanger people's lives. We are concerned that the State agency's interpretation of some requirements may place the health and safety of nursing home residents, staff, and visitors at an increased risk for harm. We suggest that the State agency consult with CMS regarding any issues of interpretation of requirements or characterization of our findings.

In addition, we continue to recommend that the State agency instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements. We commend the State agency on its participation in CMS's SFF program and for developing its own Mission Critical Team. We encourage the State agency to continue working with CMS and CMS's SFF program. However, we continue to recommend that the State agency work with CMS to develop a risk-based approach to identify nursing homes that should be inspected more frequently than once every 15 months and to address the foundational issues preventing it from conducting such surveys, which could result in better compliance by nursing homes. Survey agencies are not restricted by law from conducting surveys more frequently than the minimum required. They may conduct surveys as frequently as necessary to determine whether a facility is in compliance and confirm that a facility has corrected deficiencies previously cited (42 CFR § 488.308(c)). Our report acknowledges, as does the State agency's response, that CMS has a publicly accessible online learning portal with appropriate content on life safety requirements; however, participation by nursing home management and staff is not required. Absent required participation in a standardized training program, nursing home management and staff may be unaware of critical life safety requirements. We maintain our recommendation that the State agency work with CMS to develop standardized life safety training for nursing home staff.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of December 2021, 356 nursing homes in New Jersey participated in Medicare or Medicaid programs. Of these 356 nursing homes, we selected a nonstatistical sample of 20 nursing homes for our audit based on risk factors, including multiple high-risk deficiencies the State agency reported to CMS's ASPEN system for CYs 2016 through 2019.[33]

We did not assess the State agency's overall internal control structure. Rather, we limited our assessment of internal controls to those applicable to our audit objective. Specifically, we assessed the State agency's policies, procedures, and practices applicable to monitoring nursing homes' compliance with life safety, emergency preparedness, and infection control requirements. Our assessment would not necessarily disclose all material weaknesses in the State agency's internal controls.

We conducted unannounced site visits at the 20 nursing homes throughout New Jersey from March through May 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS and State agency officials to gain an understanding of the process for conducting nursing home life safety, emergency preparedness, and infection control surveys;
- obtained from CMS a list of all 356 active nursing homes in New Jersey that participated in the Medicare and Medicaid programs as of December 2021;
- compared the list provided by CMS with the State agency's directory of nursing homes to verify completeness and accuracy;
- obtained from CMS's ASPEN system a list of 33 nursing homes that had 1 or more deficiencies during CYs 2016 through 2019 that were considered high-risk because they: (1) were widespread and had the potential for more than minimal harm, (2) had actual

[33] The 20 nursing homes in our sample consisted of 9 nursing homes with multiple high-risk deficiencies and 11 nursing homes with at least one deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

harm that was not immediate jeopardy, or (3) presented immediate jeopardy to resident life and safety;[34]

- selected 20 nursing homes for onsite inspections from the 33 nursing homes identified in ASPEN and, for each of the 20 nursing homes:

  - reviewed deficiency reports prepared by the State agency for the nursing home's 2016 through 2019 surveys and

  - conducted unannounced site visits at the nursing home to check for life safety violations, review the nursing home's emergency preparedness plan, and review the nursing home's infection control policies and procedures; and

- discussed the results of our inspections with the selected nursing homes, the State agency, and CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[34] Deficiencies that the State agency enters into the ASPEN system are uploaded to CMS's Certification and Survey Provider Enhanced Reports system and are available to the public through the Quality Certification and Oversight Reports online reporting system. Available online at https://qcor.cms.gov/. Accessed on Apr. 24, 2023.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Georgia Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-04-22-08093	9/7/2023
Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety	A-02-21-01010	7/15/2022
Iowa Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-07-19-03238	2/16/2021
North Carolina Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-04-19-08070	9/18/2020
Illinois Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-05-18-00037	9/17/2020
Missouri Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-07-18-03230	3/13/2020
Florida Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-04-18-08065	3/6/2020
Life Safety and Emergency Preparedness Deficiencies Found at 18 of 20 Texas Nursing Homes	A-06-19-08001	2/6/2020
California Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-09-18-02009	11/13/2019
New York Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-02-17-01027	8/20/2019

