Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Report in Brief
Date: February 2024
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Why OIG Did This Audit

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations 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, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

Our objective was to determine whether Colorado ensured that selected nursing homes in Colorado 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 219 nursing homes in Colorado that participated in the Medicare and Medicaid programs, we selected a nonstatistical sample of 20 nursing homes for our audit based on location and certain risk factors, including multiple high-risk deficiencies that Colorado reported to CMS.

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

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

What OIG Found

Colorado could better ensure that nursing homes in Colorado that participated in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control. During our onsite visits, we identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that we audited, totaling 556 deficiencies. Specifically, we identified 165 deficiencies related to life safety requirements, 210 deficiencies related to emergency preparedness requirements, and 181 deficiencies related to infection control requirements. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes are at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of inadequate oversight by Colorado and by nursing home management, frequent management and staff turnover at the nursing homes, inadequate oversight by the State survey agency, and frequent State survey agency staff turnover. In addition, the State survey agency had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than was required by CMS. Finally, although not required by CMS, Colorado 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.

What OIG Recommends and Colorado Comments

We recommend that Colorado follow up with the 20 nursing homes reviewed in this audit to ensure that corrective actions have been taken regarding the life safety, emergency preparedness, and infection control deficiencies we identified; work with CMS to develop a risk-based approach to identify nursing homes at which surveys would be conducted more frequently, such as those with a history of multiple high-risk deficiencies or frequent management turnover; and work with CMS to develop standardized life safety training for nursing home staff.

Colorado concurred with our first recommendation and described corrective actions it would take. Colorado did not concur with our second recommendation and neither concurred nor nonconcurred with our third recommendation. We maintain that our findings and all our recommendations are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/72207009.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 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. Additionally, 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 to 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 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 Colorado, is one in a series of audits that also assesses compliance with CMS's infection control requirements.

Appendix B lists the eight previously conducted audits, the report summarizing the results of those audits, and the subsequently completed audits in this series.

OBJECTIVE

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

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

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[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 Aug. 31, 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 Aug. 31, 2023.

Infection Prevention, Control, and Immunizations Surveyor Checklist and *COVID-19 Focused Survey Checklist* (Infection Control Surveyor Checklists).[6, 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 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] 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 Colorado, the Department of Public Health and Environment (CDPHE) is the State survey agency. The State agency has entered into a series of interagency agreements (collectively referred to as "Agreement") with CDPHE, under which the latter would perform the survey and certification of nursing homes in Colorado and provide relevant data to CMS in accordance with CMS *State Operations Manual* requirements. As part of this Agreement, CDPHE is responsible for health and safety oversight in the facilities that it surveys. Thus, both the State agency and

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[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 Jan. 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, "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. In Colorado, both the State agency and CDPHE are responsible for ensuring that nursing homes comply with Federal, State, and local regulations.

CDPHE oversee nursing homes in Colorado and are responsible for ensuring that nursing homes comply with Federal, State, and local regulations. We are addressing this report and its recommendations to the State agency, as it retains overall responsibility for the administration of the Medicaid program in Colorado.

The State agency, under the provisions of the Agreement, is required to "evaluate and monitor CDPHE's compliance with the statutes, regulations, and the terms of this Agreement and to take prompt action when items of noncompliance are identified." Furthermore, in the event that the State agency determines that work is not completed according to the requirements of the Agreement, the State agency has remedies, outlined in the Agreement, that it may pursue. These remedies include development of a remediation plan, procedures for the resolution of disputes, the withholding of payment, and denial of payment. In addition, although the Agreement refers to the use of a risk-based survey schedule, it does so only in the context of Medicaid providers operating under Home and Community-Based Services waivers, which is a separate aspect of the Medicaid program and thus was not within the scope of this audit. The Agreement does not discuss the use of a risk-based survey schedule in nursing home surveys.

Between 2016 and 2019 (before the COVID-19 pandemic), the State agency's oversight did not ensure that CDPHE conducted standard surveys at least every 15 months at 12 of the 20 nursing homes we visited in Colorado. During the COVID-19 public health emergency and in response to CMS's March 2020 COVID-19 guidance, CDPHE shifted to performing infection control surveys and suspended standard surveys in nursing homes. Accordingly, between 2020 and 2022, because of the public health emergency and CMS guidance about the pause and resumption of standard surveys by State survey agencies, we did not evaluate whether CDPHE conducted standard surveys at least every 15 months. However, during our review of the 20 nursing homes in our nonstatistical sample, we noted that 3 nursing homes had not had a standard survey completed since the beginning of the public health emergency (a span of over 36 months). In addition, as of the issuance of our draft report, data retrieved from the ASPEN system showed that 38 of the 219 Medicare- and Medicaid-certified nursing homes in Colorado had not had a standard survey conducted since CDPHE resumed performing these surveys. The State agency acknowledged that CDPHE is still working to reduce this backlog that was created during the COVID-19 public health emergency. In collaboration with CMS, CDPHE has determined that appropriate timeframes for clearing the standard survey backlog included a 50 percent reduction of the backlog by the end of calendar year (CY) 2022 and another 50 percent reduction by the end of CY 2023. The State agency added that in its judgment, CDPHE is on track to meet these goals.

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

fire evacuation and disaster preparedness plans) are updated and tested regularly, and (3) IPCPs are updated as necessary.

Nursing Home Surveys During the COVID-19 Public Health Emergency

In March 2020, CMS suspended standard surveys in nursing homes to reduce surveyors' time onsite and modified deadlines for completing surveys during the COVID-19 public health emergency. Consequently, State survey agencies (including CDPHE in Colorado) 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 Colorado, 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 July 2022, 219 nursing homes in Colorado participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on location, number of deficiencies from previous surveys, and risk factors, including multiple high-risk deficiencies reported to CMS's ASPEN system by CDPHE for CYs 2016 through 2022.[15, 16]

We conducted unannounced site visits at each of the 20 nursing homes from September 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

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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] The 20 nursing homes consisted of 14 facilities with multiple high-risk deficiencies and 5 with at least 1 deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

[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.

