Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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December 2023
A-05-22-00019

Office of Inspector General

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Report in Brief
Date: December 2023
Report No. A-05-22-00019

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

Ohio 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 for health care facilities to improve protections for 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 Ohio ensured that selected nursing homes in Ohio 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 949 nursing homes in Ohio that participated in Medicare or Medicaid, we selected a nonstatistical sample of 20 nursing homes for our audit based on certain risk factors, including multiple high-risk deficiencies Ohio reported to CMS.

We conducted unannounced site visits at the 20 nursing homes from August through November 2022. During the site visits, we checked for life safety, emergency preparedness, and infection control deficiencies.

What OIG Found

Ohio could better ensure that nursing homes in Ohio 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 onsite inspections, we identified deficiencies related to life safety, emergency preparedness, or infection control at 18 of the 20 nursing homes that we audited, totaling 160 deficiencies. Specifically, we found 47 deficiencies related to life safety, 47 deficiencies related to emergency preparedness, and 66 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 18 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, Ohio had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Ohio 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 Ohio Comments

We recommend that Ohio follow up with the 18 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to verify that corrective actions have been taken regarding the deficiencies identified in this report. We also make procedural recommendations for Ohio to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

In written comments on our draft report, Ohio concurred with all four recommendations and described actions that it had taken or planned to take to address them. However, Ohio believes there are instances identified in our draft report where we misinterpreted the Federal requirements. We revised our report to remove two of the deficiencies related to these instances; however, we made no other changes to the report regarding the remaining instances.

The full report can be found at https://oig.hhs.gov/oas/reports/region5/52200019.asp.

TABLE OF CONTENTS

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 individuals enrolled in Medicare and Medicaid, 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 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 disease. In July 2022, we issued a report summarizing the results of a series of audits we previously conducted in eight States to assess compliance with CMS's new life safety and emergency preparedness requirements.[1] This audit, which focuses on selected nursing homes in Ohio, is one in a series of audits that also assesses compliance with CMS's infection control requirements.

Appendix B contains a list of the eight previously conducted audits, the report summarizing the results of those audits, and the completed audits in this series.

OBJECTIVE

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

[1] We conducted audits in New York, California, Texas, Florida, Missouri, Illinois, North Carolina, and Iowa. We summarized the results of these audits in *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.

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 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 (NFPA) *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99).[2] CMS lists applicable requirements on Form CMS-2786R, Fire Safety Survey Report.[3]

- *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)[4] as part of these requirements. CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.[5]

- *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

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

[3] 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.

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

[5] 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.

Infection Prevention, Control, and Immunizations Surveyor Checklist[6] and *COVID-19 Focused Survey Checklist* (Infection Control Surveyor Checklists).[7]

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.[8]

In addition to the Federal requirements noted previously, Ohio requires carbon monoxide detectors or alarms to be installed and maintained in nursing homes on the ceiling of each room containing a permanently installed fuel-burning appliance and centrally located on every habitable level in every heating/ventilation/air conditioning zone of the building (Ohio Administrative Code Rule 3701-17-25(G)(1-2)).

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.[9] 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).[10, 11] 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 the Medicare or Medicaid programs.[12] Nursing homes with repeat deficiencies can be surveyed more frequently. In Ohio, the State agency is

[6] CMS provides guidance for infection control during COVID-19 at https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf.

[7] CMS provides the latest Form CMS-20054, Infection Prevention, Control and Immunizations, revision for testing changes as of January 2022, at https://cmscompliancegroup.com/wp-content/uploads/2022/01/CMS-20054-Infection-Prevention-Control-and-Immunization-January-2022.pdf.

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

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

[10] 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).

[11] The Act §§ 1819(g) and 1919(g).

[12] 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.

the State survey agency that oversees nursing homes and is responsible for ensuring that nursing homes comply with Federal, State, and local regulations.

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 2021. However, between 2020 and 2022, the State agency did not conduct standard surveys at least every 15 months because the State agency lacked the staff resources to do so. The State agency planned to reach its nursing home survey frequency of once every year by February 2023.

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 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 Ohio'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.[13] States, including Ohio, 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."[14]

HOW WE CONDUCTED THIS AUDIT

As of August 2022, 949 nursing homes in Ohio participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on

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

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

risk factors, including multiple high-risk deficiencies the State agency reported to CMS's ASPEN system for calendar years (CYs) 2021 and 2022.[15, 16]

We conducted unannounced site visits at each of the 20 nursing homes from August through November 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 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 Ohio 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 18 of the 20 nursing homes that we audited, totaling 160 deficiencies. Specifically:

- We found 47 deficiencies with life safety requirements related to building exits, fire barriers, and smoke partitions (7); fire detection and suppression systems (22); carbon monoxide detectors (1); hazardous storage areas (2); and elevator and electrical equipment testing and maintenance (15).