APPENDIX C: DEFICIENCIES AT EACH NURSING HOME

Table 1: Summary of All Deficiencies by Nursing Home

Nursing Home	Life Safety Deficiencies	Emergency Preparedness Deficiencies	Infection Control Deficiencies	Total
1	9	6	3	**18**
2	9	10	6	**25**
3	7	6	-	**13**
4	5	-	1	**6**
5	5	7	1	**13**
6	6	10	2	**18**
7	7	6	1	**14**
8	7	6	2	**15**
9	13	4	6	**23**
10	8	18	5	**31**
11	5	2	1	**8**
12	3	3	6	**12**
13	16	10	5	**31**
14	10	3	1	**14**
15	7	23	3	**33**
16	6	6	10	**22**
17	10	13	-	**23**
18	4	2	4	**10**
19	6	9	4	**19**
20	5	8	2	**15**
Total	**148**	**152**	**63**	**363**

Table 2: Life Safety Deficiencies

Nursing Home	Building Exits, Fire Barriers, and Smoke Partitions	Fire Detection and Suppression Systems	Carbon Monoxide Detectors	Hazardous Storage Areas	Smoking Policies and Fire Drills	Elevator and Electrical Equipment Testing and Maintenance	Total
1	3	2	-	1	1	2	**9**
2	4	3	1	-	-	1	**9**
3	2	2	-	1	1	1	**7**
4	2	1	1	1	-	-	**5**
5	2	1	-	1	1	-	**5**
6	2	2	1	1	-	-	**6**
7	1	2	1	2	-	1	**7**
8	2	4	-	1	-	-	**7**
9	4	3	-	3	1	2	**13**
10	3	1	1	2	1	-	**8**
11	1	1	1	1	1	-	**5**
12	1	-	1	-	-	1	**3**
13	5	4	1	1	2	3	**16**
14	2	3	1	2	1	1	**10**
15	1	2	1	1	-	2	**7**
16	2	-	1	2	-	1	**6**
17	4	4	1	1	-	-	**10**
18	1	-	-	2	1	-	**4**
19	1	3	-	1	1	-	**6**
20	2	3	-	-	-	-	**5**
Total	**45**	**41**	**12**	**24**	**11**	**15**	**148**

Table 3: Emergency Preparedness Deficiencies

Nursing Home	Emergency Preparedness Plans	Emergency Supplies and Power	Plans for Evacuations, Sheltering in Place, and Tracking Residents and Staff During an Emergency	Emergency Communications Plans	Emergency Preparedness Plan Training and Testing	Total
1	-	3	1	1	1	**6**
2	2	2	2	2	2	**10**
3	1	3	1	1	-	**6**
4	-	-	-	-	-	**0**
5	-	1	2	3	1	**7**
6	1	3	3	3	-	**10**
7	1	-	1	-	4	**6**
8	2	1	-	3	-	**6**
9	-	2	-	1	1	**4**
10	3	4	2	5	4	**18**
11	1	1	-	-	-	**2**
12	1	1	1	-	-	**3**
13	1	2	2	3	2	**10**
14	-	-	1	1	1	**3**
15	6	2	5	10	-	**23**
16	2	-	2	2	-	**6**
17	4	2	3	3	1	**13**
18	-	2	-	-	-	**2**
19	4	1	1	2	1	**9**
20	2	1	2	2	1	**8**
Total	**31**	**31**	**29**	**42**	**19**	**152**

Table 4: Infection Control Deficiencies

Nursing Home	Infection Prevention Control and Antibiotic Stewardship Programs	Infection Preventionists	Immunizations		COVID-19 Testing	COVID-19 Case Notifications	COVID-19 Facility Visitation Signage	Total
			Non-COVID-19*	COVID-19				
1	-	-	-	3	-	-	-	**3**
2	1	1	-	2	1	1	-	**6**
3	-	-	-	-	-	-	-	**0**
4	-	-	-	1	-	-	-	**1**
5	-	-	-	-	1	-	-	**1**
6	-	-	-	-	-	1	1	**2**
7	-	-	-	1	-	-	-	**1**
8	-	-	-	1	1	-	-	**2**
9	-	-	-	5	1	-	-	**6**
10	1	-	-	3	1	-	-	**5**
11	-	-	-	-	1	-	-	**1**
12	1	-	2	2	-	1	-	**6**
13	-	-	-	4	-	1	-	**5**
14	1	-	-	-	-	-	-	**1**
15	-	-	-	3	-	-	-	**3**
16	3	1	-	4	2	-	-	**10**
17	-	-	-	-	-	-	-	**0**
18	-	1	2	-	-	-	1	**4**
19	1	-	-	-	1	1	1	**4**
20	-	1	-	1	-	-	-	**2**
Total	**8**	**4**	**4**	**30**	**9**	**5**	**3**	**63**

