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Onsite Surveys of Nursing Homes During the COVID-19 Pandemic: March 23–May 30, 2020

Christi A. Grimm
Principal Deputy Inspector General
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Report in Brief

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CMS and States share responsibility for oversight of the Nation's nearly 16,000 nursing homes. Following CMS protocols, States conduct onsite surveys to assess compliance with Federal requirements and to investigate complaints. In response to the COVID-19 pandemic, CMS suspended annual "standard" surveys in March 2020 and introduced a new focused infection control survey. On June 1, 2020, CMS directed States to conduct these focused surveys for all nursing homes and to continue surveys for the most serious complaints.

Key Takeaway

States conducted onsite surveys at 31 percent of nursing homes from March 23 through May 30, 2020, fewer than during the same time period in 2019 when States and CMS were under normal operations and conducting standard and other surveys. These surveys resulted in few deficiencies but allowed States to provide nursing homes with guidance and other support. States had challenges in securing personal protective equipment and sufficient staff to conduct onsite surveys.

Why OIG Did This Review

We did this review to determine the number and results of onsite surveys of nursing homes during the COVID-19 pandemic. Nursing home residents are particularly vulnerable to infectious diseases such as COVID-19, and infection control has been a persistent problem for most nursing homes. As of November 8, 2020, more than 67,000 nursing home residents have died of COVID-19, which represented almost 30 percent of all COVID-19 deaths in the United States at that time. Onsite State surveys, conducted on behalf of the Centers for Medicare & Medicaid Services (CMS), assess the quality of services in nursing homes, a critical function for protecting residents. CMS changed survey practices in response to the pandemic. These changes—together with nursing home residents' high-risk status and the importance of the State surveys—warrant close examination to assess the sufficiency of this oversight.

How OIG Did This Review

We analyzed CMS administrative data to determine the number of focused infection control and complaint surveys conducted from March 23 through May 30, 2020. We also identified the number and types of deficiencies cited as a result of these surveys. We interviewed officials in CMS and 10 States to learn more about their approaches to oversight, challenges to conducting onsite surveys, and experiences during the COVID-19 pandemic.

What OIG Found

Overall, States conducted onsite surveys at 31 percent of nursing homes from March 23 through May 30, 2020; however, States varied significantly. During the same time period in 2019—when States and CMS were under normal operations—53 percent of nursing homes received an onsite survey. The infection control surveys conducted during this timeframe in 2020 resulted in few deficiencies, in part because of their limited scope and less surveyor time onsite. State officials reported ongoing challenges to securing personal protective equipment (PPE) and surveyors. States provided guidance and other support—such as training—to nursing homes outside of the survey process. State officials reported concerns about mounting backlogs of standard and complaint surveys, as the pandemic continues.

What OIG Recommends

We recommend that CMS assess the results of the infection control survey and revise the survey as appropriate. We also recommend that CMS work with States to overcome challenges with PPE and staffing, and that it clarify expectations for States to complete backlogs. CMS did not explicitly concur with our recommendations to assess and revise the infection control survey or to clarify expectations for States to complete backlogs but stated that it has taken steps to implement those recommendations. CMS did not concur with our recommendation to work with States to overcome challenges with PPE and staffing, citing its lack of authority to address issues of allocating PPE and staff. OIG continues to recommend that CMS identify opportunities within its authority to support States facing challenges with PPE and staffing.

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BACKGROUND

Objectives

1. To determine the number and results of surveys of nursing homes conducted by the Centers for Medicare & Medicaid Services (CMS) and State survey agencies (States) from March 23 through May 30, 2020.
2. To describe challenges that CMS and States experienced in conducting nursing home oversight during the COVID-19 pandemic and their insights into their experiences.

Background

Nursing home residents are particularly vulnerable to infectious diseases such as COVID-19 because of their age and underlying medical conditions.[1] The early COVID-19 outbreak at the Life Care Center in Kirkland, Washington, killed at least 37 people and demonstrated just how quickly infections can spread through a nursing home.[2] As of November 8, 2020, more than 67,000 nursing home residents have died of COVID-19, which represents almost 30 percent of all U.S. COVID-19 deaths.[3, 4]

Infection control has been a persistent problem for nursing homes.[5] From 2013 through 2017, CMS and State surveyors cited 82 percent of nursing homes with infection control deficiencies, and half of those homes were cited across multiple years.[6] During the COVID-19 pandemic, these longstanding problems may be exacerbated by numerous challenges, including ensuring adequate staffing, equipment, and supplies, especially testing supplies and personal protective equipment (PPE).[7,8]

CMS plays a pivotal role in the oversight of nursing homes to ensure quality care and safety for residents. During the COVID-19 pandemic, CMS suspended some of its usual oversight activities and introduced a new oversight tool focused on infection control. In addition, CMS is providing COVID-19-related guidance and other supports to help meet the emerging and evolving needs of residents and the staff in nursing homes during the pandemic.

Nursing Home Oversight Prior to the COVID-19 Pandemic

Onsite nursing home surveys are a fundamental safeguard to ensure that nursing home residents are safe and receive quality care. CMS, in conjunction with States, oversees nearly 16,000 Medicare and Medicaid nursing homes to ensure that they meet Federal requirements.[9, 10, 11] States conduct standard certification surveys (standard surveys) on behalf of CMS for nursing homes on average every 12 months

but at least every 15 months.[12, 13] These surveys evaluate the safety and quality of care that nursing homes provide.[14, 15] In addition, between standard surveys, States conduct complaint surveys as needed in response to allegations of noncompliance with Federal requirements from residents, their families, and nursing home staff, among others.[16]

Surveyors from CMS regional offices may also conduct surveys. CMS surveyors conduct Validation Surveys and Federal Oversight Support Surveys to observe and assess State surveyor performance. CMS surveyors also conducted infection control and complaint surveys during the COVID-19 pandemic. In this report, we include surveys conducted by CMS when we reference State surveys. Together, standard and complaint surveys ensure that nursing homes meet minimum Federal requirements, provide quality of care to all their residents, identify problems, and correct those problems.

Standard Surveys. To monitor nursing home compliance with requirements for participation in Medicare and Medicaid, CMS enters into agreements with each State survey agency. State survey agencies conduct standard surveys of the State's nursing homes and investigate nursing home complaints on behalf of CMS.[17, 18] Standard surveys assess nursing home compliance with the CMS requirements for participation and evaluate the safety and quality of nursing home care.[19,]

Multidisciplinary teams of surveyors, including at least one registered nurse, complete a set of both offsite and onsite tasks to assess the nursing home.[20] Offsite tasks include, but are not limited to, a review of the nursing home quality measures, statements of deficiencies, and complaints.[21] While onsite, surveyors follow a protocol that includes a tour of the facility for observation, reviews of medical records, and interviews with residents, family, and staff, among other activities.[22]

Surveyors cite deficiencies when they observe a nursing home in violation of Federal requirement. Surveyors also determine the scope and severity of each deficiency. The scope of a deficiency refers to the number of residents affected. The severity of a deficiency refers to its impact and is categorized using four levels of harm, with the two highest levels of harm defined as actual harm that is not immediate jeopardy and immediate jeopardy to resident health or safety.[23, 24]

Complaint Surveys. In addition to conducting standard surveys, State survey agencies conduct onsite surveys to investigate complaints from residents, their families, nursing home staff, and others.[25] CMS provides States with procedural guidelines for how to intake, prioritize, and investigate complaints for Medicare/Medicaid-certified nursing homes.[26] To determine whether a complaint warrants an onsite survey, CMS requires that a qualified professional with knowledge of clinical standards and Federal requirements triage each complaint by assigning it a priority level.[27]

A complaint's priority level determines the State's required timeframe for investigation. The two most serious priority levels are immediate jeopardy (IJ) and

non-immediate jeopardy–high (high priority). These complaints allege serious injury or that there may be harm and require a rapid response to address the complaint and ensure residents' safety.[28] States must initiate investigations of IJ complaints within 2 business days of receipt and high-priority complaints within 10 business days of prioritization. From 2011 through 2018, the largest source of complaints overall—and of IJ complaints specifically—has consistently been family members of nursing home residents (about 40 percent).[29, 30]

States also conduct onsite surveys in response to nursing home incidents.[31] Incidents are self-reported by the nursing home, and nursing homes must report incidents that involve allegations of abuse, neglect, exploitation, or mistreatment.[32] As with complaints, States must conduct onsite surveys for IJ incidents.[33]

Oversight of State Survey Agency Performance. CMS oversees State survey agencies and evaluates their performance in conducting surveys.[34] The State Performance Standards System is an annual assessment that establishes performance measures and thresholds for acceptable performance. Acceptable performance is determined by three survey "dimensions": frequency, quality, and enforcement and remedy.[35] The performance measures include expectations that States begin complaint surveys within required timeframes for 95 percent of complaint allegations and that all nursing homes are surveyed at least once every 15.9 months.[36]

The Emergence of COVID-19

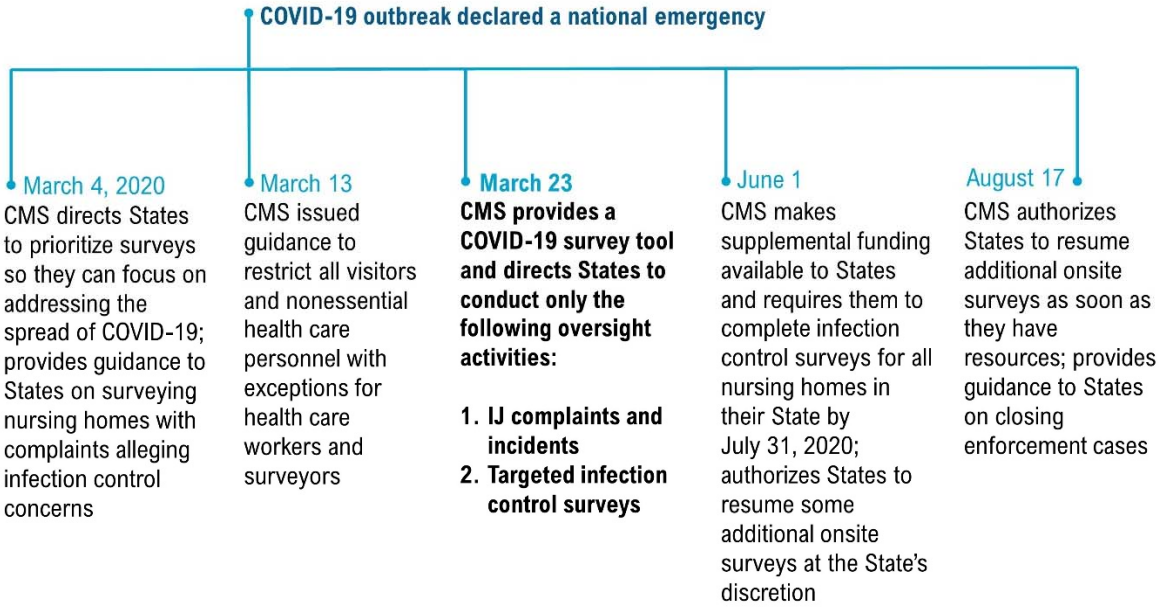
COVID-19 is a disease caused by a highly contagious coronavirus with symptoms that can include fever, fatigue, dry cough, and shortness of breath. It can be fatal in some cases.[37, 38] The first reported case of COVID-19 in the United States was on January 20, 2020.[39] On February 26, the nursing home Life Care Center of Kirkland, Washington, notified State officials of an outbreak of respiratory illness that was later determined to be COVID-19.[40]

On March 11, 2020, the World Health Organization characterized COVID-19 as a pandemic, which refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.[41, 42, 43] On March 13, 2020, President Trump declared the COVID-19 outbreak to be a national emergency.[44] The national emergency declaration triggered the Department of Health and Human Services (HHS) Secretary's authority, under section 1135 of the Social Security Act, to temporarily waive certain requirements, including requirements for oversight surveys of nursing homes.[45] Under this waiver authority, beginning in March 2020, CMS prioritized certain Federal and State surveys and suspended others to focus State and nursing home resources on limiting the spread of COVID-19.[46, 47]

CMS Guidance to States on Oversight of Nursing Homes During the COVID-19 Pandemic

Starting in February, CMS issued a series of guidance documents adjusting its approach to nursing home oversight to focus on addressing and preventing the spread of COVID-19. See Exhibit 1 below for a timeline of key CMS guidance to States early in the COVID-19 pandemic. See Appendix A for the complete list of CMS memos to States from February 2020 through June 2020.

Exhibit 1: Timeline of key CMS guidance to States early in the COVID-19 pandemic.



Source: OIG analysis of CMS guidance, 2020.