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, in its oversight of CDPHE's performance on nursing home surveys, could better ensure that nursing homes in Colorado that participated in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control. 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 556 deficiencies. Specifically:

- We identified 165 deficiencies with life safety requirements related to building exits, fire barriers, and smoke partitions (63); fire detection and suppression systems (44); hazardous storage areas (4); smoking policies and fire drills (15); and elevator and electrical equipment testing and maintenance (39).

- We identified 210 deficiencies with emergency preparedness requirements related to emergency preparedness plans (46); emergency supplies and power (14); plans for evacuations, sheltering in place, and tracking residents and staff during an emergency (32); emergency communications plans (71); and emergency preparedness plan training and testing (47).

- We identified 181 deficiencies with infection control requirements or guidance related to IPCPs and antibiotic stewardship programs[17] (29), infection preventionists[18] (10), influenza and pneumococcal immunizations (22), COVID-19 immunizations (41), COVID-19 testing (20), COVID-19 case notifications (12), and COVID-19 reporting (47).

The identified deficiencies occurred because of inadequate oversight by the State agency and by nursing home management, frequent management and staff turnover at the nursing homes, inadequate oversight by CDPHE, and frequent State survey agency staff turnover at CDPHE. In particular, CDPHE had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than was required by CMS (i.e., every 15 months). The results of these limitations are borne out by the facts that, as stated earlier: (1) between 2016 and 2019, CDPHE did not conduct standard surveys at least every 15 months at 12 of the 20 nursing homes we visited; and (2) between 2020 and 2022,

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

[18] 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.

CDPHE followed CMS guidance to pause standard surveys during the public health emergency and, as of the issuance of our draft report, had a backlog of 38 nursing homes that had not had a standard survey conducted since the resumption of these surveys in August 2020.[19] Finally, although not required by CMS, the State agency and CDPHE do 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 of these identified deficiencies, 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 of this report, 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; illumination of means of exit including exit discharge; discharges from exits that are free from hazards; illuminated exit signs; emergency lighting of at least 1.5 hours duration; self-closing doors in exit passageways that do not require tools or keys to open (unless the doors use one of the approved special locking arrangements and are not manually propped open); fire-stopped smoke and fire barriers; and delayed exit locking systems installed on door assemblies in buildings that are protected throughout by approved and supervised automatic fire detection or sprinkler systems that automatically release the doors when activated (K-Tags 211, 221–224, 241, 252, 254, 271, 281, 291–293, 381).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to building exits, fire barriers, and smoke partitions, totaling 63 deficiencies. Specifically, we found deficiencies related to exits that were not free of obstructions or impediments (two nursing homes), exit discharge lights that could not maintain a continuous operation or that were incapable of automatic operation (one nursing home), discharge from exits that were not free of obstructions (two nursing homes), and exit signs that could not maintain a continuous illumination (one nursing home). Additionally, we found deficiencies related to emergency lighting that failed to maintain a minimum of 1.5 hours of continuous operation or for which documentation that annual testing had been completed was missing (10 nursing homes). Moreover, we found deficiencies involving doors with self-closing devices that either did not close completely, were manually propped open by facility staff, or that had the self-closing

[19] Two of the 20 nursing homes we visited were among the 38 nursing homes in CDPHE's backlog.

device disconnected (eight nursing homes); smoke barrier doors that did not close completely or had gaps between the doors when closed (seven nursing homes); and patient sleeping room doors that would not open or close properly (five nursing homes). Finally, we found deficiencies related to penetrations in smoke or fire barriers, including gaps because of misaligned patient sleeping room doors, missing or unserviceable seals around patient sleeping room doors, missing sealant around pipes, and missing ceiling tiles (17 nursing homes), and delayed exit doors that would not release or sound an alarm as required when tested (10 nursing homes). The photographs below depict some of the deficiencies we identified during our site visits.

Photograph 1 (left): Missing ceiling tiles.
Photograph 2 (center): Path of exit blocked.
Photograph 3 (right): Padlock on patient room door.

Photograph 4 (left): Non-functioning emergency light.
Photograph 5 (center): Key, used to unlock gate in path of exit, missing from its lockbox.
Photograph 6 (right): Hole in ceiling and wall at fire alarm control panel.

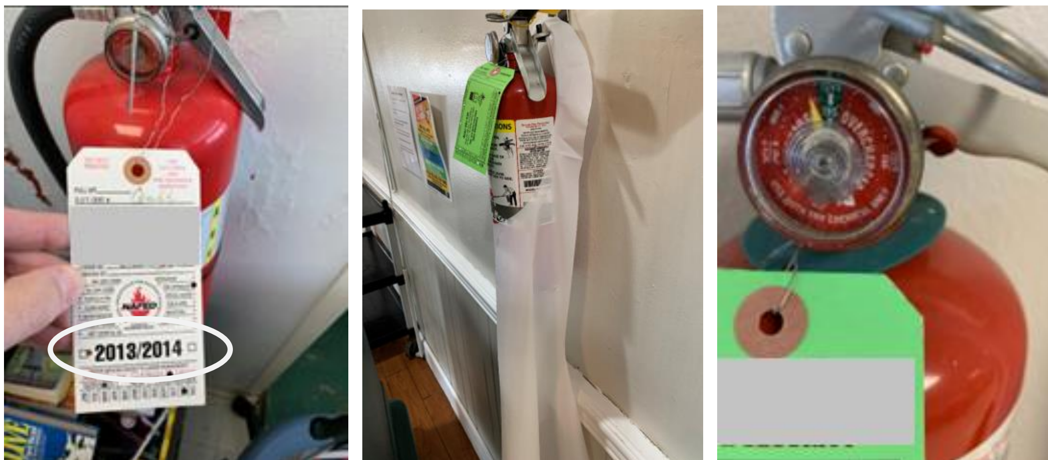
Fire Detection and Suppression Systems

Each nursing home is required to have a fire alarm system that has a functioning backup power supply and that 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 the facility. Cooking equipment and its related fire suppression systems must be inspected and 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 periods 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.[20] Smoke detectors are required in spaces open to corridors and other areas (K-Tags 324, 325, 341, 342, 344–347, 351–355, 421, 525).