- We found 47 deficiencies with emergency preparedness requirements related to emergency preparedness plans (6); emergency supplies and power (4); plans for evacuations, sheltering in place, and tracking residents and staff during an emergency (1); emergency communications plans (7); and emergency preparedness plan training and testing (29).

[15] The 20 nursing homes consisted of 3 with multiple high-risk deficiencies in both 2021 and 2022 and 17 with multiple high-risk deficiencies in at least one year.

[16] 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.

- We found 66 deficiencies with infection control requirements or guidance related to IPCPs and antibiotic stewardship programs[17] (1); influenza and pneumococcal immunizations (6); COVID-19 immunizations (17); COVID-19 testing (6); COVID-19 reporting (18); and COVID-19 case notifications (18).

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 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 18 nursing homes are at an increased risk 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

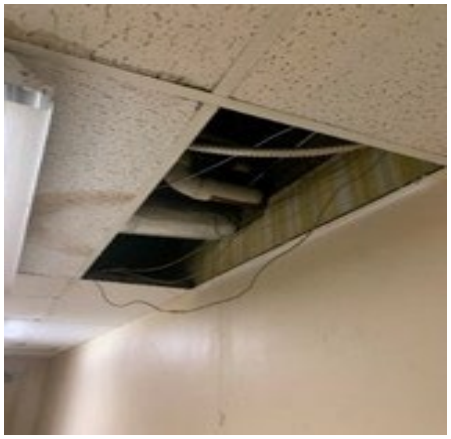
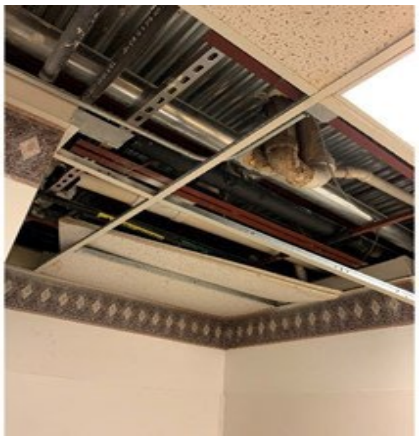
CMS's Fire Safety Survey Report form, described on page 2, lists the Federal regulations on life safety that nursing homes must comply with and references each with an identification number known as a K-Tag (numbered K-100 through K-933). In addition, Ohio requires carbon monoxide detectors or alarms to be installed and maintained in nursing homes on the ceiling of each room containing a permanently installed fuel-burning appliance and centrally located on every habitable level in every heating/ventilation/air conditioning zone of the building (Ohio Administrative Code Rule 3701-17-25(G)(1-2)).

Building Exits, Fire Barriers, and Smoke Partitions

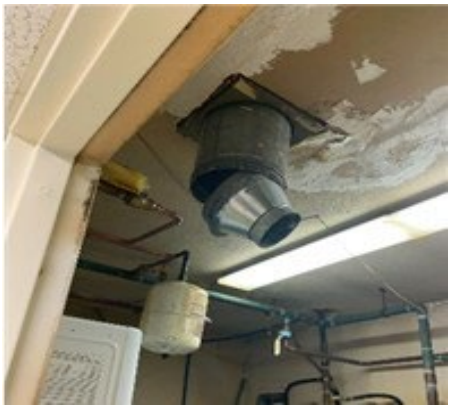
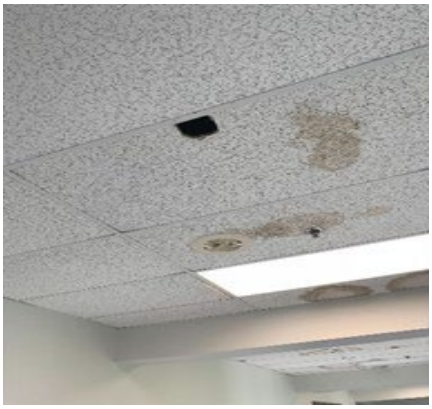
In case of fire or emergency, nursing homes are required to have unobstructed exits, self-closing doors in exit passageways that do not require tools or keys to open and are not manually propped open, pathways leading to exit doors that are not blocked or impeded, discharges from exits that are free from hazards, illuminated exit signs, and fire-stopped smoke and fire barriers (K-Tags 211, 222, 223, 271, 293, 363, 372, 374).

[17] 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.

Of the 20 nursing homes we visited, 7 had 1 deficiency related to building exits, fire barriers, and smoke partitions, totaling 7 deficiencies. Specifically, we found a deficiency related to blocked or impeded pathways leading to exit doors (one nursing home). We also found a deficiency related to a lack of policies and procedures for emergency lighting (one nursing home). Finally, we found deficiencies related to missing or damaged smoke and fire barriers (five nursing homes), including broken ceiling tiles and openings that could contribute to the spread of smoke and fire. The photographs below depict some of the deficiencies we identified during our site visits.

