



September 2022

COVID-19 IN NURSING HOMES CMS Needs to Continue to Strengthen Oversight of Infection Prevention and Control

Accessible Version

GAO Highlight

Highlights of [GAO-22-105133](#), a report to congressional addressees

Why GAO Did This Study

Implementing proper infection prevention and control practices can be critical for preventing the spread of infectious diseases. Infection prevention and control has been a long-standing concern in the nation's more than 15,000 nursing homes—one that the COVID-19 pandemic has brought into sharper focus. Some infection prevention and control practices in nursing homes, such as social isolation, may negatively affect resident mental and physical health.

The CARES Act directs GAO to monitor the federal pandemic response. GAO was also asked to review federal oversight of nursing homes in light of the pandemic. Among other objectives, this report: (1) describes what data reveal about any changes in resident health before and during the pandemic and (2) examines infection prevention and control actions CMS and CDC have taken in nursing homes before and during the pandemic.

GAO (1) reviewed CMS and CDC documents, (2) analyzed CMS resident health data from 2018 through 2021, and (3) interviewed CMS, CDC, state survey agency, and nursing home officials in a non-generalizable sample of eight states selected for variation in factors such as geographic location.

What GAO Recommends

GAO is making three recommendations to CMS related to the role of the infection preventionist and clarifying infection prevention and control guidance. HHS agreed with our first recommendation, but neither agreed nor disagreed with our other two recommendations.

View [GAO-22-105133](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

September 2022

COVID-19 IN NURSING HOMES

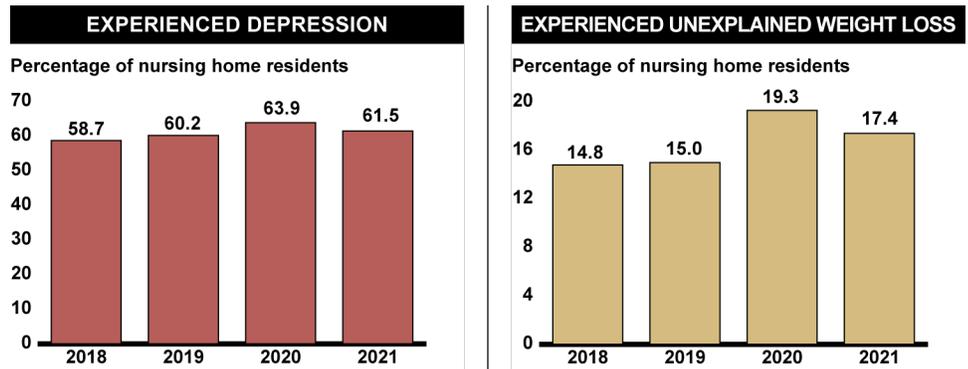
CMS Needs to Continue to Strengthen Oversight of Infection Prevention and Control

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring that nursing homes meet federal standards. CMS enters into agreements with state survey agencies to conduct surveys and investigations of the state's nursing homes. The Centers for Disease Control and Prevention (CDC) issues guidance, operates surveillance systems, and provides technical assistance to support infection prevention and control in nursing homes.

GAO analysis of CMS data reported by nursing homes shows that seven of the eight key indicators of nursing home resident mental and physical health worsened at least slightly the first year of the pandemic (2020), compared to the years prior to the pandemic. See the figure below for examples of two outcomes we reviewed.

Percentage of Residents Who Experienced Depression and Unexplained Weight Loss, by Year



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-22-105133

Accessible Data Table for Highlight Figure

Year	Percent of nursing home residents diagnosed with any level of depression	Percent of nursing home residents assessed with unexplained weight loss
2018	58.70	14.80
2019	60.20	15.00
2020	63.90	19.30
2021	61.50	17.40

CMS and CDC took actions on infection prevention and control prior to and during the COVID-19 pandemic. For example, prior to the pandemic, CMS required nursing homes to designate an infection preventionist on staff. This person is a trained employee responsible for the home's infection prevention and control program and was crucial to nursing homes during the pandemic. CMS also made changes in how nursing homes were surveyed during the pandemic. However, GAO found areas where CMS could take additional actions, including:

- **Strengthening oversight of the infection preventionist role.** GAO identified ways CMS could strengthen oversight of the infection preventionist role, such

as by establishing minimum training standards. CMS could also collect infection preventionist staffing data and use it to determine whether the current infection preventionist staffing requirement is sufficient.

- **Strengthening infection prevention and control guidance.** GAO identified how CMS could strengthen this guidance by providing information to help surveyors assess the scope and severity of infection prevention and control deficiencies they identify. For example, CMS could add COVID-19-relevant examples for scope and severity classifications to its State Operations Manual—the key guidance state survey agencies use for conducting nursing home surveys.

Contents

GAO Highlight		ii
	Why GAO Did This Study	ii
	What GAO Recommends	ii
	What GAO Found	ii
<hr/>		
Letter		1
	Background	6
	Some Indicators of Resident Mental and Physical Health Worsened during the COVID-19 Pandemic	10
	Infection Prevention and Control Deficiencies Persisted in Nursing Homes during the COVID-19 Pandemic	18
	CMS and CDC Took Actions to Strengthen Infection Prevention and Control but Should Do More	25
	Conclusions	37
	Recommendations for Executive Action	38
	Agency Comments and Our Evaluation	38
<hr/>		
Appendix I: Related GAO Products on COVID-19 in Nursing Homes		42
Appendix II: Examples of Infection Prevention and Control Deficiencies Cited in Nursing Homes during the Pandemic		44
Appendix III: Types of Surveys and Investigations to Assess Whether Nursing Homes Are Meeting Federal Standards		46
Appendix IV: Number and Percentage of Surveyed Nursing Homes with Infection Prevention and Control (IPC) Deficiencies		50
Appendix V: Federal Nursing Home Infection Prevention and Control (IPC) Actions		52
Appendix VI: Comments from the Department of Health and Human Services		56
	Text of Appendix VI: Comments from the Department of Health and Human Services	62
<hr/>		
Appendix VII: GAO Contact and Staff Acknowledgments		70
<hr/>		
Tables		
	Table 1: Selected Federal Infection Prevention and Control (IPC) Actions and Examples of Stakeholder-Reported Perspectives on Advantages and Disadvantages	30

Table 2: Illustrative Examples of Narratives from Infection Prevention and Control Deficiencies Cited in Nursing Homes during the Pandemic	44
Table 3: Number and Percentage of Surveyed Nursing Homes with Infection Prevention and Control (IPC) Deficiencies, by Calendar Year and Deficiency Code	50
Table 4: Nursing Home Infection Prevention and Control (IPC) Actions Taken by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC)	52

Figures

Figure 1: Percentage of Long-Stay Nursing Home Residents Who Experienced Selected Mental Health Indicators, by Year	12
Figure 2: Percentage of Long-Stay Nursing Home Residents Who Experienced Selected Physical Health Indicators, by Year	14
Figure 3: Type of Survey or Investigation Used by State Survey Agencies to Identify Infection Prevention and Control Deficiencies, 2018 through 2021	21
Figure 4: Types of Surveys and Investigations Used by State Survey Agencies to Assess Whether Nursing Homes Are Meeting Federal Standards, as of April 2022	48

Abbreviations

CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
IPC	Infection Prevention and Control

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



September 14, 2022

Congressional Addressees

Infection prevention and control (IPC) has been a long-standing concern in the nation's more than 15,000 Medicare- and Medicaid-certified nursing homes—one the COVID-19 pandemic has brought into sharper focus.¹ Prior to the COVID-19 pandemic, infections were a leading cause of death and hospitalization among nursing home residents, with estimates of up to 380,000 residents dying each year.² Since that time, COVID-19 has emerged as a new and highly contagious respiratory disease that has had devastating consequences for the nation's more than one million nursing home residents, including high rates of severe illness and death. COVID-19 has also substantially affected the broader nursing home industry, including nursing home staff. The initial unknown nature of the virus that causes COVID-19 and the scope of the pandemic also created unprecedented challenges for state and federal agencies that work to ensure the quality of care delivered in nursing homes and to protect public health.³

In our previous reporting, we found that, in the years prior to the pandemic, nursing homes had persistent and widespread challenges with IPC.⁴ For example, we found that implementing proper IPC practices, such as isolating infected residents, can be critical for preventing the spread of infectious diseases, including COVID-19—thus protecting both resident and staff health and well-being. However, some IPC practices in

¹According to the Centers for Disease Control and Prevention, IPC protects patients, residents, healthcare personnel, and visitors by preventing healthcare-associated infections and limiting the spread of pathogens through the implementation of evidence-based interventions.

²Department of Health and Human Services, *The National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination* (Washington, D.C.: 2013).

³As GAO has previously reported, during the COVID-19 pandemic, nursing homes experienced high staff cases and deaths and challenges related to staffing, personal protective equipment, and testing. See, for example, GAO, *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions*, [GAO-20-701](#) (Washington, D.C.: Sept. 21, 2020).

⁴GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, [GAO-20-576R](#) (Washington, D.C.: May 20, 2020).

nursing homes, such as social isolation, may negatively affect resident mental and physical health.⁵

The Department of Health and Human Services (HHS), primarily through the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), has led the response to the COVID-19 pandemic in nursing homes. CMS is the federal oversight agency responsible for ensuring that nursing homes meet federal quality standards to be eligible to participate in the Medicare and Medicaid programs. These standards require, for example, that nursing homes establish and maintain an IPC program. To monitor compliance with these standards, CMS enters into agreements with state survey agencies in each state government and oversees the work the state survey agencies do. CDC issues guidance with recommendations for preventing and managing infectious diseases, operates infectious disease surveillance systems, and provides technical assistance through programs aimed at supporting and assessing IPC in nursing homes, and tracking IPC data.

The CARES Act includes a provision directing us to monitor the federal response to the COVID-19 pandemic.⁶ Further, you also asked us to examine federal oversight of IPC protocols and the adequacy of emergency preparedness standards for emerging infectious diseases in nursing homes, as well as CMS's response to the pandemic. Since 2020, we have examined the response to COVID-19 in nursing homes in multiple studies. Some studies have been completed and released and others are ongoing. (See app. I for a list of completed related reports.)

In this report, we: (1) describe what data reveal about any changes in resident mental and physical health before and during the COVID-19 pandemic, (2) describe whether IPC challenges have persisted in nursing homes during the pandemic, and (3) examine the IPC actions that CMS

⁵National Academies of Sciences, Engineering, and Medicine, *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System* (Washington, D.C.: The National Academies Press, 2020).

⁶Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). Throughout the pandemic, we regularly issued government-wide reports on the federal response to COVID-19. All government-wide reports are available on GAO's website at <https://www.gao.gov/coronavirus>.

and CDC have taken related to nursing homes before and during the pandemic.

To describe what data reveal about any changes in resident mental and physical health before and during the COVID-19 pandemic, we analyzed 2018 through 2021 CMS Minimum Data Set resident assessment data.⁷ We compared selected health indicators across calendar years for all long-stay residents who had lived in the nursing home greater than 100 days.⁸ We selected four mental and four physical health indicators to analyze based on indicators highlighted in our review of relevant literature and during conversations with knowledgeable stakeholders.⁹ Then, using each resident's calendar year assessments, we determined the percentage of residents experiencing each selected health indicator.¹⁰ We analyzed the data in the CMS Minimum Data Set as they were reported by nursing homes to CMS. We did not otherwise independently verify the accuracy of the information with these nursing homes. We assessed the reliability of the dataset by checking for missing values and obvious errors, reviewing relevant CMS documents, and reviewing other studies

⁷2021 was the most recent calendar year available at the time of our analysis.

The CMS Minimum Data Set is reported by nursing homes, which are required to complete resident assessments at regular intervals as part of federal requirements to participate in the Medicare and Medicaid programs. Nursing homes are required to conduct resident assessments at entry, quarterly, at discharge, and if there are any significant changes or corrections. During standard surveys, surveyors can evaluate whether a nursing home's assessments meet federal standards for accuracy.

⁸The same resident may have lived in the home for multiple years and would therefore be present in each calendar year. Most nursing homes provide both long-term residential and short-term rehabilitative care.

According to CMS, the number of nursing home residents declined sharply during the pandemic.

⁹For example, see M. Levere, P. Rowan, A. Wysocki, "The Adverse Effects of the COVID-19 Pandemic on Nursing Home Resident Well-Being," *JAMDA*, vol. 22, no. 5 (2021): 948-954 and L. Fleisher et al., "Health Care Safety During the Pandemic and Beyond—Building a System That Ensures Resilience," *The New England Journal of Medicine*, vol. 386, no. 7 (2022): 609-611.

¹⁰The mental health indicators we selected and analyzed included whether, on any assessment in a given calendar year, a resident had any symptoms of depression or took anti-depressant, anti-psychotic, or anti-anxiety medications. The physical health indicators we selected and analyzed included whether, on any assessment in a given calendar year, a resident experienced at least one fall, unexplained weight loss, urinary incontinence ranging from occasionally incontinent to always incontinent, or at least one or more stage 1 or higher unhealed pressure ulcers.

that used these data and identified some limitations of our analysis.¹¹ Based on this review, we determined the data were sufficiently reliable for the purposes of this reporting objective. We also conducted interviews with officials from a non-generalizable sample of nine selected nursing homes in eight selected states: Arkansas, California, Florida, Maryland, Michigan, Montana, Rhode Island, and Washington.¹² These states were selected based on three criteria: (1) geographic location; (2) number of nursing home beds; and (3) number of nursing home residents and staff with confirmed positive cases of COVID-19.¹³ We then selected nursing homes to obtain variation in factors such as bed count and profit or not-for-profit status. We asked nursing home officials to describe resident mental and physical health during the pandemic. Additionally, we interviewed national associations, including the American Health Care Association and National Consumer Voice for Quality Long-Term Care, about these issues.

To describe whether IPC challenges have persisted in nursing homes during the pandemic, we analyzed CMS data on nursing home deficiencies cited by state surveyors in all 50 states and Washington,

¹¹Some studies have found that the Minimum Data Set data reported by nursing homes underreports anti-psychotic use and falls. Therefore, it is possible that our analysis also underreports these health indicators. For examples, see HHS Office of Inspector General, *CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes*, OEI-07-19-00490 (Washington, D.C.: May 3, 2021) and J. Mintz et al., "Validation of the Minimum Data Set Items on Falls and Injury in Two Long-Stay Facilities," *Journal of the American Geriatrics Society*, vol. 69, no. 4 (April 2021). Unless the rate of underreporting changed during the pandemic, the analysis of change over time would still likely be broadly valid.

In addition, as the pandemic progressed, it is possible that nursing homes had to delay submitting their resident assessments if, for example, they were responding to a COVID-19 outbreak. In March 2020, CMS waived the timeframe requirements for nursing homes to complete and transmit resident assessments in order to allow nursing homes to focus on infection control efforts. However, these timeframes were re-instated by CMS in April 2021. According to CMS, the majority of nursing homes were completing and transmitting their assessments in a timely fashion. This is consistent with our analysis, where we determined that less than 10 percent of nursing home quarterly assessments were delayed in each year of our review. See Centers for Medicare & Medicaid Services, *Updates to Long-Term Care Emergency Regulatory Waivers Issued in Response to COVID-19*, QSO-21-17-NH (Baltimore, Md.: April 8, 2021).

¹²In Washington State, we interviewed officials from two nursing homes, while in the other states, we interviewed officials from one home in each state.

¹³COVID-19 case rates were for the week ending May 16, 2021.

D.C., from 2018 through 2021.¹⁴ Using these data, we analyzed the deficiency codes used by state surveyors when a nursing home fails to meet CMS's requirements for IPC. We also used CMS's Quality, Certification, and Oversight Reports website to obtain high-level summary data on the percentage of nursing homes with an overdue standard survey.¹⁵ We assessed the reliability of these datasets by checking for missing values and obvious errors and reviewing relevant CMS documents and determined the data were sufficiently reliable for the purposes of this reporting objective. We also conducted interviews with state survey agency officials and nursing home officials in the non-generalizable sample of eight states described above. We asked interviewees to describe the extent to which IPC challenges persisted in nursing homes and how they have responded.