Of the 20 nursing homes we visited, 15 had 1 or more deficiencies related to their fire detection and suppression systems, totaling 44 deficiencies. Specifically, we found inadequate fire alarm system maintenance and testing activities (seven nursing homes) and inadequate sprinkler system maintenance and testing activities because inspections either were not completed or were missing documentation (seven nursing homes). We also found deficiencies involving a fire alarm system's initiation functions (one nursing home) and control functions (one nursing home). Furthermore, there were deficiencies related to sprinkler system supervisory signals (which are signals that sound and are displayed at a continuously attended location or at an approved remote facility) (two nursing homes). Finally, we identified deficiencies involving cooking facilities that had not been inspected, that had not had repairs made, or that were missing documentation of inspections (six nursing homes); documentation of sprinkler systems' out-of-service policies that did not include necessary requirements (six nursing homes); documentation of fire alarm out-of-service policies that did not include necessary requirements (six nursing homes); and portable fire extinguishers that were undercharged, were outdated, or lacked completion of their monthly serviceability checks (eight nursing homes). The photographs on the following page depict some of the deficiencies we identified during our site visits.

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

Photographs 7 (left): Stove, which is accessible to residents, covered in flammable items and therefore not properly maintained or inspected.
Photographs 8 (right): Power switch safety box (for stove in Photograph 7), which is accessible to residents, with lock that had been cut and therefore not properly maintained or repaired.



Photograph 9 (left): Fire extinguisher out of date.
Photograph 10 (center): Fire extinguisher used as clothes hanger.
Photograph 11 (right): Undercharged fire extinguisher.

Hazardous Storage Areas

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, 322, 541, 754, 905, 908, 923).

Of the 20 nursing homes we visited, 4 nursing homes each had 1 deficiency related to placement of oxygen cylinders in hazardous storage areas. These deficiencies involved unsafe

storage, improper signage, and lack of segregation of full and empty cylinders. The photographs below depict some of the deficiencies we identified during our site visits.

Photograph 12 (left): Improperly stored oxygen cylinders (in washroom).
Photograph 13 (center): Improperly stored oxygen cylinders (in hallway).

Smoking Policies and Fire Drills

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

Of the 20 nursing homes we visited, 13 had 1 or more deficiencies related to smoking policies or fire drills, totaling 15 deficiencies. Specifically, we found nursing homes whose fire drills covering all work shifts were not conducted each calendar quarter or that did not maintain complete documentation of those fire drills (13 nursing homes), and nursing homes where individuals were smoking in non-designated areas (2 nursing homes). The photographs on the following page depict some of the deficiencies we identified during our site visits.

Photograph 14 (left): Improper disposal of smoking materials in trash container with combustible materials.
Photograph 15 (center): Improper disposal of smoking materials because they were combined with combustible material in the same container.
Photograph 16 (right): Improper disposal of smoking materials because they were combined with combustible material in a container that lacked a self-closing lid.

Elevator and Electrical Equipment Testing and Maintenance

Nursing home elevators must be tested and maintained on a regular basis, with a written record of the findings created and kept on the premises. Nursing homes must also keep a record of tests and repairs of other electrical equipment, such as patient beds, lifts, and electrical receptacles. Electrical equipment instructions and maintenance manuals are to be readily available, and safety labels and condensed operating instructions on the appliance must be legible. Power strips, extension cords, and portable space heaters must meet Underwriters Laboratories (UL) requirements and be used in a safe manner (e.g., extension cords are not used as a substitute for fixed wiring of a structure) (K-Tags 531, 781, 914, 920, 921).

Of the 20 nursing homes we visited, 16 had 1 or more deficiencies related to elevator or electrical equipment testing and maintenance, totaling 39 deficiencies. Specifically, we found nursing homes with inadequate documentation of elevator testing or maintenance, which included failure to retain detailed testing reports from the elevator maintenance company (six nursing homes). In addition, we found nursing homes that failed to maintain records of testing and repairs of patient beds and lifts and that failed to maintain documentation of the inspection and maintenance of electrical receptacles at patient bed locations (nine nursing homes). Furthermore, we found deficiencies involving electrical equipment testing and maintenance requirements, which include electrical equipment instructions and maintenance manuals that were not readily available (eight nursing homes). Finally, we found nursing homes with unsafe connections of appliances to power strips and extension cords that did not meet UL

requirements instead of to fixed wiring (16 nursing homes). The photographs below depict some of the deficiencies we identified during our site visits.

Photograph 17 (left): Kitchen refrigerator plugged into extension cord.
Photograph 18 (center): Oxygen concentrator plugged into extension cord.
Photograph 19 (right): Portable air conditioner and radiant heater plugged into power strip that did not comply with UL requirements.