COVID-19-Focused Survey for Nursing Homes

As part of its March 23 guidance, CMS provided the COVID-19-focused survey tool for nursing homes to assess compliance with infection control.[48] The survey tool includes a focused framework of several infection control categories that are associated with the transmission of COVID-19 and other communicable diseases and infections, including hand hygiene, PPE, and infection surveillance, among other areas. CMS also provided a brief training and protocol to help surveyors prioritize survey activities while onsite and identify activities that they could complete offsite to decrease the transmission of COVID-19.[49, 50] The protocol also instructs States to ensure surveyors are trained in the proper use of PPE and to refrain from conducting onsite surveys if surveyors are unable to meet the PPE expectations outlined by Centers for Disease Control and Prevention (CDC).[51]

Related OIG Work

This study is part of a larger body of forthcoming work from the Office of the Inspector General (OIG) examining the impact of COVID-19 on nursing homes. For instance, OIG has work underway that will describe the characteristics of the nursing homes that were hit hardest by COVID-19 (i.e., homes with high numbers of residents who had COVID-19 or had died). This work will also describe the strategies nursing homes have used to mitigate the effects of COVID-19 on their residents and staff in the face of these unique circumstances.[52] Other forthcoming OIG work will determine whether selected nursing homes have programs for infection prevention and control and emergency preparedness in accordance with Federal requirements.[53] OIG also has work underway that will assess nursing homes' reporting of CMS-required information related to the COVID-19 pandemic.[54]

In addition, OIG has several evaluations and audits of nursing home oversight and quality of care that began prior to the COVID-19 pandemic. Two are particularly relevant to this evaluation. One is a report examining complaint trends in nursing homes. This report updates OIG's 2017 data brief and finds that States continued to fall short in meeting required timeframes for investigating nursing home complaints.[55] To complement this report, OIG has published an updated interactive map that illustrates State-by-State trends in nursing home complaints for 2016 through 2018. The interactive map is available at https://oig.hhs.gov/oei/maps/2019-nursing-home/index.asp. The other is a forthcoming OIG report that examines CMS oversight of State survey agency performance specific to nursing homes and may identify additional opportunities or recommendations for CMS to improve performance.[56] A complete listing of OIG's ongoing evaluations and audits is available in our online Work Plan at https://www.oig.hhs.gov/.

Abbreviated Methodology

Data Sources and Analysis

CMS Complaint and Incident Data. We analyzed Automated Survey Processing Environment (ASPEN) Complaints/Incidents Tracking System (ACTS) data on nursing home complaints and incidents that State survey agencies received during the same 2019 and 2020 time periods. We analyzed these data to determine the number of overall complaints and incidents States received, the number of complaints and incidents that States prioritized as IJ, and the sources of complaints (e.g., residents' family members) from March 23 through May 30, 2019, and from March 23 through May 30, 2020. We used a longer time span of data in the calculation to identify the backlog of high-priority complaints (March 23 through June 28, 2020). This longer timespan was only available for this measure.

CMS Survey and Deficiency Data. We used CMS's publicly available data on Nursing Home Compare to examine onsite surveys (infection control surveys and IJ complaint surveys) and resulting deficiencies from March 23 through May 30, 2020. We used

ASPEN and Certification and Survey Provider Enhanced Reports (CASPER) data from CMS to analyze trends in nursing home surveys and deficiencies in the same 2019 time period to provide historical context. Specifically, we assessed trends in standard surveys, surveys related to complaints/incidents, and resulting deficiencies from March 23 through May 30, 2019.

Review of CMS-2567 Forms. We conducted a limited review of CMS-2567 (statements of deficiencies) forms from onsite surveys during the pandemic. Using the CMS-2567 forms that CMS made available on Nursing Home Compare on June 24, 2020, we identified and reviewed all 68 CMS-2567 forms that included the F-880 infection prevention and control deficiency from March 23 through May 30, 2020. The CMS-2567 forms included the specific instances of noncompliance that resulted in the deficiency citation. Deficiencies may be based on more than one instance of noncompliance.

We reviewed the narrative of each CMS-2567 form and categorized the instances of noncompliance into one or more category to determine the most common reasons for noncompliance with infection control practices (e.g., hand hygiene).

Interviews with CMS and State Survey Agencies. Finally, we interviewed leadership in CMS's Survey and Operations Group and the Quality, Safety, and Oversight Group regarding their approach to oversight during the pandemic. We also interviewed a purposive sample of 10 States regarding their experiences and challenges conducting surveys during the pandemic. We selected the sample of 10 States to ensure that we included States with a range of impact from COVID-19 and to represent each of the 10 CMS locations. We conducted these interviews from June 9 through June 18, 2020.

See the Detailed Methodology section on page 26 for additional information about our data collection and analysis.

Limitations

We did not assess the extent to which the data in ACTS, ASPEN/CASPER, and Nursing Home Compare are complete. We also did not assess the appropriateness and quality of State responses to complaints and incidents or survey results. In addition, the complaint survey data from ASPEN/CASPER includes the four most recent complaint surveys in each nursing home, rather than all complaint surveys conducted in 2019. Our analysis includes self-reported data from States that we did not independently verify.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Overall, States conducted onsite surveys at 31 percent of nursing homes from March 23 through May 30, 2020; however, States varied significantly

Prior to the COVID-19 pandemic, States regularly conducted standard surveys to assess whether nursing homes met minimum Federal requirements, including evaluating nursing homes' safety and quality of care. In addition, States conducted complaint surveys as needed in response to allegations from residents, their families, and nursing home staff. The COVID-19 pandemic prompted CMS to issue policy that changed the State survey process. On March 23, 2020, CMS directed States to suspend standard surveys and conduct COVID-19-focused infection control survey for nursing homes (infection control surveys) and surveys for the most serious (IJ) complaints/incidents. CMS stated that the change in survey activities was to focus State and nursing home resources on limiting the spread of COVID-19. In June, CMS updated its direction to States to require that they conduct infection control surveys for all nursing homes by July 31, 2020.

During this time period, States conducted onsite infection control and complaint surveys.

States conducted infection control surveys and/or IJ complaint/incident surveys for 31 percent of nursing homes from March 23 through May 30, 2020. For reference, 53 percent of nursing homes received an onsite survey during the same time period in 2019, when States and CMS were conducting standard surveys and surveys for all complaints that required one. Overall, during this time in 2020, States conducted 7,193 onsite surveys in 4,805 nursing homes.[57] States surveyed 1,169 nursing homes more than once during this time period.

31%

of nursing homes had an onsite survey from March 23 through May 30, 2020

States reached most of these nursing homes for an onsite survey in the first month of this time period. From March 23 through April 23, States surveyed 19 percent of nursing homes onsite. By May 30, States and CMS had surveyed an additional 12 percent of nursing homes onsite. Although outside the scope of our analysis, CMS reported that more than 99 percent of nursing homes had some type of onsite survey from March 1 through August 21, 2020.[58]

States we spoke with used their own criteria to prioritize nursing homes for infection control surveys. Most States used nursing homes' prior deficiency citations or chose

homes with high numbers of COVID-19 infections and deaths to target these surveys. For example, one State gave top priority to nursing homes with a history of multiple infection control deficiencies. Some States used other criteria, such as complaints received against a nursing home or the number of COVID-19 cases in the local community.

Over two-thirds of States surveyed fewer than 10 percent of their nursing homes in the first month following CMS's directive to conduct only infection control surveys and immediate jeopardy complaint surveys.

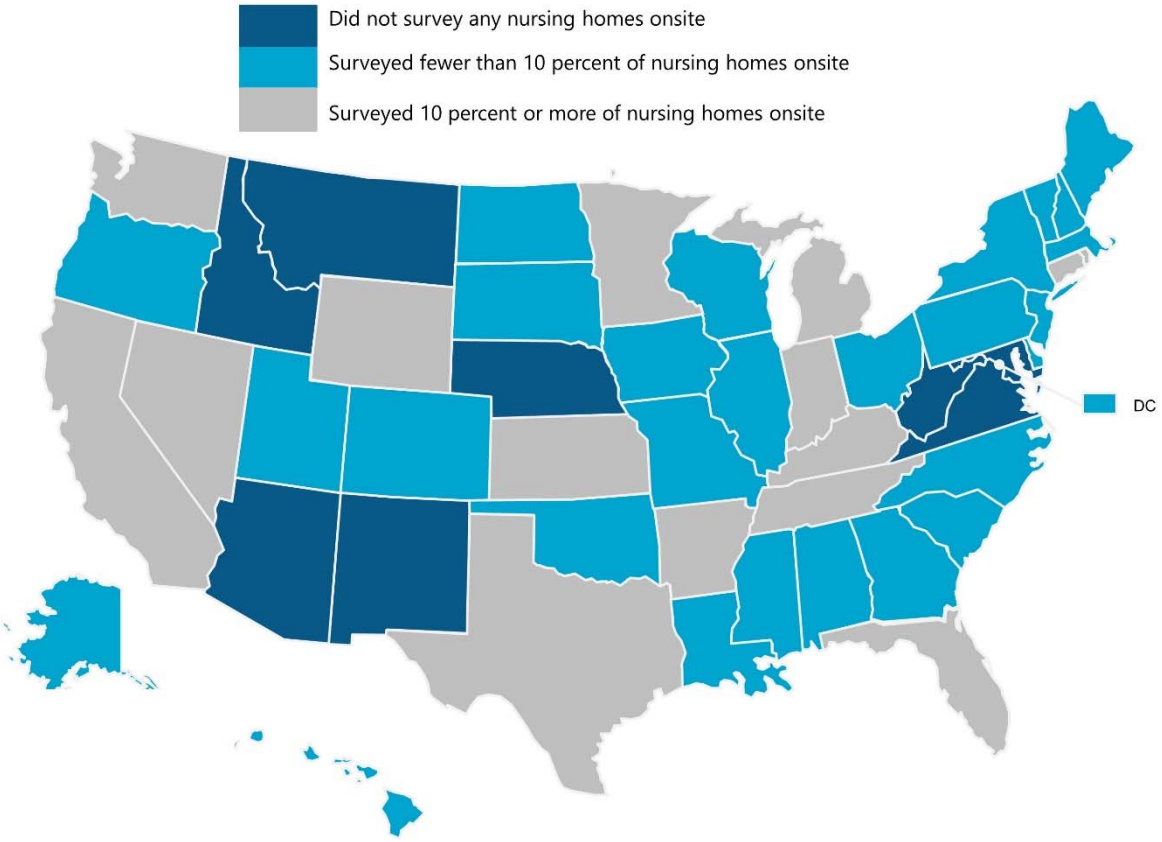
In the first month after CMS suspended certain surveys (from March 23 through April 23, 2020), 36 States surveyed fewer than 10 percent of their nursing homes onsite, and 8 States did not survey any nursing homes onsite: Arizona, Idaho, Maryland, Montana, Nebraska, New Mexico, Virginia, and West Virginia (see Exhibit 2 on the next page). Overall, States surveyed 13 percent of their nursing homes on average in this first month. For reference, in 2019, States surveyed 23 percent of their nursing homes per month on average. CMS's suspension of certain surveys—as well as States' challenges with getting equipment and staff needed to survey nursing homes onsite—contributed to the difference in onsite survey activity between 2019 and this first month after CMS's directive. See Appendix B for details on the percentage of nursing homes that received a survey from March 23 through April 23 and the average per month during 2019, by State.

The 10 States we interviewed in mid-June expected to meet CMS's July 31 deadline to survey all nursing homes, but some with substantial difficulty.

Some State officials were surprised by CMS's July 31 deadline requiring States to survey all nursing homes. One State pointed out that the timeframe was tight for the States that had a slow start on their surveys. Officials from another State reported that given the high threat of COVID-19 for nursing home residents, they had always planned to survey all nursing homes.

Although outside the scope of OIG's analysis of surveys, CMS reported to the Nursing Home Compare website that these 10 States had surveyed at least 98 percent of their nursing homes as of August 21, 2020. These results are based on data beginning March 1 and include some surveys conducted prior to the directive to suspend certain survey activities.

Exhibit 2: Most States surveyed fewer than 10 percent of their nursing homes in the month following CMS's directive to conduct only infection control surveys and surveys in response to immediate jeopardy complaints.



