Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WASHINGTON STATE DID NOT ENSURE THAT SELECTED NURSING HOMES COMPLIED WITH FEDERAL REQUIREMENTS FOR LIFE SAFETY, EMERGENCY PREPAREDNESS, AND INFECTION CONTROL

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

December 2023
A-09-22-02006

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: December 2023
Report No. A-09-22-02006

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

Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control

Why OIG Did This Audit

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all 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 develop an infection control program.

Our objective was to determine whether Washington State ensured that selected nursing homes in Washington 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 200 nursing homes in Washington State that participated in Medicare or Medicaid, we selected a nonstatistical sample of 20 nursing homes for our audit based on certain risk factors, including multiple high-risk deficiencies that Washington reported to CMS.

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, emergency preparedness, and infection control deficiencies.

What OIG Found

Washington State did not ensure that selected nursing homes in Washington that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control. During our onsite inspections, we identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that we audited, totaling 525 deficiencies. Specifically, we found 91 deficiencies related to life safety, 155 deficiencies related to emergency preparedness, and 279 deficiencies related to infection control. As a result, residents, staff, and visitors at the 20 nursing homes are at an increased risk of injury, significant illness, or death during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because nursing homes lacked adequate management oversight and had frequent management turnover. In addition, although nursing home management and staff are ultimately responsible for ensuring resident safety, Washington has a role in helping nursing homes reduce the risk of resident injury, significant illness, or death through its oversight of nursing homes' compliance with Federal requirements. However, Washington did not consistently identify deficiencies related to life safety, emergency preparedness, and infection control during surveys and take enforcement action to ensure that nursing homes complied with the requirements. Furthermore, Washington did not ensure that nursing home management was educated about life safety and emergency preparedness training resources available to nursing home staff that could be used to train staff on how to comply with Federal requirements.

What OIG Recommends and Washington's Comments

We recommend that Washington State follow up with the 20 nursing homes reviewed in this audit to ensure that these nursing homes have taken corrective actions to address the deficiencies identified. We also make procedural recommendations for Washington to provide training to State surveyors and educate nursing home management that training resources are available.

Washington concurred with all our recommendations and described actions that it had taken or planned to take to address our recommendations. Among other actions, Washington stated that it had implemented a plan to complete a review of all 20 nursing homes and had created plans to assure ongoing continuing education for staff and providers.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/92202006.asp.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its requirements related to health care facilities to improve protections for all individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems and smoke detector coverage to better protect residents, staff, and visitors from fire hazards. 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 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 its 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 new Federal life safety and emergency preparedness requirements.[1] This audit, which focuses on selected nursing homes in Washington State, is one in a series of audits that also assesses compliance with Federal 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 Washington State Department of Social and Health Services (State agency) ensured that selected nursing homes in Washington that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

BACKGROUND

Medicare and Medicaid Nursing Home Survey Requirements

Medicare and Medicaid programs cover care in nursing homes for eligible enrollees. Sections 1819 and 1919 of the Social Security Act (the Act) establish requirements for CMS and States to

[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.

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) as part of these requirements.[4] 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.[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]

[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/Downloads/CMS2786R.pdf. Accessed on June 14, 2022.

[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 Mar. 8, 2023.

[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 online at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-Resources.zip. Accessed on Sept. 9, 2022.

A CMS or State agency surveyor uses these survey documents when performing nursing home surveys. The results of each survey are recorded in CMS's Automated Survey Processing Environment (ASPEN) system.[8] The results in ASPEN are then uploaded to CMS's Certification and Survey Provider Enhanced Reporting (CASPER) system.[9]

In addition to the Federal requirements noted previously, Washington State requires carbon monoxide detectors to be installed in nursing homes that contain a fuel-burning appliance or have an attached garage (Washington Administrative Code (WAC) § 51-50-0915).

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.[10] CMS is the Federal agency responsible for certifying and overseeing all of the Nation's 15,010 Medicare- and Medicaid-certified nursing homes.[11] 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).[12, 13] 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.[14] Nursing homes with repeat deficiencies can be surveyed more frequently.

In Washington State, 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 requirements. Under the State agency's Section 1864 Agreement, the State agency also must perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS, *State Operations Manual,* § 1010).

---

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

[9] *ASPEN Central Office Procedures Guide*, version 12.0.1.0, "Upload Certification Kits."

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

[11] The number of nursing homes was up-to-date as of July 1, 2023.

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

[13] The Act §§ 1819(g) and 1919(g).

[14] State agencies oversee nursing homes in their respective States and are responsible for ensuring that nursing homes comply with Federal, State, and local regulations. In Washington State, the State fire marshal performs life safety and emergency preparedness surveys on behalf of the State agency.

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. CMS informed State survey agencies to focus on infection control surveys, which are more limited in scope than standard surveys, and more serious nursing home complaints.[15] 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."[16] In Washington State, the State agency resumed standard surveys in April 2021.

HOW WE CONDUCTED THIS AUDIT

As of July 2022, 200 nursing homes in Washington State participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on risk factors, including multiple high-risk deficiencies reported in CASPER as of July 7, 2022, for surveys completed after January 1, 2020.[17, 18]

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 and communications plans; and reviewed the nursing home's policies, procedures, and documentation related to infection control. 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.

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

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

[17] The 20 selected nursing homes consisted of 15 with multiple high-risk deficiencies and 5 with 1 deficiency related to infection prevention and control that presented immediate jeopardy to resident health or safety.

[18] 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) put resident health or safety in immediate jeopardy.

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 did not ensure that selected nursing homes in Washington State that participated in the Medicare or Medicaid programs complied 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 525 deficiencies. Specifically:

- We found 91 deficiencies related to noncompliance with life safety requirements. These deficiencies were related to building exits, smoke barriers, and smoke partitions (15);[19] fire detection and suppression systems (27); carbon monoxide detectors (2); hazardous storage areas (3); smoking policies and fire drills (10); and elevator and electrical equipment testing and maintenance (34).

- We found 155 deficiencies related to noncompliance with emergency preparedness requirements. These deficiencies were related to emergency preparedness plans (22); emergency power (6); plans for evacuations, sheltering in place, and tracking residents and staff during and after an emergency (18); emergency communications plans (62); and emergency preparedness plan training and testing (47).

- We found 279 deficiencies related to noncompliance with infection control requirements. These deficiencies were related to IPCPs and antibiotic stewardship programs (25),[20] infection preventionists (2),[21] influenza and pneumococcal immunizations (16), COVID-19 immunizations (31), COVID-19 reporting (11), COVID-19 case notifications (1), COVID-19 testing (37), and staff COVID-19 vaccination requirements (156).

[19] Smoke barriers restrict the movement of smoke and have a fire-resistance rating. Smoke partitions are designed to limit the movement of smoke and are not as substantial as smoke barriers. Smoke partitions do not always have a fire-resistance rating.

[20] 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.

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

The identified deficiencies occurred because nursing homes lacked adequate management oversight and had frequent management turnover. In addition, although nursing home management and staff are ultimately responsible for ensuring resident safety, the State agency has a role in helping nursing homes reduce the risk of resident injury, significant illness, or death through its oversight of nursing homes' compliance with Federal requirements. However, the State agency did not consistently identify deficiencies related to life safety, emergency preparedness, and infection control during surveys and take enforcement action to ensure that nursing homes complied with the requirements. Furthermore, the State agency did not ensure that nursing home management was educated about life safety and emergency preparedness training resources available to nursing home staff that could be used to train staff on how to comply with Federal requirements.

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

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

SELECTED NURSING HOMES DID NOT COMPLY WITH LIFE SAFETY REQUIREMENTS

CMS's Fire Safety Survey Report form, described on page 2, lists the Federal regulations on life safety that nursing homes must comply with and references each with an identification number, known as a K-Tag (numbered K-100 through K-933). In addition, Washington State requires carbon monoxide detectors to be installed in nursing homes that contain a fuel-burning appliance or have an attached garage (WAC § 51-50-0915).