Life Safety Training for Nursing Home Management and Staff

Under Section 1864 Agreements with CMS, State agencies agree to perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS's *State Operations Manual* § 1010). CMS has a publicly accessible online learning portal related to such life safety training.[21] Both CMS and State agency surveyors are required to receive standardized life safety training such as the training available through CMS's online learning portal.[22] 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. Additionally, neither CMS nor the State agency requires 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 turnover in nursing home management and staff. These factors

[21] Learning portal available online at https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLSCPR_WBT. Accessed on Aug. 31, 2023.

[22] 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 (HHS) (the Act §§ 1819(g)(2)(E)(iii) and 1919(g)(2)(E)(iii)).

when combined 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 of this report, 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) include a facility and community all-hazards risk assessment; (2) address emergency events and resident population needs and the types of services available during emergencies; (3) include a continuity of operations plan, delegation of authority plan, and 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 (affiliated group) 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 affiliated group's unified and integrated emergency preparedness program and actively participate in the development of the group's emergency preparedness plan (E-Tags 0001, 0004, 0006, 0007, 0009, 0013, 0042).

Of the 20 nursing homes we visited, 16 had 1 or more deficiencies related to their emergency preparedness plans, totaling 46 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that the nursing homes had not coordinated with relevant government emergency management officials (12 nursing homes), risk assessments that did not identify facility and community hazards (3 nursing homes), and risk assessments that identified the types of emergency events that could occur but that did not provide any detail about responses to those events (6 nursing homes). Additionally, we found instances in which the continuity of operations plan, delegation of authority plan, or succession plan was missing or incomplete (four nursing homes); and emergency preparedness plans that did not address resident population needs and the types of services available during emergencies (four nursing homes). Furthermore, we found deficiencies related to nursing homes that were part of affiliated groups that lacked unified emergency preparedness programs or a separate facility-based risk assessment for each individual nursing home (11 nursing homes). Finally, we found nursing homes that did not update their emergency plans annually (six nursing homes).

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.[23] 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). Nursing homes with generators must have them installed in a safe location and are required to perform weekly maintenance checks, monthly load tests, and annual fuel quality tests if fueled with diesel.[24] Nursing homes should also have a plan to keep generators fueled "as necessary" and an evacuation plan if emergency power is lost (E-Tags 0015, 0041).

Of the 20 nursing homes we visited, 8 had 1 or more deficiencies related to emergency supplies and power, totaling 14 deficiencies. Specifically, we found nursing homes with deficiencies related to insufficient emergency food, water supplies, or both (six nursing homes). In addition, we found nursing homes with deficiencies involving the lack of a policy or plan for alternate energy sources (i.e., generators) (three nursing homes). Furthermore, we found deficiencies related to generators and their transfer switches that lacked documentation showing that they had been properly tested, maintained, and inspected (four nursing homes) as well as generators that were not installed in a safe location (e.g., an area not susceptible to flooding) (one nursing home).[25]

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

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

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[23] 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.

[24] 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.

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

Of the 20 nursing homes we visited, 13 had 1 or more deficiencies related to their emergency preparedness plans for evacuations, sheltering in place, and tracking residents and staff during and after emergencies, totaling 32 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that did not address the facility's volunteer plan (eight nursing homes), sheltering in place (seven nursing homes), and tracking residents and staff (five nursing homes). We also found deficiencies related to a method for transferring medical records (four nursing homes), the role of a nursing home under an 1135 waiver to provide care at an alternate site in an emergency (three nursing homes),[26] and evacuation plans (three nursing homes). Finally, we identified deficiencies involving the nursing homes' coordination plans with other nursing homes to transfer residents during an emergency (two nursing homes).

Emergency Communications Plans

Nursing homes are required to have an emergency communications plan that includes names and contact information for staff, entities providing services, residents' physicians, other nearby nursing homes, volunteers, government emergency management offices, and the State survey agency (CDPHE in Colorado), among others. The emergency communications plan must be updated at least annually. Nursing homes are also required to have primary and alternate means of communication (e.g., landline and backup cell phones), a means to communicate residents' condition information and location in the event of an evacuation, a means to provide information about the facility to emergency management officials, and methods to share emergency preparedness plan information with residents and their families (E-Tags 0029–0035).

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to the adequacy of their emergency communications plans, totaling 71 deficiencies. Specifically, we found deficiencies related to emergency communications plans that did not include required names and contact information for: staff, entities providing services, residents' physicians, other nearby nursing homes, and volunteers (12 nursing homes); and government emergency management offices, the State Ombudsman, and the State survey agency (i.e., CDPHE in Colorado) (14 nursing homes). Furthermore, we found deficiencies related to emergency communications plans that were not updated annually (seven nursing homes) and emergency communications plans that did not document alternate means of communication (five nursing homes). We also found deficiencies related to nursing homes that did not have procedures for sharing emergency preparedness plan information with residents and their families (13 nursing homes) and nursing homes that lacked a method for sharing information and medical documentation with other health care providers in the event of an evacuation to maintain continuity of care (8 nursing homes). We also identified deficiencies related to nursing homes that did not have a means to provide information about the facility to emergency management

[26] As provided by section 1135 of the Act, an 1135 waiver can go into effect when the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Secretary of HHS declares a public health emergency under Section 319 of the Public Health Service Act. In these circumstances, the Secretary of HHS is authorized to take certain actions in addition to their regular authorities.

officials (10 nursing homes) and nursing homes that did not have an emergency communications plan (2 nursing homes).

Emergency Preparedness Plan Training and Testing

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

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to emergency preparedness plan training, totaling 47 deficiencies. Specifically, we found deficiencies related to nursing homes that did not: establish a training and testing program (one nursing home), update their training plan annually (five nursing homes), conduct the initial training of all of their staff (four nursing homes), or conduct their annual training (three nursing homes). Furthermore, we found deficiencies involving nursing homes that did not document: their annual community-based full-scale testing exercise (13 nursing homes); a second annual training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise) (9 nursing homes); or an analysis of their training exercises (12 nursing homes).