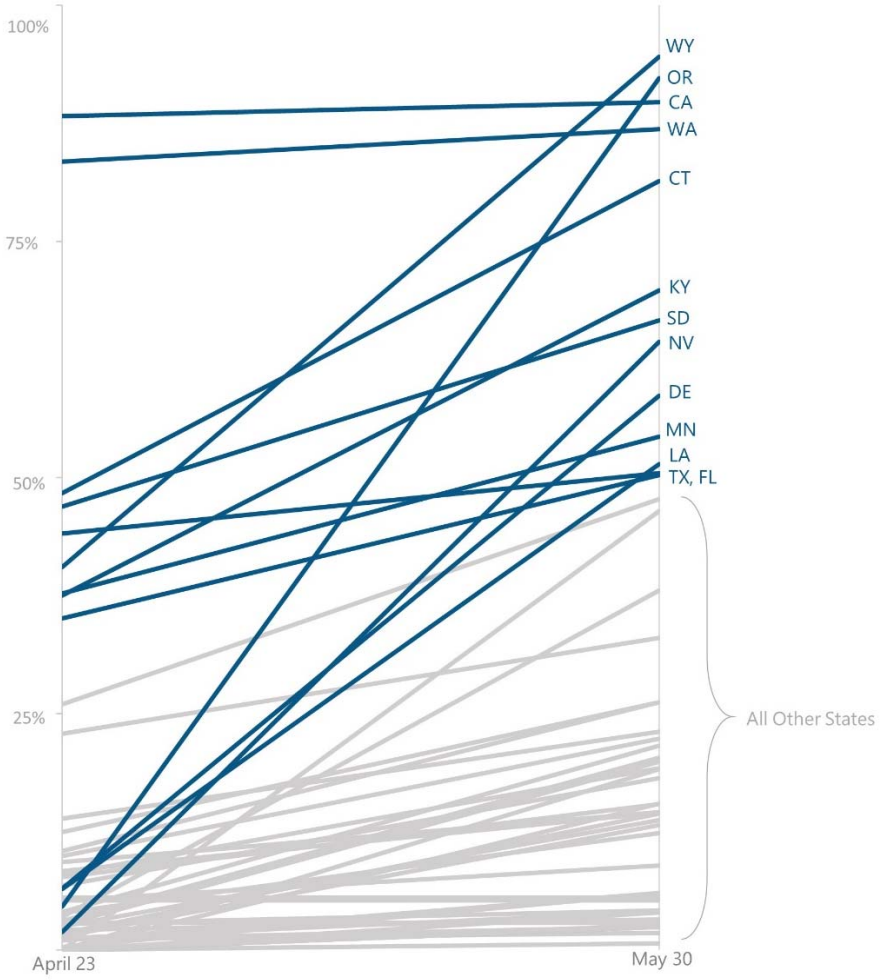
Source: OIG analysis of Nursing Home Compare data, 2020.

A couple of States reached far more nursing homes for onsite surveys than others in the first month following CMS's directive. California and Washington conducted onsite surveys for about 85 percent of nursing homes in their States during this month-long period. In addition, both States surveyed some of their nursing homes more than once. California required nursing homes to submit their daily numbers of staff and COVID-19-positive cases (prior to this being required by CMS), and the State developed a dashboard to identify high-risk facilities for onsite surveys. As California further developed the dashboard and metrics, officials formed a "strike team" to survey nursing homes with urgent problems and used predictive analytics to create a list of high-risk facilities, calculating risk by using deficiencies cited, proximity to hot spots, and other factors. Washington obtained PPE for surveyors early and was therefore able to get its surveyors onsite early to conduct surveys. Washington also surveyed some nursing homes multiple times in response to outbreaks.

As the COVID-19 pandemic progressed, some States notably increased their surveys, while others did not. By May 30, three additional States had surveyed over 80 percent of their nursing homes onsite since March 23: Connecticut, Oregon, and Wyoming. In addition, 13 States surveyed 50 percent or more of their nursing homes by May 30, compared to the 2 States that had done so in the first month. Several of these States greatly increased their onsite survey activity in May. For example, Oregon surveyed 5 percent of its nursing homes onsite in the first month, but this increased to 92 percent by May 30. (See Exhibit 3 on the following page for the 13 States that surveyed 50 percent or more of their nursing homes.) However, 16 States still surveyed less than 10 percent of their nursing homes through May. (See Appendix C for the percentage of nursing homes surveyed in each State during the period of March 23 through May 30.)

Between March 23 and May 30, States experienced different degrees of COVID-19 outbreaks, likely affecting the extent to which States could survey nursing homes and when they could conduct those surveys. For example, New York and New Jersey experienced severe COVID-19 outbreaks in March and April and they surveyed 3 percent and 8 percent, respectively, of their nursing homes in the first month following CMS's directive. By May 30, these two States had surveyed about 20 percent of their nursing homes. Other States, such as Florida and Texas, did not experience severe COVID-19 outbreaks during this time and surveyed 50 percent of their nursing homes onsite by the end of May. As outbreaks continue to affect different States at different times, States' ability to survey nursing homes onsite will likely change. For example, States may need to redirect surveyors or prioritize PPE if they experience an outbreak.

Exhibit 3: Thirteen States surveyed 50 percent or more of their nursing homes by May 30, 2020.



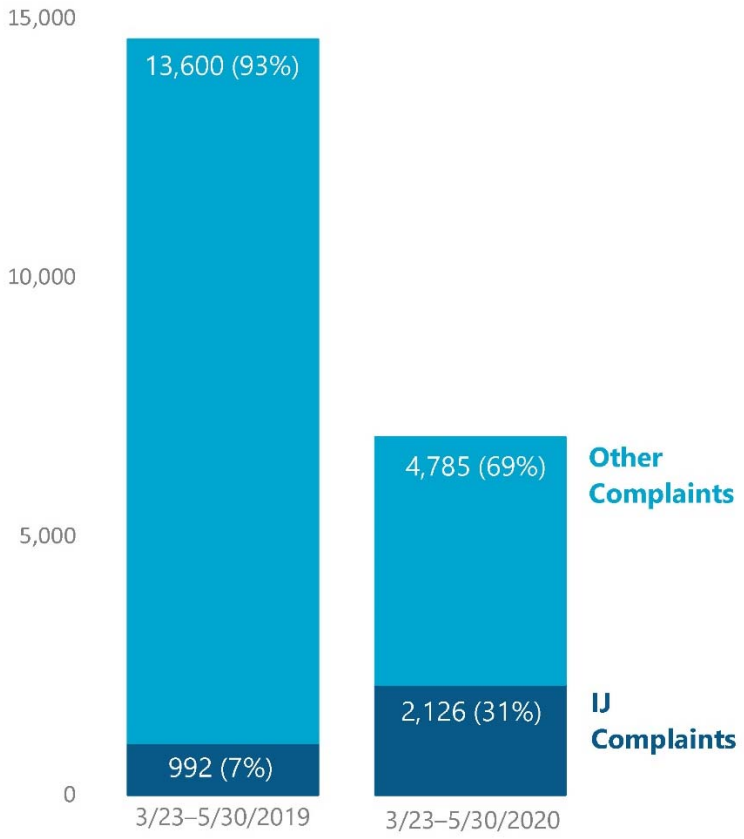
Source: OIG analysis of Nursing Home Compare data, 2020.

States prioritized more nursing home complaints as immediate jeopardy from March 23 through May 30, 2020, than during the same months in 2019 but received half as many complaints overall.

In addition to conducting infection control surveys, States conducted surveys for IJ complaints and incidents. During the COVID-19 pandemic, States have prioritized a much higher proportion of complaints as IJ. From March 23 through May 30, States prioritized 31 percent of complaints as IJ, compared to about 7 percent in the same time period in 2019. (See Exhibit 4 on the next page.) States and CMS reported that

because COVID-19 increases the likelihood of serious harm or death for residents, some States prioritized more complaints related to infection control as IJ. Not surprisingly, States also received proportionally more complaints regarding infection control during the pandemic. From March 23 through May 30, the data showed that 23 percent of complaint allegations were related to infection control. During this same time period in 2019, 1 percent of complaint allegations were related to infection control.

Exhibit 4: States prioritized a higher percentage of complaints as immediate jeopardy during the COVID-19 pandemic, but they received half as many complaints as in 2019.



Source: OIG analysis of ACTS data, 2020.

Although States prioritized a high proportion of complaints as IJ, they received far fewer complaints overall. From March 23 through May 30, States received about half the number of nursing home complaints as compared to the same time period in 2019: from 14,592 in 2019 to 6,911 in 2020. (See Exhibit 4.) Starting on March 13, CMS issued guidance to nursing homes to restrict all visitors and non-essential health care personnel to limit the spread of COVID-19 and to protect residents. This change resulted in fewer people in nursing homes to observe conditions and likely contributed to fewer complaints in the following months.

Historically, the most common source of complaints has been nursing home residents' family members, who in 2019 submitted about 6,000 complaints from March 23 through May 30. That number fell to about 2,000 for the same time period in 2020. Trends in total incidents self-reported by nursing homes and those incidents that States prioritized as IJ were similar to trends in complaints.[59]

From March 23 through May 30, limited-scope surveys resulted in few cited deficiencies but provided opportunities for surveyors to support nursing homes

While onsite, surveyors observe conditions for compliance with the Federal requirements. Infection control and complaint surveys focus on a narrower set of compliance concerns than standard surveys, which assess the overall quality of services provided in nursing homes.[60] However, surveyors may observe and cite noncompliance with other Federal requirements during these limited-scope surveys. Surveyors can cite over 200 deficiencies, which cover topics including administration, resident rights, training, infection control, and quality of care, among others. Furthermore, while onsite, surveyors also have opportunities to share information with and provide support to nursing home staff.

States cited a deficiency in 3 percent of nursing home surveys, with infection control deficiencies cited most often

States and CMS conducted 7,193 onsite surveys from March 23 through May 30, and 3 percent (193 surveys) resulted in a cited deficiency. This represents a decrease from the 40 percent of onsite surveys resulting in a cited deficiency during the same time period in 2019 when States and CMS were conducting standard surveys and surveys for all complaints that required one. Changes in State survey activities, the limited scope of the infection control surveys, and nursing facility use of CMS's self-assessment tool may all have contributed to the decrease in deficiencies cited. During this timeframe in both 2019 and 2020, infection control problems were the most commonly cited deficiencies on nursing home surveys. Surveyors cited an infection control deficiency in 1 percent of onsite surveys from March 23 through May 30, 2020 (68 surveys), and 10 percent of surveys during the same time period in 2019.

Officials from CMS and some States reported that the limited scope of the infection control surveys and an increased focus on infection control at nursing homes contributed to the low number of deficiencies cited. Given the risk of COVID-19 to residents and staff, CMS designed the focused surveys to review aspects of care that could undermine infection control—a much narrower and more specific scope than standard surveys. According to State officials we interviewed, a more limited scope led to less time onsite by fewer surveyors. State officials told us that infection control surveys typically included one to two surveyors who were onsite for less than 2 days, and one State official explained that surveyors were onsite for about 2 hours. In

contrast, State and CMS officials told us that a standard survey includes two to five surveyors who are onsite for 3 to 5 days. State officials told us that this limited time onsite may have provided fewer opportunities for surveyors to observe noncompliance leading to fewer deficiencies being cited. CMS also provided the focused infection control survey tool to nursing homes and encouraged them to conduct self-assessments to learn about the latest practices for preventing the spread of COVID-19.[61] Some officials also reported that they believed nursing homes had increased their vigilance around infection control protocols because of the risk of COVID-19, which may have also contributed to fewer citations of infection control deficiencies.

The most common types of noncompliance cited in infection control deficiencies were improper use of PPE, contaminants on surfaces, and lapses in hand hygiene

Infection control deficiencies included noncompliance with both preventive measures to avoid the spread of disease, and noncompliance with resident care. Among the 68 infection control deficiencies cited by surveyors for all States between March 23 and May 30, the most common instances of noncompliance were improper use of PPE (43 of 68 deficiencies), contaminants on environmental surfaces (32 of 68) and lapses in hand hygiene (31 of 68). Other instances included failing to isolate infected residents and failing to provide staff education about COVID-19. For example, during an onsite survey conducted in April 2020, staff from one nursing home told surveyors that they were "unaware of a policy or procedure" specific to COVID-19.

Most of the infection control deficiencies included more than one instance of noncompliance, including practices throughout the facility such as food service, laundry, and visitor entry. Analysis of the deficiencies revealed blatantly poor practices in some instances, such as one nursing home being cited for allowing staff to continue working despite showing signs of COVID-19. Surveyors found that another nursing home failed to enforce staff PPE use and handwashing despite having 54 confirmed cases among its residents. See Appendix D for summaries of the instances of noncompliance identified for the 68 infection control deficiencies.

States reported benefits of their onsite surveys beyond assessing compliance

Even though they spent limited time onsite, States reported value in their surveys. One State official suggested that the surveys "balanced" oversight with support to nursing homes during this time. Another State official said that the State was able to support and train the nursing homes to "set them up for success" against COVID-19. Another State official said that these surveys provided an opportunity for nursing homes to openly discuss concerns with surveyors. Some States reported that CMS's self-assessment tool was a good resource and encouraged its use among nursing homes to reinforce infection control practices, to target issues of concern, and to potentially limit surveyor time onsite. In addition, State officials reported benefit from the shorter time required onsite during the abbreviated surveys. One State said that the abbreviated survey allowed surveyors to access more nursing homes more often than when the State conducted standard surveys. Another State mentioned the increased time in offsite activities associated with these surveys gave surveyors opportunities to review and follow up with nursing homes in greater depth.