Building Exits, Smoke Barriers, and Smoke Partitions

In case of fire or emergency, nursing homes are required to have unobstructed exits, self-closing doors in hazardous areas, and discharges from exits that are free from hazards, and exit signs must be displayed on exits. Nursing homes are also required to have sealed smoke barriers (i.e., with no holes) and sealed smoke partitions (K-Tags 161, 211, 223, 271, 293, 372).

Of the 20 nursing homes we visited, 9 had 1 or more deficiencies related to building exits, smoke barriers, and smoke partitions, totaling 15 deficiencies. Specifically, we found deficiencies related to blocked pathways leading to emergency exit doors (two nursing homes), a hazardous storage area that did not have a self-closing door (one nursing home), and a blocked exit door discharge area (one nursing home). In addition, we found a deficiency related to emergency exit signs on two doors that did not meet the requirements for emergency exits because both doors led to a patio with a locked gate and no exit path (one nursing home). Finally, we found deficiencies related to a damaged smoke barrier that could contribute to the spread of smoke (one nursing home), and damaged smoke partitions due to small holes or missing ceiling tiles (nine nursing homes). The photographs that follow depict some of the deficiencies we identified during our site visits.

Photograph 1 (left): Door marked as emergency exit led to patio with locked gate.
Photograph 2 (right): Locked gate in patio with no exit path.

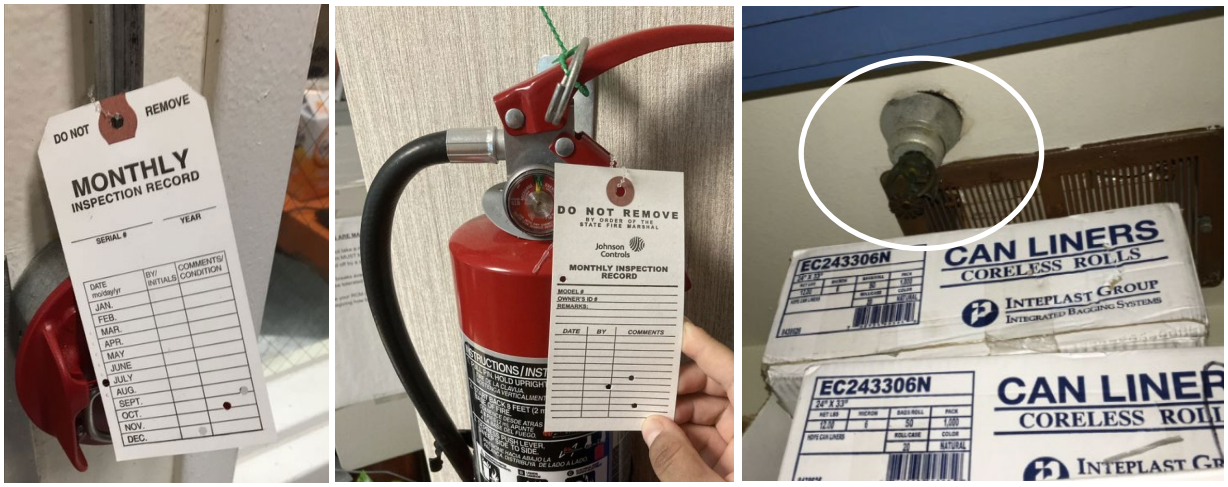
Photograph 3 (left): Pathway to exit blocked by fan.
Photograph 4 (right): Hole in smoke partition from missing ceiling tile.

Fire Detection and Suppression Systems

Each nursing home is required to have a fire alarm system that is tested and maintained in accordance with NFPA requirements. Sprinkler systems must be inspected, tested, and maintained according to NFPA requirements, which include the requirement to keep 18 inches of clearance below sprinkler system heads. Cooking equipment and its related fire suppression systems must be maintained, and repairs must be performed on all components at intervals necessary to maintain good working condition. Each nursing home must also have fire watch policies and procedures for when fire alarms or sprinkler systems are out of service (or evacuate its residents if a fire watch is not instituted), and portable fire extinguishers must be inspected at a minimum of 30-day intervals (K-Tags 324, 345, 346, 353, 354, 355).[22]

[22] 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).

Of the 20 nursing homes we visited, 14 had 1 or more deficiencies related to fire detection and suppression systems, totaling 27 deficiencies. Specifically, we found a deficiency related to a fire alarm system that was not routinely tested and maintained (one nursing home). We also found deficiencies related to blocked or obstructed sprinkler system heads (four nursing homes), sprinkler systems that were not tested and maintained (two nursing homes), and cooking equipment hoods that were not serviced or fire suppression systems that were not checked at required intervals (eight nursing homes). In addition, we found deficiencies related to fire watch policies and procedures that were not established for when the fire alarm was out of service (one nursing home) or the sprinkler system was out of service (one nursing home). Finally, we found deficiencies related to portable fire extinguisher inspections (10 nursing homes), including a deficiency at 1 nursing home that had not performed monthly inspections of any of its fire extinguishers. The photographs that follow depict some of the deficiencies we identified during our site visits.



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

Carbon Monoxide Detectors

CMS requires nursing homes to follow applicable Federal, State, and local laws, regulations, and codes (42 CFR § 483.70).[23] In Washington State, carbon monoxide detectors are required to be installed and maintained in nursing homes that contain a fuel-burning appliance or have an attached garage (WAC § 51-50-0915).

Of the 20 nursing homes we visited, 2 had 1 deficiency each related to Washington State requirements for carbon monoxide detectors. Specifically, both nursing homes had not installed carbon monoxide detectors.

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

Hazardous Storage Areas

In hazardous storage areas, nursing homes must install self-closing doors. Rooms with oxygen cylinders must have proper signage, and oxygen cylinders must be stored so that empty cylinders are segregated from full cylinders and marked to avoid confusion (K-Tags 321, 923).

Of the 20 nursing homes we visited, 2 had 1 or more deficiencies related to hazardous storage areas, totaling 3 deficiencies. Specifically, we found a deficiency related to doors to soiled linen rooms that were taped open and not self-closing (one nursing home). Additionally, we found deficiencies related to unsafe storage of oxygen cylinders (two nursing homes), in which one nursing home was missing a "no smoking" sign and a sign that indicated which oxygen tanks were full or empty, and another nursing home was missing a sign indicating which oxygen tanks were full or empty. The photograph that follows depicts one of the deficiencies we identified during our site visits.

Photograph 8: Oxygen room missing "no smoking" sign. (Sign reads "Oxygen Room – No Personal Access Allowed.")

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. No-smoking areas must include signage. Nursing homes are also required to conduct fire drills each calendar quarter that cover each work shift (K-Tags 712, 741).

Of the 20 nursing homes we visited, 9 had 1 or more deficiencies related to smoking policies and fire drills, totaling 10 deficiencies. Specifically, we found deficiencies related to smoking policies that were not being followed (five nursing homes). At four nursing homes, we observed evidence that individuals had smoked in banned areas, and one nursing home was missing "no smoking" signage outside an oxygen room. In addition, we found deficiencies related to fire drills that were not conducted each calendar quarter covering all work shifts (five

nursing homes). The photograph that follows depicts one of the deficiencies we identified during our site visits.

Photograph 9: Cigarette butts in wooden planter (not a designated smoking area).