Photograph 1 (left): Missing ceiling tiles.
Photograph 2 (right): Missing ceiling tiles.

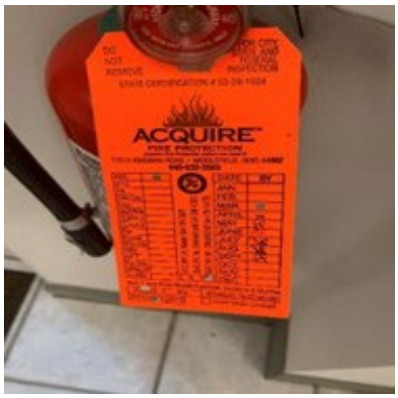
Photograph 3 (left): Metal duct dangling from ceiling.
Photograph 4 (right): Damaged ceiling tile.

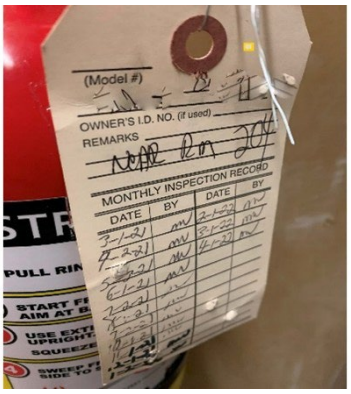
Fire Detection and Suppression Systems

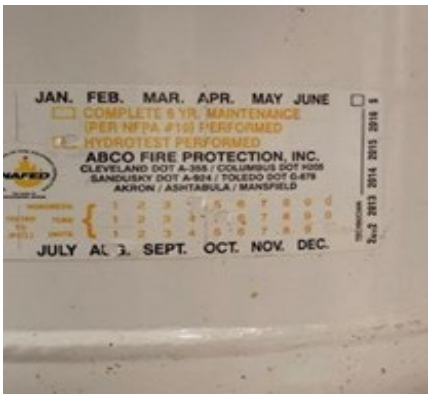
Each nursing home is required to have a fire alarm system that has a backup power supply and is tested and maintained according to NFPA requirements. Sprinkler systems must be installed,

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 their residents if a fire watch is not instituted), and portable fire extinguishers must be inspected monthly. Smoke detectors are required in patient rooms, spaces open to corridors, and other areas (K-Tags 324, 342, 344, 345, 346, 347, 351, 352, 353, 354, 355, 421).

Of the 20 nursing homes we visited, 12 had 1 or more deficiencies related to their fire detection and suppression systems, totaling 22 deficiencies. Specifically, we found five nursing homes whose fire alarm system was not routinely tested and maintained. In addition, we found deficiencies related to sprinkler systems that were not tested and maintained (three nursing homes) and fire alarm control functions that were supplied by an alternative power source that was overdue for an inspection (one nursing home). We also found deficiencies related to cooking equipment hoods that were not serviced or fire suppression systems that were not checked monthly (eight nursing homes). Finally, we found one nursing home that lacked policies and procedures for when the sprinkler system is out of service and deficiencies related to monthly portable fire extinguisher inspections (five nursing homes). The photographs below depict some of the deficiencies we identified during our site visits.







Photograph 5 (left): Fire extinguisher did not have all monthly inspections.
Photograph 6 (center): Fire extinguisher did not have all monthly inspections.
Photograph 7 (right): Kitchen fire suppression system did not have all monthly inspections.

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).[18] Ohio requires carbon

[18] 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.

monoxide detectors or alarms to be installed and maintained in nursing homes on the ceiling of each room containing a permanently installed fuel-burning appliance and centrally located on every habitable level in every heating/ventilation/air conditioning zone of the building (Ohio Administrative Code Rule 3701-17-25 (G) (1-2)).

Of the 20 nursing homes we visited, 1 had a deficiency related to Ohio requirements for carbon monoxide detectors. Specifically, we found one nursing home that failed to install carbon monoxide detectors in one or more required locations.

Hazardous Storage Areas

Every nursing home is required to store oxygen cylinders in a safe manner (e.g. in a storage rack and not lying on the ground in a patient's room) (K-Tag 923).

Of the 20 nursing homes we visited, 2 had 1 deficiency related to hazardous storage areas, totaling 2 deficiencies. Specifically, we found deficiencies related to unsafe storage of oxygen cylinders (two nursing homes).

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 (K-Tags 531, 921).

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to elevator or electrical equipment testing and maintenance, totaling 15 deficiencies. Specifically, we found five 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 10 nursing homes that failed to maintain records of testing and repairs of electrical equipment and failed to maintain documentation of the inspection and maintenance of electrical receptacles at patient bed locations.

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 State Operations Manual § 1010). CMS has a publicly accessible online learning portal related to such life safety training.[19] Both CMS and State agency surveyors are required to receive standardized life safety training such as the training available through CMS's online learning

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

portal.[20] 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 referred to 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, and 0042).