***** Influenza and pneumococcal immunizations.

APPENDIX D: State Agency Comments

State of New Jersey
DEPARTMENT OF HEALTH
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PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

June 5, 2023

Brenda M. Tierney
Department of Health and Human Services
Office of Inspector General
Regional Inspector General for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Report Number: A-02-22-01004

Dear Ms. Tierney:

Enclosed are the New Jersey Department of Health's (Department) responses to the findings of the Department of Human Services, Office of the Inspector General (OIG), dated April 2023, regarding nursing homes in New Jersey and their compliance with Federal requirements for life safety, emergency preparedness, and infection control. While the Department appreciates the efforts made by the OIG team to conduct onsite inspections and identify deficiencies, the Department respectfully disagrees with OIG's conclusions.

In the OIG audit findings, it is asserted that the deficiencies found by the auditors in the nursing homes it inspected were due to a lack of State Agency resources. Not so. The deficiencies noted by the auditors are more appropriately attributed to factors associated with the provider, such as inadequate staff training, poor management, or a lack of commitment by the provider to safety standards. Even more, OIG acknowledges that frequent management and staff turnover is a contributing reason for the identified deficiencies. Given these additional factors that are beyond the control of the Department, additional State resources would not automatically result in better compliance by the provider.

The audit findings also suggest that the Department should conduct federal surveys more frequently for certain providers. However, the audit findings fail to recognize that the Department conducts federal surveys consistent with the requirements set by the Centers

for Medicare and Medicaid Services' (CMS). Specifically, the Department is responsible for conducting recertification surveys that comply with CMS mandated requirements, with intervals of up to 15.9 months between surveys. The Department is not obligated to perform recertification surveys more frequently than this and is without the authority to require CMS to increase or alter its survey schedules.

The OIG audit also highlights the inspections the OIG conducted of New Jersey nursing homes and deficiencies that it considers to be problematic. The Department disagrees with the OIG's characterization of some of its inspection findings as "deficiencies." As outlined in detail in the Department's response to OIG's audit attached hereto, there were no federal or state requirements for corrective action for some of the deficiencies noted and, therefore, the OIG's recommendations were not based on regulatory requirements imposed upon the nursing homes. As such, the Department cannot cite a facility for failing to comply with a regulatory requirement that does not exist. Moreover, some of the deficiencies identified may not have been observable during the recertification survey, which only offers a snapshot of a particular time, and may not be present when the State Surveyors are present. Despite the Department's concerns with the OIG's findings, the Department reached out to the 20 nursing homes evaluated by OIG, communicated to the nursing home provider the deficiencies found by OIG and verified that corrective action was implemented by the provider for each instance.

Additionally, the Department would like to highlight that New Jersey has made significant efforts to address life safety, emergency preparedness and infection control issues that plague nursing homes. For example, the Department has implemented a range of measures to improve emergency preparedness and infection control in long-term care facilities, including survey staff training programs. And, while CMS does not require the nursing home provider or nursing home staff to participate in the CMS trainings, it is highly recommended by CMS and the Department that the providers take full advantage of all trainings. While there is always room for improvement, it is important to acknowledge the progress that the State has been made in these areas.

In conclusion, the Department appreciates the work done by the OIG, but respectfully disagrees with the OIG's conclusions.

Sincerely,

Judith M. Persichilli

Judith M. Persichilli, RN, BSN, MA
Commissioner

Enclosure

New Jersey's Response to Office of Inspector General

Audit Report: A-02-22-01004

"New Jersey Could Better Ensure That Nursing Homes Comply with Federal Requirements for Life Safety, Emergency Preparedness and Infection Control"

The following are New Jersey Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Audit Report: A-02-22-01004, entitled "New Jersey Could Better Ensure That Nursing Homes Comply with Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control."