> "There is no replacement for being physically present. Even if we're not citing, we're ensuring that they have all the tools they need. The presence that sends the message: you're not alone, you're not isolated, we're in this with you."
>
> **–State official**

States reported ongoing challenges to conducting safe onsite surveys of nursing homes during the COVID-19 pandemic

The health care community continues to grapple with COVID-19. The pandemic disrupted daily routines, and for many, the ability to continue working. No single roadmap existed to guide CMS's and States' oversight in this environment. State officials reported challenges to overseeing nursing homes under these conditions, and they voiced concern about mounting survey backlogs in this time of uncertainty.

States reported difficulties in conducting onsite surveys because of challenges in acquiring and fitting PPE

All of the States we interviewed reported difficulty obtaining PPE for surveyors to enter nursing homes. State officials reported that they were aware of the great need for PPE among providers and wanted to prioritize the limited amount of PPE for nursing and other medical staff. In some States—including one considered an early hot spot for its large number of COVID-19 cases—the lack of PPE delayed onsite surveys for weeks. States had particular difficulty in obtaining N95 face masks. CMS guidance stated from the outset of the pandemic that surveyors should not go onsite without protective equipment, and States reported their concerns about compromising the safety of their staff as well as that of nursing home residents.

Personal Protective Equipment (PPE)

PPE is protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer from injury or infection. PPE also includes a variety of types of respirators and face masks. A common mask type used for treatment of individuals with known or suspected cases of COVID-19 is the N95 respirator mask, a respiratory protective device designed to achieve a close facial fit and efficient filtration of airborne particles. Certain respirator masks require fit testing, during which the seal between the respirator and the face is tested for proper fit; fit testing can take 15 to 20 minutes to complete and results in a properly fitting mask of a certain make, model, and size.

States also reported difficulty in training surveyors in proper use of PPE, including putting on and taking off (donning and doffing) protective gear, and in conducting fit testing for N95 masks.[62] These difficulties were caused in part because State survey agencies did not routinely acquire or use PPE prior to the COVID-19 pandemic; rather, they received PPE from the facilities as needed when they went onsite. As another example, one State reported that some staff require medical clearance for fit testing N95 masks and that staff sometimes do not pass fit testing.

> "We did not want to be a transmission source since we knew that most cases were brought into nursing homes from the outside."
>
> **–State official**

In some cases when States were unable to secure PPE, CMS stepped in to conduct surveys, surveying hundreds of facilities in the early months of the pandemic.[63] For example, officials from one State reported that when they received IJ complaints before they could secure PPE, they requested that CMS conduct those surveys given the need for timeliness. States also sought equipment and fit testing from other sources such as the National Guard, who also visited and provided equipment and training to nursing homes. In one State, the National Guard visited every nursing home in the early weeks of the pandemic, and also joined State surveyors onsite to monitor the surveyors' donning and doffing practices. Some States also received assistance from State COVID-19 task forces—groups that included entities across State government to coordinate supplies and training.

States we interviewed reported that challenges to acquiring PPE have continued beyond the first weeks of the pandemic. Although lack of PPE was the most significant limiting factor early on, States continue to prioritize PPE for frontline workers and sometimes struggle to provide it for surveyors. As one official reported in June 2020, "Every day is a conversation about PPE." CMS officials explained that many of the challenges to acquiring PPE reflected scarcity of equipment, and not necessarily a lack of financial resources. To assist State surveyors in acquiring PPE, CMS sent a letter to governors in May 2020 encouraging them to allocate PPE resources to State surveyors.[64]

CMS also experienced challenges with surveyor availability

CMS also had difficulty in reaching some nursing homes to conduct surveys. In addition to having only 70 Federal surveyors nationwide (compared to about 8,400 State surveyors), travel restrictions limited access to some locations. CMS officials explained that in the early days of the pandemic, travel restrictions were changing, and they feared sending surveyors to hot spots when they may not be able to get home. Therefore, CMS planned survey assignments based on where surveyors could drive.

States explained that the COVID-19 pandemic exacerbated a longstanding challenge of maintaining sufficient staff levels

Securing an adequate number of surveyors is a longstanding problem for many States,[65] and State survey agencies reported that the COVID-19 pandemic led to additional shortages. Surveyors were unable to perform survey work during the pandemic for several reasons. Some surveyors had personal risk factors for contracting COVID-19, such as underlying medical conditions and older age. One State assigned these staff to tasks other than onsite surveys, including reviewing licensures and managing contact tracing.[66] One State with nurse surveyors at higher risk lent the nurses to the State's social services department to conduct clinical assistance video calls with providers. CMS officials reported that in some States, surveyors were also diverted to other urgent tasks, such as to staff testing centers and hotlines, or direct care.

Further limiting available surveyors, one State reported that individual surveyors sometimes requested to go onsite with another surveyor, even when one surveyor might technically be sufficient. The State official explained that these surveyors were accustomed to having a full team onsite (typically two to five surveyors for a standard survey) and felt uncomfortable conducting the work alone, particularly considering the added stress of having only recently learned PPE protocols, and fearing the risk of infection.

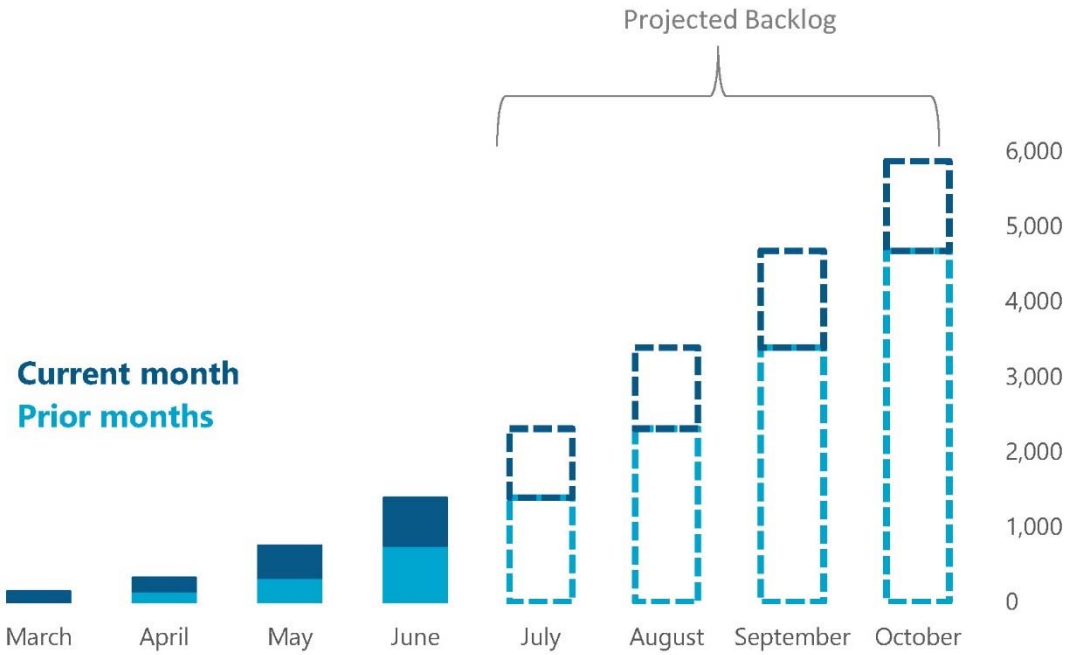
Officials from one State voiced concern that as the pandemic continues, surveyor shortages may deepen. State officials worried that the growing number of nursing home infections and deaths could make it harder to recruit and retain surveyors. To

compensate for shortages of State surveyors, States reported hiring contracted surveyors through vendors with Surveyor Minimum Qualification Test certifications.[67] States also assigned surveyors who were typically assigned to hospitals and other facility types to nursing homework.

States expressed concern about the mounting backlogs of standard surveys and high-priority complaint surveys accumulating during the COVID-19 pandemic

As of June 2020, States had delayed standard surveys and surveys in response to high-priority complaints at about one-fifth (21 percent) of nursing homes as a result of COVID-19. CMS's suspension of surveys allowed providers time to implement the most recent infection control guidance from both CMS and CDC but also created backlogs for when States resume these required surveys.[68, 69, 70] As of June 28, 2020, 8 percent of nursing homes (1,281 of 15,416) had gone more than 15 months without a standard survey and 14 percent of nursing homes (2,127) had not received surveys for high-priority complaints.[71] The backlogs could continue to grow until States resume survey activities and they may compound pre-existing problems that some States had in completing surveys within required timeframes (see Exhibit 5).

Exhibit 5: The number of nursing homes without a standard survey for more than 15 months could continue to grow.



Source: OIG analysis of ASPEN/CASPER data, 2020.

CMS authorized States to gradually expand survey activities.[72, 73, 74] As of June 1, 2020, CMS authorized States to expand certain survey activities, including standard surveys and high-priority complaint surveys, at the State's discretion.[75] CMS revised this guidance on August 17, 2020, indicating that States should resume survey activities if States have the resources to conduct the surveys.[76] Still, some States expressed concerns about completing their respective backlogs as they resume normal survey activities. Addressing the backlogs could take substantial time and make it difficult to meet the timeliness requirements for new surveys that will be due in the coming months.

Completing the backlogs of surveys as well as the upcoming surveys will add additional pressure to already tight resources and limited staff. One State estimated that it would take at least 2 years to eliminate its backlog of surveys and return to normal timeframes for completing surveys, and another reported that it would be unable to complete its backlog without external assistance. Two States also reported seeking additional funding to address their respective backlogs. (Two States made requests to CMS and one of these States also requested supplemental funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act).[77]

These backlogs—and the possibility that it could take years for States to return to normal survey timeframes—raise concerns for nursing home residents' safety and quality of care. Standard surveys are critically important for protecting nursing home residents.[78] In 2019, standard surveys identified 98,242 deficiencies at nursing homes, some involving actual harm or IJ deficiencies.[79, 80] Outside of the COVID-19 pandemic, Congress has determined that nursing homes should not exceed 15 months without a standard survey to certify compliance with Federal requirements, yet more and more nursing homes will, in fact, exceed 15 months.[81, 82] The Federal requirements include those related to resident rights and quality of care, among many others.

The backlogs in high-priority complaint surveys—which CMS also suspended—raise further concerns for resident safety and quality of care. High-priority complaints allege situations in which a nursing home's noncompliance with Federal requirements may have caused patient harm that negatively impacts residents' mental, physical, and/or psychological status. In 2019, high-priority complaints resulted in surveyors citing 21,120 deficiencies. Those complaint allegations commonly related to quality of care/treatment, resident rights, and resident neglect.

These backlogs may compound preexisting challenges that States faced in meeting required survey timeframes. According to CMS, 32 States failed to meet CMS performance standards for investigating high-priority complaints within 10 days during fiscal years 2016 through 2018 and 17 of these 32 failed to meet the performance standard in all 3 years.[83] Furthermore, 23 States did not meet CMS performance standards for conducting standard surveys within the 15-month period.[84] These past performance problems raise further concern that States may face significant difficulty in completing both their current survey activities and their backlogs. One State said that it spent 2 years overcoming performance problems

regarding survey timeliness, only to relapse during the pandemic. Officials from this State identified this relapse as their "biggest concern."

Another issue that State officials raised was their ability to manage additional surges of COVID-19 in the coming months or years. State officials expressed a desire for CMS to further finalize protocols and guidance in the future, creating even more "definitive and concrete protocols" based on lessons learned from the initial months of the pandemic. They also expressed fear of cases continuing long into the future. As one official said, "We hope that prior to [a new surge,] any additional changes that are forthcoming could come at a time where there may be a lull, so we aren't managing crises and following new protocols all at the same time."

As COVID-19 hindered onsite surveys, States made efforts to support nursing homes outside of the survey process

CMS and State officials acknowledged the enormous toll of the presence or threat of COVID-19 in nursing homes, and that much work remained to improve practices and prevent infection. State officials reported generally that they supported CMS's decision to suspend standard surveys to limit the spread of COVID-19. With the smaller number of surveys, States made efforts to increase support of nursing homes outside of the normal survey process.

> "I hope that as a Nation, we let this be an opportunity to see how we can look at quality and safety oversight in a new light, that all States are looking at creative new ways to go forward."
>
> **–State official**

In addition to their role as regulators, CMS and States placed a new emphasis on assisting nursing homes. One State survey agency reported working with State and university infectious-disease specialists to help train nursing home staff. These specialists also helped relay information about COVID-19 to nursing home providers. Another State hired social workers to communicate to resident families since nursing homes had difficulty responding to family members' concerns, such as those about new COVID-19 visitation policies.

In addition, States have communicated more with nursing homes, including conducting webinars and discussion forums, and have coordinated closely with State nursing home associations. One official said, "We have spent a lot of time telling [facilities] that they still need to communicate with residents' families. Families are champing at the bit, and if the administrator does not communicate with the families, the families call us." Another official, from a State that appeared to have recovered from a significant outbreak, explained that collaboration with nursing homes and provider associations, including guidance and webinars, resulted in improved operations.