Of the 20 nursing homes we visited, 4 had 1 or more deficiencies related to their emergency preparedness plan, totaling 6 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that were not updated at least annually (two nursing homes). In addition, we found a deficiency related to an all-hazards risk assessment that did not address all risks (one nursing home). Also, we found a deficiency related to an emergency preparedness

[20] 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)).

plan that did not provide for coordination with all Government emergency management officials (one nursing home). Finally, we found two nursing homes whose emergency preparedness plans were 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.[21] 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, nursing homes with generators must perform weekly maintenance checks, monthly load tests, and annual fuel quality tests if fueled with diesel[22] (E-Tags 0015, 0041).

Of the 20 nursing homes we visited, 4 had 1 deficiency related to emergency supplies and power, totaling 4 deficiencies. Specifically, we found four nursing homes with deficiencies related to generators that were not properly tested and maintained including:

- three nursing homes that did not have recent testing and inspection records and
- one nursing home generator inspection noted required maintenance, but there was no evidence the repairs were made.

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 and using volunteers (E-Tags 0018, 0020, 0022-0024, 0033).

Of the 20 nursing homes we visited, 1 had a deficiency related to its emergency preparedness plans for evacuations. Specifically, we found a deficiency related to an emergency preparedness plan that did not have a volunteer plan for use in emergency staffing or surge planning (one nursing home).

[21] 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.

[22] 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.

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 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 method of sharing information with other facilities in the event of an evacuation, 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 0029-0035).

Of the 20 nursing homes we visited, 3 had 1 or more deficiencies related to the adequacy of the emergency communications plans, totaling 7 deficiencies. Specifically, we found: four deficiencies for nursing homes whose emergency communications plans did not include various categories of required names and contact information,[23] two deficiencies related to nursing homes whose emergency communications plans were not updated annually, and one deficiency related to a nursing home that did not have a means to provide information about the facility to emergency management officials.

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, must be 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.[24] In addition, a second training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise[25]) 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).

[23] The four deficiencies related to nursing homes whose emergency communications plans did not include the following categories of required names and contact information: staff (1), volunteers (1), government emergency management offices (1), and the State licensing agency (1).

[24] 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 plan due to the COVID-19 public health emergency.

[25] 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, 7 had 1 or more deficiencies related to emergency preparedness plan training, totaling 29 deficiencies. Specifically, we found three deficiencies at three nursing homes that did not update their training plan annually, two deficiencies at two nursing homes that did not provide initial emergency plan training, and five deficiencies at five nursing homes that did not provide annual emergency preparedness plan training. In addition, we found six deficiencies related to nursing homes that did not conduct an annual community-based full-scale testing exercise, six deficiencies related to nursing homes that did not conduct a second annual training exercise (full-scale testing exercise, facility-based exercise, or "tabletop" exercise), and six deficiencies related to nursing homes that did not conduct an analysis of their training exercises. Also, we found one deficiency related to a nursing home that did not have an emergency preparedness plan testing and training program at all.

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. 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, 1 had a deficiency related to its IPCP and antibiotic stewardship program, totaling 1 deficiency. Specifically, we found the facility did not have a plan in place for performing an annual review of its IPCP.

Prior to our site visits, mpox was declared a public health emergency from August 4, 2022, through January 31, 2023. In conjunction with our site visits, we asked the 20 nursing homes to determine whether they: (1) updated their IPCP to mitigate mpox and (2) experienced any cases of mpox among residents or staff.

Of the 20 nursing homes, 15 did not update policies related to mpox, and 5 indicated they were revising or developing policies related to mpox or inquiring with their regional office on doing so. One nursing home reported a recent visitor who later tested positive for mpox. Staff followed testing protocols and monitored symptoms to prevent spread.

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 6 deficiencies. Specifically, we found deficiencies related to medical records that lacked documentation that each resident was offered a pneumococcal immunization and the right of refusal by the resident or their representative for the immunization (one nursing home) and that each resident was offered an influenza immunization October 1 through March 31 annually and the right of refusal by the resident or their representative for the 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 the COVID-19 vaccine (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.[26, 27] 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 the COVID-19 vaccine, and the facility documents this education and the immunization status of staff and residents. Nursing homes must also have policies and procedures that include a process for ensuring implementation of additional precautions to mitigate the transmission and spread of COVID-19 for staff who are not vaccinated. The policies and procedures must also provide each resident or resident's representative the opportunity to accept or refuse COVID-19 vaccination (F-Tags 887, 888).

Of the 20 nursing homes we visited, 5 had 1 or more deficiencies related to COVID-19 immunizations, totaling 17 deficiencies. Specifically, we found 13 deficiencies related to the

[26] 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).

