Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

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

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January 2024
A-06-22-09007

# *Office of Inspector General*

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**Report in Brief**
Date: January 2024
Report No. A-06-22-09007

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

## Why OIG Did This Audit

In 2016, CMS updated its life safety and emergency preparedness regulations for health care facilities to improve protections for individuals enrolled in Medicare and Medicaid, 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. In addition, facilities were required to develop an infection control program.

Our objective was to determine whether Oklahoma ensured that selected nursing homes in Oklahoma that participated 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 296 nursing homes in Oklahoma that participated in Medicare or Medicaid, we selected a non-statistical sample of 20 nursing homes for our audit based on certain risk factors, including the number of deficiencies Oklahoma reported to CMS.

We conducted unannounced site visits at the 20 nursing homes from October 2022 through January 2023. During the site visits, we checked for life safety, emergency preparedness, and infection control deficiencies.

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

## What OIG Found

Oklahoma could better ensure that nursing homes in Oklahoma 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 all 20 nursing homes we audited, totaling 146 deficiencies. Specifically, we found 98 deficiencies related to life safety, 16 deficiencies related to emergency preparedness, and 32 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were 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, Oklahoma had limited resources to conduct surveys of all nursing homes as required by CMS.

## What OIG Recommends and Oklahoma Comments

We recommend that Oklahoma follow up with the 20 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions. We also make procedural recommendations for Oklahoma to work with CMS to develop an approach to identifying and conducting more frequent surveys at nursing homes.

Oklahoma neither concurred or non-concurred with our recommendations but described corrective actions that it planned to take to address one of the recommendations along with other corrective actions it planned to take or was already taking to address our findings. Oklahoma planned to conduct followup inspections for the 20 nursing homes by September 30, 2024, to ensure the deficiencies had been corrected. Oklahoma also created a survey schedule for conducting timely nursing home surveys, and it described various training plans for nursing homes and nursing home surveyors that will begin in 2024.

The full report can be found at https://oig.hhs.gov/oas/reports/region6/62209007.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 to assess compliance with CMS's new life safety and emergency preparedness requirements.[1] This audit, which focuses on selected nursing homes in Oklahoma, 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 Oklahoma State Department of Health (State agency) ensured that selected nursing homes in Oklahoma 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's (NFPA's) *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,

[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 July 25, 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 July 25, 2023.

pneumococcal, and COVID-19 immunizations.[6] CMS lists applicable requirements on its *Infection Prevention, Control, and Immunizations Surveyor Checklist* 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]

**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 approximately 15,000 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] Under 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.[12] Nursing homes with repeat deficiencies can be surveyed more frequently. In Oklahoma, 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.

From 2018 through 2020, the State agency conducted standard surveys at least every 15 months for most of the 20 nursing homes we visited. In response to CMS's March 2020 COVID-19 guidance, the State agency mostly shifted its oversight to complaints. The State agency resumed standard surveys, which included assessment of all three areas, beginning in

[6] A final rule published in 88 Fed. Reg. 36485 (June 5, 2023) withdraws regulations pertaining to COVID-19 testing and staff COVID-19 vaccination effective Aug. 4, 2023.

[7] Infection Control Surveyor Checklists are available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-Resources.zip.

[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, chapter 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.

September 2021. However, from 2021 through 2022, the State agency did not conduct standard surveys at least every 15 months for many of the 20 nursing homes we visited because the State agency lacked the staff resources to do so.

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., generators, sprinkler and alarm systems, and resident call systems) 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 Oklahoma'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 Oklahoma, 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, 296 nursing homes in Oklahoma participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on certain risk factors, including the number of deficiencies the State agency reported to CMS's ASPEN system for calendar years 2017 through 2020.[15]

We conducted unannounced site visits at each of the 20 nursing homes from October 2022 through January 2023. 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

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[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).

[15] Each of the 20 nursing homes had at least one deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

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 Oklahoma 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 146 deficiencies. Specifically:

- We found 98 deficiencies with life safety requirements related to building exits, fire barriers, and smoke partitions (39); fire detection and suppression systems (37); hazardous storage areas (2); smoking policies and fire drills (19); and resident call lights not working (1).