State officials also reported assisting nursing homes with managing specific resident cases, such as by coordinating with the State Medicaid offices to transfer sick residents to facilities dedicated to COVID-19 patients. Assisting with other specific cases potentially reduced the survey workload; for example, some States worked with nursing homes and families to resolve less serious complaint issues.

CMS supported States in these expanded efforts. CMS helped States acquire supplies and support from State leadership; consulted with States on issues of guidance and regulation; and posted a toolkit of State best practices that had been compiled by Quality Improvement Organizations. States we interviewed were positive about CMS support, particularly from CMS's regional offices, citing examples of assistance and close collaboration in managing facility and resident needs.

CONCLUSION AND RECOMMENDATIONS

Conclusion

CMS has an essential, ongoing responsibility to oversee nursing homes to ensure that their residents are safe and receiving high-quality care. In March 2020, CMS adjusted its oversight approach to suspend standard surveys, prioritize the most serious complaints, elevate attention on infection control, and develop a new survey tool to ensure that nursing homes are implementing actions to prevent the spread of COVID-19.

Suspending standard surveys and surveys in response to high-priority complaints may have been the appropriate actions at that time to allow nursing homes and States to focus on responding to the COVID-19 pandemic and to reduce risks to nursing home residents, staff, and surveyors. However, the limited scope of the surveys, combined with other factors, such as a lack of PPE and limiting visitors, have resulted in less comprehensive oversight of nursing homes and residents. Onsite surveys have been fewer and shorter, and—with families often restricted from visiting—complaints have decreased. State survey agencies have shifted some of their time to providing more support to nursing homes—for example, helping homes communicate with residents' family members. Meanwhile, nursing home residents remain among those at the highest risk of COVID-19 infection and death, as evidenced by the more than 67,000 nursing home residents who have died as of November 8, 2020.

Although no system of oversight is foolproof, the spread of COVID-19 and resulting deaths in nursing homes raise questions about how well the oversight identified and addressed shortfalls in infection control.[85] As CMS continues to work with States to ensure the safety of vulnerable nursing home residents, it has an opportunity to enhance its approach to oversight and adapt this oversight to take advantage of lessons learned.

We recommend that CMS:

Assess the results of infection control surveys and revise the survey as appropriate

CMS deployed a limited-scope survey focused on infection control to ensure that nursing homes focused on preventing the spread of COVID-19 and other communicable diseases and infections. CMS should determine whether these infection control surveys are effective in determining whether nursing homes implement proper infection prevention and control practices. Because CMS mandated that States complete infection control surveys for 100 percent of nursing homes nationwide, CMS should have data from more than 15,000 nursing homes to assess the impact of this survey tool.

In considering any revisions to the infection control survey, CMS should also consider whether to add elements beyond infection control. CMS designed the infection control survey to be limited in scope so that surveyors could focus on what CMS deemed most important during the COVID-19 pandemic. However, as the pandemic continues, this interim survey protocol may not provide sufficient oversight if used in the longer term. If States are unable to resume standard surveys as the COVID-19 pandemic continues, CMS should determine whether to expand the limited scope of the infection control surveys. CMS could include assessments of additional quality of care requirements, creating a broader interim survey to be used as long as States continue to struggle obtaining PPE and staffing and may be months from reestablishing normal operations.

Work with States to help overcome challenges with PPE and staffing

CMS relies on States to ensure that nursing homes meet Federal requirements, including by conducting onsite surveys. The COVID-19 pandemic exacerbated existing staffing challenges in States as well as introduced new challenges in obtaining and appropriately using PPE. These challenges hampered some States in conducting surveys. Although CMS does not typically provide direct assistance, it responded by having Federal surveyors conduct some surveys and wrote a letter to encourage State Governors to prioritize testing in nursing homes.

States indicated that staffing and PPE shortages remain, and may be an ongoing problem. As CMS oversees States during the remainder of the pandemic, it has an opportunity to consider longer-term policies and strategies for assisting States during this pandemic and in future crises. To that end, CMS could pursue a number of avenues to assist States with staffing and PPE challenges, including:

(1) Developing plans for CMS and States to ensure sufficient capacity for conducting onsite surveys that are based on lessons learned during the early months of the

COVID-19 pandemic. The plans could include technical assistance, such as best practices for States in acquiring PPE, and sources for training and N95 fitting. The plans could also make clear the circumstances under which CMS might send its limited number of Federal surveyors to supplement State surveys and other types of direct assistance. For example, it could describe the criteria that it might use to determine how, when, and where to send Federal surveyors to assist States.

(2) Requiring States to establish their own clear action plan for reducing barriers to conducting onsite surveys, including practical information about sources for PPE and supplemental staffing, and other support as needed to assist State surveyors in conducting onsite surveys.

(3) Assisting States in other ways, such as serving as a liaison and advocate for States in interacting with Federal agencies for PPE acquisition (Federal Emergency Management Agency) or PPE training (CDC).

Clarify expectations for States to complete backlogs of standard surveys and high-priority complaint surveys

Onsite nursing home surveys, including those that respond to serious complaints, are critical safeguards to protect nursing home residents. CMS's suspension of standard surveys and high-priority complaint surveys resulted in substantial backlogs of required surveys. On August 17, CMS authorized States to resume these surveys when the States have the resources to do so. Although this will reduce the growth of the backlogs, States expressed concerns that additional resources and time are needed to address the backlogs that already exist. In addition, past performance problems—prior to COVID-19—indicate that many States were already struggling to meet required survey timeframes. CMS should provide clear expectations for addressing the backlogs of standard and complaint surveys, including guidance on how States are to prioritize survey activities and required timeframes for eliminating backlogs, as well as information about how delayed surveys will be evaluated with respect to required timeframes.

AGENCY COMMENTS AND OIG RESPONSE

We received comments on the draft report from CMS.

In its comments, CMS did not explicitly concur with our recommendation that it assess results of the infection control survey and revise as appropriate, but CMS described actions it has taken that address the recommendation. For example, in August 2020, CMS revised the infection control survey to incorporate new COVID-19 requirements regarding testing and designating a facility infection preventionist. CMS also stated that it will continue to assess and revise the survey as appropriate, and reiterated that it did not intend for the infection control survey to replace standard surveys. We encourage CMS to continue assessing and revising the infection control survey as needed, including expanding its scope if States are unable to resume standard surveys as the pandemic continues. We ask that CMS detail any additional and planned steps toward implementing this recommendation in its Final Management Decision.

CMS also did not explicitly concur with our recommendation that it clarify expectations for States to complete survey backlogs, but CMS described actions it has taken that address the recommendation. For example, CMS issued guidance regarding how States are to resume onsite surveys when they have the resources to do so. CMS also stated that it will continue working with States regarding how to address backlogs of standard and complaint surveys. As CMS continues to work with States on this, we encourage CMS to more specifically detail any required timeframes for eliminating backlogs, as well as provide information about how it will evaluate any delayed surveys with respect to required timeframes. This is especially important given the importance of surveys to resident safety and ongoing difficulties with States meeting survey timeframes. We ask that CMS detail any additional and planned steps toward implementing this recommendation in its Final Management Decision.

CMS did not concur with our recommendation that it work with States to help overcome challenges with PPE and staffing, citing its lack of authority to address issues of allocating these resources to States. CMS noted that it has taken steps to support States in these areas where feasible. OIG is not recommending CMS exceed its authority; rather, we continue to recommend that CMS identify opportunities within its authority to support States facing challenges securing PPE and staffing. CMS could do this by providing additional guidance and leadership, as articulated in this recommendation. We ask that CMS detail any additional and planned steps toward implementing this recommendation in its Final Management Decision.

For the full text of CMS's comments, see Appendix E.

DETAILED METHODOLOGY

Data Sources

This study used the following data sources: (1) complaint, incident, and associated survey information entered into ACTS; (2) survey and deficiency data from CMS's ASPEN and CASPER systems; (3) survey and deficiency data from Nursing Home Compare; (4) statements of deficiencies (CMS-2567 forms) from onsite surveys in 2020; (5) an interview with CMS; and (6) brief interviews with 10 State survey agencies.

Data Analysis

CMS Complaint and Incident Data. OIG's Division of Data Analytics (DDA) obtained ACTS data from CMS on nursing home complaints and incidents that States received in comparable 2019 and 2020 time periods. CMS extracted the data on June 29, 2020. We removed records in which the State entered a start date for the onsite survey that was prior to the complaint receipt date. Our final dataset included observations from all 50 States and the District of Columbia. We analyzed these data to determine the number of complaints and incidents that States prioritized as IJ in Medicare and Medicaid-certified nursing homes from March 23 through May 30, 2019, and from March 23 through May 30, 2020. We also determined the sources of complaints during these time periods (e.g., nursing home residents, their family members, and nursing home staff). In addition, we analyzed the types of allegations for complaints received. Finally, we determined the number of nursing homes that received a high-priority complaint from March 23 through June 28, 2020.

CMS Survey and Deficiency Data. We used CMS's publicly available data on the Nursing Home Compare website to assess surveys and deficiencies during the COVID-19 pandemic in 2020. On June 24, 2020, CMS posted data on surveys completed between March 4 and May 30, 2020. We assessed trends in onsite surveys and the deficiencies cited in these surveys from March 23 through May 30, 2020, in all 50 States and the District of Columbia. To determine the percentage of nursing homes that received an onsite survey nationally, we used the number of nursing homes by State for 2020, available on Nursing Home Compare.

OIG's DDA provided ASPEN data from CMS on nursing home surveys and deficiencies from January 1, 2018, through June 28, 2020. The data were extracted on June 29, 2020. We used these data to assess trends in surveys and deficiencies during the same time period in 2019 in all 50 States and the District of Columbia. When determining the number of nursing homes that CMS and States surveyed onsite, we counted nursing homes that had at least one standard survey or complaint survey. We excluded those complaint surveys with zero onsite hours. We calculated the average percentage of nursing homes with an onsite survey by month in 2019. For

this calculation, we used the number of nursing homes by State in 2019 available on Nursing Home Compare. For our comparison to deficiencies cited in 2019, we included any deficiency cited from standard surveys and complaint surveys between March 23 through May 30, 2019. In addition, we determined the number of nursing homes that did not have a standard survey during the 16 months prior to March 23 through June 28, 2020, to estimate the backlog of surveys for each State. To determine the number of deficiencies associated with a high-priority complaint in 2019, OIG's DDA matched complaint data from ACTS to complaint survey data in ASPEN with an algorithm provided by CMS.

Finally, we determined the number of infection control deficiencies by counting instances of CMS' F-880 infection prevention and control deficiency during both the comparable 2019 time period and the COVID-19 pandemic.

Review of CMS-2567 Forms. We conducted a limited review of CMS-2567 forms (statements of deficiencies) from onsite surveys during the pandemic. A completed CMS-2567 form includes detailed descriptions about deficiencies cited during a survey and the plan of correction for each deficiency.

Using the CMS-2567 forms that CMS made available on Nursing Home Compare on June 24, 2020, we identified and reviewed all 68 CMS-2567 forms that included the F-880 infection prevention and control deficiency from March 23 through May 30, 2020. The CMS-2567 forms included the specific instances of noncompliance that resulted in the deficiency citation. Deficiencies may be based on more than one instance of noncompliance.

We developed 11 categories to describe specific instances of noncompliance for the 68 infection control deficiencies. We based the categories on critical elements associated with the transmission of COVID-19 as described in the CMS COVID-19-focused survey. We reviewed the narrative of each CMS-2567 form and categorized the instances of noncompliance into 1 or more of the 11 categories to determine the most common reasons for noncompliance with infection control practices (e.g., hand hygiene).

Interview with CMS. We conducted an interview with leadership in the Survey and Operations Group and the Quality, Safety, and Oversight Group on June 18, 2020. We asked about CMS's approach to nursing home oversight during COVID-19, including: (1) the process for selecting and prioritizing nursing homes for focused infection control surveys, (2) the number of focused infection control surveys that CMS conducted as well as future plans to conduct surveys, (3) plans for reopening and addressing backlogs resulting from the suspension of surveys, and (4) how CMS has collaborated with States and other groups across HHS.

Interviews with State Survey Agencies. To provide additional insight about nursing home oversight during the COVID-19 pandemic, we selected a purposive sample of 10 States for brief telephone interviews: California, Illinois, Louisiana, Massachusetts, Nebraska, New Jersey, Tennessee, Utah, Washington, and

West Virginia. We conducted these interviews from June 9 through June 18, 2020. The interviews covered five topics: (1) experiences conducting complaint surveys, (2) experiences selecting and conducting focused infection control surveys, (3) any barriers to conducting surveys during the pandemic, (4) any strategies to overcome those barriers, and (5) experiences with other oversight activities conducted during the pandemic.

We selected the sample of 10 States to ensure that we captured States with a range of impact from COVID-19 and represented each of the 10 CMS regional offices. We categorized States as having a high, medium, or low impact from COVID-19 based on cumulative cases, density of the disease within the population, and percentage of deaths within the State occurring in long-term care facilities. We selected about half of the sample from States with a high impact from COVID-19 and about half from States with a moderate or low impact. See Exhibit 6 for statistics associated with the selected States.