[27] The policies and procedures do not apply to staff who exclusively provide telehealth, telemedicine, or support services outside of the facility setting (exempt staff). The Final Rule published in 88 FR 36485 withdraws regulations pertaining to staff vaccination effective Aug. 4, 2023.

lack of required elements in the nursing homes' COVID-19 immunization policies and procedures. The nursing homes' policies and procedures did not:

- require staff and residents to be offered the COVID-19 vaccination (one nursing home);
- require students, trainees, and volunteers to be fully vaccinated (one nursing home);
- require licensed practitioners to be fully vaccinated (one nursing home);
- require contractors to be fully vaccinated (one nursing home);
- include a process for ensuring implementation of additional precautions to mitigate the transmission and spread of COVID-19 for staff that are not vaccinated (two nursing homes);
- include a process ensuring documentation that supports staff requests for medical exemptions from vaccination (one nursing home);
- include information specifying which of the authorized vaccines are clinically contraindicated for the staff member to receive (one nursing home);
- include a statement by the authenticating practitioner recommending that the staff member be exempted from the vaccine requirements (one nursing home);
- include contingency plans for staff who are not fully vaccinated for COVID-19 (two nursing homes);
- indicate that staff who exclusively provided telehealth or telemedicine services outside of the facility were exempt from the COVID-19 vaccination requirement (one nursing home); and
- indicate that staff who provide support services that are performed exclusively outside of the facility were exempt from the COVID-19 vaccination requirement (one nursing home).

We also found four deficiencies related to nursing homes' documentation of COVID-19 immunization requirements. Specifically, three nursing homes did not maintain documentation that staff was provided education regarding the benefits or potential risks of immunization. At another nursing home, documentation was not maintained indicating whether staff was offered the COVID-19 vaccine.

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, 3 had 1 or more deficiencies related to COVID-19 testing, totaling 6 deficiencies. Specifically, we found 3 deficiencies related to a nursing home's policies and procedures that did not address testing frequency, response times for COVID-19 test results, or emergency testing supply shortages. Also, three nursing homes did not have policies and procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

COVID-19 Reporting

Nursing homes are required to electronically report, no less than weekly, information about suspected and confirmed COVID-19 infections, total deaths and COVID-19 deaths, personal protective equipment and hand hygiene supplies, ventilator capacity, resident beds and census, access to COVID-19 testing, staffing shortages, COVID-19 vaccination status of residents and staff, and therapeutics administered to treat COVID-19 (F-Tag 884).

Of the 20 nursing homes we visited, 2 had 1 or more deficiencies related to COVID-19 reporting, totaling 18 deficiencies. Specifically, the two nursing homes did not have access to the National Healthcare Safety network system to report weekly information, so we were unable to verify electronically reported COVID-19 information including: suspected and confirmed COVID-19 infections, total deaths and COVID-19 deaths among residents and staff, personal protective equipment and hand hygiene supplies, ventilator capacity and supplies, resident beds and census, resident access to COVID-19 testing, staffing shortages, vaccination statuses of residents and staff, and therapeutics administered to residents.

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. This notification must not include personally identifiable information; must include information on mitigating actions implemented to prevent or reduce the risk of transmission; and must include cumulative updates for residents, their representatives, and families (F-Tag 885).

Of the 20 nursing homes we visited, 12 had 1 or more deficiencies related to COVID-19 case notifications, totaling 18 deficiencies. Specifically, 12 nursing homes did not include cumulative updates for residents, their representatives, and their families each time a confirmed COVID-19 infection was identified. Two nursing homes did not include information on mitigating actions implemented to prevent or reduce the risk of transmission in their COVID-19 case notification. Two nursing homes were unable to provide the narrative of COVID-19 notification for us to verify it did not include personally identifiable information; included information on mitigating actions implemented to prevent or reduce the risk of transmission; and included cumulative updates for residents, their representatives, and their families each time a confirmed COVID-19 infection was identified. Also, two nursing homes did not notify residents, their representatives, and families of a confirmed COVID-19 infection or onset of respiratory symptoms by three or more residents or staff within 72 hours of each other.

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.

RECOMMENDATIONS

We recommend that the Ohio Department of Health:

- follow up with the 18 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to verify that corrective actions have been taken regarding the deficiencies identified in this report;

- 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;

- develop a plan with CMS 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 concurred with all four recommendations and described actions that it had taken or planned to take to address them. Specifically, at the time of the State agency's comments, all but three providers received a follow-up Life Safety Code inspection. Additionally, the State agency will assist CMS, if requested, in developing risk-based approaches to identify where more frequent surveys should occur, addressing foundational issues preventing more frequent nursing home surveys, and developing life safety training for nursing home staff. The State agency also noted that it had provided several life safety presentations to provider associations and providers. However, the State agency believes there are eight instances identified in our draft report where we misinterpreted the Federal requirements. These instances are related to smoke barriers (specifically, ceiling tiles) (three instances), alcohol-based hand rub dispensers (two instances), medical records storage (one instance), cooking facility inspections (one instance), and sprinkler system documentation (one instance). The State agency's comments are included in their entirety as Appendix D.