- We found 16 deficiencies with emergency preparedness requirements related to emergency preparedness plans (3); emergency supplies and power (1); plans for evacuations, sheltering in place, and tracking residents and staff during an emergency (1); emergency communications plans (5); and emergency preparedness plan training and testing (6).

- We found 32 deficiencies with infection control requirements or guidance related to IPCPs and antibiotic stewardship programs[16] (10), infection preventionists[17] (3), influenza and pneumococcal immunizations (10), COVID-19 immunizations (6), and COVID-19 testing (3).

The identified deficiencies occurred because of frequent management and staff turnover at 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 as required by CMS (i.e., every 15 months).

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 with which nursing homes must comply and references each with an identification number, known as a K-Tag (numbered K-100 through K-933).

### 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 and sounds an alarm when opened, pathways leading to exit doors that are not blocked or impeded, discharges from exits that are free from hazards, illuminated exit signs and emergency lighting that is routinely tested, and fire-stopped smoke and fire barriers (K-Tags 211, 222, 223, 271, 291I, 293, 372, 374).

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to building exits, fire barriers, and smoke partitions, totaling 39 deficiencies. Specifically, we found emergency exit doors that were inoperable and could not be opened easily or alarms that did not sound (14 nursing homes); exit doors that had blocked or impeded pathways (2 nursing homes); missing or non-illuminated exit signs and the lack of documentation for required emergency lighting testing (5 nursing homes); and missing or damaged smoke and fire barriers, including broken ceiling tiles and openings that could contribute to the spread of smoke and fire (18 nursing homes). The photographs on the next page depict some of the deficiencies we identified during our site visits.

**Photograph 1 (upper left): Opening in ceiling.**
**Photograph 2 (upper right): Missing ceiling tile.**
**Photograph 3 (bottom): Ceiling missing completely.**

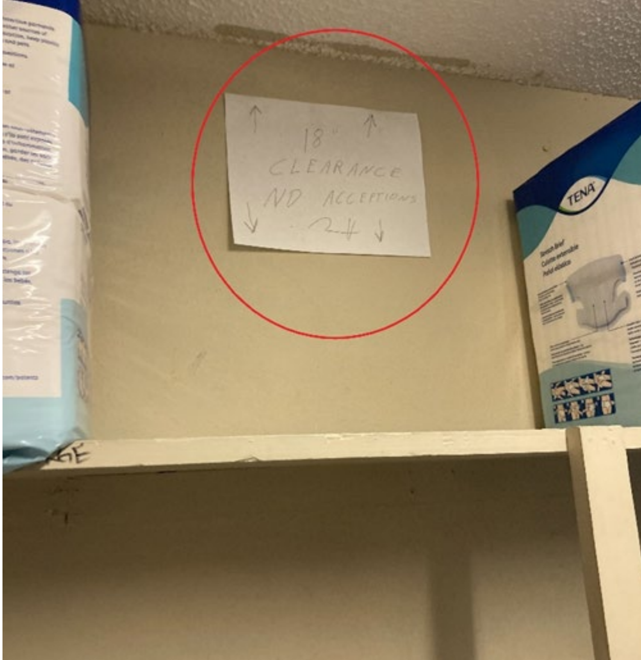
**Fire Detection and Suppression Systems**

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. Nursing homes must also have fire

watch procedures 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 (K-Tags 344, 345, 346, 351, 352, 353, 354, 355).

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to their fire detection and suppression systems, totaling 37 deficiencies. Specifically, we found one nursing home that had no documentation related to its fire alarm system and one nursing home where the fire alarm system was not routinely tested and maintained. In addition, we found deficiencies related to blocked or obstructed sprinkler heads (13 nursing homes), sprinkler systems and sprinkler heads that were not tested and maintained (12 nursing homes), and 1 nursing home that did not have a documented fire watch policy that was effective during periods when the fire alarm or sprinkler system was out of service.