To examine the IPC actions that CMS and CDC have taken related to nursing homes before and during the pandemic, we reviewed CMS and CDC regulations and guidance. We also interviewed officials at CMS and CDC and officials from state survey agencies and nine nursing homes in the non-generalizable sample of eight states described above, as well as officials from the national associations with knowledge of nursing home issues previously noted. We determined that the control environment component of internal control was significant to this objective, along with the underlying principle that management should establish expectations of competence for key roles. We also determined that the risk assessment component of internal control was significant to this objective, along with the underlying principle that management should define objectives clearly to enable the identification of risks and define risk tolerances. Finally, we determined that the information and communication component of internal control was significant to this objective, along with the underlying principle that management should use quality information to achieve the entity's objectives. We assessed CMS's oversight activities implemented leading up to and during the COVID-19 pandemic in the context of these internal control principles, as well as HHS statutory requirements, CMS regulatory requirements for

¹⁴2021 was the most recent calendar year available at the time of our analysis.

In addition, we used the CMS Care Compare Inspection Date files, which were accessed on March 28, 2022 from <https://data.cms.gov/provider-data/dataset/svdt-c123>.

¹⁵CMS's Quality, Certification, and Oversight Reports system is a website that provides summary-level data reports on nursing homes. This system is available at <https://qcor.cms.gov> and was accessed on April 7, 2022.

nursing home participation in Medicare and Medicaid programs, and CMS's State Operations Manual, to determine whether these oversight actions were clearly defined and understood to enable nursing homes and state survey agencies to address the risk posed by COVID-19; and whether the agency has access to quality information about whether its oversight actions were achieving their stated objectives.¹⁶

We conducted this performance audit from April 2021 to September 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Federal law requires nursing homes to keep residents safe from infectious diseases by establishing and maintaining an IPC program designed to help prevent the development and transmission of communicable diseases and infections.¹⁷

Infections in Nursing Homes

Even before COVID-19, nursing home residents were at a high risk for several different types of infections, including respiratory infections, gastroenteritis, skin and soft tissue infections, and urinary tract infections. Nursing home residents can be particularly susceptible to infections

¹⁶Federal law establishes minimum requirements nursing homes must meet to participate in the Medicare and Medicaid programs, and designates the HHS Secretary as responsible to ensure that requirements governing the provision of care in nursing homes, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and promote the effective and efficient use of public moneys. 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1); 42 C.F.R. §§ 483.1--483.95 (2021).

GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁷42 U.S.C. §§ 1395i-3(d)(3)(A), 1396r(d)(3)(A); 42 C.F.R. § 483.80 (2021).

because of their advanced age and higher risk of comorbidities.¹⁸ Further, nursing home residents are increasingly requiring more medically complex care and are therefore more susceptible to infection. For example, residents discharged from the hospital back to the nursing home can bring infections into the home. They may also require a high-degree of clinical monitoring in order to identify and prevent infection and to help prevent the spread of resistant pathogens between residents. In addition, while nursing homes create important social opportunities for residents through communal dining and recreational spaces, these shared spaces can increase the transmission risk for infectious diseases, especially viruses causing respiratory or gastrointestinal outbreaks.

The COVID-19 pandemic has led to high rates of infection and death in nursing home residents and staff. Nursing home residents are at increased risk because older adults and those with underlying health conditions have a high mortality rate when infected with the virus, according to CDC.¹⁹ In addition, the congregate nature of nursing homes—with staff caring for multiple residents and residents sharing rooms and other communal spaces—can increase the risk that COVID-19 will enter the home and easily spread.²⁰ The introduction of COVID-19 vaccines in December 2020 resulted in a sharp decline in nursing home cases and deaths through the first part of 2021; however, cases and deaths began to increase again with the emergence of more highly transmissible virus variants during the summer of 2021, coinciding with the emergence of the Delta variant, and again in winter 2022, coinciding with the emergence of the Omicron variant.

¹⁸Comorbidity refers to the presence of more than one distinct disease in a person at the same time.

¹⁹Centers for Disease Control and Prevention, *COVID-19: People Who Live in a Nursing Home or Long-Term Care Facility*, accessed on May 7, 2022, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-in-nursing-homes.html>.

²⁰According to CDC, COVID-19 is spread in three main ways: (1) breathing in small droplets or particles exhaled by an infected person (2) having these small droplets and particles land on the eyes, nose, or mouth, especially through a cough or a sneeze (3) touching eyes, nose, or mouth with hands that have the virus on them. See Centers for Disease Control and Prevention, *How COVID-19 Spreads*, accessed on April 16, 2022, <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>.

Federal Oversight of Nursing Homes

Federal laws establish minimum requirements nursing homes must meet to participate in the Medicare and Medicaid programs, including standards for the quality of care.²¹ Primarily through its State Operations Manual, CMS establishes the responsibilities of state survey agencies in ensuring that these federal quality standards for nursing homes are met, such as that nursing homes establish and maintain an IPC program.²² To monitor compliance with these standards, CMS enters into agreements with state survey agencies in each state to assess whether nursing homes meet CMS's standards. Prior to the pandemic, state surveyors from the state survey agencies were responsible for assessing nursing homes using (1) recurring comprehensive standard surveys, or (2) as-needed investigations for complaints from the public and facility-reported incidents.

- **Standard surveys.** State survey agencies are required by federal law to perform unannounced, on-site standard surveys of every nursing home receiving Medicare or Medicaid payment at least every 15 months, with a statewide average frequency of every 12 months.²³ Standard surveys are important for protecting nursing home residents because they serve as a comprehensive assessment of the safety and quality of nursing home care across several areas including food and nutrition, resident rights, physician and nursing services, and the physical environment.
- **Investigations.** In addition to performing standard surveys, state survey agencies are required by federal law to investigate all complaints of nursing home violations of requirements.²⁴ These fall

²¹42 U.S.C. §§ 1395i-3, 1396r; 42 C.F.R. §§ 483.1--483.95 (2021). Federal statutes and their implementing regulations use the terms "skilled nursing facility" (Medicare) and "nursing facility" (Medicaid). For the purposes of this report, we use the term nursing home to refer to both skilled nursing facilities and nursing facilities.

²²At a minimum, nursing homes must (1) have a system to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff, volunteers, visitors, and others providing services in the home; (2) have written standards, policies, and procedures for their infection prevention and control program; (3) have antibiotic use protocols and a system to monitor antibiotic use; and (4) have a system for recording incidents identified under the home's infection prevention and control program and any corrective actions taken. 42 C.F.R. § 483.80(a)(1)-(4) (2021).

²³42 U.S.C. §§ 1395i-3(g)(1)(A), (g)(2)(A)(iii), 1396r(g)(1)(A), (g)(2)(A)(iii); 42 C.F.R. § 488.308(a)-(b) (2021).

²⁴42 U.S.C. §§ 1395i-3(g)(4), 1396r(g)(4); 42 C.F.R. § 488.332(a) (2021).

into two categories: (1) complaints submitted by residents, family members, friends, physicians, and nursing home staff; and (2) “facility-reported incidents” that are self-reported by the nursing homes. These investigations offer the state survey agency a unique opportunity to identify and correct care problems, as they can provide a timely alert of acute issues that otherwise might not be addressed until a standard survey takes place.

If a surveyor from a state survey agency determines that a nursing home violated a federal standard during a survey or investigation, the nursing home is cited for the deficiency using a specific deficiency code (referred to as an F-tag). Cited deficiencies are then classified into categories according to scope (the number of residents potentially affected) and severity (the potential for or occurrence of harm to residents). For most cited deficiencies, nursing homes are required to submit a plan of correction that addresses how the home plans to correct the noncompliance and implement systemic change to ensure the deficient practice would not recur.²⁵ In addition, when nursing homes are cited with deficiencies, federal enforcement actions can be implemented to encourage homes to make corrections.²⁶ In general, for deficiencies with a higher scope and severity, CMS may implement the enforcement action immediately.²⁷ For other deficiencies with a lower scope and severity, the nursing home may be given an opportunity to correct the deficiencies, which, if corrected before the scheduled effective date, can result in the planned enforcement action not being implemented.

²⁵The plan of correction serves as the nursing home’s allegation of compliance. Depending on the severity of the deficiency cited, surveyors revisit the nursing home to ensure that the home actually implemented its plan and corrected the deficiency.

²⁶CMS does not require enforcement actions be implemented for all deficiencies. Enforcement actions include, but are not limited to, directed in-service training, fines known as civil money penalties, denial of payment, and termination from the Medicare and Medicaid programs.

²⁷The scope and severity of a deficiency is one of the factors that CMS may take into account when implementing enforcement actions. CMS may also consider a nursing home’s prior compliance history, desired corrective action and long-term compliance, and the number and severity of all the nursing home’s deficiencies.

In 2016, CMS finalized a comprehensive update to its nursing home standards.²⁸ The update included new requirements and aligned existing requirements with current clinical practices. These standards covered a variety of categories, such as quality of care and IPC.

Prior GAO Work

We have issued several reports examining COVID-19 in nursing homes, part of our larger bodies of work on nursing home oversight and on the federal response to the COVID-19 pandemic (see app. I.) For example, in May 2020, we analyzed CMS deficiency data and found that most nursing homes were cited for IPC deficiencies, such as failure to use proper hand hygiene, in the years prior to the COVID-19 pandemic.²⁹ In addition, during the COVID-19 pandemic, most nursing homes had multiple outbreaks and weeks of sustained COVID-19 transmission from May 2020 through January 2021.³⁰ In response to the CARES Act, we have examined the federal response to COVID-19 in nursing homes in multiple reports, where we reported on nursing home-related actions HHS had taken in response to the pandemic, as well as challenges nursing homes faced responding to COVID-19.

Some Indicators of Resident Mental and Physical Health Worsened during the COVID-19 Pandemic

Our analysis of CMS data shows that seven of the eight key indicators of nursing home resident mental and physical health that we reviewed worsened at least slightly in 2020, the first year of the pandemic,

²⁸Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688 (Oct. 4, 2016). Phase 1 (effective November 28, 2016) implemented most minor modifications to the existing nursing home regulations; phase 2 (effective November 28, 2017) implemented new regulations and re-structured CMS's deficiency code system; and phase 3 (effective November 28, 2019) implemented the remaining requirements.

²⁹See [GAO-20-576R](#).

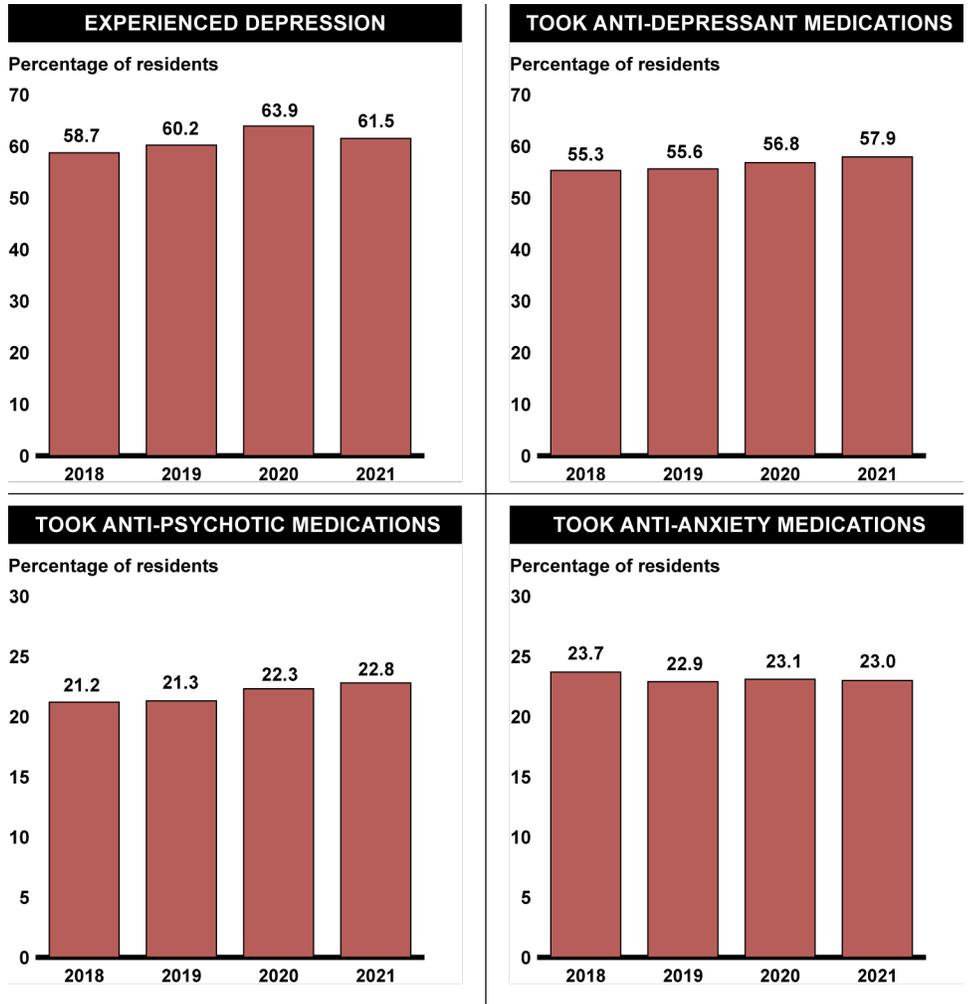
³⁰GAO, *COVID-19 in Nursing Homes: Most Homes Had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021*, [GAO-21-367](#) (Washington, D.C.: May 19, 2021).

compared to the years prior to the pandemic.³¹ Six of these key indicators continued to be worse in the second year of the pandemic than in the years prior to the pandemic.³² For example, the percentage of residents who experienced depression was 58.7 percent in 2018, 63.9 percent in 2020, and 61.5 percent in 2021. Similarly, the percentage of residents who experienced unexplained weight loss was 14.8 percent in 2018, 19.3 percent in 2020, and 17.4 percent in 2021. (See figures 1 and 2.)

³¹During the COVID-19 pandemic, there have been concerns about mental health in the general population. For example, in January 2021, four in 10 U.S. adults reported symptoms of anxiety or depressive disorder, up from one in 10 in 2019. See N. Panchal, R. Kamal, C. Cox, and R. Garfield, *The Implications of COVID-19 for Mental Health and Substance Abuse* (San Francisco, Calif.: Henry J. Kaiser Family Foundation, 2021).

³²We observed a large decrease (44 percent) in the number of long-stay nursing home residents between 2018 and 2021 (from about 1.9 million to 1.0 million). CMS officials indicated that they also observed a sharp decline in the number of nursing home residents during the pandemic. It is likely that more residents left nursing homes or passed away during the pandemic, either due to COVID-19 or other factors, compared to prior years. It is unclear whether the residents who remained in nursing homes during the pandemic in 2020 and 2021 had different health issues than residents who lived in nursing homes prior to the pandemic.

Figure 1: Percentage of Long-Stay Nursing Home Residents Who Experienced Selected Mental Health Indicators, by Year



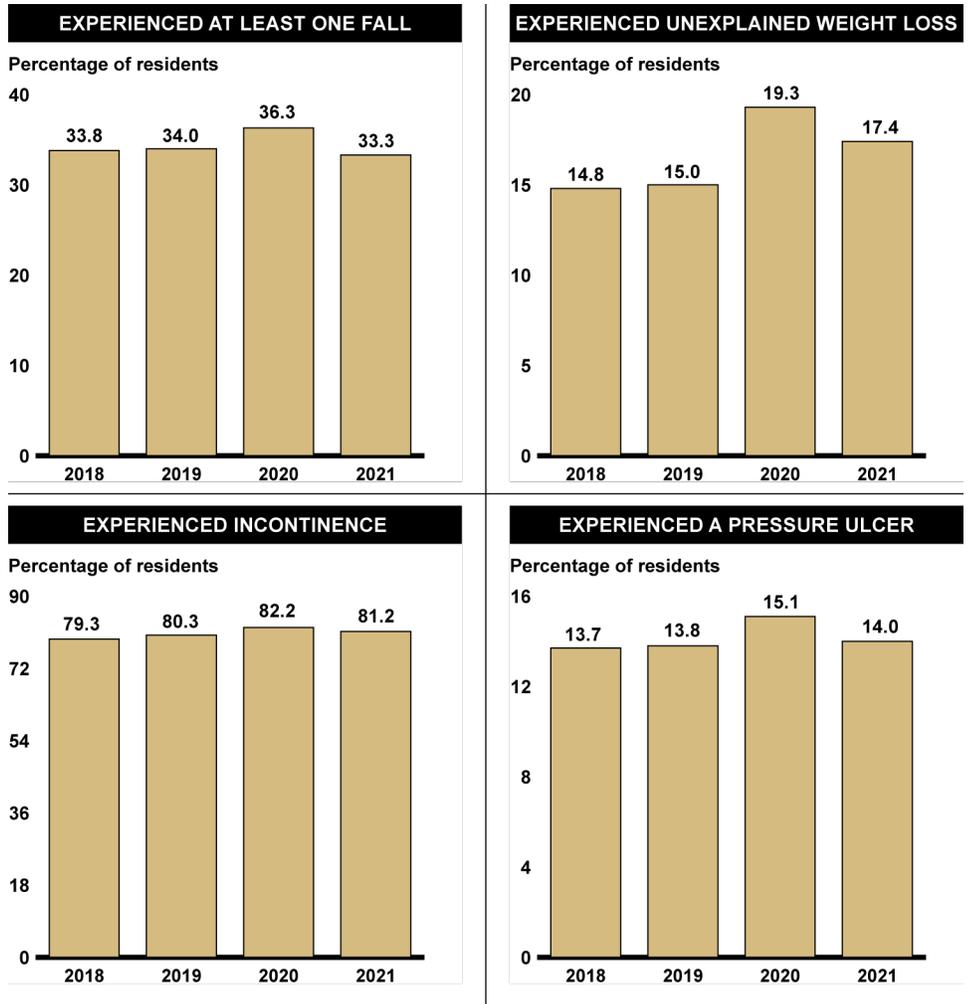
Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-22-105133

Accessible Data Table for Figure 1

	Antipsychotics	Antianxiety	Antidepressants	Depression diagnosis
Year	Percent of residents assessed as taking antipsychotic drugs	Percent of residents assessed as taking antianxiety drugs	Percent of residents assessed as taking antidepressant drugs	Percent of residents diagnosed with any level of depression
2018	21.20	23.70	55.30	58.70
2019	21.30	22.90	55.60	60.20
2020	22.30	23.10	56.80	63.90
2021	22.80	23.00	57.90	61.50

Notes: Long-stay residents are those living in a nursing home for greater than 100 days. The data in the Minimum Data Set are self-reported to CMS by nursing homes. "Experienced depression" indicates whether a resident had any symptoms of depression on any assessment in a given calendar year. "Took anti-depressant medications," "took anti-psychotic medications," and "took anti-anxiety medications" indicates if, on any assessment in a given calendar year, a resident took anti-depressant, anti-psychotic, or anti-anxiety medications in the prior 7 days before the assessment or, if less than 7 days, since admission.