We agree with the State agency regarding one of the instances related to alcohol-based hand rub dispensers and the instance related to the sprinkler system documentation and have removed the associated deficiencies from this final report. The second instance related to alcohol-based hand rub dispensers and the instance related to medical records storage were not identified in our draft report as deficiencies; therefore, we do not address them. However, we disagree with the State agency regarding the remaining four instances. Specifically, for the three instances related to water-stained ceiling tiles, all of the deficiencies we identified involved missing or broken tiles, and therefore remain deficiencies. The remaining instance related to cooking facility inspections also remains a deficiency because, although the State agency provided documentation for the fire suppression system inspection, it was not completed timely.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of August 2022, 949 nursing homes in Ohio participated in the Medicare or Medicaid programs. Of these 949 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 2021 and 2022.[28]

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 Ohio from August through November 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 949 active nursing homes in Ohio that participated in the Medicare and Medicaid programs as of August 2022;
- 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 804 nursing homes in CY 2021 and 656 in CY 2022 that had 1 or more deficiencies;
- identified 50 nursing homes in CY 2021 and 54 nursing homes in CY 2022 that had 10 or more deficiencies and that were considered high-risk because they: (1) were widespread

[28] The 20 nursing homes consisted of 3 with multiple high-risk deficiencies in both 2021 and 2022 and 17 with multiple high-risk deficiencies in at least 1 year.

and had the potential for more than minimal harm, (2) had actual harm that was not immediate jeopardy, or (3) presented immediate jeopardy to resident life and safety;[29]

- selected 20 nursing homes for onsite inspections from the high-risk 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 2022 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.

[29] 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 June 14, 2022.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-09-22-02006	12/8/2023
Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-03-22-00206	11/8/2023
New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-02-22-01004	9/29/2023
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	-	-	10	**10**
2	5	-	1	**6**
3	2	5	2	**9**
4	4	-	-	**4**
5	1	7	-	**8**
6	4	-	21	**25**
7	3	1	-	**4**
8	1	9	1	**11**
9	1	-	-	**1**
10	-	-	-	**0**
11	-	-	-	**0**
12	4	9	1	**14**
13	1	1	1	**3**
14	2	7	2	**11**
15	5	-	1	**6**
16	4	5	5	**14**
17	1	3	4	**8**
18	6	-	13	**19**
19	2	-	2	**4**
20	1	-	2	**3**
Total	**47**	**47**	**66**	**160**

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	Elevator and Electrical Equipment Testing and Maintenance	Total
1	-	-	-	-	-	**0**
2	1	3	-	-	1	**5**
3	1	1	-	-	-	**2**
4	-	3	-	1	-	**4**
5	-	1	-	-	-	**1**
6	-	3	-	-	1	**4**
7	-	1	-	1	1	**3**
8	-	1	-	-	-	**1**
9	1	-	-	-	-	**1**
10	-	-	-	-	-	**0**
11	-	-	-	-	-	**0**
12	1	2	-	-	1	**4**
13	-	-	-	-	1	**1**
14	-	-	-	-	2	**2**
15	1	2	-	-	2	**5**
16	1	1	-	-	2	**4**
17	-	-	-	-	1	**1**
18	1	2	1	-	2	**6**
19	-	2	-	-	-	**2**
20	-	-	-	-	1	**1**
Total	**7**	**22**	**1**	**2**	**15**	**47**

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	-	-	-	-	-	**0**
2	-	-	-	-	-	**0**
3	-	1	-	-	4	**5**
4	-	-	-	-	-	**0**
5	1	1	-	2	3	**7**
6	-	-	-	-	-	**0**
7	-	1	-	-	-	**1**
8	3	-	-	-	6	**9**
9	-	-	-	-	-	**0**
10	-	-	-	-	-	**0**
11	-	-	-	-	-	**0**
12	1	-	1	2	5	**9**
13	-	1	-	-	-	**1**
14	-	-	-	-	7	**7**
15	-	-	-	-	-	**0**
16	1	-	-	3	1	**5**
17	-	-	-	-	3	**3**
18	-	-	-	-	-	**0**
19	-	-	-	-	-	**0**
20	-	-	-	-	-	**0**
Total	**6**	**4**	**1**	**7**	**29**	**47**