In addition, we found deficiencies related to monthly portable fire extinguisher inspections (nine nursing homes). The photographs below depict some of the deficiencies we identified during our site visits.



**Photograph 4 (upper left): Boxes are too high and obstruct sprinkler.**
**Photograph 5 (upper right): Boxes are too high and obstruct sprinkler.**
**Photograph 6 (bottom): Sprinkler head improperly positioned and ceiling obstructs sprinkler.**

**Hazardous Storage Areas**

Nursing homes must install a fire barrier or an automatic fire extinguishing system with smoke-resistant partitions and self-closing doors with a ¾-hour fire rating in hazardous storage areas. 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, 923).

Of the 20 nursing homes we visited, 1 had 2 deficiencies related to hazardous storage areas. Specifically, we found the nursing home did not have policies and procedures related to its oxygen cylinders, and full and empty oxygen cylinders were stored together and not separated as required. We also found fire doors with fire ratings that could not be verified because the fire ratings were painted over and not visible.

**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).

Of the 20 nursing homes we visited, 18 had 1 or more deficiencies related to smoking policies or fire drills, totaling 19 deficiencies. Specifically, we found that 18 nursing homes were not following smoking policies (e.g., smoking in banned areas). In addition, one of those nursing homes was not conducting fire drills each calendar quarter that covered all work shifts. The photographs on the next page depict some of the deficiencies we identified during our site visits.

**Photographs 7 and 8 (left and right): Cigarette butts in trash cans with combustible materials and not in ash receptacles.**

**Resident Call Systems**

Nursing homes must be adequately equipped to allow residents to call for staff assistance through a communication system, referred to as a “call system,” which relays calls directly to a staff member or to a centralized staff work area from each resident’s bedside and toilet and bathing facilities.[18] We found one nursing home where the resident call system was inoperable due to nursing home renovations.

## 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 with which nursing homes must comply 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)

[18] 42 CFR § 483.90(g).

include a facility and community all-hazards risk assessment; (2) address emergency events and resident population needs; (3) include a continuity of operations 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 (E-Tag 0004, 0006, 0007, 0009, 0013).

Of the 20 nursing homes we visited, 3 had 1 deficiency related to their emergency plans. Specifically, we found each had emergency plans that were not updated at least annually.

**Emergency Supplies and Power**

Nursing homes' emergency preparedness plans must address emergency supplies and power, and nursing homes with generators must have them installed in a safe location and must perform weekly maintenance checks, monthly load tests, and annual fuel quality tests if fueled with diesel (E-Tag 0015, 0041).[19]

Of the 20 nursing homes we visited, 1 had a deficiency related to emergency supplies and power. Specifically, we found a generator that was not properly tested and maintained.

**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, using volunteers, and transferring residents, and procedures to provide care at alternate sites during emergencies (E-Tag 0018, 0020, 0022, 0023, 0024, 0025).

Of the 20 nursing homes we visited, 1 had a deficiency related to its emergency plan. Specifically, we found the nursing home had an emergency plan that did not address the roles of volunteers.

**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 (E-Tags 0029, 0030, and 0031).

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[19] 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.

Of the 20 nursing homes we visited, 4 had 1 or more deficiencies related to the adequacy of their emergency communications plans, totaling 5 deficiencies. Specifically, we found one nursing home that did not include required names and contact information for Federal and Ombudsman officials in its plan, and three nursing homes that did not update their plans annually.

### 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. Nursing homes must also conduct an annual community-based, full-scale testing exercise.[20] In addition, a second testing exercise (full-scale testing exercise, facility-based exercise, or "tabletop" exercise[21]) must be completed annually. An analysis of all training exercises (and actual events) must be completed and documented, and the emergency plan revised, if necessary (E-Tag 0036, 0039).

Of the 20 nursing homes we visited, 3 had 2 deficiencies related to emergency preparedness plan training, totaling 6 deficiencies. Specifically, we found six deficiencies where nursing homes did not conduct the required second training exercises and did not complete an analysis of the training exercises.