Figure 2: Percentage of Long-Stay Nursing Home Residents Who Experienced Selected Physical Health Indicators, by Year



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-22-105133

Accessible Data Table for Figure 2

Year	Weight loss	Falls	Incontinent	Pressure Ulcer
	Percent of residents assessed with unexplained weight loss	Percent of residents assessed with a fall since their last assessment	Percent of residents experiencing incontinence	Percent of residents diagnosed with a pressure ulcer
2018	14.80	33.80	79.30	13.70
2019	15.00	34.00	80.30	13.80
2020	19.30	36.30	82.20	15.10
2021	17.40	33.30	81.20	14.00

Notes: Long-stay residents are those living in a nursing home for greater than 100 days. The data in the Minimum Data Set are self-reported to CMS by nursing homes. "Experienced at least one fall" indicates if, on any assessment in a given calendar year, a resident experienced at least one fall since the prior assessment or since admission, whichever was more recent. "Experienced unexplained weight loss" indicates if, on any assessment in a given calendar year, a resident experienced weight loss of 5 percent or more in the last month or 10 percent or more in the last six months. "Experienced incontinence" indicates if, on any assessment in a given calendar year, a resident experienced urinary incontinence ranging from occasionally incontinent to always incontinent. "Experienced at least one pressure ulcer" indicates if, on any assessment in a given calendar year, a resident had at least one or more stage 1 or higher unhealed pressure ulcers.

The results of our data analysis were supported by our interviews with nursing home officials in selected states, who told us they observed worsening resident mental and physical health during the COVID-19 pandemic. Specifically, for resident mental health, officials from some nursing homes we interviewed told us they observed more residents who experienced depression, as well as more residents who took anti-psychotic medication. Nursing home officials and national organizations we interviewed attributed this in part to the isolation residents felt from the limitations CMS placed on visitation or group activities in nursing homes during the pandemic to limit the transmission of COVID-19. CMS initially restricted visitation and suspended group activities in March 2020. After the initial restrictions, CMS made changes to its guidance multiple times during the pandemic to allow for more visitation and group activities, while identifying some situations where limitations would be appropriate to help prevent COVID-19 infections. In November 2021, all visitation limitations were fully lifted.³³ According to CDC, these restrictions were intended to help limit transmission of COVID-19 early in the pandemic, when nursing homes faced multiple complex challenges, including: understanding a novel virus, inability to test to detect asymptomatic infected individuals, variable personal protective equipment supply access, staffing shortages that made controlled visitation more difficult, increasing cases across the country with few effective treatments available, and no vaccine availability.

Nursing home officials in our selected states also told us that they observed worsening resident physical health during the COVID-19 pandemic. Officials from some of the nursing homes we interviewed told us they observed more residents who experienced weight loss and falls when visitation and group activities were limited. One factor contributing to unintended weight loss by residents may have been that, prior to the pandemic, visitors assisted some residents with eating. Officials from one nursing home said that these residents did not eat as well when being fed by a busy staff member rather than an attentive visitor and thus lost

³³These restrictions began in March 2020, were changed in September 2020, March 2021, and April 2021, and were fully lifted for all residents in November 2021. See Centers for Medicare & Medicaid Services, *Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes*, QSO-20-14-NH (Baltimore, Md.: March 13, 2020) and Centers for Medicare & Medicaid Services, *Nursing Home Visitation – COVID-19*, QSO-20-39-NH (Baltimore, Md.: Sept. 17, 2020), revised March 10, 2021, April 27, 2021, and November 12, 2021. CMS also released question and answer documents to help enable visitation and frequently asked question documents on visitation, such as this example published March 10, 2022: <https://www.cms.gov/files/document/nursing-home-visitation-faq-1223.pdf> accessed June 8, 2022.

weight. Officials from another nursing home said that residents were at a higher risk for falls for various reasons including, for example, they were alone in their rooms and would try to move independently without staff assistance or with inadequate staff assistance. According to CMS, some nursing homes may have been overly restrictive on visitation in a manner that was inconsistent with CMS guidance. CMS noted that the agency requires nursing homes to implement care plans for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

In November 2021, CMS updated its guidance to allow visitation and group activities with no restrictions, noting that the agency recognized that physical separation from family had taken a physical and emotional toll on residents.³⁴ Officials from some of the nursing homes we interviewed described seeing a visible improvement in residents once visitation and group activities were allowed again. For example, officials from one selected nursing home said that depression decreased and residents began eating better.

There may be other factors that have contributed to worsening resident mental and physical health during the pandemic. For example, in April 2022, CMS cited significant concerns with the quality of resident care identified by surveyors, such as weight loss, depression, and pressure ulcers as a key rationale for its plans to end certain emergency blanket waivers issued during the pandemic, such as waived training requirements for certified nurse aides.³⁵ In addition, according to one study we reviewed, changes in nursing home resident well-being could be the result of a variety of causes, including the direct effects of being sick with COVID-19, fears associated with contracting the virus, grief from losing friends and loved ones, changes in care practices, such as the

³⁴See Centers for Medicare & Medicaid Services, QSO-20-39-NH (November 12, 2021 revision).

³⁵CMS noted that by waiving these training requirements, certified nurse aides may not have received the necessary training to, for example, help identify and prevent weight loss in residents. As a result, CMS stated that the agency is concerned about how residents' health and safety has been impacted by the regulations that have been waived. See Centers for Medicare & Medicaid Services, *Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers*, QSO-22-15-NH (Baltimore, Md.: April 7, 2022).

declines in the provision of therapy, and other policies put in place to limit the spread of the virus.³⁶

Infection Prevention and Control Deficiencies Persisted in Nursing Homes during the COVID-19 Pandemic

The percentage of nursing homes cited for infection prevention and control deficiencies during the COVID-19 pandemic was generally consistent with the years prior. Nursing homes received IPC deficiencies during the COVID-19 pandemic in 2020 and 2021 for failing to follow basic practices, such as proper handwashing, but also for failing to follow COVID-19-specific practices. Officials from the state survey agencies we interviewed said the most persistent IPC challenges in nursing homes during the pandemic were often attributed to staffing challenges. Despite these challenges, stakeholders we interviewed said that nursing homes had gained valuable knowledge about IPC during the pandemic.

The Percentage of Nursing Homes Cited for Infection Prevention and Control Deficiencies during the Pandemic Was Generally Consistent with Prior Years

Our analysis of CMS data shows that the percentage of nursing homes cited for infection prevention and control deficiencies in 2020 and 2021 was generally consistent with the years prior.³⁷ Specifically, about 44 percent of nursing homes were cited for at least one IPC deficiency in 2020, which decreased to about 37 percent in 2021. Prior to the pandemic, in 2018 and 2019, about 43 percent of nursing homes were cited for at least one IPC deficiency. We also previously reported that, in each year from 2013 through 2017, the percent of all nursing homes

³⁶See M. Levere, P. Rowan, A. Wysocki, "The Adverse Effects of the COVID-19 Pandemic on Nursing Home Resident Well-Being," *JAMDA*, vol. 22, no. 5 (2021): 948-954.

³⁷For this analysis, we analyzed the deficiency code F-880 for nursing homes that were cited for not meeting federal standards for establishing and maintaining an IPC program.

inspected by state surveyors with an IPC deficiency ranged from 39 to 41 percent.³⁸

According to most of the state survey agency officials we interviewed and our review of IPC deficiency narratives written by state surveyors, nursing homes received IPC deficiencies during the pandemic for failing to follow basic IPC practices, such as proper handwashing and personal protective equipment usage, but some state survey officials noted that nursing homes also received IPC deficiencies for failing to follow COVID-19-specific practices such as failing to quarantine and isolate COVID-19 positive residents. (See app. II for illustrative examples of IPC deficiencies.) When examining the severity of the deficiencies cited, we found that in 2018 and 2019, only 1 percent of IPC deficiencies were classified at a high severity where the surveyor determined that residents were harmed or in immediate jeopardy of being harmed.³⁹ However, during the pandemic in 2020 and 2021, this increased to about 8 and 4 percent, respectively.

CMS put greater emphasis on IPC when it temporarily suspended standard surveys and introduced focused infection control surveys beginning in March 2020. (See app. III for more information on the focused infection control survey and the next finding for how it fits in with other actions CMS took during the pandemic.) While the enhanced scrutiny of IPC through CMS's focused infection control survey does not appear to have resulted in a greater percentage of nursing homes being cited by surveyors for IPC deficiencies during the pandemic compared to prior years, the focused infection control surveys were the key source of

³⁸See [GAO-20-576R](#).

³⁹This is consistent with our prior reporting, where we found that, in each year from 2013 through 2017, nearly all IPC deficiencies (about 99 percent in each year) were classified by surveyors as not severe, meaning the surveyor determined that residents were not harmed. See [GAO-20-576R](#).

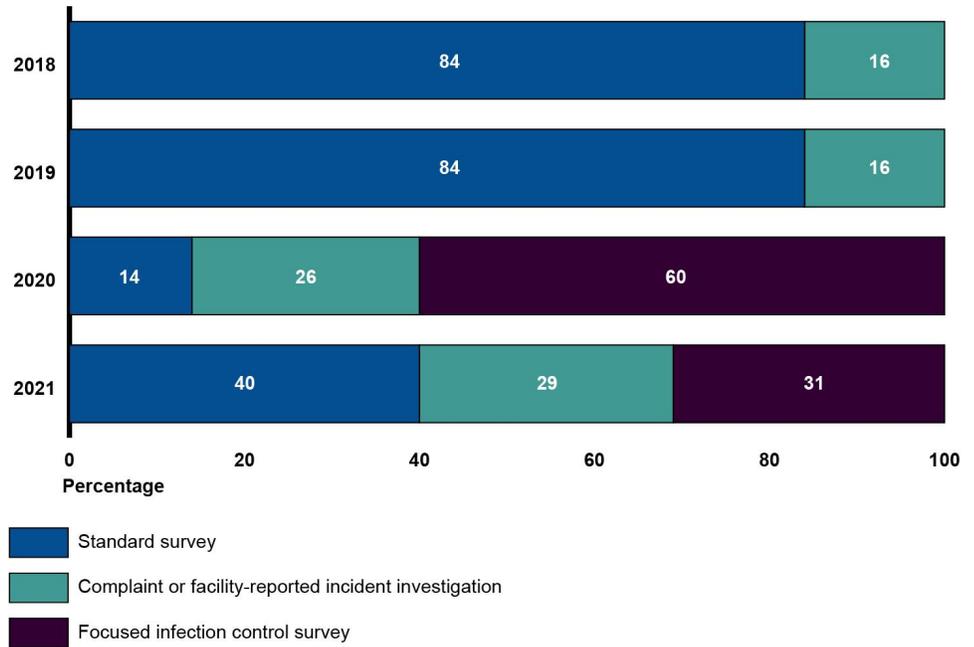
IPC deficiencies were also categorized by scope—whether the incident was an isolated occurrence, a part of a pattern of behavior, or a widespread behavior. In 2018 and 2019, about 50 percent of IPC deficiencies cited were categorized as isolated, about 30 percent categorized as a pattern, and about 14 percent categorized as widespread. In 2020 and 2021, about 35 percent of IPC deficiencies cited were categorized as isolated, about 40 percent were categorized as pattern, and about 20 percent were categorized as widespread. Percentages do not add to 100 due to rounding.

IPC deficiencies in 2020.⁴⁰ Specifically, our analysis of the CMS data showed that, prior to the pandemic, the vast majority of IPC deficiencies were identified during standard surveys (about 84 percent in 2018 and 2019).⁴¹ In contrast, in 2020, which encompasses the period when standard surveys were temporarily suspended, the majority of IPC deficiencies were identified during focused infection control surveys—60 percent in 2020, which decreased to 31 percent in 2021. Further, as the percentage of IPC deficiencies identified during standard surveys dropped during the pandemic, the percentage of IPC deficiencies identified during complaint or facility-reported incident inspections increased from about 16 percent in 2018 and 2019, to 26 percent in 2020 and 29 percent in 2021. (See fig. 3.)

⁴⁰In January 2021 and again in November 2021, CMS gave state survey agencies more capacity to conduct additional standard surveys by changing the criteria for how often a focused infection control survey must be conducted, after a year of state survey agencies mainly conducting the more frequent focused infection control surveys. See Centers for Medicare & Medicaid Services, *COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control Deficiencies, and Quality Improvement Activities in Nursing Homes*, QSO-20-31-ALL (Baltimore, Md.: June 1, 2020) (revised January 4, 2021) and Centers for Medicare & Medicaid Services, *Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes*, QSO-22-02-ALL (Baltimore, Md.: Nov. 12, 2021). Nursing homes could be inspected multiple times in a calendar year with a focused infection control survey, depending on the number of outbreaks. On average, nursing homes had four focused infection control surveys in 2020 and three in 2021. In each year from 2018 through 2021, nursing homes had, on average, two complaint or facility-reported incident investigations and one standard survey.

⁴¹For 352 of the 34,522 IPC deficiencies cited from 2018 through 2021 (about 1 percent), we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint or facility-reported incident investigation, or focused infection control survey. We excluded these deficiencies from our percentages.

Figure 3: Type of Survey or Investigation Used by State Survey Agencies to Identify Infection Prevention and Control Deficiencies, 2018 through 2021



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-22-105133

Accessible Data Table for Figure 3

Year	Standard Survey	Complaint or facility-reported incident investigation	Focused infection control survey
2018	84	16	
2019	84	16	
2020	14	26	60
2021	40	29	31

Notes: For 352 of the 34,522 IPC deficiencies cited from 2018 through 2021 (about 1 percent), we were unable to determine from CMS's data whether the deficiency was identified during a standard survey, complaint or facility-reported incident investigation, or focused infection control survey. We excluded these deficiencies from our percentages.

CMS's suspension of standard surveys and shift to prioritizing the new focused infection control survey in 2020 was a factor contributing to standard survey backlogs in some states due to the growing number of nursing homes exceeding the federal standard of 15 months without a standard survey.⁴² According to CMS data, as of April 2022, about 40 percent of nursing homes went at least 16 months without receiving a standard survey.⁴³ Our review of CMS data found that about 95 percent of nursing homes had a standard survey conducted in each of the 2 years we examined prior to the pandemic. During the pandemic, only 28 percent of nursing homes had a standard survey in 2020 while nearly all homes had at least one focused infection control survey, resulting in half as many total deficiencies as prior to the pandemic. In 2021, about 57 percent of nursing homes had a standard survey, and about 80 percent of nursing homes had at least one focused infection control survey, but the resulting number of total deficiencies cited by surveyors was still about one-quarter less than pre-pandemic levels.⁴⁴ This may be because the standard survey provides a comprehensive assessment across multiple areas of a nursing home's safety and quality of care, while the focused infection control survey is more narrowly scoped to assess a nursing home's IPC practices in light of COVID-19.