Summary:

The Department is dedicated to safeguarding the well-being and safety of all residents in nursing homes that receive services within New Jersey. Through a partnership with the Centers for Medicare and Medicaid Services (CMS), the Department conducts thorough inspections of nursing home operations and investigates complaints against them. This is done to ensure that nursing homes adhere to both federal and state regulatory standards. These standards aim to ensure that nursing homes deliver care and services tailored to individual needs, fostering an environment that enhances the quality of resident life. In accordance with the federally mandated surveillance process, which all states must follow, the Department issues citations to nursing homes that fail to meet the requirements and ensures that necessary corrections are made to address noncompliance.

The Department formally requests that its comments on specific findings be considered during the development of the final report for the audit. Furthermore, the Department requests that any necessary adjustments be made to the audit recommendations based on this response.

The Department aligns with the objectives of the OIG to safeguard the well-being and safety of nursing home residents. The Department remains committed to conducting comprehensive inspections of nursing home operations, investigating complaints against nursing homes, issuing citations in cases of noncompliance, and ensuring that necessary corrective measures are taken to prevent recurrence.

Recommendation: New Jersey follow up with the 20 nursing homes reviewed as part of this audit to ensure corrective actions have been taken regarding the deficiencies identified in this report and instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements:

Department Response: The Department has followed up with the 20 nursing homes that were reviewed as part of this audit for any deficiencies identified in this report that are violations of the applicable regulations or code. Please see the following detailed analysis of many of the findings and the inconsistencies with applicable regulations or code.

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In particular, please note that there appears to be a misunderstanding on the applicable New Jersey regulations requiring the installation of carbon monoxide detectors. More details are provided below.

Building Exits, Fire Barriers, and Smoke Partitions

The auditors noted several deficient practices during their observations, which would typically be cited in any state survey. It is important to understand that these observations represent a specific moment in time and do not necessarily reflect a consistent condition that would have been observed during the previous state-conducted survey of the facility. Additionally, it should be noted that some of the deficient practices cited by the OIG auditors were too vague to determine the validity of the citation, while others were contradictory to the NFPA 101:2012 Edition as listed below:

- The auditors have interpreted the regulatory requirements for exit door to have a closing requirement. Several facilities were cited for the exit doors being difficult to close. The requirements for these doors are to open for evacuation. Closing requirements are not included in the NFPA 101:2012-Sections 7.2.1, 7.2.1.4, and 19.2.2.2.
- The facilities were cited for exit door locking arrangements releasing improperly but did not indicate any reason the releasing system was improper in accordance with NFPA 101:2012 Edition-Section 19.2.2.2.1 through 19.2.2.2.6.
- One facility was cited for failing to provide a panic bar and another facility was cited for failing to have delayed egress on doors, neither of which are required by NFPA 101:2012 Edition-Section 19.2.2.2.
- Another facility was cited for an exit sign being "faded" but non-specific to how it was deficient as faded in accordance with NFPA 101:1012 Edition-Section 7.10.
- One facility was cited for the smoke barrier door hold-open magnet that was not connected to the wall, leaving the door closed. However, there is no requirement to hold the door open in accordance with NFPA 101:2012 Edition-Sections 19.2.2.2.7 (Including the Appendix narrative) and 19.2.2.2.8.

Fire Detection and Suppression Systems

The auditors noted several deficient practices during their observations, which would typically be cited in any state survey. It is important to understand that these observations represent a specific moment in time and do not necessarily reflect a consistent condition that would have been observed during the previous state-conducted survey of the facility. Additionally, it should be noted that some of the deficient practices cited by the OIG auditors were too vague to determine the validity of the citation, while others were contradictory to the NFPA 101:2012 Edition, NFPA 10:2010 Edition, NFPA 13:2010 Edition, NFPA 25:2011 Edition, NFPA 72:2010 Edition, NFPA 96:2011, and CMS Appendix Z Edition as listed below:

- Numerous facilities were cited for failing to inspect the kitchen range-hood fire suppression system (commonly known as an ANSUL system) on a monthly interval. However, NFPA 96:2011 Edition-Section 11.2.1 requires an inspection every 6-months. Only the hand-held portable fire extinguishers required a monthly inspection in accordance with NFPA 10:2010 Edition-Section 7.2.1.2. The system identified in the citations clearly refer to the main system, for which a monthly inspection is not required.
- One facility was cited for a missing door panel on a fire extinguisher cabinet located outdoors in the smoking area under an awning. There was no indication that the exposure resulted in the condition of the extinguisher being compromised in accordance with NFPA 10:2010 Edition Section 6.3.1.10.
- One facility was cited for 4 portable fire extinguishers that were "out of compliance" but did not provide a rational to determine validity in accordance with NFPA 10:2010 Edition-Section 7.
- Numerous facilities were cited for failing to provide a fire watch policy or alarm system/fire sprinkler system policy at the fire panel. This is not a requirement of NFPA 101:2012 Edition Section 9.6.1.6 or 9.7 and not required in NFPA 25:2011 Edition-Section 15.5.2 or its Appendix narrative. The facility is required to implement an approved fire watch under certain conditions but there is no policy requirement. Additionally, a system out of service policy may be required to be available for Emergency Preparedness regulations in accordance with Appendix Z, but there is no requirement to be posted at the fire alarm panel. One facility was also cited for failing to provide emergency contact numbers at the fire panel, but that is not required in accordance with Appendix Z.