## 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 with which nursing homes must comply 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 (1) a surveillance system designed to identify possible communicable diseases or infections, (2) when and to whom possible incidents should be reported, (3) when and how to isolate individuals, and (4) the circumstances that would prohibit employees from direct contact with residents or their food. Nursing homes must also have a system for recording

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[20] 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.

[21] 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.

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 IPCPs and antibiotic stewardship program, totaling 10 deficiencies. Specifically, we found deficiencies related to IPCP policies and procedures that did not include (1) the circumstances that would prohibit employees from direct contact with residents or their food (three nursing homes), (2) when and to whom possible incidents should be reported (two nursing homes), and (3) when and how isolation should be used (one nursing home). In addition, we found deficiencies regarding the IPCP annual review: two nursing homes did not review or update their IPCPs, as required.[22]

We also found one nursing home that did not have a system for recording identified incidents and corrective actions taken. Finally, we found that one nursing home did not have an antibiotic stewardship program that included all required elements.

Before our site visits, mpox was declared a public health emergency from August 4, 2022, through January 31, 2023. We asked officials at the 20 nursing homes to determine whether 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, 5 indicated that they received or accessed guidance related to mpox, and 1 had updated its IPCP with policies and procedures related to mpox. The remaining 14 nursing homes did not receive guidance or have information about mpox in their IPCPs. None of the facilities indicated that they had experienced 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 (1) have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field; (2) be qualified by education training, experience, or certification; (3) work at least part time at the facility; and (4) 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, 3 had 1 deficiency related to infection preventionists. Specifically, the infection preventionists at two nursing homes did not regularly report to the

[22] The IPCP had not been updated since 2021.

facility's quality assessment and assurance committee on the facility's IPCP. At the third nursing home, the infection preventionist had not completed specialized training in infection prevention and control.

**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, 3 had 1 or more deficiencies related to influenza and pneumococcal immunizations, totaling 10 deficiencies. Specifically, the nursing homes lacked policies and procedures that required the facility to provide education regarding the benefits and potential side effects of influenza immunizations (three nursing homes) and pneumococcal immunizations (three nursing homes) before offering them to each resident. Additionally, the three nursing homes also had one deficiency each related to offering an influenza immunization to residents, and one of the nursing homes had an additional deficiency related to offering pneumococcal immunizations to residents.

**COVID-19 Immunizations**

Nursing homes are required to include in their IPCPs 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.[23, 24] 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, resident's representative, or staff member the opportunity to accept or refuse COVID-19 vaccination. In addition, in situations in which COVID-19 vaccination requires multiple

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[23] 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).

[24] 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 Fed. Reg. 36485 withdraws regulations pertaining to staff vaccination effective Aug. 4, 2023.

doses, the nursing home must have policies and procedures in place that provide each resident, or resident's representative, or staff member current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the vaccines, before requesting consent for administration of any additional doses (F-Tag 887, 888).

Of the 20 nursing homes we visited, 1 had 6 deficiencies related to COVID-19 vaccinations. At the time of our visit, the nursing home was in the process of completing its IPCP and had yet to include policies and procedures related to offering COVID-19 vaccinations (one deficiency). The nursing home's IPCP did not have policies and procedures that require staff and residents or residents' representatives to receive education regarding the benefits or potential side effects of COVID-19 vaccination (two deficiencies); offer residents or residents' representatives the opportunity to accept or refuse COVID-19 vaccination (one deficiency); or offer residents, residents' representatives, or staff members current information regarding additional doses—including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine—which the nursing home is required to provide before requesting consent for administration of any additional doses (one deficiency). Lastly, the medical records did not include documentation that the nursing home educated the residents or residents' representatives regarding the benefits and potential risks associated with the COVID-19 vaccine (one deficiency).