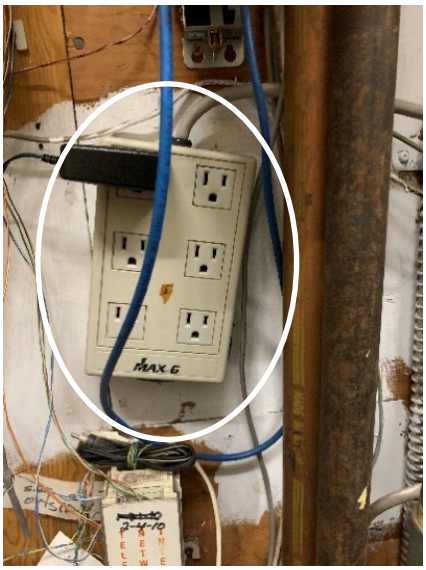
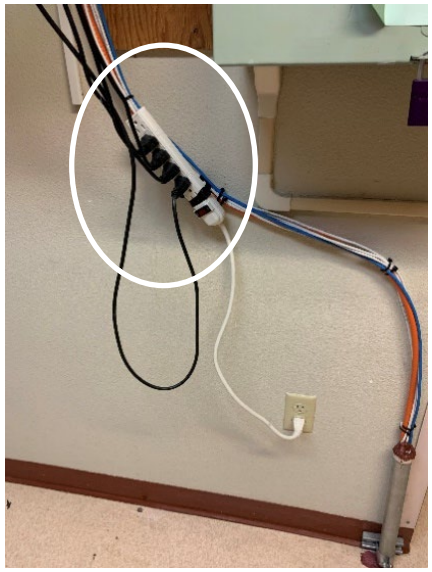
Elevator and Electrical Equipment Testing and Maintenance

Nursing home elevators must be tested and maintained on a regular basis, including performing a monthly Firefighter's Service.[24] Nursing homes must also keep a record of tests and repairs of other electrical equipment, such as receptacles, patient beds, and lifts. If power strips are used, they must meet Underwriters Laboratories (UL) requirements and be used in a safe manner; they cannot be mounted to building surfaces or connected to appliances. Extension cords may be used temporarily but must be removed immediately after use. Portable space heaters are allowed only in nonsleeping staff and employee areas (K-Tags 531, 781, 914, 920, 921).

Of the 20 nursing homes we visited, 16 had 1 or more deficiencies related to elevator and electrical equipment testing and maintenance, totaling 34 deficiencies. Specifically, we found deficiencies related to elevators that were missing a monthly Firefighter's Service (six nursing homes). In addition, we found deficiencies related to receptacles that were not tested (five nursing homes), and patient beds and lifts that were not tested (six nursing homes). Furthermore, we found deficiencies related to power strips that were mounted to building surfaces or were unsafely connected to appliances, or extension cords that were not used according to requirements (16 nursing homes). Finally, we found a deficiency related to a portable space heater that was left turned on in an empty office (one nursing home).

The photographs that follow depict some of the deficiencies we identified during our site visits.

[24] During a Firefighter's Service, an elevator's emergency lighting is tested as well as the elevator's ability to safely operate during a fire.


Photograph 10 (left): Power strip mounted to a wall.
Photograph 11 (center): Power strip mounted to voice and data cables.
Photograph 12 (right): Unallowable use of extension cord connected to item in locked storage container (nursing home management did not have access to storage container).

SELECTED NURSING HOMES DID NOT COMPLY WITH EMERGENCY PREPAREDNESS REQUIREMENTS

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

Emergency Preparedness Plans

Nursing homes are required to develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The emergency preparedness plan must: (1) include a facility and community all-hazards risk assessment; (2) include strategies for addressing emergency events that were identified by the risk assessment; (3) address resident population needs and services available during an emergency; (4) include a succession plan; and (5) address coordination with Federal, State, and local emergency management officials (E-Tags 0004, 0006, 0007, 0009).

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to their emergency preparedness plans, totaling 22 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that were not updated at least annually (eight nursing homes). In addition, we found deficiencies related to all-hazard risk assessments that were not completed (two nursing homes) and risk assessments that did not address all risks, e.g., the risk that residents would go missing (three nursing homes). We also found deficiencies related to emergency preparedness plans that did not have strategies for addressing emergency events

(e.g., volcanic activity) that were identified in risk assessments (two nursing homes), did not address resident population needs and services available during an emergency (e.g., the emergency preparedness plan was not specific to the facility or its residents) (five nursing homes), and did not have a succession plan (one nursing home). Finally, we found a deficiency related to an emergency preparedness plan that did not address coordination with all government emergency management officials (one nursing home).

Emergency Power

Nursing homes' emergency preparedness plans must address emergency power. Nursing homes are required to provide an alternate source of energy (usually a generator). Nursing homes with generators are required to perform weekly maintenance checks, monthly load tests, annual inspections, and annual fuel quality tests (if applicable) (E-Tag 0041).

Of the 20 nursing homes we visited, 6 had 1 deficiency each related to emergency power. Specifically, all six nursing homes had generators that were not properly inspected, tested, or 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 utilizing volunteers and transferring residents and procedures for their roles under a waiver to provide care at alternate sites during emergencies (E-Tags 0018, 0020, 0022, 0024, 0025, 0026).

Of the 20 nursing homes we visited, 8 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 18 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that did not address evacuations (two nursing homes), sheltering in place (one nursing home), tracking staff during and after an emergency (four nursing homes), utilizing volunteers (three nursing homes), transferring residents during disasters (two nursing homes), and providing care at alternate sites under a waiver during emergencies (six nursing homes).

Emergency Communications Plans

Nursing homes are required to have an emergency communications plan that includes names and contact information for staff, residents' physicians, other nearby nursing homes, volunteers, government emergency management offices, the State licensing agency, and the State ombudsman, 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., a landline and backup cell phones); a means to communicate a facility's occupancy, needs, and ability to provide assistance; and methods to share emergency

preparedness plan information with residents and their families (E-Tags 0029–0032, 0034, 0035).

Of the 20 nursing homes we visited, 18 had 1 or more deficiencies related to emergency communications plans, totaling 62 deficiencies. Specifically, two nursing homes did not have emergency communications plans. We also found deficiencies related to emergency communications plans that did not include various categories of required names and contact information (18 nursing homes);[25] emergency communications plans that were not updated annually (9 nursing homes); an emergency communications plan that did not address primary and alternate means of communication (1 nursing home); emergency communications plans that did not have a means to communicate a facility's occupancy, needs, and ability to provide assistance (2 nursing homes); and an emergency communications plan that did not have procedures for sharing emergency preparedness plan information with residents and their families (1 nursing home).

Emergency Preparedness Plan Training and Testing

Nursing homes are required to have a training and testing program related to their emergency preparedness plans and to update the training and testing program 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.[26] In addition, a second training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise) must be completed annually.[27] An analysis of all training exercises (and actual events) must be completed and documented, and the emergency preparedness plan must be revised, if necessary (E-Tags 0036, 0037, 0039).

Of the 20 nursing homes we visited, 15 had 1 or more deficiencies related to emergency preparedness plan training and testing, totaling 47 deficiencies. Specifically, we found deficiencies related to training and testing programs that did not meet Federal requirements

[25] At the 18 nursing homes, we identified a total of 47 deficiencies related to emergency communications plans that did not include the following categories of required names and contact information: staff (14 nursing homes), residents' physicians (13 nursing homes), other nearby nursing homes (2 nursing homes), volunteers (2 nursing homes), government emergency management offices (7 nursing homes), the State licensing agency (3 nursing homes), the State ombudsman (5 nursing homes), and other various required entities (1 nursing home).

[26] The exercise may be facility-based if a community-based exercise is not possible. A nursing home is exempt from this requirement if it activated its 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 a facility's activation of its emergency preparedness plan due to the COVID-19 public health emergency.

[27] 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.