Exhibit 6: Statistics for 10 sample States as of May 14, 2020.

State	COVID-19 Cumulative Cases	COVID-19 Cases Per 1,000,000 Population	Percentage of State COVID-19 Deaths in Long-Term Care Facilities
California	73,218	2,160	39
Illinois	84,874	7,925	48
Louisiana	32,662	7,597	39
Massachusetts	80,497	12,908	63
Nebraska	9,075	5,609	71
New Jersey	141,560	16,975	52
Tennessee	16,261	2,696	32
Utah	6,624	2,405	40
Washington	18,604	2,470	53
West Virginia	1,404	862	55

Source: Kaiser Family Foundation.[86]

APPENDIX A

CMS guidance to States pertaining to nursing homes from February through August 2020

Date	Title & Number	Key Provisions
February 6, 2020	*Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2012-nCoV),* QSO-20-09-ALL[87]	Strongly urges the review of CDC guidance and encourages facilities to review their own infection prevention and control policies and practices to prevent the spread of infection
March 4, 2020	*Suspension of Survey Activities*, QSO-20-12-All[88]	Limits survey activity to the following (in Priority Order): • surveys in response to all immediate jeopardy complaints and allegations of abuse and neglect; • surveys in response to complaints alleging concerns about infection control, including facilities with potential COVID-19 or other respiratory illnesses; • statutorily required recertification surveys; • any re-visits necessary to resolve current enforcement actions; • initial certifications surveys; • surveys of facilities that have a history of infection control deficiencies at the immediate jeopardy level in the past 3 years; and • surveys of facilities centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.
March 13, 2020	*Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised)*, QSO-20-14-NH[89]	Updates the March 4, 2020, memo with guidance to restrict all visitors and non-essential health care personnel with exceptions for health care workers and surveyors
March 23, 2020	*Prioritization of Survey Activities*, Admin Info: QSO-20-20-All[90]	Limits surveys to: • surveys prompted by complaint/facility-reported incident surveys, • targeted Infection Control surveys, and • self-assessments. Instructs State or Federal surveyors to refrain from performing an onsite survey if they are unable to meet the PPE expectations outlined by CDC

Date	Title & Number	Key Provisions
April 19, 2020	*Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons Under Investigation) Among Residents and Staff in Nursing Homes*, QSO-20-26-All[91]	Requires that facilities notify residents and their representatives to keep them informed of the conditions inside the facility.
April 24, 2020	*Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts and Frequently Asked Questions*, QSO-20-28-NH[92]	Waives the timeframe requirement for submitting resident assessment data and staff data. Announced that the results of health inspections conducted on or after March 4, 2020, will be posted publicly but not used to calculate inspection star ratings.
May 6, 2020	*Interim Final Rule Updating Requirements of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes*, QSO-20-29-NH[93]	Requires nursing homes to report COVID-19 facility data to the CDC and to residents, their representatives, and families of residents in facilities.
May 18, 2020	*Nursing Home Reopening Recommendations for State and Local Officials,* QSO-20-30-NH[94]	Provides recommendations to determine the level of mitigation needed for their communities to allow for relaxing restrictions in nursing homes.
June 1, 2020	*COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies and Quality Improvement Activities in Nursing Homes*, QSO-20-31-NH[95]	Requires States to complete 100 percent of infection control surveys for all nursing homes. Authorized States to expand certain survey activities, including standard surveys and high-priority complaint surveys.
June 4, 2020	*Posting of Nursing Home Inspections*, QSO-20-33-NH[96]	Announces posting of health inspection (i.e., surveys) results that were conducted on or after March 4, 2020, which is the first date that CMS altered the way inspections are scheduled and conducted.
June 4, 2020	*Release of COVID-19 Nursing Home Data*, QSO-20-32-NH[97]	Announces posting of COVID-19 data submitted by facilities via the CDC National Healthcare Safety Network.
June 25, 2020	*Changes to Staffing Information and Quality Measures Posted on the Nursing Home Compare Website and Five Star Quality Rating System due to the COVID-19 Public Health Emergency*, QSO-20-34-NH[98]	Ends the waiver requirement for nursing homes to submit staffing data through the Payroll-Based Journal System.
August 17, 2020	*Enforcement Cases Held During the Prioritization Period and Revised Survey Prioritization,* QSO-20-35-ALL	Authorizes the expansion of survey activities and provides guidance to States about resolving suspended enforcement cases.

APPENDIX B

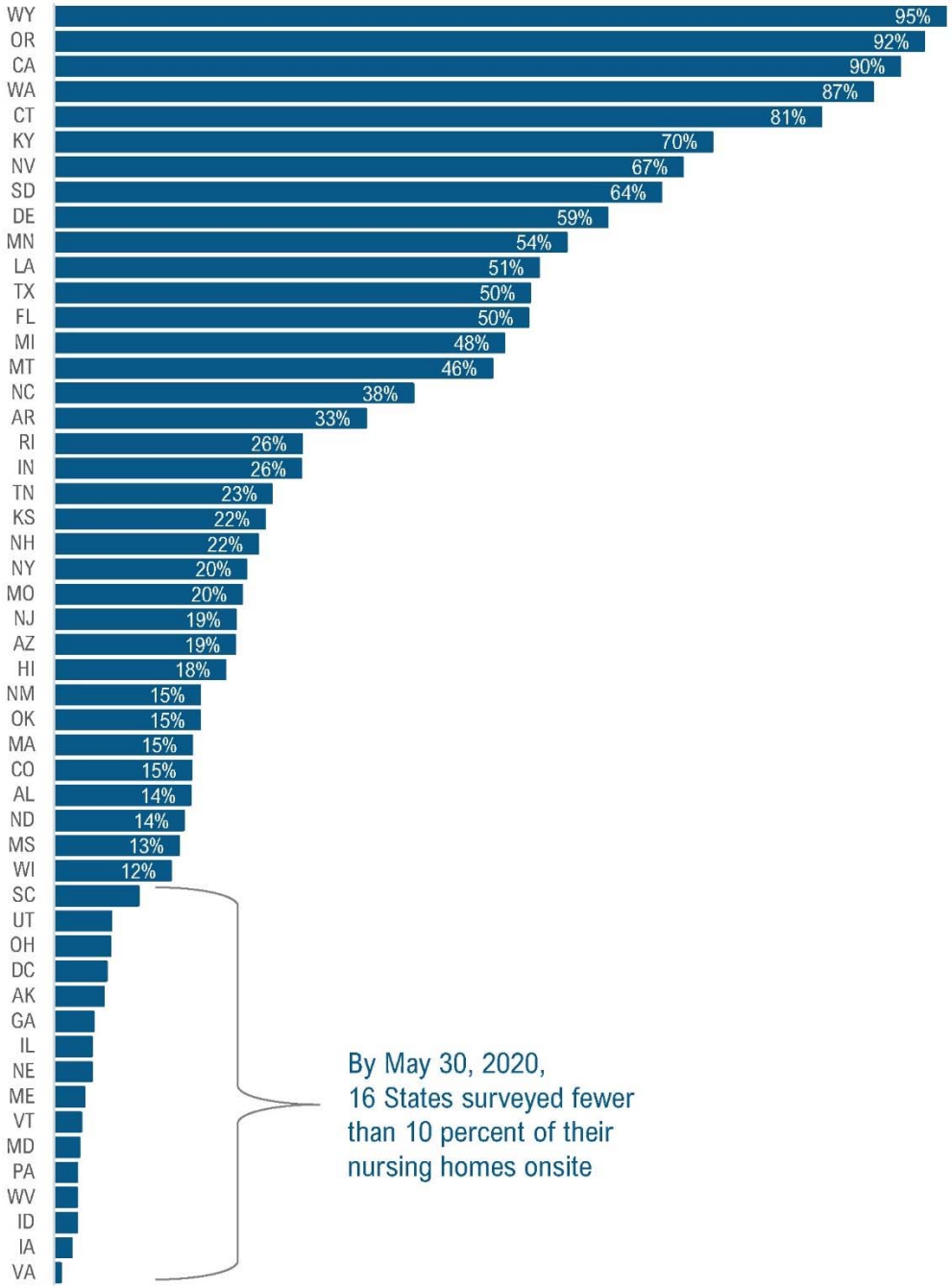
Percentage of Nursing Homes With Onsite Survey, by State

State	March 23–April 23, 2020	Average per Month in 2019
ALABAMA	2%	10%
ALASKA	5%	11%
ARIZONA	0%	10%
ARKANSAS	23%	31%
CALIFORNIA	88%	56%
COLORADO	8%	21%
CONNECTICUT	48%	13%
DELAWARE	7%	19%
DISTRICT OF COLUMBIA	6%	21%
FLORIDA	35%	33%
GEORGIA	3%	18%
HAWAII	7%	10%
IDAHO	0%	9%
ILLINOIS	1%	43%
INDIANA	11%	33%
IOWA	1%	16%
KANSAS	10%	27%
KENTUCKY	38%	24%
LOUISIANA	6%	21%
MAINE	2%	30%
MARYLAND	0%	21%
MASSACHUSETTS	9%	21%
MICHIGAN	26%	35%
MINNESOTA	38%	21%
MISSISSIPPI	1%	21%
MISSOURI	3%	49%
MONTANA	0%	13%
NEBRASKA	0%	16%
NEVADA	47%	27%
NEW HAMPSHIRE	4%	12%
NEW JERSEY	8%	18%
NEW MEXICO	0%	18%
NEW YORK	3%	22%
NORTH CAROLINA	4%	23%
NORTH DAKOTA	3%	9%

State	March 23–April 23, 2020	Average per Month in 2019
OHIO	0%	33%
OKLAHOMA	8%	19%
OREGON	5%	19%
PENNSYLVANIA	1%	28%
RHODE ISLAND	13%	23%
SOUTH CAROLINA	5%	10%
SOUTH DAKOTA	2%	11%
TENNESSEE	14%	37%
TEXAS	44%	42%
UTAH	1%	15%
VERMONT	3%	30%
VIRGINIA	0%	10%
WASHINGTON	84%	77%
WEST VIRGINIA	0%	11%
WISCONSIN	4%	24%
WYOMING	41%	24%
AVERAGE ACROSS STATES	13%	24%

APPENDIX C

Percentage of Nursing Homes Surveyed in Each State, March 23–May 30, 2020



APPENDIX D

Summaries of Instances of Noncompliance Identified for 68 Infection Control Deficiencies

Exhibit D-1: Categories of Noncompliance with Infection Control.

Code	Category	Examples
A	Improper PPE Usage	Staff not wearing or changing PPE, staff unaware of PPE practices
B	Environmental Contamination	Staff contaminating and/or not properly disinfecting facility equipment and resident surroundings
C	Improper Hand Hygiene	Staff not washing hands or washing inadequately
D	Transmission Concerns	Lack of PPE, handwashing, and/or signage within or outside of transmission-based precaution rooms
E	Resident Care Concerns	Lack of resident isolation or social distancing, not communicating with hospitals about transfers
F	Screening, Monitoring, and Education of Staff	Not screening and monitoring staff for infectious disease; lack of staff education; lack of appropriate return-to-work policies
G	IPCP Standards	Facility's Infection Prevention and Control Program (IPCP) not meeting standards
H	Infection Surveillance	Facility not tracking, monitoring, and/or testing for reported infectious disease
I	Visitor Entry	Facility not screening, monitoring, or properly restricting visitors
J	Laundry	Staff not handling contaminated laundry appropriately
K	Other	Additional problems not listed above, such as staff not storing equipment and supplies or handling food correctly, and the facility's water not reaching correct temperatures

Source: OIG Analysis of nursing home infection control surveys nationally, March 23–May 30, 2020.

Exhibit D-2: Instances of Noncompliance by Category for 68 Infection Control Deficiencies, (March 23–May 30, 2020).

Instance of Noncompliance	Number	Percentage (n = 68)
Improper PPE Usage	43	63%
Environmental Contamination	32	47%
Improper Hand Hygiene	31	46%
Transmission-based Precautions	18	26%
Resident Care	13	19%
Screening, Monitoring, and Education of Staff	13	19%
IPCP Standards	7	10%
Infection Surveillance	7	10%
Visitor Entry	6	9%
Laundry	4	6%
Other	6	9%

Source: OIG Analysis of nursing home infection control surveys nationally, March 23–May 30, 2020.

Exhibit D-3: Summary of 68 Infection Control Deficiencies with Categories of Noncompliance (March 23–May 30, 2020).