**COVID-19 Testing**

Nursing homes are required to test residents and staff, including contractors and volunteers, for COVID-19.[25] 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. When an individual has symptoms consistent with COVID-19, or tests positive for COVID-19, nursing homes are required to take actions to prevent the transmission of COVID-19. 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, 1 had 3 deficiencies related to COVID-19 testing. Specifically, the nursing home's policies and procedures did not address the actions to take to prevent the transmission of COVID-19 after the identification of a positive individual. In addition, the nursing home did not have policies and procedures for addressing individuals who refused to be tested or were unable to be tested. Finally, the nursing home did not have

[25] 88 Fed. Reg. 36485 (June 5, 2023) removed COVID-19 Testing requirements (42 CFR § 483.80(h)). While these COVID-19 testing requirements were still in place during our audit, they were no longer applicable once the public health emergency ended on May 11, 2023, and the requirements were effectively removed Aug. 4, 2023.

policies and procedures for contacting State and local health departments for testing assistance.

## CONCLUSION

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.

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 Oklahoma State 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;

- work with CMS to develop an 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 deficiencies or frequent management turnover; and

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

## STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency neither concurred or non-concurred with our recommendations but described corrective actions that it planned to take to address one of the recommendations along with other corrective actions it planned to take or was already taking to address our findings. The State agency described the challenges it has had related to conducting nursing home surveys in a timely manner, which included hiring and training qualified personnel, and addressing the increased volume of high priority nursing home complaints that required resources to be redirected for those investigations.

Regarding our first recommendation, the State agency said that it planned to conduct followup

inspections for the 20 nursing homes by September 30, 2024, to ensure the deficiencies had been corrected. The State agency did not specifically address the remaining two recommendations. To address some of our findings, the State agency has created a survey schedule, and the long-term care survey management team meets weekly to ensure that the State agency surveys all nursing home facilities no later than 15.9 months after their previous survey. The State agency also described various training plans for nursing homes and nursing home surveyors that will begin in 2024.

The State agency's comments are included in their entirety as Appendix D.

Although the State agency did not address two of our recommendations, we continue to recommend that the State agency work with CMS to (1) develop an approach to identify nursing homes where surveys should be conducted more frequently than once every 15 months and (2) develop a plan to address the foundational issues preventing more frequent surveys at nursing homes with a history of multiple deficiencies.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

As of August 2022, 296 nursing homes in Oklahoma participated in the Medicare or Medicaid programs. Of these 296 nursing homes, we selected a non-statistical sample of 20 nursing homes for our audit based on certain risk factors, including the number of deficiencies the State agency reported to CMS's ASPEN system for calendar years 2017 through 2020.[26]

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 Oklahoma from October 2022 through January 2023.

### 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 296 active nursing homes in Oklahoma 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 255 nursing homes that had 1 or more deficiencies during calendar years 2017 through 2020 and certain other risk factors;[27]

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[26] Each of the 20 nursing homes had at least 1 deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

[27] 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 and Certification Oversight Reports online reporting system (https://qcor.cms.gov/).

- selected 20 nursing homes for onsite inspections from the 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 2018 through 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.

## APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

| Report Title | Report Number | Date Issued |
|---|---|---|
| *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 and 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 | 3 | 0 | **13** |
| 2 | 5 | 0 | 0 | **5** |
| 3 | 5 | 0 | 0 | **5** |
| 4 | 4 | 2 | 0 | **6** |
| 5 | 3 | 0 | 1 | **4** |
| 6 | 4 | 4 | 1 | **9** |
| 7 | 4 | 0 | 11 | **15** |
| 8 | 6 | 2 | 0 | **8** |
| 9 | 4 | 0 | 0 | **4** |
| 10 | 5 | 0 | 0 | **5** |
| 11 | 4 | 0 | 6 | **10** |
| 12 | 4 | 0 | 0 | **4** |
| 13 | 4 | 0 | 0 | **4** |
| 14 | 6 | 0 | 0 | **6** |
| 15 | 4 | 0 | 3 | **7** |
| 16 | 2 | 0 | 0 | **2** |
| 17 | 5 | 1 | 8 | **14** |
| 18 | 5 | 0 | 0 | **5** |
| 19 | 5 | 2 | 0 | **7** |
| 20 | 9 | 2 | 2 | **13** |
| **Total** | **98** | **16** | **32** | **146** |