(8 nursing homes) and that were not updated annually (11 nursing homes). We also found deficiencies related to initial training that was not conducted (four nursing homes) and annual refresher training that was not conducted (four nursing homes). In addition, we found deficiencies related to full-scale testing exercises that were not conducted (seven nursing homes), second annual training exercises (a full-scale testing exercise, a facility-based exercise, or a tabletop exercise) that were not conducted (six nursing homes), and analyses of training exercises that were not conducted (seven nursing homes).

SELECTED NURSING HOMES DID NOT COMPLY WITH INFECTION CONTROL REQUIREMENTS

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

Infection Prevention and Control and Antibiotic Stewardship Programs

Each nursing home is 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, and must conduct an annual review of its IPCP and update it as necessary. 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, precautions to follow to prevent the spread of infection, when and how to isolate individuals, hand-hygiene procedures, and the circumstances that would prohibit employees from having direct contact with residents or their food. Nursing home staff must handle, store, process, and transport linens to prevent the spread of infection. Nursing homes must also have a system for recording identified incidents and corrective actions taken. 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 IPCPs and antibiotic stewardship programs, totaling 25 deficiencies. Specifically, we found deficiencies related to an IPCP that was not established (one nursing home); an IPCP that did not have a system to prevent, identify, report, investigate, and control infections and communicable diseases (one nursing home); IPCPs that were not reviewed annually or updated as necessary (seven nursing homes); and an IPCP that did not have written standards, policies, and procedures (one nursing home). In addition, we found deficiencies related to IPCP policies and procedures that did not include a surveillance system designed to identify possible communicable diseases or infections (one nursing home), when and to whom possible incidents should be reported (three nursing homes), precautions to follow to prevent the spread of infection (one nursing home), when and how to isolate individuals (one nursing home), hand-hygiene procedures (one nursing home), and circumstances that would prohibit employees from having direct contact with residents or their food (four nursing homes). We also found deficiencies related to an IPCP that did not have policies and procedures to ensure that nursing

home staff handled, stored, processed, and transported linens to prevent the spread of infection (one nursing home). Finally, we found deficiencies related to IPCPs that did not have a system for recording identified incidents and corrective actions taken (two nursing homes), and an antibiotic stewardship program that did not include all required elements (one nursing home).

On August 4, 2022, mpox was declared a public health emergency, which lasted until January 31, 2023.[28] While performing our site visits, we determined whether each nursing home had: (1) updated its IPCP to mitigate mpox and (2) experienced any cases of mpox among residents or staff. Of the 20 nursing homes, 2 had updated their IPCPs, and none reported experiencing any cases of mpox among residents or staff.

Infection Preventionists

Nursing homes are required to designate at least one individual as the infection preventionist responsible for the facility's IPCP. The infection preventionist must have 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, 2 had 1 deficiency each related to infection preventionists. Specifically, one nursing home had an infection preventionist who had not completed specialized training in infection prevention and control, and one nursing home had an infection preventionist who did not attend the facility's quality assessment and assurance committee meetings and therefore did not regularly report on the facility's IPCP.

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 influenza and pneumococcal immunizations, totaling 16 deficiencies. Specifically, we identified deficiencies related to policies and procedures that did not ensure each resident was offered influenza

[28] Mpox is a disease similar to smallpox and is caused by the mpox virus. It causes flulike symptoms, followed by a rash with blisters that may take up to 3 weeks to resolve.

immunizations (one nursing home) or pneumococcal immunizations (one nursing home). We also found deficiencies related to policies and procedures that did not ensure that each resident or resident's representative: (1) received education regarding the influenza immunization (one nursing home) or pneumococcal immunization (one nursing home) and (2) had the opportunity to refuse the influenza immunization (one nursing home) or pneumococcal immunization (one nursing home). Finally, we found deficiencies related to residents' medical records that lacked documentation that the facility provided required education regarding the influenza immunization (three nursing homes) or pneumococcal immunization (five nursing homes) and documentation that a resident did or did not receive an influenza immunization (one nursing home) or a pneumococcal immunization (one nursing home).

COVID-19 Immunizations

Nursing homes are required to develop policies and procedures to ensure that each resident and staff member is offered the COVID-19 vaccine (unless the immunization is medically contraindicated, or the resident or staff member has already been immunized). These policies and procedures must also ensure that, before a nursing home offers immunizations, all staff and each resident or resident's representative receive education regarding the benefits and potential side effects of the COVID-19 vaccine, current education is provided with each additional dose of the vaccine to staff and residents, and each resident or resident's representative is provided the opportunity to accept or refuse the COVID-19 vaccine. The facility must document that education was provided, the immunization status of staff and residents, and whether the resident received or refused each dose (F-Tag 887).

Of the 20 nursing homes we visited, 14 had 1 or more deficiencies related to COVID-19 immunizations, totaling 31 deficiencies. Specifically, we found deficiencies related to policies and procedures that did not require that education was provided regarding the benefits or potential side effects before immunizations were offered to staff (three nursing homes) or to residents or residents' representatives (two nursing homes), and that did not require providing residents or residents' representatives the opportunity to accept or refuse the COVID-19 vaccine (one nursing home). We also found deficiencies related to documentation that did not show:

- education was provided regarding the benefits or potential side effects before immunizations were offered to staff (6 nursing homes) or to residents or residents' representatives (2 nursing homes),

- current education was provided with each additional dose of the COVID-19 vaccine to staff or residents (12 nursing homes),

- the immunization status of staff (2 nursing homes), and

- whether residents received or refused the COVID-19 vaccine (3 nursing homes).

COVID-19 Reporting

Nursing homes are required to electronically report information about COVID-19 on a weekly basis through the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network. The information to be reported includes COVID-19 vaccination status of residents and staff, including total numbers of residents and staff vaccinated, and numbers of each dose of COVID-19 vaccine received. Nursing homes are also required to report staff shortages (F-Tag 884).

Of the 20 nursing homes we visited, 11 had 1 deficiency each related to COVID-19 reporting. Specifically, we found deficiencies related to COVID-19 vaccination status of staff that was not accurately reported (10 nursing homes) and staffing shortages that were not reported (1 nursing home).

COVID-19 Case Notifications

Nursing homes are required to notify residents, their representatives, and families by 5 p.m. on the calendar day following either a single confirmed COVID-19 infection or the presence of three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. The notification must include information on mitigating actions implemented to prevent or reduce the risk of transmission (F-Tag 885).

Of the 20 nursing homes we visited, 1 had a deficiency related to COVID-19 case notifications. Specifically, the case notification did not include information on mitigating actions implemented to prevent or reduce risk of transmission.

COVID-19 Testing

Nursing homes are required to test residents and staff, including contractors and volunteers, for COVID-19.[29] Each nursing home must, at a minimum, conduct testing based on parameters set forth by the Secretary of Health and Human Services (the Secretary), 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 must conduct testing in a manner that is consistent with current standards and take actions to prevent the transmission of COVID-19 when an individual is identified with symptoms or tests positive. Nursing homes are required to document that testing was completed and the results for each staff test. Nursing homes are also required to document in each resident's record that testing was offered and completed, as well as the

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

results of each test. Nursing homes must also establish 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, 10 had 1 or more deficiencies related to COVID-19 testing, totaling 37 deficiencies. Specifically, we found deficiencies related to policies and procedures that did not address conducting testing based on parameters set forth by the Secretary (two nursing homes), testing frequency (two nursing homes), identification of individuals diagnosed with COVID-19 (two nursing homes), identification of individuals with symptoms of or with known or suspected exposure to COVID-19 (two nursing homes), criteria for testing asymptomatic individuals (three nursing homes), response times for tests (four nursing homes), and other factors specified by the Secretary (two nursing homes).