Summary of Deficiency	Categories of Noncompliance										
	A	B	C	D	E	F	G	H	I	J	K
Staff did not place resident on transmission precautions. Facility did not isolate resident; did not report infectious disease.				X	X			X			
Staff had no documentation of tuberculosis screening.						X					
Staff did not disinfect scissors between uses.		X									
Facility did not implement social distancing.					X						
Staff entered isolation room without PPE; did not wash hands; did not know which residents had infectious disease. Facility did not isolate residents; did not educate staff; did not require visitors to wear PPE.	X		X	X	X	X		X	X		
Staff did not change soiled gloves.	X										
Staff left a catheter bag on the floor.											X
Staff did not wear PPE when treating resident on isolation; did not sanitize thermometer; entered resident's room without washing hands.	X	X	X	X							
Staff fed resident with bare hands; placed supplies on surface with no barrier; did not wash hands. Facility did not educate staff; had no protocols regarding handling PICC [peripherally inserted central catheter lines].	X	X	X			X	X				X
Staff wore masks improperly; did not wash hands; entered room marked for droplet isolation without protective eyewear.	X		X	X							
Staff did not disinfect a blood pressure cuff.		X									
Facility held event without social distancing; did not prohibit visitors.					X				X		
Facility did not monitor staff temperatures.						X					
Staff did not wash hands between glove changes; did not sanitize shower chair between uses; cross-contaminated linens.	X	X	X							X	
Staff touched a soiled mop pad with bare hands, then touched cleaning supply cart; did not wash hands after taking out trash.	X	X	X								
Staff changed gloves without washing hands.	X		X								
Staff placed personal items on isolation cart; did not wash hands. Facility did not ask visitors to wash hands; dishwasher did not reach 120°F.		X	X	X					X		X
Staff did not disinfect a blood pressure cuff.		X									
Staff changed gloves without washing hands.	X		X								
Staff stored clean laundry and open box of PPE alongside dirty laundry.		X								X	X
Staff did not use PPE when caring for resident on transmission precautions; cleaned a thermometer with a contaminated sponge.	X	X		X							
Staff did not wash hands before donning PPE or touching environment. Facility did not monitor staff compliance with COVID-19 protocols.	X	X	X					X			
Staff did not don PPE or wash hands before entering isolation room.	X		X	X							
Staff did not sanitize an emergency eyewash station.		X									
Staff brought dirty linen into clean linen area.										X	
Staff did not doff contaminated PPE. Facility did not report COVID-19.	X			X				X			
Staff did not remove gloves or wash hands before leaving resident's room. Facility had vent filled with gray substance.	X	X	X								

Summary of Deficiency	Categories of Noncompliance										
	A	B	C	D	E	F	G	H	I	J	K
Facility did not monitor its staff for COVID-19; did not document or report instances of COVID-19; did not implement entry procedures for staff or visitors in accordance with CDC guidelines.						X	X	X			
Staff did not require residents to wear masks over mouths; did not disinfect a mechanical lift; did not wash hands after handling laundry; left dirty laundry on the floor. Facility did not implement social distancing.	X	X	X		X					X	
Staff did not provide a visitor with mask. Facility did not implement social distancing; did not screen visitors for COVID-19.	X				X				X		
Staff wore masks improperly; exited rooms and handled food without washing hands. Facility did not require visitors to wash hands.	X		X				X		X		X
Staff did not disinfect a blood pressure cuff.		X									
Staff did not doff contaminated PPE; picked up a dead roach and then touched water faucet; did not wash hands before donning PPE.	X	X	X								
Staff doffed PPE incorrectly. Facility did not post isolation signage; did not maintain a list of COVID-19 cases.	X			X				X			
Staff did not wear a mask while moving resident.	X										
Staff did not wash hands before entering room.			X								
Staff changed gloves without washing hands; placed supplies on soiled surface with no barrier.	X	X	X								
Staff wore masks improperly. Facility policy did not address hand washing; did not ask visitors or staff to wash hands when entering.	X		X				X		X		
Staff donned gloves and prepared medicine without washing hands.	X		X								
Staff did not wear masks. Facility policy did not implement masks due to a mandate from its corporate office.	X						X				
Staff did not sanitize a pulse oximeter; did not wash hands.		X	X								
Staff placed PPE in pocket; did not sanitize handrails; did not wash hands; placed isolation room tray on cart. Facility did not implement social distancing.	X	X	X	X	X						
Staff sanitized equipment with the same disinfectant wipe.		X									
Staff did not disinfect a mechanical lift.		X									
Staff did not wear PPE in kitchen. Facility had no policy requiring staff to wear PPE in kitchen despite guidelines.	X						X				
Staff entered room without removing soiled gloves; did not sanitize a blood glucose monitor; did not wash hands.	X	X	X								
Facility did not complete fit testing for masks; did not isolate residents with COVID-19; had no policies for addressing residents with COVID-19. Staff continued to work despite chills and fever.	X				X	X	X				
Staff did not wear masks. Facility did not train staff to ask residents to cover their faces and mouths with masks.	X					X					
Staff did not wash hands prior to taking resident's blood pressure.			X								
Staff wore masks improperly; did not wash hands; did not isolate resident; did not cover their face while serving food.	X		X		X						X
Staff changed gloves and did not wash hands; cleaned toilet and then touched countertop. Facility did not post isolation signage or implement social distancing.	X	X	X	X	X						
Staff did not monitor resident's temperature despite doctor's orders.								X			

Summary of Deficiency	Categories of Noncompliance										
	A	B	C	D	E	F	G	H	I	J	K
Staff entered transmission precautions room without PPE or washing hands.	X		X	X							
Staff did not wear masks; transferred maskless resident through facility; did not isolate resident.	X			X	X						
Staff entered a room without PPE or washing hands; touched controller with contaminated hands.	X	X	X								
Staff did not disinfect a blood pressure monitor; did not wash hands.		X	X								
Staff did not disinfect equipment; did not ask residents to wear masks. Facility did not train staff to ask residents to cover faces and mouths with masks.	X	X				X					
Staff entered transmission precautions room without PPE or washing hands; touched wheelchair with contaminated hands.	X	X	X	X							
Staff wore mask improperly; touched wheelchair with contaminated gloves. Facility did not post isolation signage; did not implement social distancing; did not train staff on proper PPE practices.	X	X		X	X	X					
Staff wore masks improperly.	X										
Facility did not have a screening station for staff and visitor entry.						X					
Staff reused PPE. Facility did not require staff to discontinue this practice.	X					X					
Staff entered room without PPE or washing hands; touched wheelchair.	X	X	X								
Staff cleaned surfaces with mislabeled chemicals without knowledge of dwell time. Facility did not document staff temperatures.		X				X					
Staff did not allow surface cleaner to sit for the appropriate dwell time.		X									
Staff did not use PPE; did not sanitize equipment; did not wash hands. Facility did not post isolation signage.	X	X	X	X							
Staff did not stock isolation room carts with PPE.	X			X							
Staff did not use PPE. Facility did not educate staff on COVID-19; did not isolate resident; did not transfer resident to emergency room despite orders.	X			X	X	X					

APPENDIX E

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: November 23, 2020

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General Draft Report: Onsite Surveys of Nursing Homes during the COVID-19 National Emergency, March 23—May 30, 2020, OEI-01-20-00430

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is charged with developing and enforcing quality and safety standards across the nation's health care system, a responsibility that the Agency takes seriously. CMS shares responsibility of nursing home oversight with State Survey Agencies (SSAs) who conduct onsite surveys to assess compliance with CMS requirements and are generally also responsible for state licensure. SSAs serve as the front-line responders to address health and safety concerns raised by residents, their families, and nursing home staff.

CMS conducts a formal assessment of each SSA's performance relative to measures included in the State Performance Standard System (SPSS) program, which CMS revised in 2019 to strengthen our oversight of state performance, including targeting state specific issues. CMS works with the SSAs to ensure that the care provided in nursing homes is of the highest quality. This duty is especially critical now as we respond to the coronavirus disease 2019 (COVID-19) pandemic. During this pandemic, nursing homes have faced unique challenges, as their population of high-risk seniors are more vulnerable to respiratory pathogens like COVID-19. CMS is using every tool at our disposal to protect our nation's most vulnerable citizens and aid the facilities that care for them.

These efforts augment CMS's Five Part Plan to ensure safety and quality in America's nursing homes, which was announced in April 2019. CMS's Five-Part Plan focuses on strengthening oversight, enhancing enforcement, increasing transparency, improving quality, and putting patients over paperwork. CMS is continuously looking for ways to improve our oversight approach to nursing home safety and quality. Over the past two years, CMS has undertaken a comprehensive review of its regulations, guidelines, and processes related to safety and quality in nursing homes. CMS also reviewed its internal structure and implemented a reorganization to align regional office staff responsible for state oversight more closely to the CMS headquarters staff to ensure consistency in approach and process improvement.

Since the public health emergency declaration in early 2020, CMS has taken unprecedented action to address COVID-19 within nursing homes. For example, on February 6, 2020, CMS took action by reissuing longstanding infection control guidelines. After the President declared a national emergency in March, CMS moved quickly to use its authority to address the rapid spread of infection by issuing guidance on new screening processes for facilities, on the use of personal protective equipment (PPE), and on temporary restrictions on non-essential medical staff and visitors.

CMS immediately followed these actions by requiring SSAs to conduct focused infection control and complaints surveys triaged at the Immediate – Jeopardy level. Due to the importance of completing these surveys, CMS informed states that those that did not complete 100 percent of their surveys by July 31, 2020, would be required to submit a corrective action plan to CMS outlining a strategy for completion of those surveys within 30 days. States that failed to meet these requirements could have their Coronavirus Aid, Relief, and Economic Security (CARES) Act Fiscal Year 2021 allocation reduced. In addition to completing the focused infection control surveys, states were also required to perform onsite surveys of nursing homes with COVID-19 cases or previous outbreaks as the public health emergency continued. As such, CMS and the SSAs have conducted approximately 40,000 focused infection control surveys, representing nearly all (99.9 percent) of Medicare and Medicaid certified nursing homes nationwide as of September 2020.

In addition, CMS also shared the infection control survey tool with facilities to use as a voluntary self-assessment tool so facilities can review their own compliance with federal infection control requirements. The infection control survey tool was developed in concert with the Centers of Disease Control and Prevention (CDC). As the public health emergency continues, the infection control survey has been revised to incorporate new infection control requirements to address the spread of COVID-19. The most recent revision of the survey tool in late August 2020 included assessing compliance with the new COVID-19 testing requirements and with the requirements for facilities to designate one or more individual(s) as the infection preventionist who are responsible for the facility's infection prevention and control program at 42 CFR§483.80(b), along with other COVID-19 guidance updates.

Beginning in April 2020, CMS announced a new requirement for facilities to report data to the CDC about COVID-19 cases, deaths, and supply levels, among other things. CMS promptly fined any facility that did not complete the weekly reporting requirements, and as of mid-September, 99.3 percent of facilities are currently submitting these reports. This data is used as a coordinated effort between CMS and CDC to provide detailed information to state and local health departments, and nursing homes to inform national infection prevention and control policies and strategies to further support nursing home residents. CMS shares data with the SSAs each week so they know which nursing homes may have potential problems with preventing or controlling the spread of COVID-19 cases and require swift onsite surveys.

On June 1, 2020, CMS unveiled enhanced enforcement for nursing homes with violations of longstanding infection control practices. These enhanced and targeted accountability measures

were based on early trends in the most recent data regarding incidence of COVID-19 in nursing homes, as well as data regarding the results of the agency's focused infection control inspections. CMS is increasing enforcement (e.g., civil money penalties) for facilities with persistent infection control violations, and imposing enforcement actions on lower level infection control deficiencies to ensure they are addressed with increased gravity.

Since survey inspections are only a point-in-time assessment of nursing homes' compliance, CMS has continued to use data submitted by nursing homes to monitor COVID-19 cases, as well as nursing homes' abilities to control the spread of COVID-19, and take action to support struggling nursing homes. In August 2020, CMS issued further guidance directing the resumption of onsite revisit surveys, non-immediate jeopardy complaint surveys and annual recertification surveys as soon as resources are available.

Recognizing that physical separation from family and other loved ones has taken a significant toll on nursing home residents, CMS also issued revised guidance in September that would enable nursing homes to begin resuming visitation in a safe way. This includes both indoor and outdoor settings and in compassionate care situations. The guidance also outlines certain core principles and best practices to reduce the risk of COVID-19 transmission to adhere to during visitations.