Carbon Monoxide Detectors

Many of the deficiencies observed by the auditors were indeed deficiencies that would be cited during any state survey. However, during a meeting with the OIG, it was discussed that the auditors conducted the survey using incorrect occupancy code requirements. Specifically, they referred to the original version of the New Jersey State requirements DCA Bulletin 2003-3 (04/07/2003) and Bulletin 2017-1 (06/2017) and overlooked the absence of I-2 Use Group inclusion. Furthermore, the auditors failed to acknowledge the revision made to the requirements of Bulletin 2017-1 (REV. 12/12/2017), which only mandated that I-2 Use Group meet a fraction of the requirements of NJAC 5:70-4.9(d)3i(4) compared to other occupancies. The OIG auditors responded that they were unaware that the revision was meant to supersede the original requirements.

Hazardous Storage Areas

The auditors identified numerous deficient practices that would have been cited in any state survey. It is important to recognize that these observations provide a momentary snapshot and do not reflect a consistent condition that would have necessarily been observed in the previous

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state-conducted survey of the facility. Furthermore, it is noteworthy that many of the deficient practices cited by the OIG auditors were in direct contradiction to NFPA 101:2012 Edition and NFPA 99:2012 Edition as outlined below.

- Three facilities were cited for failing to store Oxygen cylinders properly but there was no indication of what was improper about their storage in accordance with NFPA 99:2012 Edition-Section 11.6.2.
- Two facilities were cited for having "hollow" doors to hazardous areas, one being an electrical room and one a boiler room. These doors are within existing construction facilities and are fully sprinklered. In accordance with the Code, these doors are only required to be smoke resistant due to the provided fire sprinkler protection, not fire rated in accordance with NFPA 101:2012 Edition-Section 19.3.2.1.

Smoking Policies and Fire Drills

Numerous deficient practices identified by the auditors would have been cited during any standard state survey. It is important to note that these observations capture a specific moment in time and do not represent a consistent condition that would have necessarily been observed during the previous state-conducted survey of the facility. However, it is worth mentioning that several deficient practices pointed out by the OIG auditors contradicted NFPA 101:2012 Edition, as outlined below.

- The auditors cited numerous facilities for failing to provide "NO SMOKING" signs at Oxygen tank storage areas. However, the auditors failed to observe their own checklist which indicates, as does the regulation, that Non-Smoking facilities need NOT provide these signs where Oxygen is stored or used. Additionally, NFPA 99:2012 Edition-Section 11.5.3.2 states the same language. All New Jersey nursing facilities are Non-Smoking as required by law and would not require the cited signage.

Elevator and Electrical Equipment Testing and Maintenance

New Jersey acknowledges and concurs with the deficiencies identified in this area, which align with the observations made by the OIG auditor. It is important to recognize that these findings represent a specific moment in time and may not necessarily reflect the conditions observed during the previous state survey.

Emergency Preparedness Plan

Many deficient practices identified by the auditors would typically be cited during any state survey. It is important to recognize that these observations capture a specific moment in time and do not represent a fixed condition that would necessarily have been observed during the previous state-conducted survey of the facility. Moreover, it is worth noting that several of the

deficient practices cited by the OIG auditors were in direct contradiction to the CMS Appendix Z as outlined below.

- One facility was cited for the Emergency Preparedness Plan due to misnumbered pages. There is no requirement to number pages in CMS Appendix Z.
- One facility was cited because there was no plan for an active shooter. While this plan is encouraged, there is no specific requirements in Emergency Preparedness Appendix Z unless the facility themselves have determined that an active shooter is one of their identified hazardous vulnerabilities in their assessment for E6. Survey Procedures for E6 specify that surveyors are to look at the facility's Hazardous Vulnerability Analysis, but the facility determines their risk to a hazard, not the surveyor.