**Table 2: Life Safety Deficiencies**

| Nursing Home | Building Exits, Fire Barriers, and Smoke Partitions | Fire Detection and Suppression Systems | Hazardous Storage Areas | Smoking Policies and Fire Drills | Resident Call Systems | Total |
|---|---|---|---|---|---|---|
| 1 | 3 | 4 | 2 | 1 | - | **10** |
| 2 | 2 | 2 | - | 1 | - | **5** |
| 3 | 2 | 2 | - | 1 | - | **5** |
| 4 | 1 | 2 | - | 1 | - | **4** |
| 5 | - | 2 | - | 1 | - | **3** |
| 6 | 1 | 2 | - | 1 | - | **4** |
| 7 | 2 | 2 | - | - | - | **4** |
| 8 | 3 | 2 | - | 1 | - | **6** |
| 9 | 3 | - | - | 1 | - | **4** |
| 10 | 2 | 2 | - | 1 | - | **5** |
| 11 | 2 | 1 | - | 1 | - | **4** |
| 12 | 2 | 1 | - | 1 | - | **4** |
| 13 | 2 | 1 | - | 1 | - | **4** |
| 14 | 2 | 3 | - | 1 | - | **6** |
| 15 | 2 | 1 | - | 1 | - | **4** |
| 16 | 1 | 1 | - | - | - | **2** |
| 17 | 1 | 3 | - | 1 | - | **5** |
| 18 | 3 | 1 | - | 1 | - | **5** |
| 19 | 2 | 1 | - | 1 | 1 | **5** |
| 20 | 3 | 4 | - | 2 | - | **9** |
| **Total** | **39** | **37** | **2** | **19** | **1** | **98** |

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

**Table 4: Infection Control Deficiencies**

| Nursing Home | Infection Prevention, Control and Antibiotic Stewardship Programs | Infection Preventionists | Immunizations | | COVID-19 Testing | Total |
|---|---|---|---|---|---|---|
| | | | Non-COVID-19* | COVID-19 | | |
| 1 | - | - | - | - | - | **0** |
| 2 | - | - | - | - | - | **0** |
| 3 | - | - | - | - | - | **0** |
| 4 | - | - | - | - | - | **0** |
| 5 | 1 | - | - | - | - | **1** |
| 6 | 1 | - | - | - | - | **1** |
| 7 | 1 | 1 | 3 | 6 | - | **11** |
| 8 | - | - | - | - | - | **0** |
| 9 | - | - | - | - | - | **0** |
| 10 | - | - | - | - | - | **0** |
| 11 | 2 | - | 4 | - | - | **6** |
| 12 | - | - | - | - | - | **0** |
| 13 | - | - | - | - | - | **0** |
| 14 | - | - | - | - | - | **0** |
| 15 | - | - | 3 | - | - | **3** |
| 16 | - | - | - | - | - | **0** |
| 17 | 4 | 1 | - | - | 3 | **8** |
| 18 | - | - | - | - | - | **0** |
| 19 | - | - | - | - | - | **0** |
| 20 | 1 | 1 | - | - | - | **2** |
| **Total** | **10** | **3** | **10** | **6** | **3** | **32** |

***** Influenza and pneumococcal immunizations.

## APPENDIX D: STATE AGENCY COMMENTS

Dr. LaTrina Frazier
123 Robert S. Kerr Ste. 1702
Oklahoma City, OK 73102

December 6, 2023

**RE: OIG Audit of Nursing Homes**

To Office of Inspector General,

The Oklahoma State Department of Health (OSDH) State Survey Agency has completed review of the OIG audit of Nursing homes, related to life safety, emergency preparedness, and infection control, conducted at 20 nursing homes, in the state. OSDH has identified action steps and plans to ensure facilities have taken action to correct deficiencies. Please see the attached Corrective Action Plan.