To further assist nursing homes in responding to the ongoing pandemic, as of mid-October, CMS deployed federal Task Force Strike Teams in ten waves, and have thus far deployed these teams in 30 states and 96 facilities particularly affected by COVID-19 to share best practices and gain a better understanding of how the virus spreads. Additionally, CMS has contracted with 12 Quality Innovation Network – Quality Improvement Organizations (QIN – QIOs) to work with providers, community partners, beneficiaries and caregivers on data-driven quality improvement initiatives designed to improve the quality of care for beneficiaries across the United States. The QIN-QIOs are being deployed to provide technical assistance to nursing homes, which includes a targeted focus on approximately 3,000 low performing nursing homes who have a history of infection control challenges. The QIN – QIOs are also reaching out to nursing homes across the country to provide virtual technical assistance for homes that have an opportunity for improvement based on an analysis of previous citations for infection control deficiencies using publicly available data found on Nursing Home Compare. With varying degrees of intensity, QIN-QIOs provide education and training to every nursing home in the country. For instance, they train staff on proper use of PPE, cohorting residents appropriately and transferring residents safely. All nursing homes across the country can take advantage of weekly National Infection Control Training that focuses on all aspects of infection control, prevention and management to help nursing homes prevent the transmission of COVID-19 in facilities and keep residents safe. Additionally, as part of their ongoing work, the QIN-QIOs provide more direct assistance to around 6,000 small, rural nursing homes and those serving vulnerable populations in areas where access to care is limited with helping them understand and comply with CMS and CDC reporting requirements, sharing best practices related to infection control, testing and patient transfers.

In addition, the Department of Health and Human Services (HHS) has supported nursing homes financially during this challenging time, distributing over $21 billion to America's nursing homes – more than $1.5 million each on average. This additional funding can help nursing

homes with COVID-19 testing efforts, as CMS now requires nursing homes to test residents and staff including individuals providing services under arrangement and volunteers, a requirement that was paired with HHS's distribution of approximately 14,000 point-of-care testing devices to America's nursing homes. These new testing requirements are part of CMS's efforts to keep COVID-19 from entering and spreading through nursing homes, detecting cases quickly, and stopping transmission.

CMS also created an educational toolkit to support states, local leaders, and nursing homes in identifying best practices to protect our vulnerable elderly in nursing homes. The toolkit, which is being updated regularly, outlines best practices for a variety of subjects ranging from infection control to workforce and staffing. It also provides contact information for organizations who stand ready to assist with the unique challenges posed by caring for individuals in long-term care settings. Every state was involved in the creation of this toolkit, which is regularly updated, resulting in a robust resource that may be leveraged by a variety of entities serving this vulnerable population. CMS has also posted a chart listing all of CMS's COVID-19 guidance documents and updates for nursing homes during the pandemic on its website.[1]

CMS thanks OIG for its efforts on this important issue and looks forward to working with OIG on this and other issues in the future. OIG's recommendations and CMS's responses are below.

OIG Recommendation

Assess the results of infection control surveys and revise the survey as appropriate.

CMS Response

CMS has already worked to assess and revise the focused infection control survey and therefore, has already addressed this recommendation. As stated above, CMS prioritized focused infection control and immediate jeopardy surveys, allowing SSAs to turn their focus on the most serious health and safety threats like infectious disease and abuse. This shift in approach allowed SSAs to focus on addressing the spread of COVID-19. CMS also shared the focused infection control survey tool with facilities to use as a voluntary self-assessment tool so facilities can review their own compliance with federal infection control requirements. The infection control survey has been revised to incorporate new infection control requirements to address the spread of COVID-19.The most recent revision of the survey tool in late August 2020 included assessing compliance with the new COVID-19 testing requirements and with the requirements for facilities to designate one or more individual(s) as the infection preventionist who are responsible for the facility's infection prevention and control program at 42 CFR§483.80(b), along with other COVID-19 guidance updates. CMS and the SSAs have conducted approximately 40,000 focused infection control surveys, representing nearly all (99.9 percent) of Medicare and Medicaid certified nursing homes nationwide as of September 2020. As CMS continues to adapt to the evolving public health emergency, CMS will continue to assess and revise the focused infection control survey as appropriate. However, this survey is not intended to replace normal survey operations and requirements, as the limited nature of the infection control survey is intended to be used during the public health emergency to limit the impact on nursing home activities, while ensuring they are implementing actions to protect the health and safety of residents.

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[1] COVID-19 Guidance and Updates for Nursing Homes during COVID-19, August 25, 2020, https://edit.cms.gov/files/document/covid-guidance-and-updates-nursing-homes-during-covid-19.pdf

OIG Recommendation
Work with States to help overcome challenges with PPE and staffing.

CMS Response
CMS non-concurs with OIG's recommendation. SSAs are responsible for surveying facilities' compliance with CMS requirements and recommending appropriate enforcement action as needed. CMS has released guidance regarding proper use of PPE based on CDC recommendations and provided training to nursing home staff on PPE; however, addressing issues of allocation of PPE and staffing is outside of CMS's authority, as these are largely state prioritization decisions, in some cases with assistance from other Federal agencies. CMS has taken efforts to support states where feasible. For example, as OIG notes, CMS sent a letter to governors in May 2020 encouraging them to allocate PPE resources to state surveyors. In addition, OIG notes in their report that in some cases when states were unable to secure PPE, CMS stepped in to conduct surveys, surveying hundreds of facilities in the early months of the public health emergency. Additionally, CMS utilized contractor surveyors to investigate immediate-jeopardy complaints when the state could not survey.

The CARES Act allocated $100 million in supplemental funds for survey and certification efforts with a focus on areas where there is community spread of COVID-19. Of this amount, CMS is providing states approximately $81 million which will be available for spending through September 30, 2023. With this funding, states will be able to purchase additional PPE (for example, N-95 face masks, surgical gowns, goggles, gloves, and thermometers) for surveyors to ensure worker safety and hire or contract for additional staff.

OIG Recommendation
Clarify expectations for States to complete backlogs of standard surveys and high-priority complaint surveys.

CMS Response
CMS is already addressing this recommendation by working to clarify expectations for states to complete backlogs of standard surveys and high-priority complaint surveys. CMS works closely with states, and in August 2020, CMS released guidance to states that described how to expand survey activity and a detailed guide for surveyors to use to resolve outstanding enforcement cases that were paused because of the public health emergency. CMS will work with states to provide additional information on how to specifically address their backlog of standard surveys and high-priority complaint surveys.

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This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office; and Amy Ashcraft and Danielle Fletcher, Deputy Regional Inspectors General in the Dallas and Boston regional offices, respectively.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

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ENDNOTES

[1] CDC, *Coronavirus Disease 2019 (COVID-19): Older Adults*, June 25, 2020. Accessed at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html on July 23, 2020.

[2] New York Times, *Nursing Home Linked to 37 Coronavirus Deaths Faces Fine of $600,000*, April 2, 2020. Accessed at https://www.nytimes.com/2020/04/02/us/virus-kirkland-life-care-nursing-home.html on July 13, 2020.

[3] CMS, *COVID-19 Nursing Home Data*, submitted data as of week ending November 8, 2020. Accessed at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ on November 24, 2020.

[4] Johns Hopkins University of Medicine, *Coronavirus Resource Center, COVID-19 United States by County*. Accessed at https://coronavirus.jhu.edu/us-map on November 24, 2020.

[5] Government Accountability Office, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemics, GAO-20-576R*, May 20, 2020.

[6] *Ibid.*

[7] Washington Post, *Mask shortage for most health-care workers extended into May, Post-Ipsos poll shows*, May 20, 2020. Accessed at https://www.washingtonpost.com/health/mask-shortage-for-most-health-care-workers-extended-into-may-post-ipsos-poll-shows/2020/05/20/1ddbe588-9a21-11ea-ac72-3841fcc9b35f_story.html on June 24, 2020.

[8] OIG, *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020, OEI-06-20*-00300, April 4, 2020.

[9] Social Security Act § 1864(a); 42 CFR § 488.330; CMS, *State Operations Manual (SOM)*, Pub. No. 10-07 ch. 1, Program Background and Responsibilities, Section 1002.

[10] When we refer to nursing homes, we make no distinction between Medicare Skilled Nursing Facilities and Medicaid Nursing Facilities. We calculated the number of nursing homes nationally by counting the number of distinct skilled nursing facilities and Medicaid Nursing Facilities that received a standard survey in the past 4 years (Source: OIG analysis, 2020).

[11] Social Security Act §§ 1819(g) and 1919(g).

[12] 42 CFR § 488.308.

[13] Sections 1819(f)(1) and 1919(f)(1) of the Social Security Act.

[14] *Ibid.*

[15] CMS, *Action Plan for Further Improvement of Nursing Home Quality*. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf on July 12, 2020.

[16] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 155, 06-10-16).

[17] Social Security Act § 1864(a); 42 CFR § 488.330; *SOM*, ch. 1, Section 1002.

[18] Social Security Act §§ 1819(g) and 1919(g).

[19] Sections 1819(g) and 1919(g) of the Social Security Act.

[20] Social Security Act §§ 1819(g)(2)(E) and 1919(g)(2)(E); CMS, *SOM*, Pub. No. 100-07, ch. 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities (Revised 185, 11-16-18).

[21] CMS, *SOM,* Pub. No. 100-07 Appendix P: Survey Protocol for Long Term Care Facilities—Part I. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/som107ap_p_ltcf.pdf on July 13, 2020.

[22] *Ibid.*

[23] CMS defines the other two levels of harm as follows: no actual harm with potential for minimal harm and no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

[24] CMS, *Nursing Home Enforcement.* Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Nursing-Home-Enforcement on July 23, 2020.

[25] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 155, 06-10-16).

[26] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 155, 06-10-16).

[27] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 191, 07-19-19), Section 5070.

[28] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 155, 06-10-16).

[29] OIG analysis of ASPEN Complaint Tracking System (ACTS) data, April 2020.

[30] A complaint survey focuses on the specific issues of the complaint. However, if surveyors observe other compliance issues while investigating the complaint allegation then they will cite the nursing home for these deficiencies as well.

[31] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 155, 06-10-16).

[32] 42 CFR § 483.12(c)(1).

[33] CMS, *SOM*, Pub. No. 100-07, ch. 5, Complaint Procedures (Revised 191, 07-19-19), Section 5075.9.

[34] CMS, *SOM*, Pub. No. 100-07, ch. 1, Program Background and Responsibilities, Section 1006.

[35] CMS, *FY 2016 to FY 2017 Nursing Home Action Plan*, May 2016, p. 11. Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-26.pdf on August 20, 2019.

[36] CMS, *FY 2020 State Performance Standards System Guidance, Admin Info: 20-02-ALL*, October 17, 2019.

[37] CDC, *Coronavirus Disease 2019 (COVID-19) Symptoms of Coronavirus*. Accessed at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html on March 29, 2020.

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[55] OIG, *States Continued to Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016–2018,* OEI-01-19-00421, September 2020.

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[57] During the COVID-19 pandemic, CMS surveyors conducted about 700 surveys, from March 19 through July 9, to assist the States.

[58] These results are based on data beginning March 1, 2020, and include some surveys conducted prior to the directive to suspend certain survey activities. CMS, *Nursing Home Compare—Nursing Home Infection Control Survey Reports*, August 24, 2020. Accessed at https://www.cms.gov/files/zip/nursing-home-infection-control-surveys.zip on August, 26, 2020.

[59] Incidents are self-reported by nursing homes and, as with complaints, do not depend on visitors observing conditions. There is some duplication between incidents and complaints in nursing homes. We do not know why incidents also decreased during the COVID-19 pandemic as compared to 2019.

[60] 42 CFR § 488.301.

[61] CMS, *Prioritization of Survey Activities*, Ref: QSO-20-20-All, March 23, 2020. Accessed at https://www.cms.gov/files/document/qso-20-20-all.pdf on July 7, 2020.

[62] Fit testing is an important component to a respiratory protection program to ensure users receive the expected level of protection. The Occupational Safety and Health Administration requires annual fit testing for any respirator, such as N95 respirators used by surveyors, before being used in the workplace. CMS does not require N95 fit testing for health care providers in certified facilities.

[63] CMS surveyors also conducted infection control and complaint surveys during the COVID-19 pandemic. The data in this report include surveys conducted by both CMS and States.

[64] CMS, *Letter to the Governors,* May 31, 2020. Accessed at https://www.cms.gov/files/document/6120-letter-governors.pdf on July 13, 2020.

[65] OIG, *Nursing Home Complaint Investigations, OEI-01-04-00340*, July 2006.

[66] Contact tracing is the practice of identifying and monitoring individuals who may have had contact with an infectious person as a means of controlling the spread of a communicable disease. Source: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html.

[67] All nursing home surveyors are required to successfully complete the Surveyor Minimum Qualifications Test (SMQT). The SMQT addresses the knowledge, skills, and abilities needed to conduct surveys in nursing homes. Section 1819(g)(2) and 19191(g)(2) of the Social Security Act requires surveyors to meet minimum qualifications. Source: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter08-14.pdf.

[68] CMS, *Suspension of Survey Activities,* Ref: QSO-20-12-All, March 4, 2020. Accessed at https://www.cms.gov/files/document/qso-20-12-all.pdf on July 7, 2020.

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[79] CMS defines Serious Injury, Harm, or Death (Actual OR Likely), as a component of Immediate Jeopardy, as follows: "Has caused or is likely to cause serious injury, harm, impairment, or death to a resident" CMS, *SOM*, Pub. No. 100-07, Appendix Q: Guidelines for Determining Immediate Jeopardy. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf on July 25, 2020.

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