Emergency Supplies and Power

Many deficient practices identified by the auditors would typically be cited during any state survey. It is important to recognize that these observations capture a specific moment in time and do not represent a fixed condition that would necessarily have been observed during the previous state-conducted survey of the facility. Moreover, it is worth noting that several of the deficient practices cited by the OIG auditors were in direct contradiction to the CMS Appendix Z and NFPA 99:2012 Edition as outlined as follows.

- Facilities were cited for failing to provide emergency power to the kitchen. This is not a requirement. The facilities are required to provide *temperatures to protect patient health and safety and for the safe and sanitary storage of provisions under CMS Appendix Z-E15.* It does not state kitchens must have emergency power.
- Two facilities were cited for failing to provide emergency power to HVAC systems and PTAC units in resident rooms. This is vague as there would only be the requirement if that was their only source of heating/cooling and there was no evacuation plan in accordance with CMS Appendix Z-E15.
- Two facilities were cited for failing to store enough emergency water per the auditor's determination, not the facility's determination. One facility was cited for having 400 vs. 600 gallons of emergency water and one was cited as deficient with 210 gallons. CMS Appendix Z-E15 Interpretive Guidelines requires the facility to determine their allotment, not the surveying entity under the cited regulations.
- Emergency generators were cited at facilities for failing to have a 3-day supply of fuel. This is not a requirement under any regulation. CMS Appendix Z-E41 states the facility must have a plan for maintaining fuel for the emergency generator unless it evacuates.

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- One facility was cited for failing to test the emergency generator weekly. There is only a weekly requirement of an inspection, not testing. Testing is required on a monthly (state) and 12 times per year on a 20–40-day interval per NFPA 99:2012 Edition-Section 6.4.4.1.1.4.
- One facility was cited for failing to complete their generator log with additional information not required by the NFPA 99:2012 Edition-Section 6.4.4.2.
- One facility was cited for a broken fuel gauge on the generator although other methods of tracing fuel were available including fuel tank measurements and rate of consumption calculating.
- One facility was cited for failing to inspect the generator for 1 of 52 weekly inspections being 4 days late.
- Two facilities were cited to provide an emergency generator that provided power to the entire facility and relocate the new generator to a safer area from possible flooding. CMS Appendix Z-E-41 requires newly installed generators to be placed in consideration of flood prone areas but there is no requirement to relocate existing emergency generators.

According to the CMS guidelines for Emergency Preparedness Appendix Z-Introduction (page 5), any citations related to Emergency Power under E-15 or E-41 that are also required under the Life Safety Code (LSC) 101 regulations should be cited under the LSC rather than the Emergency Preparedness (EP) regulations. Many of the instances mentioned above fall into this category, and if they are deemed valid, they would be cited as deficiencies under the appropriate LSC requirements.

Plans for Evacuations, Sheltering in Place, and Tracking Residents and Staff During an Emergency

Numerous deficient practices identified by the auditors would typically be cited during any state survey. It is important to recognize that these observations capture a specific moment in time and do not represent a fixed condition that would necessarily have been observed during the previous state-conducted survey of the facility. Moreover, it is worth noting that several of the deficient practices cited by the OIG auditors were in direct contradiction to the CMS Appendix Z as outlined below.

- Some facilities were cited for portions of the plans that were not updated; however, the plan was reviewed in its entirety and was not cited.
- One facility was cited for failing to update their transfer agreement with their own sister facility, owned and run by the same ownership which shares services in an emergency. CMS Appendix Z-E25 states that the agreements *may* be in writing but does not state they *must* be in writing.

- One facility was cited for 1 of numerous transfer agreements that was not in writing but had transfer agreements with other facilities that would provide transfer accommodations. CMS Appendix Z-E25 states that the agreements *may* be in writing but does not state they *must* be in writing.

Emergency Communications Plans

Numerous deficient practices identified by the auditors would typically be cited during any state survey. It is important to recognize that these observations capture a specific moment in time and do not represent a fixed condition that would necessarily have been observed during the previous state-conducted survey of the facility. Moreover, it is worth noting that several of the deficient practices cited by the OIG auditors were in direct contradiction to the CMS Appendix Z, as outlined below.