In addition, we found deficiencies related to policies and procedures that did not address conducting testing in a manner that was consistent with current standards (two nursing homes) or taking action to prevent the transmission of COVID-19 when an individual is identified with symptoms or tests positive (two nursing homes). Furthermore, we found deficiencies related to documentation that did not show that testing was offered and completed for each staff member (one nursing home), or did not show that testing was offered and completed or the results of completed tests for each resident (one nursing home). Finally, we found deficiencies related to policies and procedures that did not address individuals who refused testing or were unable to test (4 nursing homes), or did not address contacting State and local health departments to assist in testing efforts when necessary (10 nursing homes).

Staff COVID-19 Vaccination Requirements

Nursing homes are required to develop policies and procedures to ensure that staff are fully vaccinated for COVID-19 except for individuals granted an exemption from the vaccination requirements or individuals whose vaccination had to be temporarily delayed, as recommended by CDC, because of clinical precautions and considerations.[30, 31] The policies and procedures must apply to staff who provide any care, treatment, or other services for a facility or its residents, including facility employees; licensed practitioners; students, trainees, and volunteers; and contractors. The policies and procedures do not apply to staff who exclusively provide telehealth, telemedicine, or support services outside of the facility setting. The policies and procedures must also include processes for:

[30] Under Federal law, workers who cannot be vaccinated because of a disability, a medical condition, or a sincerely held religious belief, practice, or observance may, in some circumstances, be granted an exemption. Staff are considered fully vaccinated if it has been 2 or more weeks since they completed a primary vaccine series for COVID-19 (i.e., a single-dose vaccine or all required doses of a multidose vaccine).

[31] The requirement for staff vaccination was in place during our audit period. However, the *Federal Register* (88 Fed. Reg. 36485 (June 5, 2023)) removed staff vaccination requirements, noting that because facilities were no longer operating under public health emergency circumstances, staff vaccination provisions would not be enforced from June 5 through Aug. 4, 2023, when the removal of the vaccination requirements became effective.

- ensuring that all staff (except for individuals with pending requests for or those granted an exemption from the vaccination requirements or individuals whose vaccination had to be temporarily delayed) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multidose COVID-19 vaccine, before providing any care, treatment, or other services for the facility or its residents;

- staff to request an exemption from the staff COVID-19 vaccination requirements;

- implementing additional precautions to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated;

- tracking and documenting the COVID-19 vaccination status of all staff, including the status of any staff member who received a booster dose or for whom COVID-19 vaccination must be temporarily delayed, and information provided by those staff who requested and were granted any exemption from the staff COVID-19 vaccination requirements;

- ensuring that all documentation (which confirms recognized clinical contraindications to COVID-19 vaccines and supports staff requests for medical exemptions from vaccination) has been signed and dated by a licensed practitioner and contains all information specifying which of the COVID-19 vaccines are clinically contraindicated for the staff member to receive, the recognized clinical reasons for the contraindications, and a statement by the practitioner recommending that the staff member be exempted from the vaccination requirements;[32] and

- contingency plans for staff who are not fully vaccinated (F-Tag 888).

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to staff COVID-19 vaccination requirements, totaling 156 deficiencies. Specifically, we found deficiencies related to policies and procedures that did not:

- ensure that all staff were fully vaccinated for COVID-19, except for those staff who were granted exemptions or for whom vaccination was temporarily delayed (12 nursing homes);

- apply to all staff who provided any care, treatment, or other services for a facility or its residents, including facility employees (6 nursing homes); licensed practitioners

[32] Clinical contraindications are conditions in a COVID-19 vaccine recipient that preclude the administration of the vaccine because of an increased risk for a serious adverse reaction to vaccination and include, among other things, a history of a severe allergic reaction after a previous dose or to a component of the COVID-19 vaccine and a known, diagnosed allergy to a component of the COVID-19 vaccine. Available online at https://www.cms.gov/files/document/attachment-ltc-injunction-lifted.pdf. Accessed on May 11, 2023.

(11 nursing homes); students, trainees, and volunteers (10 nursing homes); and contractors (8 nursing homes); and

- exclude from the vaccination requirements staff who exclusively provided telehealth or telemedicine services outside of the facility setting (14 nursing homes) and staff who provided support services for the facility that were performed exclusively outside of the facility setting (14 nursing homes).

In addition, we found deficiencies related to policies and procedures that did not include a process:

- to ensure that all staff (except for individuals with pending requests for or those granted an exemption from the vaccination requirements or individuals whose vaccination had to be temporarily delayed) received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multidose COVID-19 vaccine, before providing any care, treatment, or other services for the facility or its residents (12 nursing homes);

- for staff to request an exemption from the staff COVID-19 vaccination requirements (1 nursing home);

- to implement additional precautions to mitigate the transmission and spread of COVID-19 for all staff who were not fully vaccinated (6 nursing homes);

- to track and securely document the COVID-19 vaccination status of all staff (7 nursing homes), including the status of any staff who received a booster dose (6 nursing homes) or for whom COVID-19 vaccination was temporarily delayed (13 nursing homes), and information provided by those staff who requested and were granted an exemption (4 nursing homes);

- to ensure that all documentation, which confirmed recognized clinical contraindications and supported staff requests for medical exemptions from vaccination, was signed by a licensed practitioner (9 nursing homes) and contained:

    - all information specifying which of the COVID-19 vaccines were clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications (10 nursing homes), and

    - a statement by the practitioner recommending that the staff member be exempted from the vaccination requirements (8 nursing homes); and

- for contingency plans for staff who were not fully vaccinated (5 nursing homes).

STATE AGENCY COULD IMPROVE ITS OVERSIGHT OF NURSING HOMES' COMPLIANCE WITH FEDERAL REQUIREMENTS

Although nursing home management and staff are ultimately responsible for ensuring resident safety, the State agency has a role in helping nursing homes reduce the risk of resident injury, significant illness, or death through its oversight of nursing homes' compliance with Federal requirements. We found that the State agency did not consistently identify deficiencies related to life safety, emergency preparedness, and infection control during surveys and take enforcement action to ensure that nursing homes complied with the requirements. Specifically, we found deficiencies related to life safety, emergency preparedness, and infection control at all 20 nursing homes that State surveyors did not identify when they conducted surveys before our site visits. For example:

- Two of the six life safety deficiencies we identified for nursing homes that missed monthly elevator inspections were not identified by State surveyors. A State agency official informed us that a State surveyor missed identifying this deficiency because the surveyor was unaware of the requirement.

A NURSING HOME THAT THE STATE SURVEYOR DETERMINED TO BE IN COMPLIANCE HAD 23 EMERGENCY PREPAREDNESS DEFICIENCIES

One nursing home had emergency preparedness surveys conducted by the State agency in January 2020 and March 2022. During the January 2020 survey, the facility was cited for 26 emergency preparedness deficiencies because it could not provide an emergency preparedness plan. During the March 2022 survey, the facility was found to be in compliance and was not cited for any emergency preparedness deficiencies. During our September 2022 site visit, we identified 23 emergency preparedness deficiencies. The emergency preparedness plan was dated 2017, and several sections were left blank or were missing, including the risk assessment, plans for evacuation and sheltering in place, transfer agreements with nearby nursing homes, and the communications plan, as well as most contact information required by Federal regulations. The State agency could not provide insight on the March 2022 survey because the surveyor no longer had notes on the survey.

- Six of the sixteen life safety deficiencies we identified for nursing homes' misuse of power strips, including power strips being mounted to building surfaces, were not identified by State surveyors. Several nursing homes informed us that State surveyors instructed them to mount the power strips. When we asked the State agency about this issue, an official informed us that it was not standard practice for State surveyors to instruct nursing homes to mount power strips but that State surveyors would not always cite nursing homes for mounting them, depending on how they were mounted.