SELECTED NURSING HOMES DID NOT COMPLY WITH INFECTION CONTROL REQUIREMENTS

CMS's Infection Control Surveyor Checklists, described on page 2 of this report, 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,

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

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

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

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to their IPCPs and antibiotic stewardship programs, totaling 29 deficiencies. Specifically, for 9 of the 10 nursing homes, we found deficiencies related to IPCP policies and procedures that did not include Information on: the circumstances that would prohibit employees from direct contact with residents or their food (4 nursing homes), when and to whom possible incidents should be reported (3 nursing homes), and when and how isolation should be used (1 nursing home). Additionally, we identified deficiencies with nursing homes' systems for identifying, reporting, investigating, and controlling infections and communicable diseases (one nursing home); and with inadequate documentation of annual reviews of nursing homes' IPCPs (because the documentation did not support that the nursing homes had conducted these annual reviews) (eight nursing homes).

Moreover, the remaining nursing home (of the 10) had deficiencies in every category of infection control requirements that we tested, which totaled 12 out of the 29 IPCP-related deficiencies we identified at the 20 sampled nursing homes. This nursing home lacked a viable infection control plan. When we asked for the plan, staff at this nursing home gave us a printed copy of an example infection control plan that did not contain any details and did not include any information specific to that nursing home.

Infection Preventionists

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

Of the 20 nursing homes we visited, 4 had 1 or more deficiencies related to infection preventionists, totaling 10 deficiencies. Specifically, we found deficiencies related to infection preventionists who had not completed specialized training in infection prevention and control (one nursing home) and infection preventionists who were not in attendance at the facility's most recent quality assessment and assurance committee meetings and therefore did not

regularly report on the facility's IPCP (one nursing home). Furthermore, some nursing homes lacked documentation that designated an individual as an infection preventionist (one nursing home) and lacked documentation of completed infection preventionist training, experience, or certification (one nursing home).

The deficiencies described just above involved three of the four nursing homes. The remaining six deficiencies were related to the nursing home that did not have a viable infection control plan.

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 a nursing home offers 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, 6 had 1 or more deficiencies related to medical record documentation of influenza and pneumococcal immunizations, totaling 22 deficiencies. Specifically, with respect to these immunizations, for five of the six nursing homes, we found deficiencies related to medical records that lacked documentation that: each resident had been offered the influenza immunization (one nursing home), each resident had been given the opportunity to refuse the influenza immunization (one nursing home), each resident was provided relevant education for the influenza immunization (two nursing homes), each resident had been given the opportunity to refuse the pneumococcal immunization (one nursing home), and each resident was provided relevant education for the pneumococcal immunization (four nursing homes). We also identified deficiencies involving medical records that lacked documentation that a resident either did or did not receive an influenza or pneumococcal immunization (two nursing homes).

The remaining 11 deficiencies were related to the nursing home that did not have a viable infection control plan.

COVID-19 Immunizations

Nursing homes are required to develop policies and procedures to ensure that each resident and staff member is offered COVID-19 vaccination (unless the immunization is medically contraindicated or the resident or staff member has already been immunized) and that staff

(except exempt staff) are fully vaccinated for COVID-19.[29, 30, 31] These policies and procedures must also ensure that, before a nursing home offers the immunizations, all staff and each resident or resident's representative receives education regarding the benefits and potential side effects of COVID-19 vaccination, and the facility documents this education and the immunization status of staff and residents. The policies and procedures must also: provide each resident or resident's representative the opportunity to accept or refuse COVID-19 vaccination, describe a process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, and include contingency plans for staff who are not fully vaccinated for COVID-19 (F-Tags 887, 888).

Of the 20 nursing homes we visited, 6 had 1 or more deficiencies related to COVID-19 immunizations, totaling 41 deficiencies. These deficiencies were related to the lack of required elements in nursing homes' COVID-19 immunization policies and procedures. Specifically, the nursing homes' policies and procedures for five of the six nursing homes did not:

- require residents, residents' representatives, or staff to be provided education on additional doses of the COVID-19 vaccine (one nursing home);
- require all residents or residents' representatives to be provided with vaccine education (one nursing home);
- state that residents or residents' representatives can accept or refuse COVID-19 vaccination (one nursing home);
- require documentation that residents or residents' representatives received education on the COVID-19 vaccine (one nursing home);
- require all staff to be provided with vaccine education (one nursing home);
- require the nursing home to document that staff members were provided education on the COVID-19 vaccine (two nursing homes);
- apply to students, trainees, and volunteers (two nursing homes);

[29] 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 multi-dose vaccine).

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

[31] The final rule published in 88 Fed. Reg. 36485 withdraws regulations pertaining to staff vaccination, effective Aug. 4, 2023.

- require the nursing home to develop and implement a process to track and document the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed (one nursing home); or

- include contingency plans for staff who are not fully vaccinated for COVID-19 (two nursing homes).

The remaining 29 deficiencies were related to the nursing home that did not have a viable infection control plan.

COVID-19 Testing

Nursing homes are required to test residents and staff, including contractors and volunteers, for COVID-19.[32] 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, identification of any individual diagnosed with COVID-19 in the facility, identification of any individual with symptoms of or with known or suspected exposure to COVID-19, criteria for testing asymptomatic individuals, response time for tests, and other factors specified by the Secretary. 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 who are unable to be tested and for contacting State and local health departments to request assistance in testing efforts when necessary (F-Tag 886).