- Facilities were cited for failing to update the communications portion of the emergency plan, but the overall review was not cited Under E-6.
- Two facilities were cited for failing to include the Ombudsman's contact information in the emergency preparedness binder, but the contact information is posted with the New Jersey Complaint hotline information in the public areas. CMS Appendix Z-E31 states facilities have discretion in the formatting of this information; however, it should be readily available and accessible to leadership during an emergency event.
- One facility was cited for failing to include the specific people in the delegation of authority. Only the position is required, not the individual's name in accordance with CMS Appendix Z-E7.
- One facility was cited for failing to update the communication plan annually, but the facility was within 12 months (annual) of the last review and update as required by CMS Appendix Z-E29

Emergency Preparedness Plan Training and Testing

Numerous deficient practices identified by the auditors would typically be cited during any state survey. It is important to recognize that these observations capture a specific moment in time and do not represent a fixed condition that would necessarily have been observed during the previous state-conducted survey of the facility. Moreover, it is worth noting that several of the deficient practices cited by the OIG auditors were in direct contradiction to the CMS Appendix Z, as outlined below.

- One facility was cited for failing to conduct a "full critique" of a 2nd tabletop drill, but it was unclear if there was no critique or just not to the auditor's standard.

- 5 facilities were cited for failing to conduct a full-scale exercise although the facilities were currently under an 1135 waiver for the Covid-19 Pandemic. This waiver allows facilities to forego full scale emergency preparedness drills while under the Covid-19 Pandemic or within 1 year of the most recent activation of their emergency plan in accordance with QSO-20-41-ALL.

Infection Prevention and Requirements:

The observations made by the auditors regarding deficient practices during the OIG survey were acknowledged by the Department as valid at that time. If these practices had been observed by the Department state surveyors during their own surveys, they would have cited them as well. It is important to note that all observations are a momentary snapshot of the situation. If the Department surveyors had noted the same deficient practices, they would have followed the survey process by conducting further investigations to establish the existence of these deficiencies. They would have ensured that the facility staff adhered to facility policies, procedures, and Centers for Disease Control guidelines to confirm the accuracy of the findings. As such, the deficiencies found by OIG do not reflect or demonstrate any failures with the Department's survey process.

As per the OIG auditors the infection prevention and control program identified the yearly infection control plan was outdated for one nursing home and for another nursing home the plan had not been updated to included COVID-19. It is not clear as to whether the Infection Preventionist was in the facility to provide them with the most current IP plan and there is no mention if the facility policies and procedures were updated to include COVID-19.

Antibiotic Stewardship Programs:

Nursing homes are required to have an antibiotic stewardship program that includes protocols for using antibiotics and a system to monitor antibiotic use. They must ensure there is a system for recording identified incidents and corrective actions taken, and they must conduct annual review updates. The observations made by the auditors regarding deficient practices during the OIG survey were acknowledged by the New Jersey state agency as valid at that time. If these practices had been observed by the New Jersey state surveyors during their own surveys, they would have cited them as well. However, the Department takes issue with some of OIG's deficiencies:

- Some of the findings made by the OIG auditors were unclear and lacked sufficient specificity to determine the validity of the citations. The OIG auditors were not specific. In one nursing home, the OIG auditors referenced guidelines from Minnesota in the New Jersey report.

Infection Preventionists:

As previously mentioned, the survey provides a snapshot of a specific moment in time. Nursing homes have a statutory obligation to appoint at least one individual as the Infection Preventionist (IP) responsible for the facility's Infection Prevention and Control Program. In several instances documented in the OIG surveys, multiple nursing homes had experienced the loss of IPs, some of whom may have been present during the state surveys in New Jersey but may have recently resigned from their positions due to the challenges posed by the pandemic. In some cases, these resignations occurred with little or no notice, leaving the nursing homes with insufficient time to fill the vacant IP role. If the state agency surveyors had encountered the same issues during the survey, they would have identified and reported the deficient practice.

Influenza and Pneumococcal Immunizations:

The auditors' observations of deficient practices were valid at the time of the OIG survey and would also be cited, had they been observed by the NJ state agency surveyors during the state survey.

- One of the nursing homes did not have a section noted in the consent for contraindication/refusal and we concur the auditors that it should be cited. However, a medical record reviewed by the auditors did not provide documentation that education was provided. In another nursing home the facility was unable to provide documentation that education was provided on the influenza vaccine in a particular medical record. These examples again are a snapshot in time. The auditors reviewed medical records that the state agency did not review. Had they reviewed the same medical records, the State survey agency would have cited the facility.