- Five emergency preparedness deficiencies we identified for one nursing home for not completing a risk assessment (the nursing home provided a risk assessment that was for another nursing home), not including emergency events in its emergency preparedness plan based on the risk assessment, having outdated contact information for staff, and failing to provide initial and annual refresher training to staff on its emergency preparedness plan were not identified by State surveyors. We identified these

deficiencies during our site visit in September 2022, but the State surveyor did not identify these deficiencies in an inspection report for a survey performed in August 2022. A State agency official informed us that the nursing home was not cited for not having a risk assessment and not addressing emergency events because the State surveyor would have discussed the concerns with the nursing home rather than citing it. The official added that the State surveyor missed that the staff contacts were outdated and did not cite the nursing home for missing initial and annual training on the emergency preparedness plan, because the surveyor confused the E-Tags for initial and annual training and the E-Tag for testing, which the surveyor did cite during the survey.

- One or more infection control deficiencies related to COVID-19 requirements at 19 nursing homes were not identified by State surveyors. State agency officials did not inform us why State surveyors did not identify the deficiencies.

Additionally, the State agency did not ensure that nursing home management was educated about life safety and emergency preparedness training resources available to nursing home staff that could be used to train staff on how to comply with Federal requirements.

While conducting our site visits, we found that there was frequent turnover of nursing home management and that staff needed to be trained on Federal requirements. Although the State agency is not required to provide life safety and emergency preparedness training to nursing homes, training resources are available through CMS's website that nursing homes can use to teach staff about life safety and emergency preparedness requirements related to various topics, including fire extinguisher inspections, fire alarm and sprinkler maintenance, conducting and documenting fire drills, and training and testing staff on a nursing home's emergency preparedness plan.[33, 34]

RECOMMENDATIONS

We recommend that the Washington State Department of Social and Health Services:

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

[33] Although CMS does not specifically require the State agency to provide comprehensive life safety and emergency preparedness training to nursing homes, under the State agency's Section 1864 Agreement with CMS, the State agency agreed to perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS, *State Operations Manual* § 1010).

[34] Life safety training is available online at https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLSCPR_WBT, and emergency preparedness training is available online at https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSEmPrep_ONL. Accessed on Mar. 6, 2023.

- provide training to State surveyors to ensure that deficiencies related to life safety, emergency preparedness, and infection control are consistently identified; and

- educate nursing home management that life safety and emergency preparedness training resources are available to nursing home staff.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with all our recommendations and described actions that it had taken or planned to take to address our recommendations. Specifically:

- Regarding our first recommendation, the State agency said that it had implemented a plan to complete a review of all 20 nursing homes. The State agency said that State surveyors will give special attention to address areas of concern during life safety and emergency preparedness surveys and will take our findings into consideration when completing infection control surveys.

- Regarding our second recommendation, the State agency said that it had created a plan to assure ongoing continuing education through multiple outlets for staff. Among other actions, the State agency said that it planned to fill one full-time position to work with stakeholders on rules, policies, and procedures related to emergency preparedness and one full-time position to work with staff and providers on creating emergency preparedness systems. The State agency also said that it planned to fill two full-time positions to provide training and support to staff and providers on infection control regulations.

- Regarding our third recommendation, the State agency said that it had created a plan to assure ongoing continuing education through multiple outlets for providers. In addition to describing the full-time positions discussed above, among other actions, the State agency said that it had added a link on its website to CMS training resources and had sent a letter to nursing homes informing them of this new resource.

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

We appreciate the State agency for its cooperation throughout our audit and for actions it has taken and plans to take to address our recommendations. Regarding our second recommendation, we encourage the State agency to also develop a plan to ensure that training related to life safety is provided to State surveyors.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of July 2022, 200 nursing homes in Washington State participated in the Medicare or Medicaid programs. Of these 200 nursing homes, we selected a nonstatistical sample of 20 nursing homes for our audit based on risk factors, including multiple high-risk deficiencies reported in CASPER as of July 7, 2022, for surveys completed after January 1, 2020.[35]

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 Washington State from September through November 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS and State agency officials to gain an understanding of the process for conducting nursing home life safety, emergency preparedness, and infection control surveys;
- obtained from CMS's provider data catalog a list of all 200 Medicare- and Medicaid-certified nursing homes in Washington State as of July 2022;[36]
- obtained from CASPER a list of 52 nursing homes that had 1 or more deficiencies that were reported in CASPER as of July 7, 2022, for surveys completed after January 1, 2020, and that were considered high-risk because they: (1) were widespread and had the

[35] The 20 nursing homes in our sample consisted of 15 nursing homes with multiple high-risk deficiencies and 5 nursing homes with 1 deficiency related to infection prevention and control that presented immediate jeopardy to resident health or safety.

[36] Available online at https://data.cms.gov/provider-data/dataset/4pq5-n9py. Accessed on July 7, 2022.

potential for more than minimal harm, (2) involved actual harm that was not immediate jeopardy, or (3) put resident life and safety in immediate jeopardy;[37]

- selected 20 nursing homes for onsite inspections from the 52 nursing homes identified in CASPER and for each of the 20 nursing homes:

    - conducted unannounced site visits at the nursing home to check for life safety violations, reviewed the nursing home's emergency preparedness and communications plans, and reviewed the nursing home's policies, procedures, and documentation related to infection control, and

    - compared deficiencies we found with deficiencies that the State agency identified in inspection reports to determine whether the deficiencies we found could have been identified during State agency surveys conducted before our site visit; 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.

[37] Deficiencies that the State agency enters into ASPEN are uploaded to CASPER 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 May 12, 2023.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-03-22-00206	11/8/2023
New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-02-22-01004	9/29/2023
Georgia Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control	A-04-22-08093	9/7/2023
Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety	A-02-21-01010	7/15/2022
Iowa Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-07-19-03238	2/16/2021
North Carolina Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-04-19-08070	9/18/2020
Illinois Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-05-18-00037	9/17/2020
Missouri Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-07-18-03230	3/13/2020
Florida Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-04-18-08065	3/6/2020
Life Safety and Emergency Preparedness Deficiencies Found at 18 of 20 Texas Nursing Homes	A-06-19-08001	2/6/2020
California Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-09-18-02009	11/13/2019
New York Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness	A-02-17-01027	8/20/2019

APPENDIX C: DEFICIENCIES AT EACH NURSING HOME

Table 1: Summary of All Deficiencies by Nursing Home

Nursing Home	Life Safety Deficiencies	Emergency Preparedness Deficiencies	Infection Control Deficiencies	Total
1	4	7	9	**20**
2	10	10	17	**37**
3	6	12	22	**40**
4	-	3	13	**16**
5	6	5	10	**21**
6	6	11	14	**31**
7	11	14	11	**36**
8	1	6	10	**17**
9	4	4	14	**22**
10	-	10	3	**13**
11	5	15	44	**64**
12	1	9	10	**20**
13	7	6	5	**18**
14	4	1	7	**12**
15	3	6	14	**23**
16	8	-	7	**15**
17	4	2	2	**8**
18	2	11	18	**31**
19	9	23	34	**66**
20	-	-	15	**15**
Total	**91**	**155**	**279**	**525**

Table 2: Life Safety Deficiencies

Nursing Home	Building Exits, Smoke Barriers, and Smoke Partitions	Fire Detection and Suppression Systems	Carbon Monoxide Detectors	Hazardous Storage Areas	Smoking Policies and Fire Drills	Elevator and Electrical Equipment Testing and Maintenance	Total
1	1	-	-	-	-	3	**4**
2	2	3	-	-	2	3	**10**
3	-	2	-	-	1	3	**6**
4	-	-	-	-	-	-	**-**
5	2	2	-	-	-	2	**6**
6	1	2	-	-	1	2	**6**
7	1	5	1	-	1	3	**11**
8	-	-	-	-	-	1	**1**
9	-	1	-	-	1	2	**4**
10	-	-	-	-	-	-	**-**
11	1	2	-	-	-	2	**5**
12	-	-	-	-	-	1	**1**
13	1	2	-	-	1	3	**7**
14	-	2	-	-	1	1	**4**
15	-	1	-	-	-	2	**3**
16	3	1	1	-	1	2	**8**
17	-	1	-	1	-	2	**4**
18	-	2	-	-	-	-	**2**
19	3	1	-	2	1	2	**9**
20	-	-	-	-	-	-	**-**
Total	**15**	**27**	**2**	**3**	**10**	**34**	**91**