Of the 20 nursing homes we visited, 6 had 1 or more deficiencies related to COVID-19 testing, totaling 20 deficiencies. Specifically, for five of the six nursing homes, we found deficiencies related to nursing homes' policies and procedures that did not:

- require the identification of any individual diagnosed with COVID-19 in the facility (one nursing home);

- require the identification of any individual with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19 (one nursing home);

- specify the criteria for conducting testing of asymptomatic individuals, such as the positivity rate of COVID-19 in a county (one nursing home);

- require the identification of other factors that help identify and prevent the transmission of COVID-19 (one nursing home);

[32] 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.

- require procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested (one nursing home); or

- require, when necessary, the nursing home to contact State and local health departments to request assistance in testing efforts (two nursing homes).

The remaining 13 deficiencies were related to the nursing home that did not have a viable infection control plan.

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 the identification of three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. This information must not include personally identifiable information. Notifications must include information on mitigating actions implemented to reduce the risk of transmission and must provide cumulative updates for residents, their representatives, and their families at least weekly or by 5 p.m. the next calendar day of a subsequent occurrence of either of the two previously mentioned circumstances (F-Tag 885).

Of the 20 nursing homes we visited, 5 had 1 or more deficiencies related to COVID-19 case notifications, totaling 12 deficiencies. Specifically, for four of the five nursing homes, we identified nursing homes whose policies and procedures did not: specify that COVID-19 case notifications should not include personally identifiable information (three nursing homes); or include information on mitigating actions to prevent or reduce risk of transmission, including information on whether normal operations of the facility will be altered in the event of a confirmed infection or onset of respiratory symptoms by three or more residents or staff within 72 hours of each other (four nursing homes). Moreover, we identified nursing homes whose policies and procedures did not include directions to provide any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the occurrence of either a confirmed infection or onset of respiratory symptoms by three or more residents or staff within 72 hours of each other (two nursing homes).

The remaining three deficiencies were related to the nursing home that did not have a viable infection control plan.

COVID-19 Reporting

On May 8, 2020, CMS published an interim final rule that described requirements for CMS-certified nursing homes to report to the National Healthcare Safety Network (NHSN) for both residents and staff, on a weekly basis, suspected and confirmed COVID-19 infections, total deaths, and COVID-19 deaths. In addition, nursing homes are also required to report information about personal protective equipment, hand hygiene supplies, and ventilator

capacity and related supplies in the facility; resident beds and census; and information on access to COVID-19 testing while residents are in the facility as well as staffing shortages.[33, 34] Furthermore, on May 13, 2021, CMS published an additional interim final rule including new requirements for reporting COVID-19 vaccination data, as well as therapeutics treatment information for residents (F-Tag 884).[35]

Of the 20 nursing homes we visited, 6 had one or more deficiencies related to COVID-19 reporting, totaling 47 deficiencies. Specifically, five of the six nursing homes were required to report, but did not report, the following:

- suspected and confirmed COVID-19 infections among residents and staff (three nursing homes);
- total deaths and COVID-19 deaths among residents and staff (three nursing homes);
- amount of personal protective equipment and hand hygiene supplies in the facility (three nursing homes);
- status of ventilator capacity and related supplies in the facility (four nursing homes);
- number of resident beds and census (three nursing homes);
- access to COVID-19 testing while the resident is in the facility (three nursing homes);
- information on any staffing shortages (four nursing homes);
- the COVID-19 vaccination status of residents and staff, including total numbers of residents and staff, number of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, and any COVID-19 vaccination-related adverse events (four nursing homes); or
- type and amount of therapeutics administered to residents for treatment of COVID-19 (four nursing homes).

In addition, some nursing homes did not provide the information specified above on at least a weekly basis to the NHSN (two nursing homes).

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[33] 85 Fed. Reg. 27550 (May 8, 2020).

[34] The Centers for Disease Control and Prevention's NHSN is the Nation's most widely used health care-associated infection tracking system. NHSN provides facilities, States, regions, and the Nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care-associated infections.

[35] 86 Fed. Reg. 26306 (May 13, 2021).

The remaining 14 deficiencies were related to the nursing home that did not have a viable infection control plan.

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 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 Colorado Department of Health Care Policy & Financing:

- 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 a risk-based approach to identify nursing homes at which surveys would be conducted more frequently than once every 15 months, such as those with a history of multiple high-risk deficiencies or frequent management turnover; and

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first recommendation, did not concur with our second recommendation, and neither concurred nor nonconcurred with our third recommendation. For our first recommendation, the State agency said that it had already initiated a plan to follow up with each nursing home, including in-person visits and targeted reviews, to ensure that corrective actions have been taken for the deficiencies that our audit identified. Specifically, the State agency stated that "[a]ll facilities will be revisited on or prior to their next survey depending on the severity and volume of deficiencies identified."

The State agency explained its nonconcurrence with our second recommendation by stating that it and CDPHE conduct recertification surveys "at a frequency that is established by Federal law and regulation." The State agency added that oversight already includes surveys that occur more frequently than 15 months as directed by CMS. These types of surveys include revisit

surveys, complaint-based surveys, targeted infection controls surveys, and additional surveys for special focus facilities. Furthermore, the State agency said that if the OIG has data that suggest a more optimal standard survey cadence, the State agency would encourage OIG to share these data with its colleagues at CMS to update the Federal regulations that govern nursing facilities.

The State agency also noted that OIG has made this recommendation in all States chosen for this or similar audits in recent years, and added that this recommendation is "outside the scope and authority of any individual [S]tate agency and contradicts existing Federal guidance that originates from the Department of Health and Human Services."

With respect to our third recommendation, the State agency said that it and CDPHE are supportive of expanded training opportunities regarding life safety for nursing home staff. The State agency added that it could commit to evaluating opportunities for developing training related to life safety in nursing homes and also stated that it would promote training required or developed by CMS. The State agency commented, though, that "there is no such Federal requirement for standardized training related to Federal life safety regulatory compliance." As with our second recommendation, the State agency noted that OIG has made this third recommendation in all States chosen for this or similar audits in recent years; accordingly, the State agency encouraged OIG to engage with CMS "to review the need for enhanced Federal requirements in this area."