Our analysis of CMS data shows that a smaller percentage of nursing homes were cited for eight other IPC deficiency codes during the time

⁴²According to CMS, some state survey agencies had staffing issues during the pandemic that hindered their ability to conduct standard surveys, including staff reassignments and retirements, which also contributed to the backlog. For example, CMS officials said that many states had to pull their surveyors, most of whom were nurses, from their survey roles and deploy them to provide direct care to community residents or to fill other clinical roles in response to the pandemic. Also, many state survey agencies saw an increase in complaint allegations that needed to be investigated, which took resources away from conducting standard surveys.

⁴³This is a decrease from May 2021, when the HHS Office of Inspector General reported that 71 percent of nursing homes had gone at least 16 months without receiving a standard survey. See HHS Office of Inspector General, *States' Backlogs of Standard Surveys of Nursing Homes Grew Substantially During the COVID-19 Pandemic*, OEI-01-20-00431 (Washington, D.C.: July 27, 2021). One factor contributing to this decrease could be the steps CMS announced in November 2021 to assist state survey agencies in addressing the backlog of standard surveys, such as by revising the criteria for conducting a focused infection control survey and guidance for resuming standard surveys. See Centers for Medicare & Medicaid Services, QSO-22-02-ALL (Nov. 12, 2021).

⁴⁴The percentage of nursing homes with a complaint or facility-reported incident investigation was about 53 percent in 2018, about 56 percent in 2019, about 45 percent in 2020, and about 52 percent in 2021.

period examined.⁴⁵ Specifically, four of these eight IPC deficiency codes were established by CMS during the pandemic.⁴⁶ For example, a deficiency code for not meeting federal standards for informing residents, representatives, and families of COVID-19 cases in a nursing home went into effect in May 2020 and, in 2020 and 2021, less than 3 percent of nursing homes inspected by surveyors were cited for this deficiency code. The remaining four IPC deficiency codes were established by CMS in the years prior to the pandemic. For example, the antibiotic stewardship program deficiency code went into effect in November 2017 and, from 2018 through 2021, 5 percent or less of the nursing homes inspected by surveyors were cited for this deficiency code. (See app. IV for additional data on deficiencies cited.)

Selected State Officials Attributed Persistent Infection Prevention and Control Challenges to Staffing Shortages and High Turnover

Officials from seven of the eight state survey agencies we spoke to said that persistent IPC challenges faced by nursing homes during the pandemic, were rooted in staffing challenges, including staffing shortages and high rates of staff turnover.⁴⁷ According to CMS officials, the reasons for staffing shortages can be complex and unclear, ranging from an inadequate recruitment pool to management decisions. Officials we interviewed from four state survey agencies said that, if a nursing home does not have enough staff, it could be challenging for staff to adhere to proper IPC practices, such as taking the time to properly put on and remove personal protective equipment or wash their hands between caring for multiple residents. Officials from one state survey agency we interviewed said that staffing shortages have occurred in nursing homes

⁴⁵These eight other deficiency codes are F-881 for the antibiotic stewardship program, F-882 for the infection preventionist role, F-883 for influenza and pneumococcal immunization, F-945 for infection control training, F-884 for reporting to the National Healthcare Safety Network, F-885 for reporting to residents, representatives, and family, F-886 for COVID-19 testing for residents and staff, and F-887 for COVID-19 immunizations.

⁴⁶See 42 C.F.R. § 483.80(d)(3), (g), (h) (2021).

⁴⁷Even before the COVID-19 pandemic, nursing homes have historically struggled with staffing shortages and high rates of staff turnover. For more, see National Academies of Sciences, Engineering, and Medicine, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Nursing Home Residents, Families, and Staff* (Washington, D.C.: The National Academies Press, 2022).

throughout the pandemic because, for example, employees are out sick. In addition, officials from four nursing homes we interviewed said that they have sought to adhere to CDC guidance recommending a dedicated space in the home, if possible, for residents with confirmed COVID-19 infections, which has resulted in additional staffing needs.⁴⁸ Officials from seven of the nine nursing homes we spoke with said they have experienced a staffing shortage during the pandemic.

Officials from five of the state survey agencies we spoke with noted that there had been a lot of staff turnover during the pandemic, which made it difficult for a home to ensure that new or temporary staff are trained on IPC. (In response to the pandemic, CMS gave nursing homes more flexibility in hiring temporary employees to work as nurse aides by suspending certain training and certification requirements.⁴⁹) According to officials from one state survey agency, some of these temporary employees had never worked in a nursing home before. Officials from some nursing homes we interviewed also reported using temporary staff from nurse staffing agencies. Officials we interviewed from three state survey agencies said that while nursing homes typically do in-service training for their own permanent staff, they may not have had the time or resources to provide the same training to temporary staff during the pandemic, including staff from nurse staffing agencies. Officials from seven nursing homes we interviewed noted that this was compounded by the challenges of keeping staff trained on guidance, which officials said was constantly changing due to the changing circumstances of the pandemic.

Despite Challenges, Nursing Home Officials from Selected States Reported Gaining Knowledge about

⁴⁸CDC guidance specifies that staff should be assigned to work only in this unit when it is in use and that at a minimum, staff in the COVID-19 unit should include the primary nursing assistants and nurses assigned to care for these residents. Accessed on November 8, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>.

⁴⁹Specifically, from March 2020 through June 2022, CMS waived the requirement that a nursing home not employ anyone for more than 4 months unless they meet certain training and certification requirements to address potential staffing shortages in nursing homes due to the COVID-19 pandemic. See Centers for Medicare & Medicaid Services, *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*, (Baltimore, Md.: March 13, 2020) and Centers for Medicare & Medicaid Services, QSO-22-15-NH (April 7, 2022).

Infection Prevention and Control Practices during the Pandemic

Nursing home officials we interviewed from our selected states said that nursing homes gained valuable knowledge about IPC practices during the COVID-19 pandemic. For example, nursing home officials said their understanding of the significance and additional application of basic IPC practices—such as the importance of proper handwashing and the proper use of personal protective equipment—was enhanced. Officials from one nursing home said that, prior to the pandemic, the home would conduct an annual IPC “boot camp” training but the pandemic taught them that those IPC skills were easy to forget when they were not constantly put into practice. An official from another nursing home said that the IPC lessons that staff learned during the COVID-19 pandemic were applicable to preventing the spread of other types of infections.

Nursing home officials we interviewed also described learning new COVID-19 specific practices, such as how to conduct on-site testing, set up quarantine and isolation units, and screen visitors and staff. Officials from one nursing home described developing a process for swabbing and testing nearly 150 staff members for COVID-19 twice a week. Officials from another nursing home said they learned how to work with the design of their building to locate adequate quarantine and isolation spaces. Officials from two other nursing homes described IPC practices they implemented during the pandemic that they hoped to continue going forward. For example, officials from one nursing home said that when the pandemic ends they plan to continue the visitor and staff symptom screening they put in place for COVID-19 to prevent the spread of infections.

CMS and CDC Took Actions to Strengthen Infection Prevention and Control but Should Do More

CMS and CDC Took Numerous Actions on Infection Prevention and Control

Our review of agency documentation and interviews with agency officials show that CMS and CDC took numerous actions to improve infection prevention and control both prior to and during the pandemic. For

example, prior to the pandemic, CMS required nursing homes to designate an infection preventionist on staff and, during the pandemic, CMS and CDC provided infection prevention resources to nursing homes. (See app. V for a full list of IPC actions identified by CMS and CDC.)

The infection preventionist role

The infection preventionist is a nursing home employee with training in infection prevention and control who is responsible for the home's program for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Beginning November 2019, the Centers for Medicare & Medicaid Services (CMS) required all nursing homes to designate one or more infection preventionists who has completed specialized training in infection prevention and control and who works at the nursing home at least part-time. Some of the responsibilities of the infection preventionist may include contact tracing during an infectious disease outbreak, reporting surveillance data, and educating staff on proper adherence to infection prevention and control practices.

Source: GAO summary of CMS and the Centers for Disease Control and Prevention documents. | GAO-22-105133

Examples of actions CMS and CDC took prior to the COVID-19 pandemic include the following:

- **Required designated infection preventionist.** CMS updated IPC requirements to include the requirement that nursing homes designate at least one infection preventionist to oversee the facility's IPC program, effective beginning November 2019.
- **Developed infection preventionist training.** To support the infection preventionist requirement, CMS, in consultation with CDC, developed a free online infection preventionist training program that was available to nursing homes as of March 2019.⁵⁰ The specialized training provided content covering a range of IPC topics to prepare infection preventionists for their role.
- **Conducted IPC pilot program and released Infection Control Worksheet tool.** To help assess and prevent infections in nursing homes, CMS, in consultation with CDC, conducted a 3-year IPC pilot project from fiscal year 2016 through 2018, which used a worksheet tool, developed with CDC and expert input, to identify gaps in nursing home IPC practices and guide assistance to address those gaps.⁵¹ CMS released the worksheet as an IPC self-assessment tool to nursing homes in November 2019.⁵²

Examples of key actions CMS and CDC took during the pandemic include the following:

⁵⁰See Centers for Medicare & Medicaid Services, *Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting is Now Available*, QSO-19-10-NH (Baltimore, Md.: March 11, 2019).

⁵¹See Centers for Medicare & Medicaid Services, *Infection Control Pilot Project*, S&C-16-05-ALL (Baltimore, Md.: Dec. 23, 2015).

⁵²For the pilot, the new survey tool was used for educational purposes rather than to assess compliance with existing IPC requirements. After the surveyors assessed the participating nursing homes' IPC practices, the nursing homes were provided with technical assistance based on the survey's results. See Centers for Medicare & Medicaid Services, S&C-16-05-ALL (Dec. 23, 2015).

- **Initiated focused infection control surveys.** In March 2020, CMS made key changes in how it oversees nursing homes by requiring state survey agencies to conduct a new survey type known as the focused infection control survey that assessed IPC-related requirements specific to COVID-19, such as adherence to visitor screening and personal protective equipment protocols.⁵³ (See app. III.)
- **Restricted visitation and group activities.** In March 2020, to limit the transmission of COVID-19, CMS temporarily restricted visitation from all visitors and non-essential health care personnel, except for certain compassionate care situations and suspended group activities.⁵⁴ In November 2021, CMS lifted these restrictions.⁵⁵
- **Developed IPC-specific training and technical assistance.** CMS and CDC developed training and technical assistance resources to help nursing homes implement IPC practices. For example, in May 2020, CMS released a toolkit of COVID-19 best practices.⁵⁶ In June 2020, CMS deployed a network of quality improvement organizations to provide technical assistance to approximately 3,000 low performing nursing homes with a history of infection control challenges.⁵⁷ Beginning in July 2020, CDC deployed “strike teams” of infection

⁵³CMS continued to require state survey agencies to conduct high-priority complaint investigations, such as those conducted in response to alleged abuse or neglect. See Centers for Medicare & Medicaid Services, *Prioritization of Survey Activities*, QSO-20-20-ALL (Baltimore, Md.: March 20, 2020).

⁵⁴These restrictions included ombudsmen, which are advocates for nursing home residents. These restrictions were later clarified to allow certain conditions for visitation, such as to allow residents access to long-term care ombudsmen. See Centers for Medicare & Medicaid Services, QSO-20-14-NH (Mar. 13, 2020 revision) and Centers for Medicare & Medicaid Services, *Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts, Frequently Asked Questions, and Access to Ombudsman*, QSO-20-28-NH (Baltimore, Md.: April 24, 2020 and Jul. 9, 2020 revision). After the initial restrictions, CMS made changes to its visitation guidance multiple times during the pandemic to allow increased visitation and group activities. See Centers for Medicare & Medicaid Services QSO-20-39-NH (Sept. 17, 2020), revised March 10, 2021 and April 27, 2021.

⁵⁵See Centers for Medicare & Medicaid Services, QSO-20-39-NH (Nov. 12, 2021 revision).

⁵⁶See Centers for Medicare & Medicaid Services, *CMS Issues Nursing Homes Best Practices Toolkit to Combat COVID-19*, May 13, 2020, accessed April 18, 2022, <https://www.cms.gov/newsroom/press-releases/cms-issues-nursing-homes-best-practices-toolkit-combat-covid-19>.

⁵⁷See Centers for Medicare & Medicaid Services, QSO-20-31-ALL (June 1, 2020).

prevention and public health professionals to nursing homes facing challenges with infection control.⁵⁸ In August 2020, CMS released online IPC training courses developed in consultation with CDC.

- **Mandated COVID-19 surveillance reporting.** In May 2020, CMS required nursing homes to report data at least weekly through CDC's National Healthcare Safety Network on COVID-19 cases and deaths among residents and staff, personal protective equipment supplies, access to testing, and staff shortages, among other things.⁵⁹
- **Increased IPC enforcement actions.** In June 2020, CMS increased financial and other penalties, such as requiring directed plans of correction, for nursing home noncompliance with IPC requirements and made enforcement actions more significant for nursing homes with a history of past infection control deficiencies.⁶⁰

⁵⁸The strike teams identified challenges related to staffing, personal protective equipment supplies, COVID-19 testing, and infection prevention and control measure implementation. See L. Anderson et al., "Protecting Nursing Home Residents from COVID-19: Federal Strike Team Findings and Lessons Learned," *New England Journal of Medicine Catalyst* (June 28, 2021).

⁵⁹85 Fed. Reg. 27,550, 27,627 (May 8, 2020) (codified at 42 C.F.R. § 483.80(g)). Until December 31, 2024, the new requirement provides for these data to be reported at the federal level through CDC's National Healthcare Safety Network and to be updated and publicly reported. Prior to this reporting requirement, state and local health departments may have required nursing homes to report certain COVID-19 related information to them as part of their infectious disease surveillance programs. See 42 C.F.R. § 483.80(a)(2)(ii) (2021). In May 2021, CMS also required nursing homes to report COVID-19 vaccine and therapeutics treatment information to the CDC's National Healthcare Safety Network. Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities Residents, Clients, and Staff, 86 Fed. Reg. 26,306, 26,336 (May 13, 2021) (codified at 42 C.F.R. § 483.80(g)(1)(viii)-(ix)).

⁶⁰As part of these efforts, CMS encouraged state survey agencies to develop and issue to noncompliant nursing homes directed plans of correction, as their enforcement action, in which state survey agencies specify actions a nursing home must take to address infection control deficiencies, such as obtaining further IPC training or hiring an IPC consultant. See Centers for Medicare & Medicaid Services, QSO-20-31-ALL (June 1, 2020).

On February 28, 2022, the White House announced that it would lead further efforts to improve quality and safety in nursing homes through enforcement actions. For example, it announced a commitment to hold poorly performing nursing homes accountable for improper and unsafe care by expanding financial penalties and other sanctions and including more nursing homes in an enhanced oversight program targeting the poorest performers.

Stakeholders Reported Advantages and Disadvantages of CMS and CDC Infection Prevention and Control Actions

Nursing home and state survey agency officials reported to us what they believed were advantages and disadvantages for selected IPC actions taken before and during the pandemic. For example, state survey agency and nursing home officials told us that CMS's requirement to designate an infection preventionist was crucial to nursing homes during the COVID-19 pandemic. See table 1.