Table 3: Emergency Preparedness Deficiencies

Nursing Home	Emergency Preparedness Plans	Emergency 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	-	1	5	**7**
2	-	-	2	3	5	**10**
3	3	1	-	4	4	**12**
4	-	-	1	2	-	**3**
5	2	-	-	1	2	**5**
6	2	1	1	5	2	**11**
7	1	1	2	5	5	**14**
8	2	-	-	2	2	**6**
9	-	-	-	3	1	**4**
10	3	-	2	3	2	**10**
11	2	1	2	5	5	**15**
12	1	-	-	4	4	**9**
13	1	-	-	4	1	**6**
14	-	-	-	1	-	**1**
15	-	-	-	3	3	**6**
16	-	-	-	-	-	**-**
17	-	-	-	2	-	**2**
18	1	1	2	4	3	**11**
19	4	-	6	10	3	**23**
20	-	-	-	-	-	**-**
Total	**22**	**6**	**18**	**62**	**47**	**155**

Table 4: Infection Control Deficiencies

Nursing Home	Infection Prevention and Control and Antibiotic Stewardship Programs	Infection Preventionists	Immunizations		COVID-19 Reporting	COVID-19 Case Notifications	COVID-19 Testing	Staff COVID-19 Vaccination Requirements	Total
			Influenza and Pneumococcal	COVID-19					
1	-	-	-	-	1	-	-	8	**9**
2	1	-	-	2	-	-	1	13	**17**
3	-	-	1	3	1	-	11	6	**22**
4	-	-	-	-	1	-	-	12	**13**
5	1	-	-	1	-	-	3	5	**10**
6	1	-	-	1	1	-	1	10	**14**
7	-	-	1	2	-	-	-	8	**11**
8	-	-	-	-	1	-	-	9	**10**
9	-	1	-	1	-	-	-	12	**14**
10	-	-	-	2	-	-	1	-	**3**
11	13	1	10	8	1	-	4	7	**44**
12	1	-	2	3	1	-	-	3	**10**
13	-	-	-	3	1	-	-	1	**5**
14	1	-	-	1	-	-	-	5	**7**
15	1	-	-	2	1	-	2	8	**14**
16	1	-	-	-	1	-	-	5	**7**
17	-	-	-	-	-	-	-	2	**2**
18	1	-	1	1	1	-	1	13	**18**
19	4	-	1	1	-	-	11	17	**34**
20	-	-	-	-	-	1	2	12	**15**
Total	**25**	**2**	**16**	**31**	**11**	**1**	**37**	**156**	**279**

APPENDIX D: STATE AGENCY COMMENTS

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, WA 98504-5600

November 20, 2023

Lori A. Ahlstrand, Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region IX
90 - 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Auditor Ahlstrand:

Thank you for the opportunity to review and respond to the Office of Inspector General (OIG) draft report *Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control*. The Department of Social and Health Services, Aging and Long-Term Support Administration, Residential Care Services worked to provide this response.

We appreciate the opportunity to review the OIG findings and to properly consider the facts and reasonableness of the recommendations in this report. The state of Washington takes the health and safety of each long-term care resident seriously and we appreciate recommendations that may improve our process and procedures to assure the highest quality of care in long-term care programs.

Enclosed please find the state agency reply to the OIG report, including the response to each recommendation and the action plan for improvement.

Sincerely,

Amy Abbott

Amy Abbott, Director
Residential Care Services

cc: Bea Rector, Assistant Secretary, Aging and Long-Term Support Administration
Dylan Montgomery, Chief Deputy State Fire Marshal, Washington State Patrol
Laura Holloway, QA Administrator, Aging and Long-Term Support Administration
Rick Meyer, External Audit Compliance Manager, Department of Social and Health Services
Kari Summerour, External Audit And Compliance Manager, Health Care Authority
Charissa Fotinos, Medicaid Director, Health Care Authority

OFFICIAL STATE AGENCY RESPONSE TO THE OFFICE OF INSPECTOR GENERAL REPORT: WASHINGTON STATE DID NOT ENSURE THAT SELECTED NURSING HOMES COMPLIED WITH FEDERAL REQUIREMENTS FOR LIFE SAFETY, EMERGENCY PREPAREDNESS, AND INFECTION CONTROL

The Department of Social and Health Services, Aging and Long-Term Support Administration, Residential Care Services Division responses to the Office of Inspector General report received on October 26, 2023.

OFFICE OF INSPECTOR GENERAL (OIG) OBJECTIVES:

This performance review was designed to determine:

- Whether the Washington State Department of Social and Health Services (State agency) ensured that selected nursing homes in Washington that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Recommendations to the DSHS :

OIG Recommendation 1:

Follow up with the 20 nursing homes reviewed in this audit to ensure that these nursing homes have taken corrective actions to address the life safety, emergency preparedness, and infection control deficiencies identified.

State Response:

The State concurs with the recommendation to follow up with the 20 nursing homes reviewed in this audit. The State met with the OIG in early 2023 to discuss the preliminary results of the review and implemented a plan to complete a review of all 20 nursing homes at that time.

Action plan:

Infection Control

- Prioritize the 20 nursing homes reviewed for this report into the 20% Focused Infection Control Surveys required by the Center for Medicare and Medicaid Services if the home is not due for a recertification survey in the next 6 months. For those already on the calendar for recertification survey, the survey team will review the OIG report prior to a review of the infection control systems in the facility and take the OIG findings into consideration when completing the Infection Control pathway. **This prioritization began in April 2023 and will be completed November 2023**

Life Safety and Emergency Preparedness

- Survey Agency staff will be provided the information regarding the OIG findings in the 20 nursing facilities and as these homes are due for recertification, special attention to the areas of concern will be addressed. A number of these homes have been prioritized for a recertification survey between April 2023 and November 2023 based on the OIG findings **This prioritization began in April 2023 and will be completed by the end of CY 2023**

OIG Recommendation 2:

Provide training to State surveyors to ensure that deficiencies related to life safety, emergency preparedness, and infection control are consistently identified.

State Response:

The State concurs with the recommendation to provide training to State surveyors to ensure that deficiencies related to life safety, emergency preparedness, and infection control are consistently identified. The State met with the OIG in early 2023 to discuss the preliminary results of the review and created a plan to assure ongoing continuing education (CE) through multiple outlets for staff.