Sincerely,

**LaTrina Frazier, Ph.D., MHA, RN | Deputy Commissioner**
Quality Assurance & Regulatory
Oklahoma State Department of Health
405-426-8469 I c. 405-250-2718 | f. 405-900-7559

Oklahoma State Department of Health
(405) 426 8000 · (800) 522 0203 · Oklahoma.gov/Health

OKLAHOMA
State Department
of Health

December 6, 2023

The Oklahoma State Department of Health (OSDH) takes its regulatory role seriously and recognizes the important part that is played in oversight through surveys, education, and interaction with nursing homes in the state of Oklahoma. OSDH does concur that Management and staff at nursing homes are responsible for ensuring the safety and well-being of their residents and for complying with Federal, State, and local regulations, while ensuring nursing homes are providing quality care and services to residents. We also agree that standard surveys provide relevant feedback for facilities.

OSDH does concur with difficulty completing survey workload of all nursing homes due to the suspension of all standard surveys by CMS, in March 2020 and resumption of standard surveys in August 2021. The State Survey Agency experienced a disproportionate increase in high priority complaints, which required resources to be directed towards those complaint investigations, to ensure the safety and security of residents in Oklahoma. Thereby extending the backlog. OSDH continues to see a high rate of complaints that are triaged at the IJ and Non-IJ High level, requiring an escalated focus of the surveyor staff.

Oklahoma is not alone with transition of surveyors to retirement and the inability to compete with higher wages being offered to uniquely trained and qualified surveyors. Oklahoma has had survey staff recruited by CMS contractors, CMS, and private industry. The OSDH has not seen an increase in federal funding. The Oklahoma State Department of Health took a proactive approach to improve the ability to compete for quality qualified individuals to fill surveyor vacant positions. OSDH provided 11-23% salary increases with no additional federal financial support to bolster retention and provide competitive wages. The agency has also implemented opportunities for tuition reimbursement for OSDH employees.

Oklahoma has advocated and continued to alert CMS to the difficulties identified in the delay to complete qualifying training for newly hired individuals to fill vacant Life Safety Code (LSC) surveyor positions. The CMS LSC surveyor training process did not allow seamless training for LSC surveyors, which also created an additional backlog to OSDH completing the LSC portion of standard surveys in a timelier manner. Prior to recent LSC changes, LSC trainees were not able to access QSEP training until after the NFPA exam and practicum which required a written element were scored. CMS Memo # 24-04-LSC (issued October 31,2023), has created a path to remedy the training needs for future LSC surveyors. While we are appreciative of the change, this was not the guidance while our three new LSC surveyors navigated the extensive process to become qualified. This has resulted in delays for the hired staff in Oklahoma to be deemed qualified LSC surveyors, per CMS standards.

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OSDH has continued to triage a high volume of complaints and is tracking complaints to assure complaint investigation is in alignment with triage priorities.

OSDH has created a survey schedule and the Long Term Care survey management team meets weekly to ensure that OSDH is on target for all nursing home facilities to be surveyed no later than 15.9 months after the previous standard survey, with a statewide average between standard surveys of 12.9 months.

OSDH has and will continue to distribute updates and guidance from CMS and State requirements to facilities via GovDelivery for awareness of regulatory requirements.

During the COVID-19 PHE OSDH enacted a weekly provider call that has recently been reduced to every other month, in order to provide detailed information regarding Emergency Preparedness, Infection Control and Prevention, and regulatory requirements at the federal, and state level. This call included OSDH HAI staff (for current CDC guidance discussions), QIN/QIO (for helpful strategies and connections outside of OSDH), and other collaborative partners to provide education that supported requirements.

OSDH has presented and continues to provide education to providers via Association Trade shows, where education is provided regarding top state deficiencies cited at the federal and state level for health, life safety and emergency preparedness.

OSDH will resume its statewide training seminars for nursing homes, in 2024, to provide education on the regulations and compliance.

OSDH will have training with all nursing home and life safety code surveyors to discuss findings and provide education on areas of concern.

Oklahoma will conduct follow-up inspections/surveys for the 20 facilities that were identified as being deficient with life safety, emergency preparedness and infection control requirements, by September 30, 2024, to ensure deficiencies have been corrected and each facility's compliance with requirements.

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