Table 1: Selected Federal Infection Prevention and Control (IPC) Actions and Examples of Stakeholder-Reported Perspectives on Advantages and Disadvantages

Action	Description	Advantages	Disadvantages
Required designated infection preventionist	The Centers for Medicare & Medicaid Services (CMS) updated IPC requirements to include the designation of infection preventionists.	<ul style="list-style-type: none"> Critical role in nursing homes during the pandemic (eight of nine nursing homes and five of eight state survey agencies) 	<ul style="list-style-type: none"> Requirement needs strengthening to ensure sufficient infection preventionist staffing levels (two of nine nursing homes and three of eight state survey agencies) Difficult to hire or retain infection prevention professionals in order to comply (one of nine nursing homes and two of eight state survey agencies)
Developed infection preventionist training	CMS, in consultation with the Centers for Disease Control and Prevention (CDC), developed infection preventionist training in preparation for the infection preventionist requirement.	<ul style="list-style-type: none"> Training is helpful, comprehensive (six of nine nursing homes and three of eight state survey agencies) 	<ul style="list-style-type: none"> Training is time intensive (one of nine nursing homes and two of eight state survey agencies) Training curriculum is limited, other training opportunities needed (one of nine nursing homes and four of eight state survey agencies)
Conducted IPC pilot program and released Infection Control Worksheet	CMS, in consultation with CDC, conducted a pilot from fiscal year 2016 through 2018 to help prevent the spread of infections in nursing homes. CMS released the Infection Control Worksheet for nursing homes.	Generally, the information we gathered from stakeholders indicated limited awareness of the worksheet as a tool to help nursing homes.	
Initiated focused infection control surveys	CMS developed the focused infection control survey to assess IPC-related requirements specific to COVID-19.	<ul style="list-style-type: none"> Helps improve IPC practices (seven of nine nursing homes and four of eight state survey agencies) 	<ul style="list-style-type: none"> Punitive rather than helpful approach (five of nine nursing homes and one of eight state survey agencies) Frequent and distracting from resident care (four of nine nursing homes and five of eight state survey agencies) Guidance unclear (three of nine nursing homes and eight of eight state survey agencies) Contributed to state survey agencies' backlogs of standard surveys (six of eight state survey agencies)
Restricted visitation and suspended group activities	CMS temporarily restricted nursing home visitation and suspended group activities.	<ul style="list-style-type: none"> Necessary to keep residents and staff safe (three of nine nursing homes and four of eight state survey agencies) 	<ul style="list-style-type: none"> Isolated residents and resulted in some mental or physical declines in health (six of nine nursing homes and five of eight state survey agencies)

Action	Description	Advantages	Disadvantages
Developed IPC-specific training and technical assistance	CMS and CDC developed training and technical assistance resources to help nursing homes implement IPC practices.	<ul style="list-style-type: none"> Helps improve IPC practices (six of nine nursing homes and six of eight state survey agencies) 	<ul style="list-style-type: none"> Content basic or not timely and accessible (three of nine nursing homes and six of eight state survey agencies)
Mandated COVID-19 surveillance reporting	CMS required nursing homes to report to CDC weekly surveillance data, such as COVID-19 cases and deaths.	<ul style="list-style-type: none"> Useful for directing resources and policy improvements (one of nine nursing homes and four of eight state survey agencies) 	<ul style="list-style-type: none"> Weekly reporting burden (five of nine nursing homes and four of eight state survey agencies) Lack of clear training and instructions (three of nine nursing homes)
Increased IPC enforcement actions	CMS increased financial and other penalties for nursing home noncompliance with IPC requirements.	<ul style="list-style-type: none"> Incentivizes improvements (five of eight state survey agencies) Provides more effective options, such as directed plans of correction, for system change (four of eight state survey agencies) 	<ul style="list-style-type: none"> Overly punitive during a pandemic (four of nine nursing homes and five of eight state survey agencies)

Source: GAO interviews with selected state survey agency and nursing home officials in eight states. | GAO-22-105133

CMS Has Opportunities to Strengthen Infection Prevention and Control Oversight

In our review of CMS IPC oversight, we identified areas where CMS could take more actions to strengthen oversight of IPC in nursing homes. Specifically, we found that CMS could take steps to strengthen both the role of the infection preventionist in nursing homes and IPC guidance.

Strengthen Oversight of the Infection Preventionist Role

As previously described, most nursing home and state survey agency officials we interviewed indicated that CMS’s requirement that nursing homes have an infection preventionist was critical to helping nursing homes address IPC challenges during the pandemic. Some of these officials, representing two very distinct perspectives, suggested CMS take actions to clarify and strengthen requirements for the role. We identified two ways that CMS could strengthen its oversight of the infection preventionist role: (1) establish minimum training standards and (2) collect and use infection preventionist staffing data to assess the sufficiency of the current staffing requirement.

Establish minimum infection preventionist training standards. We found that training for nursing home infection preventionists is inconsistent because CMS has not specified the minimum training that

infection preventionists need to receive so that they can be effective performing their role in nursing homes.

As part of its 2016 regulatory update of nursing home requirements, CMS began requiring nursing homes to designate an infection preventionist by November 28, 2019, and required infection preventionists to have completed “specialized training in IPC.” However, the requirement lacks specificity about what, at a minimum, the specialized training should comprise. According to CMS, the agency does not set minimum training requirements for other types of nursing home personnel and expects nursing homes to provide the amount of training needed to ensure staff have the skills to do their jobs.⁶¹ One state survey agency official told us that nursing homes are using a variety of training programs that are not equally rigorous to meet the CMS requirement, each with different curricula and covering different topics. Therefore, the official saw a need for standardizing infection preventionist training programs.⁶² Further, survey results from a 2018 study found that only 39 percent of nursing homes surveyed reported that their infection preventionists had completed specialized training in IPC.⁶³ Additionally, CMS, CDC, and state survey agency officials from some of our selected states identified noticeable gaps in the skills of nursing home infection preventionists during the pandemic, with CMS and CDC officials noting that some infection preventionists were unable to develop strategies for addressing

⁶¹CMS said that the agency requires nurse aides to complete 75 hours of training, because this minimum initial training standard is established in statute. See 42 U.S.C. §§ 1395i-3(f)(2)(A)(i)(II), 1396r(f)(2)(A)(i)(II).

⁶²Further, CDC officials said that historically there have been limited training courses available for a nursing home infection preventionist to obtain nursing-home specific IPC knowledge because many of the available training programs were not initially designed for nursing home settings. CDC officials also noted that since 2016, when the infection preventionist requirement was published, multiple courses have been developed and that these courses may be variable in terms of training time and topics since they were not developed in response to required specifications.

In addition, studies have found a lack of training among the personnel responsible for infection prevention and control in nursing homes. See National Academies of Sciences, Engineering, and Medicine, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Nursing Home Residents, Families, and Staff* (Washington, D.C.: The National Academies Press, 2022).

⁶³P. Stone et al., “Nursing Home Infection Control Program Characteristics, CMS Citations, and Implementation of Antibiotic Stewardship Policies: A National Study,” *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 55 (2018) 1-7.

common IPC practice errors, such as with hand hygiene. According to CMS and CDC officials, there are numerous trainings available for infection preventionists, including a comprehensive training program developed by CMS, in consultation with CDC, in March of 2019.

Establishing minimum training requirements would be consistent with federal standards for internal control that call for management to set clear expectations of competence for key roles, such as the role of the infection preventionist.⁶⁴ CMS planned to issue additional guidance to clarify the role of the infection preventionist, which could include more information about the minimum training infection preventionists need, but CMS officials told us that the agency has delayed issuance multiple times due to the COVID-19 pandemic. In June 2022, CMS released an advance copy of guidance, which clarifies the role of the infection preventionist but does not clarify infection preventionists' minimum training requirements, such as how many hours of training infection preventionists must complete.⁶⁵ Until CMS establishes minimum training standards for infection preventionists, nursing homes may not know which training programs are adequate and required for preparing their infection preventionists, and the skills of infection preventionists may not be adequate to allow them to effectively perform their role.

Collect and use infection preventionist staffing data. We found that CMS does not collect staffing data on infection preventionists in its staffing data system as it does for other positions. As a result, the agency lacks information it could use to assess whether CMS's minimum staffing standard for a part-time infection preventionist is sufficient to address infection risks to both residents and staff in all nursing homes.

Some nursing home and state survey agency officials from our selected states told us that many part-time infection preventionists do not have sufficient time to conduct the IPC tasks that could limit the risk of infections. Specifically, we heard from some of the nursing homes and state survey agency officials that having only a part-time infection preventionist was not sufficient for some homes. Infection preventionists we interviewed from five of nine nursing homes in our review were staff members who shared other significant and demanding roles, such as serving as the Director of Nursing, and, as a result, some were hampered

⁶⁴GAO-14-704G.

⁶⁵See Centers for Medicare & Medicaid Services, *Revised Long-Term Care Surveyor Guidance*, QSO-22-19-NH (Baltimore, Md.: June 29, 2022).

in their ability to carry out all of their infection prevention responsibilities. For example, one nursing home infection preventionist said that, because she also serves as the facility's assistant director of nursing, often her infection preventionist role is a "second thought assignment."

When discussing the requirement that nursing homes must have at least one part-time infection preventionist on staff, CMS officials told us the requirement was designed to allow nursing homes flexibility to determine the amount of time needed for an infection preventionist to effectively oversee the facility's IPC program. In June 2022, CMS released an advance copy of guidance, which notes that, while the CMS requirement is to have an infection preventionist at least part-time, nursing homes are responsible for an effective IPC program and should ensure the role of the infection preventionist is tailored to meet the nursing home's needs.⁶⁶ However, nursing home and state survey agency officials from four states in our review told us that nursing homes do not always dedicate funding to hire infection preventionists beyond the minimum required, regardless of the need. Finally, the CMS Coronavirus Commission for Safety and Quality in Nursing Homes' report from September 2020, highlighted findings that part-time infection preventionists often cannot adequately respond to the demands of the COVID-19 pandemic and recommended that CMS determine whether or under what circumstances nursing homes should have more than one part-time preventionist.⁶⁷

To the extent that CMS's current infection preventionist requirement may be inadequate for some nursing homes, it poses a potential risk to CMS's goal of ensuring quality care for nursing home residents. Addressing risk is consistent with federal standards for internal control that call for management to identify, analyze, and respond to risks by estimating their effect on achieving a defined objective.⁶⁸ CMS could begin to assess this risk with data on preventionist staffing levels across the nursing homes it oversees. It could require nursing homes to submit staffing data on infection preventionists through its Payroll Based Journal System, as it

⁶⁶See Centers for Medicare & Medicaid Services, QSO-22-19-NH (June 29, 2022).

⁶⁷Specifically, the commission recommended that CMS establish an evidence-based standard for an infection preventionist educator full-time equivalent to bed ratio, among a number of other recommended steps CMS could take to strengthen the role of infection preventionists in nursing homes. See MITRE, Coronavirus Commission on Safety and Quality in Nursing Homes, *Commission Final Report* (McLean, Va.: The MITRE Corporation, 2020). This report was written for CMS under a government contract.

⁶⁸[GAO-14-704G](#).

does with other staffing positions, which would result in the agency having comprehensive data on the number of hours infection preventionists are paid to work each day.⁶⁹ CMS could then use these staffing data to examine what level of infection preventionist staffing is needed based on nursing home size and the complexity of resident care needs. The agency could also use the data to compare the relationship, if any, between IPC deficiencies and infection preventionist staffing levels. CMS does not currently collect the infection preventionist staffing data in this way because the infection preventionist role was created after the Payroll Based Journal System was rolled out in 2015.

Collecting and utilizing quality information to inform agency decisions is consistent with federal standards for internal control to use quality information to achieve objectives.⁷⁰ Having comprehensive data on infection preventionist staffing levels across nursing homes would allow the agency to begin assessing whether the standard is sufficient for protecting nursing home residents and staff or whether it needs to be modified.

Strengthen Infection Prevention and Control Guidance

As previously described, some nursing home and state survey agency officials from our selected states indicated that the guidance issued by CMS for some IPC oversight actions was unclear and, in some situations, resulted in concerns about the enforcement actions taken against nursing homes. We identified how CMS could strengthen its guidance around IPC oversight actions by providing additional guidance to help nursing homes and state survey agencies to assess IPC practices.

We found that CMS's State Operations Manual—the key guidance state survey agencies use for conducting nursing home surveys—does not contain important IPC-related guidance. Specifically, as of May 2022, the State Operations Manual does not have examples that surveyors can use

⁶⁹The Payroll Based Journal System was developed in 2015 in response to the Patient Protection and Affordable Care Act, which required CMS to establish a national system to collect and report payroll data on nurse staffing hours. Pub. L. No. 111-148, §§ 6103, 6106, 124 Stat. 119, 704 (2010) (codified at 42 U.S.C. §§ 1320-7j(g), 1395i-3(i)(1)(A)(i)), 1396r(i)(1)(A)(i)). The system allows the agency to collect staffing data on a regular and more frequent basis than previously, when the data were reported by the homes during surveys, and the system allows the data to be auditable to ensure accuracy.

⁷⁰[GAO-14-704G](#).

to assess the scope and severity of deficiencies applicable to COVID-19-related IPC requirements. For example, the scope and severity examples for the IPC deficiency code (F-880) did not include examples related to the use of personal protective equipment, cohorting (or grouping) residents and staff to limit opportunities for transmission, and quarantining, that may be more applicable to stopping the spread of outbreaks from COVID-19 and other respiratory diseases spread by droplets and aerosols (e.g., influenza).⁷¹ According to CMS, routine updates to the State Operations Manual have not been made during the pandemic due to the temporary nature of certain guidance and the need for issuing more frequent, immediate updates, which CMS released through memoranda. In June 2022, while this report was with the agency for review and comment, CMS released an advance copy of the State Operations Manual to provide additional guidance to state surveyors for IPC-related deficiencies, including additional scope and severity classification examples, but these examples were not specific to COVID-19 or other types of respiratory diseases. Without COVID-19-relevant examples for scope and severity classification, some state survey agencies told us they are sometimes uncertain about how to inspect nursing homes for adherence to COVID-19 specific requirements, which officials say can lead to surveyors applying these requirements inconsistently.

Clarifying its guidance for surveyors would be consistent with CMS's State Operations Manual, which states that CMS is responsible for "conveying operational instructions and official interpretations of policy."⁷² It would also be consistent with federal standards for internal control that indicate management should communicate the necessary quality information to achieve its objectives.⁷³ By providing examples of scope

⁷¹While Appendix PP of the State Operations Manual provides examples of non-compliance with precautions around topics such as bloodborne infections, gastrointestinal illness, and the handling of soiled linens during scabies or head lice outbreaks, the manual does not contain examples of scope and severity categorization for deficiencies related to masking, cohorting and quarantining, or other precautions that may be more applicable to COVID-19 or other respiratory diseases such as influenza transmission. See Centers for Medicare & Medicaid Services, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities* (Baltimore, Md.: November 22, 2017). In June 2022, CMS released an advance copy of Appendix PP that will go into effect on October 24, 2022. See Centers for Medicare & Medicaid Services, QSO-22-19-NH (June 29, 2022).

⁷²Centers for Medicare & Medicaid Services, *State Operations Manual, Chapter 1—Program Background and Responsibilities* (Baltimore, Md.: October 3, 2014).

⁷³[GAO-14-704G](#).

and severity determinations for IPC related issues in the State Operations Manual, CMS can help ensure that state survey agencies are better able to understand and uphold the requirements for managing COVID-19 and other infectious diseases.

Conclusions

The COVID-19 pandemic has not only led to high rates of severe illness and death in the nation's nursing homes, but it also contributed to worsened mental and physical health among residents and highlighted persistent problems with infection prevention and control. While CMS and CDC have taken important actions to try to improve nursing home infection prevention and control both prior to and during the COVID-19 pandemic, there is more CMS should do. First, CMS should do more to strengthen oversight of the role of the infection preventionist, a position whose creation was reported to be critical for helping nursing homes during the pandemic. Specifically, until CMS sets minimum training standards for infection preventionists, nursing homes will not know which training programs are adequate for preparing their infection preventionists, and the skills of infection preventionists may not be adequate to allow them to effectively perform their role. Similarly, until CMS collects and uses infection preventionist staffing data, the agency will lack information critical to understanding whether infection preventionists are dedicating enough time to IPC to meet the risks of infectious disease in nursing homes. Finally, CMS should clarify its IPC guidance to nursing homes and state survey agencies. Specifically, until CMS clarifies guidance on the scope and severity examples for IPC deficiencies specific to COVID-19 and other respiratory diseases, state survey agencies will continue to face uncertainty about how to inspect nursing homes for adherence to IPC requirements.

Recommendations for Executive Action

We are making the following three recommendations to the Administrator of CMS to:

- 1) Establish minimum infection preventionist training standards. (Recommendation 1)
- 2) Collect infection preventionist staffing data and use these data to determine whether the current infection preventionist staffing requirement is sufficient. (Recommendation 2)
- 3) Provide additional guidance in the State Operations Manual on making scope and severity determinations for IPC-related deficiencies. (Recommendation 3)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. In its written comments, printed in appendix VI, HHS agreed with the first of our three recommendations, but did not state whether the department agreed or disagreed with our other two recommendations.

Specifically, HHS concurred with our first recommendation and noted that CMS will consider this recommendation when proposing new requirements through the rulemaking process.