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings, conclusions, and recommendations are valid. We are pleased that the State agency concurred with our first recommendation and said that it had initiated a plan to follow up with the 20 nursing homes that we visited.

Regarding our second recommendation, we maintain that the State agency should work with CMS to develop a risk-based approach to conduct surveys at some facilities more frequently. Rather than recommending a one-size-fits-all standard survey frequency or cadence, our recommendation is meant to have the State agency work with CMS to determine how best to use its limited resources on more frequent standard surveys of nursing facilities that are more likely to have compliance issues. Although survey frequency is, as the State agency mentioned, set by Federal law, this frequency speaks to the maximum amount of time between surveys and requires nursing homes to be surveyed no later than 15 months after the end of the previous standard survey. Nothing prevents the State agency from conducting these surveys more frequently. In fact, Federal criteria at 42 CFR § 488.308(c) allow a survey agency to conduct a survey as frequently as necessary to: (1) determine whether a facility complies with the participation requirements and (2) confirm that the facility has corrected deficiencies previously cited.

Additionally, the CMS *State Operations Manual*, chapter 7, section 7205.2, states: "There is no required minimum time which must elapse between surveys." This document then gives examples of changes that may prompt surveys, such as change of ownership, management firm, administrator, and Director of Nursing, and adds that facilities with a poor history of compliance may be surveyed more frequently. During our site visits, we noted the high turnover rates of administrators, Directors of Nursing, and maintenance directors in many of the nursing homes. Furthermore, Colorado ranked near the top of States nationwide for nursing homes in terms of the average turnover of total nursing staff, Registered Nurses, and administrators.[36] The findings detailed in our report show that nursing homes in Colorado, as well as their residents, could benefit from more frequent surveys. We reiterate the importance of the State agency working with CMS to develop a risk-based approach to identify nursing homes for more frequent surveys. In this context, we disagree with the State agency's statement that coordination with CMS, in the manner suggested in our second recommendation, would be "outside the scope and authority of any individual [S]tate agency."

With respect to our third recommendation, we are pleased that the State agency and CDPHE are supportive of expanding and evaluating opportunities regarding training related to life safety in nursing homes. We believe that more frequent and standardized training would generally result in fewer high-risk deficiencies and would, more importantly, reduce risks to the health and safety of nursing home residents. Absent a standardized training program that includes a provision for mandatory participation, nursing home management and staff may be unaware of critical life safety requirements.

[36] Data downloaded from https://Data.CMS.gov/provider-data/. This website gives direct access to public data released by CMS. We selected the provider type "Nursing Homes including rehab services," which allows a user to find and download quality-of-care data on every Medicare- and Medicaid-certified nursing home in the country, including over 15,000 nationwide. We then selected the dataset "State U.S. Averages," which lists a variety of averages for each State or Territory as well as the national average, including each quality measure, staffing data, amounts of fines levied, and numbers of deficiencies. Each row displays a specific State or Territory, the associated quality measure, and the average. We reviewed the data sets from July 2022, January 2023, July 2023, and November 2023.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of July 2022, 219 nursing homes in Colorado participated in the Medicare or Medicaid programs. Of these 219 nursing homes, we selected a nonstatistical sample of 20 nursing homes for our audit based on location, numbers of deficiencies from previous surveys, and risk factors, including multiple high-risk deficiencies that the State agency reported to CMS's ASPEN system for CYs 2016 through 2022.[37, 38]

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 Colorado from September through November 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

- held discussions with State agency and CDPHE officials to gain an understanding of the process for conducting nursing home life safety, emergency preparedness, and infection control surveys;

- obtained from CMS's ASPEN system a list of all 219 active nursing homes in Colorado that participated in the Medicare program, the Medicaid program, or both as of July 2022;

- compared the nursing home list from CMS's ASPEN system with the State agency's directory of nursing homes to verify completeness and accuracy;

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[37] The 20 nursing homes consisted of 14 facilities with multiple high-risk deficiencies and 5 facilities with at least 1 deficiency related to sprinkler or fire system maintenance, building exits, or infection prevention and control.

[38] 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.

- obtained from CMS's ASPEN system a list of 219 nursing homes that had 1 or more deficiencies during CYs 2016 through 2022;[39]

- selected 20 nursing homes for onsite inspections from the 219 nursing homes identified in ASPEN and, for each of the 20 nursing homes:

    - reviewed deficiency reports prepared by CDPHE for the nursing home's 2016 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 and the State agency.

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.

[39] 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 Aug. 31, 2023.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Oklahoma Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-06-22-09007	1/4/2024
Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-05-22-00019	12/20/2023
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

Report Title	Report Number	Date Issued
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	11	10	4	**25**
2	10	-	-	**10**
3	9	8	1	**18**
4	10	12	4	**26**
5	8	5	1	**14**
6	16	6	88	**110**
7	10	19	-	**29**
8	-	4	-	**4**
9	12	26	1	**39**
10	4	3	1	**8**
11	9	10	5	**24**
12	8	16	30	**54**
13	14	21	-	**35**
14	-	11	5	**16**
15	1	2	-	**3**
16	7	7	9	**23**
17	9	15	15	**39**
18	10	10	3	**23**
19	3	13	7	**23**
20	14	12	7	**33**
Total	**165**	**210**	**181**	**556**