Action Plan:

Infection Control

- Infection Control Positions - In recognition of the difficulties both State Agency (SA) staff and providers have in keeping current with infection prevention practices, the SA created 2 dedicated Infection Prevention and Control (IPC) Full-Time Equivalent (FTE). One FTE is a nurse with IPC background who also acts as the liaison between the SA and the local and state health jurisdictions. One IPC has a background in Public Health and/or epidemiology. Together these FTEs will be able to provide training and support to SA staff and providers in infection control regulations, standards, and best practices. *Completion date:* **Both positions will be filled by the end of November 2023**
- Expanded the SA enrollment in the Association for Professionals in Infection Control and Epidemiology (APIC) to increase participation in the local and national chapter meetings and obtain current relevant information that can be utilized in trainings for staff. Previously the SA did not belong to the Association and only participated in the Association programing by sending 2 staff to the yearly conference. The SA now pays for full Association membership for 4 FTEs to allow for full participation in all Association activities related to Infection control *Completion date:* **April 2023 and ongoing**
- Support Calls - The SA provides monthly 2 hour virtual meetings for all staff for continuing education purposes. All staff are welcome and the trainings are recorded for those who are unable to attend the live call. *Completion date:* **April 2023 and ongoing**

    - Monthly Infection Prevention and Control (IPC) specific Support Calls were provided between March 2022 - March 2023
    - From April 2023 ongoing the dedicated IPC calls are quarterly
    - IPC topic slides (up to 15 min) continue to be presented at each Monthly Support Call even when the focus of the call is not directly related to IPC
    - Each call includes a live Q&A for staff to bring up topics they are not sure how to address. This includes any Infection Control questions
- A weekly Infection Prevention and Control focused article is included as a part of the SAweekly newsletter for staff *Completion date:* **April 2023 and ongoing**
- Just-in-time IPC advice/support for staff questions on current guidance, references & resources needed is provided via direct email *Completion date:* **April 2023 and ongoing**
- Creation of "Ask RCS" dedicated email where staff can submit IPC or general topic questions & receive answers at the monthly support call *Completion date:* **April 2023 and ongoing**
- Basic IPC education in Standard & Transmission Based precautions included in New Employee Orientation onboarding for all staff *Completion date:* **April 2023 and ongoing**
- All NH SA staff take the required CMS Quality, Safety and Education Portal (QSEP) infection control trainings, as well as the *CDC TRAIN* IPC courses that were created for NH IPC staff. This is also prioritized as a part of new employee onboarding. *Completion date:* **April 2023 and ongoing**
- In Partnership with Washington State Department of Health:
    - Ongoing IPC education for NH staff every quarter during the IPC Support Call. July, October 2023 - January & March 2024. *Completion date:* **July 2023 and ongoing**
    - Provider Training: Flu, infection control, respiratory protection, PPE *Completion date:* **Ongoing**
    - The SA assisted in the creation of training for the Local Health Jurisdictions (LHJ) regarding Long-Term Care (LTC)setting regulatory requirements to help the LHJs better understand and support LTC communities in WA *Completion date:* **July 2023**
    - Ongoing participation in the Healthcare-Associated Infections and Antimicrobial Resistance Advisory Committee *Completion date:* **Ongoing**

Emergency Preparedness

- Emergency Preparedness positions - In recognition of the need for increased structure, both within the SA and for many of the providers, related to emergency preparedness, as well as the need for ongoing education and support for providers and SA staff, the SA created 2 dedicated emergency preparedness FTEs. One FTE to work with stakeholders on rules, policies, and procedures related to emergency preparedness, and one FTE to work with SA staff and providers on creating Emergency prep systems, as well as

providing ongoing education and support. *Completion date:* **Both positions will be filled by the end of November 2023**

OIG Recommendation 3:

Educate nursing home management that life safety and emergency preparedness training resources are available to nursing home staff.

State response: The State concurs with the recommendation to provide training to providers to ensure that deficiencies related to life safety, emergency preparedness, and infection control are consistently identified and addressed. The State met with the OIG in early 2023 to discuss the preliminary results of the review and created a plan to assure ongoing continuing education (CE) through multiple outlets for providers.

Action Plan:

Infection Control

- Infection Control positions - In recognition of the difficulties both SA staff and providers have in keeping current with infection prevention practices, the SA created 2 dedicated Infection Prevention and Control (IPC) FTEs. One FTE is a nurse with IPC background who also acts as the liaison between the SA and the local and state health jurisdictions. One IPC has a background in Public Health and/or epidemiology. Together these FTE will be able to provide training and support to SA staff and providers in infection control regulations, standards, and best practices. *Completion date:* **Both positions will be filled by the end of November 2023**

- A website supported by the SA is available to Nursing home providers where they can access updated information, educational materials, and tools. The SA added a link on this website to the CMS Quality, Safety and Education Portal (QSEP) training site (the site used by SA staff for training) with an explanation regarding what the site is and what the site offers. This site has a great deal of training information related to infection control, life safety, and emergency prep and is used to prepare SA staff for their role as surveyors and investigators. A *Dear Administrator* letter was sent to providers making them aware of this new resource. *Completion date:* **July 2023 link posted, November 2023 Letter sent**

- Revamp and restart the Quarterly Forums with SA leadership staff and providers. Forum is 2 hours and will include "Micro-Lesson" topics based on ideas or questions raised by providers, concern areas brought forward by SA staff, or most common citations for that quarter. These topics will also include discussions about infection control, life safety, and emergency preparedness. *Completion date:* **July 2023 and ongoing**

- The SA created a Long-Term Care Quality Improvement (LTC QIP) Program to support providers using a non-punitive quality improvement approach. Services are voluntary. These services include protocols for assessment and strategies for organization and individual change in care areas such as infection prevention and control. Providers are referred to the program through:
    - RCS review of regulatory compliance history
    - Recommendation of RCS Field Manager
    - Provider request to RCS Field Manager

    Completion date: **April 2023 and ongoing**

Emergency Preparedness

- Emergency Preparedness positions - In recognition of the need for increased structure, both within the SA and for many of the providers, related to emergency preparedness, as well as the need for ongoing education and support for providers and SA staff, the SA created 2 dedicated emergency preparedness FTEs. One FTE to work with stakeholders on rules, policies, and procedures related to emergency preparedness, and one FTE to work with SA staff and providers on creating Emergency prep systems, as well as providing ongoing education and support. *Completion date:* **Both positions will be filled by the end of November 2023**
- A website supported by the SA is available to Nursing home providers where they can access updated information, educational materials, and tools. The SA added a link on this website to the CMS Quality, Safety and Education Portal (QSEP) training site (the site used by SA staff for training) with an explanation regarding what the site is and what the site offers. This site has a great deal of training information related to infection control, life safety, and emergency prep and is used to prepare SA staff for their role as surveyors and investigators. A *Dear Administrator* letter was sent to providers making them aware of this new resource. *Completion date:* **July 2023 link posted, November 2023 Letter sent**
- Revamp and restart the Quarterly Forums with SA leadership staff and providers. Forum is 2 hours and will include "Micro-Lesson" topics based on ideas or questions raised by providers, concern areas brought forward by SA staff, or most common citations for that quarter. These topics will also include discussions about infection control, life safety, and emergency preparedness. *Completion date:* **July 2023 and ongoing**
- We will work with other SA involved in Emergency preparedness to assure a coordinated effort to help facilities understand the magnitude of what an Emergency Preparedness program needs and how providers can establish and maintain that level of preparedness. This will be done through participation in monthly and quarterly Statewide Health Care Emergency Response network meetings *Completion date*: **April 2023 and ongoing**
- Facilities tend to have a high turnover rate with their staffing. We will prioritize working more closely with them on survey to assure they are aware of the resources available for better education around requirements. *Completion date:* **April 2023 and ongoing**

Life Safety

- A website supported by the SA is available to Nursing home providers where they can access updated information, educational materials, and tools. The SA added a link on this website to the CMS Quality, Safety and Education Portal (QSEP) training site (the site used by SA staff for training) with an explanation regarding what the site is and what the site offers. This site has a great deal of training information related to infection control, life safety, and emergency prep and is used to prepare SA staff for their role as surveyors and investigators. A Dear Administrator letter was sent to providers making them aware of this new resource. *Completion date*: **July 2023 link posted, November 2023 Letter sent**
- Revamp and restart the Quarterly Forums with SA leadership staff and providers. Forum is 2 hours and will include "Micro-Lesson" topics based on ideas or questions raised by providers, concern areas brought forward by SA staff, or most common citations for that quarter. These topics will also include discussions about infection control, life safety, and emergency preparedness. *Completion date:* **July 2023 and ongoing**
- Facilities tend to have a high turnover rate with their staffing. We will prioritize working more closely with them on survey to assure they are aware of the resources available for better education around requirements. *Completion date***: April 2023 and ongoing**