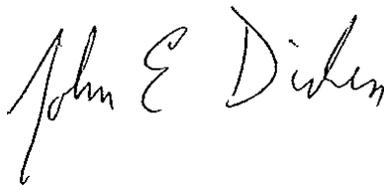
Regarding our second recommendation, while HHS did not specifically state whether it agreed or disagreed, the department said that CMS will consider this recommendation when proposing new requirements through the rulemaking process. Further, HHS said that CMS will evaluate the feasibility of collecting infection preventionist staffing data and take appropriate actions based on this evaluation.

Regarding our third recommendation, HHS did not state whether it agreed or disagreed, but the department noted that it believes that CMS addressed this recommendation prior to GAO's report publication and therefore requested that GAO remove this recommendation. In June 2022, while a draft of this report was with HHS for review and comment, CMS released an advance copy of revised guidance, including revisions to sections of the State Operations Manual relevant to this

recommendation. CMS stated that the agency believes this revised guidance addresses this recommendation. In response, we updated our report to reflect this revised guidance. We acknowledge that the revisions, scheduled to go into effect in October 2022 provide needed additional guidance on determining the scope and severity of IPC-related deficiencies. However, none of the revised scope and severity examples relate to stopping the spread of outbreaks from COVID-19 or other respiratory diseases spread by droplets and aerosols (e.g., influenza), as we describe in our report. For example, as we note in our report, none of the examples in the prior guidance or the revised guidance relate to the use of personal protective equipment, cohorting residents and staff, or quarantining residents to limit opportunities for transmission. While we recognize that CMS has taken some important steps toward addressing the clarity of the scope and severity examples in the recent update, we maintain the importance of having examples related to COVID-19 or respiratory diseases more generally in this guidance. In addition, HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of HHS, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in Appendix VII.



John E. Dicken
Director, Health Care

List of Addressees

The Honorable Patrick Leahy
Chairman
The Honorable Richard Shelby
Vice Chairman
Committee on Appropriations
United States Senate

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Patty Murray
Chair
The Honorable Richard Burr
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Gary C. Peters
Chairman
The Honorable Rob Portman
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Rosa L. DeLauro
Chair
The Honorable Kay Granger
Ranking Member
Committee on Appropriations
House of Representatives

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy and Commerce
House of Representatives

The Honorable Bennie G. Thompson
Chairman
The Honorable John Katko
Ranking Member
Committee on Homeland Security
House of Representatives

The Honorable Carolyn B. Maloney
Chairwoman
The Honorable James Comer
Ranking Member
Committee on Oversight and Reform
House of Representatives

The Honorable Richard E. Neal
Chairman
The Honorable Kevin Brady
Republican Leader
Committee on Ways and Means
House of Representatives

The Honorable Michael F. Bennet
United States Senate

Appendix I: Related GAO Products on COVID-19 in Nursing Homes

Health Care Capsule: Improving Nursing Home Quality and Information. [GAO-22-105422](#). Washington, D.C.: January 14, 2022.

COVID-19: Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity. (Nursing Homes Enclosure). [GAO-21-551](#). Washington, D.C.: July 19, 2021.

COVID-19: Most Homes Had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021. [GAO-21-367](#). Washington, D.C.: May 19, 2021.

COVID-19: Sustained Federal Action is Crucial as Pandemic Enters its Second Year. (Nursing Homes Enclosure). [GAO-21-387](#). Washington, D.C.: March 31, 2021.

COVID-19 in Nursing Homes: HHS Has Taken Steps in Response to Pandemic, but Several GAO Recommendations Have Not Been Implemented. [GAO-21-402T](#). Washington, D.C.: March 17, 2021.

COVID-19: Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention. (Nursing Homes Enclosure). [GAO-21-265](#). Washington, D.C.: January 28, 2021.

COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response. (Nursing Homes Enclosure). [GAO-21-191](#). Washington, D.C.: November 30, 2020.

COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions. (Nursing Homes Enclosure). [GAO-20-701](#). Washington, D.C.: September 21, 2020.

COVID-19: Opportunities to Improve Federal Response and Recovery Efforts. (Nursing Homes Enclosure). [GAO-20-625](#). Washington, D.C.: June 25, 2020.

Appendix I: Related GAO Products on COVID-19 in Nursing Homes

Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic. [GAO-20-576R](#). Washington, D.C.: May 20, 2020.

Appendix II: Examples of Infection Prevention and Control Deficiencies Cited in Nursing Homes during the Pandemic

Infection prevention and control (IPC) practices can be critical to preventing the spread of infectious diseases, including those specific to COVID-19. We reviewed examples of IPC deficiency narratives written by state surveyors to illustrate IPC deficiencies from different time points during the pandemic.

Table 2: Illustrative Examples of Narratives from Infection Prevention and Control Deficiencies Cited in Nursing Homes during the Pandemic

Narrative details	Month and year survey was conducted
<p>State surveyors observed that high-touch surfaces were not being disinfected and that disinfecting supplies were not readily available for staff use. In addition, surveyors observed certified nursing assistants and a nurse in a nursing home not properly wearing personal protective equipment. Specifically, they observed these staff failing to change or properly wear personal protective equipment between residents with known or suspected COVID-19, such as two certified nursing assistants who did not change their gowns after providing care to a resident on droplet precautions. Two staff members indicated to surveyors that they had not been given any guidance on how long to wear personal protective equipment and when to change it.</p>	July 2020
<p>State surveyors observed staff members in a nursing home having direct contact with residents across both the COVID-19 negative and positive units. The surveyors also learned that the nursing home had not previously quarantined any residents after a known exposure to a COVID-19 positive roommate. In addition, surveyors learned that the infection preventionist continued to work in the facility and have direct contact with multiple residents in her role as a charge nurse after testing positive for COVID-19. She was immediately sent home after testing positive, but then she was directed to return to work the next day by the administration and continued to work her schedule. Further, surveyors observed challenges with personal protective equipment. They observed a certified nursing assistant provide personal care and assistance to several residents on the COVID-19 positive unit wearing a jumpsuit, instead of a gown, that she did not change between residents. She told the surveyors that she had been provided with the jumpsuit by the home and had been wearing it for several days. She did not remove the jumpsuit prior to leaving the nursing home at the end of her shift and would instead remove it on her porch and leave it there until her next shift. Then, she would clean it with disinfecting spray before putting it back on and returning to the home for her shift.</p>	Sept. 2020
<p>State surveyors observed newly admitted residents were not being quarantined from other residents at a nursing home because, according to the Director of Nursing, there were challenges with space at the home. In addition, staff failed to properly use full personal protective equipment. The surveyors observed a certified nursing assistant coming out of a resident's room with her facemask around her chin and wearing eyeglasses with no face shield or goggles.</p>	Feb. 2021

**Appendix II: Examples of Infection Prevention
and Control Deficiencies Cited in Nursing
Homes during the Pandemic**

State surveyors observed certified nursing assistants in a nursing home assisting residents without performing any hand hygiene between residents. One certified nursing assistant was observed assisting a resident with adjusting a wheelchair and a bed side table. Then, she removed the resident's slice of bread from its wrapping with her bare hands and spread butter on the bread without performing any hand hygiene. Another certified nursing assistant did not perform hand hygiene when passing out lunch trays and setting up tray tables between residents. The certified nursing assistant said that she knew she should wash her hands between residents but she was trying to pass out the trays faster. April 2021

Source: GAO analysis of Form-2567 deficiency narrative reports from the Centers for Medicare & Medicaid Services (CMS). | GAO-22-105133

Appendix III: Types of Surveys and Investigations to Assess Whether Nursing Homes Are Meeting Federal Standards

As previously described, the Centers for Medicare & Medicaid Services (CMS) monitors nursing home compliance with federal standards primarily through the comprehensive standard surveys and as-needed investigations state survey agencies conduct. Beginning in March 2020, CMS required state survey agencies to conduct focused infection control surveys, a new type of survey developed by CMS and the Centers for Disease Control and Prevention (CDC) in response to the pandemic with a narrower scope than a standard survey. Focused infection control surveys assess federal standards for nursing home infection prevention and control that could contribute to the transmission of COVID-19, such as standards for personal protective equipment, testing, and isolating positive cases. CMS also suspended standard surveys and low priority investigations to limit surveyor time on site and focus state survey agency resources on limiting the spread of COVID-19.¹ Initially, state survey agencies conducted the focused infection control surveys in nursing homes specifically identified by HHS, and, beginning in June 2020, state survey agencies were required to conduct the focused infection control surveys any time a nursing home experienced a new COVID-19

¹Under section 1135 of the Social Security Act, the Secretary of the Department of Health and Human Services (HHS) may temporarily waive or modify certain federal health care requirements, including those relating to standard surveys of nursing homes, when both a public health emergency and a disaster or emergency have been declared. 42 U.S.C. § 1320b-5. This authority was triggered on March 13, 2020, when the President declared the COVID-19 outbreak to be a national emergency under the National Emergencies Act and a nationwide emergency under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Secretary of HHS had previously declared COVID-19 a public health emergency on January 31, 2020, retroactive to January 27, 2020. See Centers for Medicare & Medicaid Services, QSO-20-20-ALL (March 20, 2020).

Appendix III: Types of Surveys and Investigations to Assess Whether Nursing Homes Are Meeting Federal Standards

outbreak.² Beginning in August 2020, CMS indicated state survey agencies should resume standard surveys as soon as they have the resources to conduct the surveys but also required them to continue conducting focused infection control surveys.³ In January 2021 and again in November 2021, CMS changed the requirement for when a focused infection control survey must be conducted. Specifically, in November 2021, CMS required state survey agencies to perform focused infection control surveys for 20 percent of nursing homes in their state annually, prioritizing those facilities that report new COVID-19 cases and low vaccination rates, in addition to continuing to conduct standard surveys and investigations.⁴ See figure 4 for a description of the types of surveys and investigations used to assess whether nursing homes are meeting federal standards as of April 2022.

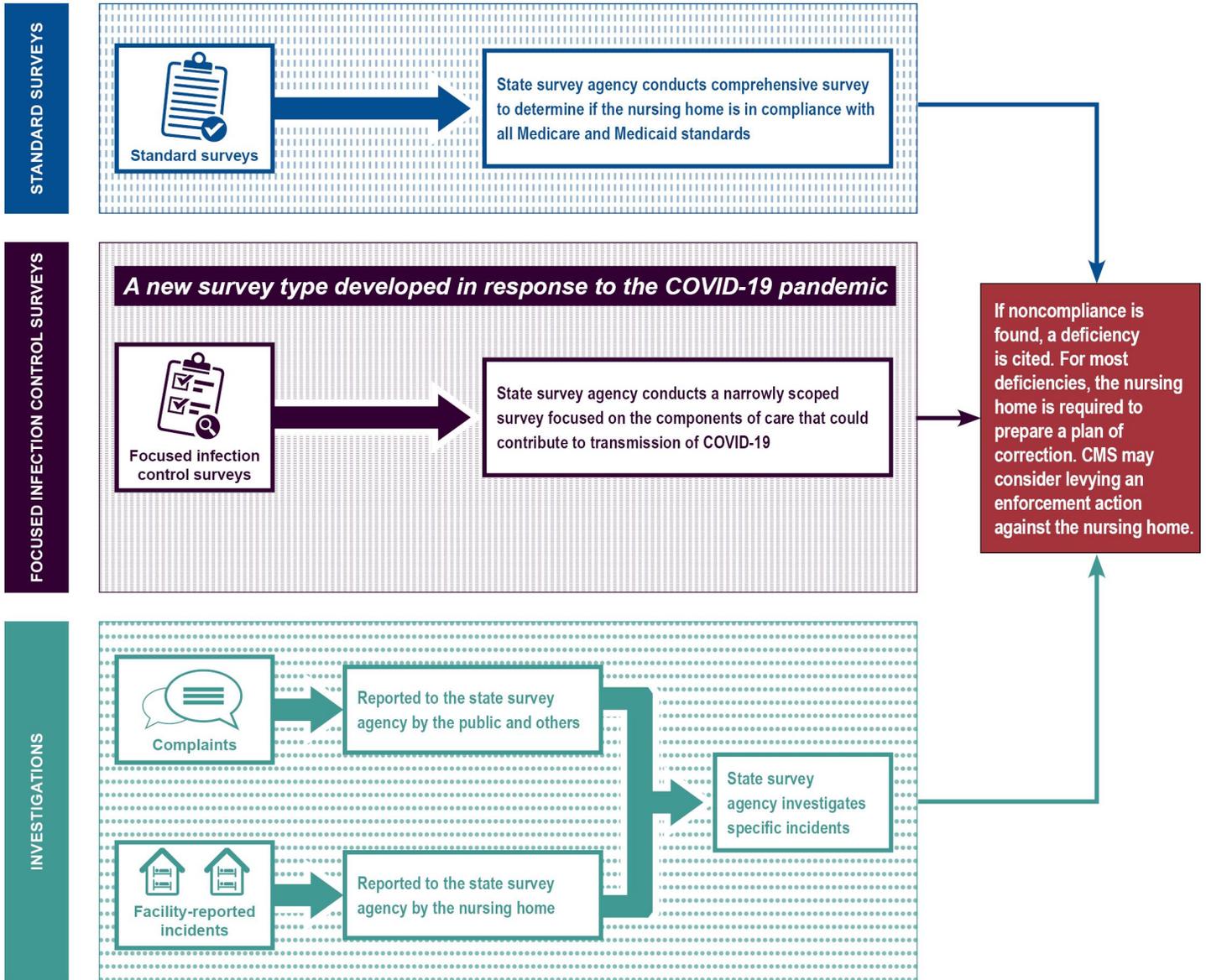
²CMS also required state survey agencies to conduct focused infection control surveys in all the nursing homes in their states by July 31, 2020 and in 20 percent of nursing homes in their states starting in fiscal year 2021. CMS also authorized states to expand certain survey activities, including standard surveys and high-priority complaint surveys, at the state's discretion. See Centers for Medicare & Medicaid Services, QSO-20-31-ALL (June 1, 2020) and Centers for Medicare & Medicaid Services, QSO-20-20-ALL (March 20, 2020).

³See Centers for Medicare & Medicaid Services, *Enforcement Cases Held During the Prioritization Period and Revised Survey Prioritization*, QSO-20-35-ALL (Baltimore, Md.: August 17, 2020).

⁴On November 30, 2020, elements of the focused infection control survey were incorporated into the standard survey process, in addition to maintaining the focused infection control survey as a stand-alone tool. See Centers for Medicare & Medicaid Services, QSO-20-31-ALL (January 4, 2021 revision). Also see Centers for Medicare & Medicaid Services, QSO-22-02-ALL (Nov. 12, 2021).

Appendix III: Types of Surveys and Investigations to Assess Whether Nursing Homes Are Meeting Federal Standards

Figure 4: Types of Surveys and Investigations Used by State Survey Agencies to Assess Whether Nursing Homes Are Meeting Federal Standards, as of April 2022



-  Conducted at least every 15 months, with a statewide average of every 12 months
-  Conducted on 20 percent of nursing homes in a state each calendar year^a
-  Conducted as-needed based on the priority of reports

Source: GAO summary of Centers for Medicare & Medicaid Services (CMS) policies. | GAO-22-105133

**Appendix III: Types of Surveys and
Investigations to Assess Whether Nursing
Homes Are Meeting Federal Standards**

^aInitially, state survey agencies conducted the focused infection control surveys in nursing homes specifically identified by the Department of Health and Human Services, and beginning in June 2020, state survey agencies were required to conduct the focused infection control surveys any time a nursing home experienced a new COVID-19 outbreak. Beginning in August 2020, CMS indicated state survey agencies should resume standard surveys as soon as they have the resources to conduct the surveys but also required them to continue conducting focused infection control surveys. In January 2021 and again in November 2021, CMS changed the requirement for when a focused infection control survey must be conducted. Specifically, in November 2021, CMS required state survey agencies to perform focused infection control surveys for 20 percent of nursing homes in their state annually, prioritizing those facilities that report new COVID-19 cases and low vaccination rates, in addition to continuing to conduct standard surveys and investigations.