Table 4: Infection Control Deficiencies

Nursing Home	Infection Prevention Control and Antibiotic Stewardship Programs	Immunizations		COVID-19 Testing	COVID-19 Reporting	COVID-19 Case Notifications	Total
		Non-COVID-19*	COVID-19				
1	-	-	-	-	9	1	**10**
2	-	-	-	-	-	1	**1**
3	-	-	2	-	-	-	**2**
4	-	-	-	-	-	-	**0**
5	-	-	-	-	-	-	**0**
6	-	4	11	4	-	2	**21**
7	-	-	-	-	-	-	**0**
8	-	-	-	-	-	1	**1**
9	-	-	-	-	-	-	**0**
10	-	-	-	-	-	-	**0**
11	-	-	-	-	-	-	**0**
12	-	-	-	-	-	1	**1**
13	-	-	-	-	-	1	**1**
14	-	-	-	-	-	2	**2**
15	-	-	-	-	-	1	**1**
16	-	2	-	1	-	2	**5**
17	-	-	1	-	-	3	**4**
18	1	-	2	1	9	-	**13**
19	-	-	-	-	-	2	**2**
20	-	-	1	-	-	1	**2**
Total	**1**	**6**	**17**	**6**	**18**	**18**	**66**

***** Influenza and pneumococcal immunizations.

APPENDIX D: STATE AGENCY COMMENTS

Department of Health

odh.ohio.gov

Mike DeWine, *Governor* Jon Husted, *Lt. Governor* Bruce Vanderhoff, MD, *Director*

November 17, 2023

Mr. Mike Barton
Assistant Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region V
233 North Michigan Ave., Suite 802
Chicago, Illinois 60601

Report Number: A-05-22-00019

Dear Mr. Barton,

Please see below for the Ohio Department of Health's response to your office's draft report A-05-22-00019 – "Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control."

Thank you for the opportunity to comment.

Sincerely,

Bruce Vanderhoff, MD, MBA
Director of Health

246 North High Street
Columbus, Ohio 43215 U.S.A.

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Overview:

The mission of the Ohio Department of Health (ODH) is to advance the health and well-being of all Ohioans. This includes residents of nursing homes. Through an agreement with the Centers for Medicare and Medicaid Services (CMS), ODH inspects nursing homes to ensure that state and federal standards of care are met for each individual living in the home. We use the federally prescribed survey process to meet the timing standards of survey inspections along with issuing citations and following up on noncompliance to ensure nursing home providers have corrected deficient practices.

ODH supports the Office of Inspector General's (OIG) mission of promoting the health and welfare of residents in nursing homes. However, we do not agree with all of OIG's survey findings in report A-05-22-00019. It should be noted that the OIG auditors acknowledged not being trained in life safety or health inspections, which may have led to some federal requirements being misinterpreted. By contrast, ODH's survey inspectors must meet federal minimum qualifications for both life safety and health standards as prescribed by CMS.

For your consideration, please see the following instances in your report where OIG auditors may have misinterpreted the federal requirements and our response:

[redacted]
Inspection Date: Oct. 31, 2022.

Deficient Area K372: Penetrations in smoke/fire barrier 42 CFR 483.90(a)(1)(i). "Water damaged ceilings."

- Federal Requirement: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5 of NFPA 101 2012 Edition. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. NFPA 101, 2012 Edition 19.3.7.3, 8.6.7.1(1).

- ODH Response: In Type 000 buildings, ceiling tiles are smoke barriers, and the presence of water staining does not impact the functionality of the ceiling tile.

Deficient Area K325: Alcohol Based Hand Rub Dispenser 42 CFR 483.90(a)(4). "There were a few empty dispensers; and one dispenser was not on the wall."

- Federal Requirement: Alcohol Based Hand Rub Dispenser (ABHR). ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:
  - Corridor is at least 6-feet wide.

- Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.
- Dispensers shall have a minimum of 4-foot horizontal spacing.
- Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.
- Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.
- Dispensers are not installed within 1 inch of an ignition source.
- Dispensers over carpeted floors are in sprinklered smoke compartments.
- ABHR does not exceed 95 percent alcohol.
- Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).
- ABHR is protected against inappropriate access.
- NFPA 101, 2012 Edition 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485.

- ODH Response: Empty hand sanitizer dispensers are not surveyed by the Life Safety Code and should be looked at as part of a facility's infection control program.

[redacted].
Inspection Date: Nov. 2, 2022.

Deficient Area K372: Penetrations in smoke/fire barrier 42 CFR 483.90(a)(1)(i). Ceiling tiles had water stains. "Ceiling tile has water damage and missing tiles with wires hanging".

- Federal Requirement: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5 of NFPA 101, 2012 Edition. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. NFPA 101, 2012 Edition 19.3.7.3, 8.6.7.1(1).

- ODH Response: In Type 000 buildings, ceiling tiles are smoke barriers, and the presence of water staining does not impact the functionality of the ceiling tile.

Deficient Areas E23 and E33: Medical Records System 42 CFR §483.73 b5, 42 CFR §483.73 c4. "Medical records stored in an unlocked room, not secured."