COVID-19 Case Notifications:

Nursing homes are required to notify residents, their representatives, and families by 5 p.m. the calendar day following either a single confirmed COVID-19 infection or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. The auditors' observations of deficient practices were valid at the time of the OIG survey and would also have been cited by New Jersey State agency, had they been observed during the state survey. The OIG and the New Jersey state agency surveyors did not review the exact same medical records. Per CMS policy, the State agency samples records to verify compliance during the survey. If the auditors did not sample the exact same records, it is not a comparable review.

- In one of the nursing homes a notification was done on 2/23/22 at 5:35 PM, 35 minutes late; in another nursing home notification of infection was forwarded on 1/22/22 at 10:58 PM when the triggering cases were confirmed 1/20/22. In another nursing home notification was not sent out by 5 PM when the last infection was 1/31/22 and notification was sent out on 2/1/22 at 5:51 PM. These are valid deficiencies and would

have been cited as a deficient practice if these medical records were reviewed by the state agency.

COVID-19 Facility Visitation Signage:

Nursing homes are required to post signage at the facility entrances with visitation and screening procedures. According to the auditors, three nursing homes did not post appropriate signage at entrances.

- According to the auditors' observations three facilities were observed with no signage posted at the entrance regarding visitation policy and screening procedures. The deficient practices were valid at the time of the OIG survey. All observations are a snapshot in time. If the appropriate signage was missing during the New Jersey state survey, they would have been cited as valid deficiencies.

Recommendation: The Department should work with CMS to develop a risk-based approach to identify nursing homes at which surveys should be conducted more frequently than once every 15 months, such as those with a history of multiple high-risk deficiencies or frequent management turnover; work with CMS to obtain additional resources to implement more frequent surveys using this risk-based approach; and work with CMS to develop standardized life safety training for nursing home staff.

Response: The Department will continue to operate the State Survey Process in compliance with CMS requirements. Included in the CMS authority is the ability to identify facilities as Special Focus Facilities (SFF). CMS began the SFF initiative to address the problem facilities that consistently provide poor quality of care but periodically make enough improvement in the presenting problems to pass one survey, only to fail the next (for many of the same problems as before). Facilities with such a "yo-yo" history rarely address the underlying systemic problems that give rise to repeated cycles of serious deficiencies. The SFF initiative is intended to promote more rapid and substantial improvement in the quality of care in identified nursing homes and end the pattern of repeated cycles of non-compliance with quality-of-care requirements. SFF nursing homes are provided with more frequent survey and certification oversight. CMS' policy of progressive enforcement means that any nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions, and/or termination of the Medicare provider agreement.

- A problem facility will graduate from the SFF program once it has met the following criteria (these surveys must have occurred after the facility has been selected as an SFF): Two consecutive standard health surveys with 12 or fewer deficiencies cited at scope and severity level (S/S) of "E" or less on each survey.

- SFFs will not graduate if the following occurs: Any standard health survey results in deficiencies cited at an S/S level of "F" or higher, or any LSC or EP survey results in deficiencies cited at an S/S level of "G" or higher; and 13 or more total deficiencies cited on any survey (standard health, LSC, EP, or complaint); intervening complaint surveys with 13 or more total deficiencies, or any deficiencies cited at an S/S level of "F" or higher. Additionally, an SFF cannot graduate with pending complaint surveys triaged at IJ, or Non-IJ High, or until it has returned to substantial compliance.

The Department currently has the CMS maximum of two facilities enrolled in the SFF program and these facilities receive more frequent surveys.

The Department also implemented a Mission Critical Team beginning in 2022, separate and apart from the State Survey team, whose goal is to evaluate Long Term Care Facilities using 10 key measures and identifying those facilities that appear to be in need of assistance. The Mission Critical Team (a team of experienced Administrators and nurses) are then deployed to the facility and offer assistance to the facility. This process is separate from the State Survey Regulatory process.

Conclusion:

The Department acknowledges the thorough review that the OIG conducted of Long Term Care facilities in New Jersey and concurs with their overall finding that the deficiencies identified in Long Term Care Facilities occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, State and Federal requirements. However, as noted in this response, the Department does not concur with many of the specific findings of the OIG in this audit.

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