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	Elevator and Electrical Equipment Testing and Maintenance	Total
1	3	4	-	2	2	**11**
2	6	2	1	-	1	**10**
3	3	3	1	1	1	**9**
4	6	2	1	-	1	**10**
5	3	2	-	1	2	**8**
6	5	7	-	1	3	**16**
7	2	3	-	1	4	**10**
8	-	-	-	-	-	-
9	5	2	-	1	4	**12**
10	3	-	-	-	1	**4**
11	4	1	-	1	3	**9**
12	2	3	-	1	2	**8**
13	5	5	-	1	3	**14**
14	-	-	-	-	-	-
15	-	1	-	-	-	**1**
16	3	-	1	1	2	**7**
17	3	2	-	1	3	**9**
18	2	3	-	1	4	**10**
19	3	-	-	-	-	**3**
20	5	4	-	2	3	**14**
Total	**63**	**44**	**4**	**15**	**39**	**165**

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	4	**10**
2	-	-	-	-	-	-
3	4	-	1	2	1	**8**
4	3	-	2	3	4	**12**
5	1	-	-	2	2	**5**
6	1	-	-	4	1	**6**
7	4	-	3	6	6	**19**
8	-	-	-	4	-	**4**
9	5	1	7	8	5	**26**
10	-	-	-	2	1	**3**
11	2	2	1	4	1	**10**
12	2	4	3	4	3	**16**
13	5	2	4	7	3	**21**
14	4	-	1	3	3	**11**
15	-	-	-	2	-	**2**
16	4	-	-	1	2	**7**
17	3	2	2	6	2	**15**
18	2	1	2	3	2	**10**
19	3	1	3	3	3	**13**
20	2	1	1	4	4	**12**
Total	**46**	**14**	**32**	**71**	**47**	**210**

Table 4: Infection Control Deficiencies

Nursing Home	Infection Prevention, Control and Antibiotic Stewardship Programs	Infection Preventionists	Immunizations		COVID-19 Testing	COVID-19 Case Notifications	COVID-19 Reporting	Total
			Non-COVID-19*	COVID-19				
1	4	-	-	-	-	-	-	**4**
2	-	-	-	-	-	-	-	-
3	1	-	-	-	-	-	-	**1**
4	-	-	-	-	2	-	2	**4**
5	1	-	-	-	-	-	-	**1**
6	12	6	11	29	13	3	14	**88**
7	-	-	-	-	-	-	-	-
8	-	-	-	-	-	-	-	-
9	1	-	-	-	-	-	-	**1**
10	-	-	-	1	-	-	-	**1**
11	2	1	-	1	1	-	-	**5**
12	4	2	3	7	1	3	10	**30**
13	-	-	-	-	-	-	-	-
14	-	-	2	2	1	-	-	**5**
15	-	-	-	-	-	-	-	-
16	-	-	-	-	-	-	9	**9**
17	1	-	-	1	-	3	10	**15**
18	1	-	2	-	-	-	-	**3**
19	-	1	2	-	-	2	2	**7**
20	2	-	2	-	2	1	-	**7**
Total	**29**	**10**	**22**	**41**	**20**	**12**	**47**	**181**

* Influenza and pneumococcal immunizations.

COLORADO
Department of Health Care Policy & Financing

303 E. 17th Avenue
Denver, CO 80203

November 28, 2023

James I. Korn
Regional Inspector General for Audit Services
601 E. 12th St., Room 0429
Kansas City, MO 64106

RE: Report Number A-07-22-07009

Dear Mr. Korn,

The Colorado Department of Health Care Policy and Financing (HCPF) has reviewed audit A-07-22-07009 and the associated recommendations. The report concluded that Colorado could better ensure that nursing homes comply with Federal requirements and offered 3 recommendations. Below we offer our response to the auditor's specific recommendations.

Recommendation 1:

- 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.

HCPF Response: Concur

- Agree. The Colorado Department of Public Health and the Environment (CDPHE) has already initiated a plan to follow-up with each facility including in person visits and targeted reviews at standard surveys to ensure that corrective action has been taken for the deficiencies identified in the audit. All facilities will be revisited on or prior to their next survey depending on the severity and volume of deficiencies identified.

Recommendation 2:

- Work with CMS to develop a risk-based approach to identify nursing homes at which surveys would be conducted more frequently than once every 15 months, such as those with a history of multiple high-risk deficiencies or frequent management turnover.

HCPF Response: Does not concur

- HCPF and CDPHE conduct recertification surveys at a frequency that is established by Federal law and regulation. Oversight already includes surveys that occur more frequently than 15 months as directed by CMS such as revisit surveys, complaint-based surveys, targeted infection control surveys and additional surveys for special focus facilities. HCPF also notes this recommendation has been made in all the states chosen for this or similar audits in recent years. Should the auditor have data that suggests a more optimal standard survey cadence, we would

encourage them to share this with their colleagues at CMS to update the Federal regulations that govern nursing facilities. As is, this recommendation is outside the scope and authority of any individual state agency and contradicts existing Federal guidance that originates from the Department of Health and Human Services.

Recommendation 3:

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

HCPF Response: Neither concurrence nor non-concurrence

- HCPF and CDPHE are supportive of expanded training opportunities regarding life safety for nursing home staff and can commit to evaluating opportunities for developing training related to life safety in nursing homes. We would promote any Federal training required or developed by CMS; however, there is no such Federal requirement for standardized training related to Federal life safety regulatory compliance. As this recommendation has been made in all the states chosen for this or similar audits in recent years, we would again encourage the auditor to engage with their colleagues at CMS to review the need for enhanced Federal requirements in this area.

We thank you for the opportunity to respond to the audit as well as the communications regarding findings over the past year. We would welcome follow-up conversations regarding this, or other Federal processes related to health safety and welfare oversight.

Sincerely,

/S/
Kim Bimestefer
Executive Director
Colorado Health Care Policy and Financing