- Federal Requirement E23: [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the

emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: [(5) or (3), (4), (6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

- Federal Requirement E33: [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:
  - (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
  - (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]
  - (6) [(4) or (5)] A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

- ODH Response E22 and E33: Requires secure transfer of resident medical records during an emergency, not the storage of records in the medical record room.

[redacted]-
Inspection Date: Aug. 24, 2022.

Deficient Area K372: Penetrations in smoke/fire barrier 42 CFR 483.90(a)(1)(i). "Several ceiling tiles have water damage."

- Federal Requirement: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5 of NFPA 101 2012 Edition. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. NFPA 101, 2012 Edition 19.3.7.3, 8.6.7.1(1).

- ODH Response: In Type 000 buildings, ceiling tiles are smoke barriers, and the presence of water staining does not impact the functionality of the ceiling tile.

Deficient Area K324: Cooking Facilities 42 CFR 483.90(a)(1)(i). "The last inspection for the kitchen extinguishing system was in 2012."

- Federal Requirement: Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:
  - Residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2.
  - Cooking facilities open to the corridor in smoke compartments with 30 or fewer patients complying with the conditions under 18.3.2.5.3, 19.3.2.5.3.
  - Cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.
  - Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas but shall not be open to the corridor.
  - NFPA 101, 2012 Edition 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2.

- ODH Response: State Survey Agency completed on June 11, 2021 had documentation provided for a hood suppression inspection by Alpha Fire completed Feb. 16, 2021.

Deficient Area K354: Sprinkler System – Out of Service 42 CFR 483.90(a)(8). "There are no procedures for "Sprinkler System – Out of Service".

- Federal Requirement: Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. NFPA 101, 2012 Edition 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25).

- ODH Response: Sprinkler-Alarm system Fire Watch documentation was provided to the State Agency surveyor at 2/16/21 survey.

[redacted]-
Inspection Date: Sept. 21, 2022.

- **Deficient Area K325:** Alcohol Based Hand Rub Dispenser 42 CFR 483.90(a)(4). Empty hand sanitizer dispensers. "3rd floor sanitizers were empty, at least 3 on the same hallway. Maintenance stated that he would contact housekeeping to get them filled."

- Federal Requirements: Alcohol Based Hand Rub Dispenser (ABHR). ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:
  - Corridor is at least 6-feet wide.
  - Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.
  - Dispensers shall have a minimum of 4-foot horizontal spacing.
  - Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.
  - Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.
  - Dispensers are not installed within 1 inch of an ignition source.
  - Dispensers over carpeted floors are in sprinklered smoke compartments.
  - ABHR does not exceed 95 percent alcohol.
  - Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).
  - ABHR is protected against inappropriate access.
  - NFPA 101, 2012 Edition 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485.

- ODH Response: Empty hand sanitizer dispensers are not surveyed by the Life Safety Code and should be looked at as part of a facility's infection control program.

ODH Response to OIG Recommendations

Recommendation 1: "Follow up with the 18 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions."

ODH Response: ODH concurs with the recommendation. We will follow up with the 18 nursing homes at normal survey intervals. At the time of our response, all but three providers received a follow-up Life Safety Code inspection from the original OIG inspection.

Recommendation 2: "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."

ODH Response: We concur with the recommendation. We will assist CMS in developing a risk-based approach to identify nursing homes where more frequent surveys should occur, if requested by CMS and additional funding is procured to cover the additional surveys.

Recommendation 3: "Develop a plan with CMS to address the foundational issues preventing more frequent surveys at nursing homes with a history of multiple high-risk deficiencies."

ODH Response: We concur with the recommendation. We will assist CMS in addressing foundational issues, preventing more frequent nursing home surveys, if requested by CMS.

Recommendation 4: "Work with CMS to develop standardized life safety training for nursing home staff."

ODH Response: ODH concurs with the recommendation. We will assist CMS in developing standardized life safety training for nursing home staff, if requested by CMS and additional funding is procured to cover the additional training costs.

ODH currently holds quarterly life safety meetings with provider associations and providers. Upcoming meeting dates include Dec. 27, 2022, Jan. 13, 2023, April 11, 2023, and Sept. 25, 2023.

In addition to quarterly provider meetings, we conducted life safety presentations at the following provider association conferences:

- Ohio Department of Developmental Disabilities (group homes), Sept. 22, 2022.
- The Academy of Senior Health Sciences, Inc. (nursing homes), Oct. 27, 2022.
- Ohio Health Care Association (nursing homes), Nov. 3, 2022.
- Northwest Ohio Fire Prevention Association, Nov. 22, 2023.
- LeadingAge Ohio (nursing homes), Sept. 28, 2023.
- Ohio Health Care Association (nursing homes), Nov. 2, 2023.

Moving Forward

ODH is aggressively working internally on a state training plan to assist providers in areas of survey, including life safety training for nursing home staff.