Appendix IV: Number and Percentage of Surveyed Nursing Homes with Infection Prevention and Control (IPC) Deficiencies

Appendix IV: Number and Percentage of Surveyed Nursing Homes with Infection Prevention and Control (IPC) Deficiencies

Table 3: Number and Percentage of Surveyed Nursing Homes with Infection Prevention and Control (IPC) Deficiencies, by Calendar Year and Deficiency Code

	2018	2019	2020	2021
Deficiency codes that went into effect prior to the pandemic				
F-880: IPC program ^a	6,316 (43.3%)	6,283 (42.5%)	6,810 (44.2%)	5,265 (37.3%)
F-881: Antibiotic stewardship program ^b	698 (4.8)	739 (5)	195 (1.3)	307 (2.2)
F-882: Infection preventionist role ^c	n/a	n/a	138 (0.9)	240 (1.7)
F-883: Influenza and pneumococcal immunization ^d	564 (3.9)	643 (4.4)	269 (1.7)	597 (4.2)
F-945: Infection control training ^e	n/a	n/a	n/a	n/a
Deficiency codes that went into effect during the pandemic				
F-884: Reporting to the National Healthcare Safety Network ^f	n/a	n/a	1,811 (11.8)	4,702 (33.3)
F-885: Reporting to residents, representatives, and families ^g	n/a	n/a	335 (2.2)	274 (1.9)
F-886: COVID-19 testing for residents and staff ^h	n/a	n/a	424 (2.8)	576 (4.1)
F-887: COVID-19 immunizations ⁱ	n/a	n/a	n/a	158 (1.1)
Total surveyed nursing homes	14,591	14,773	15,406	14,128

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-22-105133

^aF-880 is the deficiency code for not meeting federal standards for establishing and maintaining an IPC program. This code went into effect as part of CMS's restructuring of its deficiency codes on November 28, 2017, replacing a prior deficiency code that had been in effect for several years.

^bF-881 is the deficiency code for not meeting federal standards for establishing an effective antibiotic stewardship program. This deficiency code went into effect on November 28, 2017.

^cF-882 is the deficiency code for not meeting federal standards for designating an infection preventionist. This deficiency code went into effect on November 28, 2019. State survey agencies began surveying nursing homes on it beginning August 26, 2020.

^dF-883 is the deficiency code for not meeting federal standards for influenza and pneumococcal immunizations. This deficiency code went into effect as part of CMS's restructuring of its deficiency codes on November 28, 2017, replacing a prior deficiency code that had been in effect for several years.

^eF-945 is the deficiency code for not meeting federal standards for infection control training. This deficiency code went into effect on November 28, 2019, but, at the time of our review, CMS had not yet directed state survey agencies to begin surveying homes on it. In June 2022, CMS announced that state survey agencies should begin surveying homes on this deficiency code beginning October 2022.

**Appendix IV: Number and Percentage of
Surveyed Nursing Homes with Infection
Prevention and Control (IPC) Deficiencies**

^fF-884 is a COVID-19-specific deficiency code for not meeting federal standards for weekly COVID-19 reporting to the National Healthcare Safety Network. This deficiency code went into effect on May 6, 2020. Review for F-884 is conducted off-site by federal surveyors, who automatically cite nursing homes for not submitting timely and complete data of all reporting elements.

^gF-885 is a COVID-19-specific deficiency code for not meeting federal standards for reporting COVID-19 cases to residents, representatives, and family. This deficiency code went into effect on May 6, 2020.

^hF-886 is a COVID-19-specific deficiency code for not meeting federal standards for COVID-19 testing for residents and staff. This deficiency code went into effect on August 26, 2020.

ⁱF-887 is a COVID-19 specific deficiency code for not meeting federal standards for COVID-19 immunizations. This deficiency code went into effect on May 11, 2021.

Appendix V: Federal Nursing Home Infection Prevention and Control (IPC) Actions

Table 4: Nursing Home Infection Prevention and Control (IPC) Actions Taken by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC)

Date	Action
Actions prior to the pandemic	
2009	<p>CDC helped develop the <i>National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination</i>, a plan intended to coordinate and maximize the efficiency of healthcare-associated infection prevention efforts across the federal government.^a</p> <p>CDC began working with state-based Healthcare-Associated Infection programs, which are able to provide on-the-ground IPC assessments and technical assistance in nursing homes and other health care facilities.</p>
2012	<p>CDC created a module in the National Healthcare Safety Network for national infection surveillance that allowed nursing homes to voluntarily report infections, such as <i>C. difficile</i>.^b</p> <p>CDC conducted the National Survey of Long-Term Care Providers to collect information from nursing homes on IPC practices, as well as the immunization status of and infection burden among nursing home residents.</p> <p>CMS begins to publicly report influenza and pneumococcal vaccination of nursing home residents and other IPC quality measures, such as urinary tract infections among residents.</p>
2015	<p>CDC developed and released the Core Elements of Antibiotic Stewardship for Nursing Homes which outlines steps nursing homes and other long-term care facilities could take to improve antibiotic prescribing practices and reduce their inappropriate use.</p>
2016	<p>CDC developed and released an IPC assessment tool to assist health departments and facilities assess infection control programs and practices in nursing homes and other long-term care facilities.^c</p> <p>CMS published a final rule revising requirements for nursing homes' broader IPC program with varying implementation dates. The requirements implemented in 2016 included that nursing homes must have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for residents and staff.^d</p>
2017	<p>CMS required nursing homes to develop an antibiotic stewardship program to combat the growing concern of multi-drug resistant organisms.^e</p>
2019	<p>CMS and CDC collaborated on the development of a free on-line infection preventionist training course.^f</p> <p>CMS and CDC released the Nursing Home Infection Control Worksheet, a nursing home self-assessment tool developed through a 3-year pilot program across 40 participating nursing homes.</p> <p>CMS required nursing homes to designate an infection preventionist who works at least part-time at the facility.</p> <p>CMS updated surveyor interpretive guidance to clarify that a facility's emergency preparedness planning should include "emerging infectious diseases."</p>
Actions during the pandemic	
Feb. 14, 2020	<p>CMS created and released the "Head to Toe Toolkit," offering educational materials and interventions for bedside staff to prevent common infections.</p>
Starting on Feb. 27, 2020	<p>CDC conducted about 100 COVID-19 outbreak investigations in nursing homes and other long-term care facilities in collaboration with local and state health departments.^g</p>

**Appendix V: Federal Nursing Home Infection
Prevention and Control (IPC) Actions**

Date	Action
Mar. 1, 2020	CDC issued guidance to assist nursing homes' response to COVID-19. ^h CMS initiated blanket waivers to grant nursing homes flexibilities, such as waiving certain training and certification requirements for certified nurse aides.
Mar. 4, 2020	CMS prioritized certain survey activities, such as surveys responding to allegations of abuse and neglect.
Mar. 13, 2020	CMS restricted all visitors and non-essential health care personnel from entering nursing homes, with exceptions made for compassionate care situations, such as end-of-life situations. Surveyors were also granted access. Cancelled communal dining and group activities.
Mar. 20, 2020	CMS temporarily suspended all standard surveys and suspended some other types of survey work. CMS released a targeted IPC survey tool—the focused infection control survey—and instructed states to use this survey in place of the standard survey process. CMS suspended most enforcement actions for facilities not in substantial compliance, until revisit surveys could be resumed.
May 6, 2020	CMS created new deficiency codes, known as F-tags (F-884 and F-885) associated with required reporting of cases and deaths to CDC through the National Healthcare Safety Network and to residents, their representatives, and their families.
June 1, 2020	CMS initiated a performance-based funding requirement tying CARES Act supplemental grants for state survey agencies to the completion of focused infection control surveys. CMS increased penalties for noncompliance with IPC, making the penalties more significant for those nursing homes with a history of past IPC deficiencies or that caused actual harm to residents or immediate jeopardy. CMS announced the deployment of Quality Improvement Organizations to provide technical assistance to approximately 3,000 low-performing nursing homes that had a history of IPC challenges.
June 4, 2020	CMS announced it will post survey results that were conducted on or after March 4, 2020 on Nursing Home Compare.
June 23 through Aug. 19, 2020	CMS convened the Coronavirus Commission for Safety and Quality in Nursing Homes, a committee of experts tasked to identify lessons learned from the early days of the pandemic and develop recommendations for future actions to improve IPC measures in nursing homes. ⁱ
July 18, 2020	The Department of Health and Human Services (HHS), including CDC and CMS staff, began sending strike teams to nursing homes to assist with responding to COVID-19 outbreaks.
Aug. 17, 2020	CMS authorized the resumption of standard surveys.
Aug. 25, 2020	CMS released a national nursing home training program for frontline staff and management.
Aug. 26, 2020	CMS set civil monetary penalties for failure to report COVID-related data to the National Healthcare Safety Network, associated with any F-884 citation.
Aug. 26, 2020	CMS created a new F-tag (F-886) associated with required COVID-19 testing of nursing homes staff and residents and proper documentation of testing data. CMS updated the focused infection control survey tool to assess compliance with new COVID-19 testing requirements, as well as prior updates in guidance. CMS temporarily updated the focused infection control survey tool to assess compliance with the requirement to designate an infection preventionist.
Sept. 17, 2020	CMS changed restrictions on nursing home visitation to allow limited indoor visits while still adhering to social distancing precautions. ^j
Oct. 29, 2020	CDC launched the Project Firstline Healthcare Infection Control Training Collaborative, a coalition of health care, public health, and academic partners who developed interactive infection control trainings for all health care workers, including nursing home staff.

Appendix V: Federal Nursing Home Infection Prevention and Control (IPC) Actions

Date	Action
Nov. 30, 2020	CMS integrated elements of the focused infection control survey tool into the standard survey IPC pathway for all standard surveys beginning after November 30, 2020, in addition to maintaining the focused infection control survey as a stand-alone tool.
Dec. 4, 2020	CMS announced the agency will resume calculating nursing home health inspection and quality measure ratings on January 27, 2021.
Dec. 21, 2020	CDC launched the federal Pharmacy Partnership for Long-term Care program to bring COVID-19 vaccine clinics to residents and staff members in nursing homes across the country.
Jan. 4, 2021	CMS revised the criteria requiring states to conduct focused infection control surveys.
Mar. 10, 2021	CMS further changed some visitation restrictions by allowing visitation even when a nursing home had COVID-19 positive residents and permitting physical contact between visitors and residents when a resident is vaccinated.
May 11, 2021	CMS published an interim final rule that established requirements regarding offering COVID-19 vaccines to residents and staff and established an accompanying new F-tag (F-887). CMS also began requiring the reporting of vaccination data to CDC. ^k
Oct. 1, 2021	CDC, in partnership with CMS, provided funding for state-based strike teams to provide surge capacity, address staffing shortages, and strengthen IPC activities in nursing homes. ^l
Nov. 12, 2021	CMS announced steps to assist state survey agencies in addressing the backlog of complaint and standard surveys. These steps included revising the criteria for conducting a focused infection control survey so that a survey is not required in response to COVID-19 outbreaks and providing guidance for resuming standard surveys.
Nov. 12, 2021	CMS began allowing nursing home visitation for all residents at all times.
Dec. 28, 2021	CMS began issuing guidance requiring health care staff vaccination. Additional guidance was released in January 2022.
April 7, 2022	CMS announced plans to phase in an end to certain emergency declaration blanket waivers for nursing homes, such as the waiver allowing nursing homes to employ nurse aides that have not completed a full course of training, which would end on June 6, 2022. ^m

Source: GAO summary of CMS and CDC identified actions. | GAO-22-105133

^aIn 2013, the Department of Health and Human Services released an update to the National Action Plan that included a chapter on healthcare-associated infection prevention across the long-term care spectrum, including in nursing homes. Department of Health and Human Services, *The National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination* (Washington, D.C.: 2013).

^bBetween 2016 and 2018, CDC, CMS, and a network of health care quality improvement organizations enrolled 2,000 nursing homes in the National Healthcare Safety Network to report and track *C. difficile* bacterial infections in order to support antibiotic stewardship and infection prevention practices. *C. difficile* is a bacterium that causes severe diarrhea and inflammation of the colon and infections result in disproportionately higher rates of hospitalization and death in individuals over the age of 65. During the pandemic, CDC expanded the National Health Care Safety Network to allow for reporting of COVID-19 cases and deaths from nursing homes, as well as other COVID-19 related data such as nursing home access to testing, personal protective supplies, and staff and resident vaccinations.

^cThe IPC assessment for nursing homes—known as the Infection Control Assessment and Response tool—was later adapted and used by health departments and other partners to perform remote video-assisted or onsite assessment of COVID-19-specific IPC practices and guide quality improvement activities in nursing homes.

^dMedicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688 (Oct. 4, 2016).

^eCDC also implemented initiatives to address antibiotic-resistant infections and to promote antibiotic stewardship efforts in nursing homes to align with CDC’s activities to address antibiotic resistance as outlined in the U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria, which was

Appendix V: Federal Nursing Home Infection Prevention and Control (IPC) Actions

issued in 2015. See The White House, *U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria* (Washington, D.C.: March 2015).

^fCMS also created a nursing home antibiotic stewardship program training.

^gCDC has provided further outbreak investigation and support services. For example, according to CDC officials, the CDC funded Healthcare-Associated Infection and Antimicrobial Resistance Prevention Programs that assisted with over 21,000 COVID-19 outbreak investigations in nursing homes. CDC staff along with state and local health departments also conducted thousands of Infection Control Assessment and Response assessments (both in-person and by telephone) in long-term care facilities, including nursing homes.

^hSpecifically, on March 1, 2020, CDC issued *Responding to COVID-19 in Nursing Homes* and *Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes*, as a supplemental addition to CDC's overall IPC guidance, initially released January 28, 2020. The nursing home-specific guidance was updated multiple times during the pandemic. In addition, on March 17, 2020, CDC began a series of clinician outreach and communication activity calls on COVID-19 in nursing homes and other long-term care facilities. See Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes*, accessed on November 8, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>. This online guidance was merged with Centers for Disease Control and Prevention, *Responding to COVID-19 in Nursing Homes* and Centers for Disease Control and Prevention, *Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes*, as of March 29, 2021.

ⁱThe Commission's final report was issued in September 2020. MITRE, Coronavirus Commission on Safety and Quality in Nursing Homes, *Commission Final Report* (McLean, Va.: The MITRE Corporation, 2020). This report was written for CMS under a government contract.

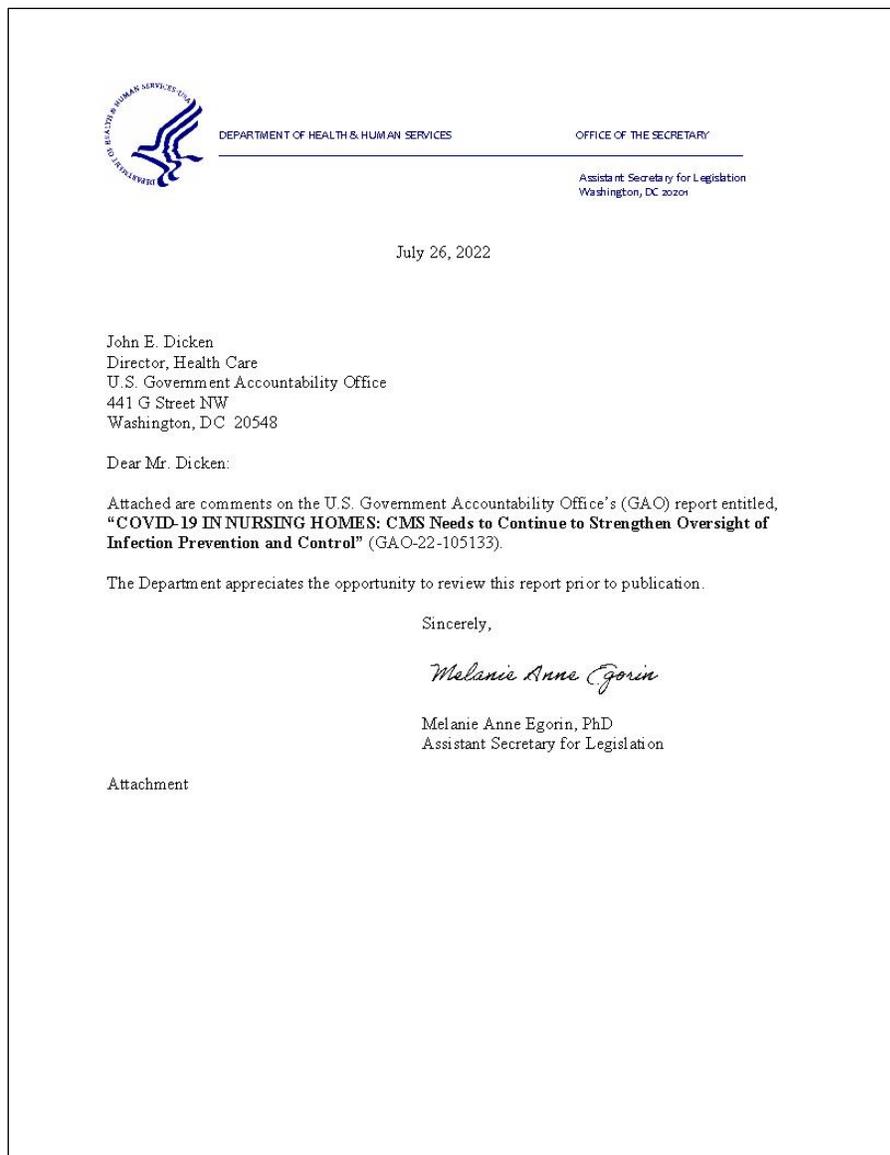
^jCMS also changed restrictions on communal activities and dining.

^kMedicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities Residents, Clients, and Staff, 86 Fed. Reg. 26,306, 26,336 (May 13, 2021).

^lThe purpose of the funding is to assist nursing homes during their response to COVID-19 infections, and to build and maintain the infection prevention infrastructure necessary to support resident, visitor, and facility healthcare personnel safety. According to CDC officials, funding to health departments to conduct these activities has been distributed and CDC continues to provide technical expertise and assistance to the recipients.

^mCMS had previously waived the requirement that nursing homes may not employ anyone for longer than four months unless they met the training and certification requirements under section 483.35(d) of title 42 of the Code of Federal Regulations.

Appendix VI: Comments from the Department of Health and Human Services



Appendix VI: Comments from the Department of Health and Human Services

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (GAO-22-105133)

The Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report.

General Comments

The Centers for Medicare & Medicaid Services (CMS) takes seriously its role in improving the safety and quality of care in our nation's nursing homes, and as such, CMS is leading the Biden-Harris Administration's new efforts to increase accountability for nursing homes. The Administration has laid out 21 initiatives spread across five key strategic goals, including a goal to ensure pandemic and emergency preparedness in nursing homes and carry forward lessons learned during the COVID-19 public health emergency.¹ These initiatives were developed with extensive input from advocates, industry experts, nursing home workers, and most importantly, residents and their loved ones. CMS is considering a wide range of methods to accomplish this important work.

Nursing homes receiving Medicare or Medicaid payments are required to comply with CMS quality and safety standards, including those relating to infection prevention and control and emergency preparedness. CMS shares management of nursing home oversight with State Survey Agencies (SSAs) who conduct onsite surveys to assess compliance with the Federal requirements and investigate facility complaints. SSAs serve as the front-line responders to address health and safety concerns raised by residents, their families, and facility staff. Accordingly, when an SSA identifies an issue of non-compliance, the nursing home is cited for a deficiency and is required to correct the issue(s) and demonstrate substantial compliance with all Federal requirements.

Long before the COVID-19 pandemic began, CMS had acted to strengthen infection prevention and control practices in nursing homes. CMS took pivotal actions in the 2016 final rule, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, which outlined the need for nursing homes to prepare for infectious disease threats.² CMS also outlined specific reform requirements for long-term care (LTC) facilities in the 2016 final rule, Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, which was the impetus for the requirement that nursing homes develop an infection prevention and control program that includes an antibiotic stewardship program.³

Since the COVID-19 public health emergency declaration in early 2020, CMS has taken a number of actions to further strengthen infection prevention and control within nursing homes. CMS began by issuing guidance to nursing homes encouraging them to take appropriate action to address potential and confirmed COVID-19 cases and mitigate transmission. CMS reiterated the importance of longstanding infection control guidelines, and guidelines on screening processes and the use of personal protective equipment. CMS has held regular calls with stakeholders, nursing home associations, and State Agencies to keep them up to date on the latest information to respond to COVID-19. Through the Quality Improvement Organizations (QIOs) CMS also sent federal strike teams comprised of representatives from Centers for Disease Control and

¹ The White House, [FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes, February 23, 2022](#).

² Medicare and Medicaid Programs, Emergency Preparedness Requirements, 81 Fed. Reg. 63860, 63862 (Sept. 16, 2016).

³ Medicare and Medicaid Programs, Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68683 (Nov. 23, 2016).

**Appendix VI: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (GAO-22-105133)

Prevention (CDC), CMS, and the Office of the Assistant Secretary for Health (OASH) to help facilities address COVID-19 challenges related to staffing, personal protective equipment supplies, COVID-19 testing, and infection prevention and control measure implementation.

In an effort to focus on controlling the spread of COVID-19, CMS provided SSAs with a streamlined review tool to conduct focused infection control surveys of providers identified through collaboration with the CDC and the Assistant Secretary for Preparedness and Response (ASPR). This tool was shared with providers who were encouraged by CMS to use it to self-assess their own ability to prevent the spread of COVID-19. By July 2020, over 99 percent of nursing homes had a focused infection control survey conducted onsite. As the public health emergency continued, the focused infection control survey was revised to incorporate new infection control requirements to address the spread of COVID-19. While the COVID-19 public health emergency warranted a more targeted approach for assessing a nursing homes' compliance with infection prevention and control requirements, in November 2021, CMS released a memorandum on Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes to help SSAs focus their efforts on identifying concerns for all aspects of quality of care, quality of life, and ensuring health and safety.⁴ CMS now requires SSAs to perform annual focused infection control surveys at 20 percent of nursing homes.⁵ CMS also published a toolkit comprised of recommendations and best practices from a variety of frontline health care providers, state governors' COVID-19 task forces, associations, and other experts that is intended to serve as a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19.⁶ CMS continues to review and revise guidance as appropriate.

In addition to the survey process used to verify compliance with Federal requirements, CMS uses data submitted by nursing homes to improve oversight and inform the public. CMS implemented a requirement that Medicare-certified nursing homes report COVID-19 testing, case, and mortality data for residents and staff to the CDC's National Healthcare Safety Network.⁷ Thereafter, in September of 2021, CMS began posting nursing home staff and resident COVID-19 vaccination data in a user-friendly format on its Nursing Home Care Compare website. Subsequently, in February 2022, CMS began posting staff and resident booster shot data to the website.⁸ To further enhance the information available to consumers, residents, and families and to help support their healthcare decisions and incentivize quality improvement among nursing homes, CMS began posting weekend nurse staffing levels as well as nursing home staff turnover data.⁹

These data are also used in the coordinated effort between CMS and CDC to provide detailed information to state and local health departments and nursing homes to inform infection

⁴ [OSO-22-02-All: Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes.](#)

⁵ [OSO-22-02-All: Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes.](#)

⁶ [OSO-21-08-NLTC: COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care Providers and Suppliers.](#)

⁷ [OSO-20-26-NH: Upcoming Requirements for Notification of Confirmed COVID-19 \(or COVID-19 Persons under Investigation\) Among Residents and Staff in Nursing Homes.](#)

⁸ [CMS Makes Nursing Home COVID-19 Booster Vaccination Online Increasing Transparency, CMS News Alert, Feb. 09, 2022.](#)

⁹ [OSO-22-0-08-NH: Nursing Home Staff Turnover and Weekend Staffing Levels.](#)

**Appendix VI: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (GAO-22-105133)

prevention and control policies and strategies across the country to further support nursing home residents. These data are also used by CMS when it is considering adjusting or introducing new policies. They have informed CMS's national policies as to when to implement, revise, or terminate waivers, and they have allowed CMS to target specific nursing homes for assistance with infection control or vaccine uptake. Specifically, through the work of the Quality Improvement Organization (QIO) program, CMS assists nursing homes in strengthening infection control practices to reduce and prevent transmission of COVID-19.

The QIOs provide educational activities, including frontline training of nursing home staff and management on infection prevention practices to reduce the spread of infection and manage outbreaks effectively, as well as providing individualized training resources based on the nursing homes' specific needs through toolkits, resource materials, guides, webinars, and clinician office hours to provide expert consultation on the particular challenges nursing homes face. CMS collects best practices and lessons learned from each of the QIOs and coordinates the sharing of that information across QIOs nationally for rapid deployment. Additionally, CMS partners with Federal agencies such as the CDC and ASPR, who are the national leaders in disease prevention and control and public health emergency response to ensure coordination of services and alignment of guidance for nursing homes.

As we continue to emerge from the COVID-19 pandemic, ensuring that residents in nursing home receive safe, high-quality care is critical. CMS is continuing the work it started before the COVID-19 pandemic to strengthen its health and safety requirements that protect residents' rights and improve the quality of care they receive. Based on lessons learned from the pandemic, CMS released guidance related to the requirement for all nursing homes to have an Infection Preventionist (IP) who has specialized training to effectively oversee the facility's infection prevention and control program. With emerging infectious disease such as COVID-19, CMS believes the role of the IP is critical in nursing homes' efforts to mitigate the onset and spread of infections. CMS recently revised guidance to clarify its expectations for infection control and prevention.¹⁰

HHS and CMS thank GAO for its efforts on this important issue and look forward to working with GAO on this and other issues in the future. GAO's recommendations and CMS' responses are below.

GAO Recommendation 1

Establish minimum infection preventionist training standards.

HHS Response

CMS concurs with this recommendation. CMS will consider this recommendation when proposing new requirements. We note that any proposed regulation requires notice and comment rulemaking. Currently, the regulation at 42 C.F.R. § 483.80(b) states that the IP who is responsible for the facility's infection prevention and control program must 1) have primary

¹⁰ [QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide.](#)

**Appendix VI: Comments from the Department
of Health and Human Services**

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (GAO-22-105133)

professional training in nursing, medical technology, microbiology, epidemiology, or another related field; 2) be qualified by education, training, experience or certification; 3) have completed specialized training in infection prevention and control.¹¹ Additionally, CDC and CMS developed specialized IP training to include topics such as transmission based precautions and antibiotic stewardship programs.¹² While CMS does not dictate which specialized training in infection prevention and control is required, the IP would be expected to have completed specialized training prior to being hired or being designated as an IP.

GAO Recommendation 2

Collect infection preventionist staffing data and use these data to determine whether the current infection preventionist staffing requirement is sufficient.

HHS Response

CMS will consider this recommendation when proposing new requirements. We note that any proposed regulation requires notice and comment rulemaking. CMS recently revised guidance for implementing Phase 3 regulations, among which requires nursing homes to have an IP who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program.¹³ With emerging infectious diseases such as COVID-19, CMS believes the role of the IP is critical in a facility's efforts to mitigate the onset and spread of infections. Currently, the regulation at 42 C.F.R. § 483.70(f) states all LTC facilities are responsible for employing full-time, part-time, or on a consultant basis those professionals necessary to carry out the provisions of the LTC requirements.¹⁴ Thus, LTC facilities are currently required to have *at least* a part-time IP, which should be seen as a minimum for LTC facilities needing an IP for a longer time, as the IP must meet the needs of the facility. SSAs are responsible for ensuring nursing homes are complying with this and other Federal requirements.

Further, the current regulation at 42 C.F.R. § 483.70 requires LTC facilities to submit complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, which is currently done through the Electronic Staffing Data Submission Payroll-Based Journal.¹⁵ CMS must consider the ability to audit the staffing data in order to be consistent with the statutory requirement. CMS will evaluate the feasibility of collecting this information, and will take appropriate actions based on this evaluation.

GAO Recommendation 3

Provide additional guidance in the State Operations Manual on making scope and severity determination for IPC-related deficiencies

¹¹ See also, [Medicare and Medicaid Programs, Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 63688 \(Nov. 28, 2016\)](#).

¹² [CDC Train, Nursing Home Infection Preventionist Training Course](#).

¹³ [QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide](#).

¹⁴ [Requirements for States and Long-Term Care Facilities, 42 CFR Part 483.70](#).

¹⁵ [S&C: 17-45-NH Electronic Staffing Submission - Payroll-Based Journal \(PBJ\)](#).

**Appendix VI: Comments from the Department
of Health and Human Services**

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE
TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL
(GAO-22-105133)**

HHS Response

In June 2022, CMS updated Appendix PP of the State Operations Manual to, among other things, provide additional guidance for infection prevention and control (IPC)-related deficiencies.¹⁶ The new guidance includes additional examples surveyors can use to assess the scope and severity of IPC-related deficiencies. For example, CMS provided deficiency categorization examples at each of the four severity levels for both the infection control deficiency F-880 and the infection preventionist deficiency F-883. Given this additional information, CMS believes it met the recommendation requirements prior to the report publication and requests that GAO remove this recommendation.

¹⁶ [QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide.](#)

Text of Appendix VI: Comments from the Department of Health and Human Services

July 26, 2022

John E. Dicken
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "COVID-19 IN NURSING HOMES: CMS Needs to Continue to Strengthen Oversight of Infection Prevention and Control" (GAO-22-105133).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,
Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - COVID-19 IN NURSING HOMES: CMS NEEDS TO CONTINUE TO STRENGTHEN OVERSIGHT OF INFECTION PREVENTION AND CONTROL (GAO-22-105133)

The Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report.

General Comments

The Centers for Medicare & Medicaid Services (CMS) takes seriously its role in improving the safety and quality of care in our nation's nursing homes, and as such, CMS is leading the Biden- Harris Administration's new efforts to increase accountability for nursing homes. The Administration has laid out 21 initiatives spread across five key strategic goals, including a goal to ensure pandemic and emergency preparedness in nursing homes and carry forward lessons learned during the COVID-19 public health emergency.¹ These initiatives were developed with extensive input from advocates, industry experts, nursing home workers, and most importantly, residents and their loved ones. CMS is considering a wide range of methods to accomplish this important work.

Nursing homes receiving Medicare or Medicaid payments are required to comply with CMS quality and safety standards, including those relating to infection prevention and control and emergency preparedness. CMS shares management of nursing home oversight with State Survey Agencies (SSAs) who conduct onsite surveys to assess compliance with the Federal requirements and investigate facility complaints. SSAs serve as the front-line responders to address health and safety concerns raised by residents, their families, and facility staff. Accordingly, when an SSA identifies an issue of non-compliance, the nursing home is cited for a deficiency and is required to correct the issue(s) and demonstrate substantial compliance with all Federal requirements.

Long before the COVID-19 pandemic began, CMS had acted to strengthen infection prevention and control practices in nursing homes. CMS took pivotal actions in the 2016 final rule, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, which outlined the need for nursing homes to prepare for infectious disease threats.² CMS also outlined specific reform requirements for long-term care (LTC) facilities in the 2016 final rule, Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, which was the impetus for the requirement that nursing homes develop an infection prevention and control program that includes an antibiotic stewardship program.³

Since the COVID-19 public health emergency declaration in early 2020, CMS has taken a number of actions to further strengthen infection prevention and control within nursing homes. CMS began by issuing guidance to nursing homes encouraging them to take appropriate action to address potential and confirmed COVID-19 cases and mitigate transmission. CMS reiterated the importance of longstanding infection control guidelines, and guidelines on screening processes and the use of personal protective equipment. CMS has held regular calls with stakeholders, nursing home associations, and State Agencies to keep them up to date on the latest information to respond to COVID-19. Through the Quality Improvement Organizations (QIOs) CMS also sent federal strike teams comprised of representatives from Centers for Disease Control and

1 The White House, FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes, February 28, 2022.

2 Medicare and Medicaid Programs; Emergency Preparedness Requirements, 81 Fed. Reg. 63860, 63862 (Sept. 16, 2016).

3 Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 (Nov. 28, 2016).

Prevention (CDC), CMS, and the Office of the Assistant Secretary for Health (OASH) to help facilities address COVID-19 challenges related to staffing, personal protective equipment supplies, COVID-19 testing, and infection prevention and control measure implementation.

In an effort to focus on controlling the spread of COVID-19, CMS provided SSAs with a streamlined review tool to conduct focused infection control surveys of providers identified through collaboration with the CDC and the Assistant Secretary for Preparedness and Response (ASPR). This tool was shared with providers who were encouraged by CMS to use it to self-assess their own ability to prevent the spread of COVID-19. By July 2020, over 99 percent of nursing homes had a focused infection control survey conducted onsite. As the public health emergency continued, the focused infection control survey was revised to incorporate new infection control requirements to address the spread of COVID-19. While the COVID-19 public health emergency warranted a more targeted approach for assessing a nursing homes' compliance with infection prevention and control requirements, in November 2021, CMS released a memorandum on Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes to help SSAs focus their efforts on identifying concerns for all aspects of quality of care, quality of life, and ensuring health and safety.⁴ CMS now requires SSAs to perform annual focused infection control surveys at 20 percent of nursing homes.⁵ CMS also published a toolkit comprised of recommendations and best practices from a variety of frontline health care providers,

state governors' COVID-19 task forces, associations, and other experts that is intended to serve as a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19.⁶ CMS continues to review and revise guidance as appropriate.

In addition to the survey process used to verify compliance with Federal requirements, CMS uses data submitted by nursing homes to improve oversight and inform the public. CMS implemented a requirement that Medicare-certified nursing homes report COVID-19 testing, case, and mortality data for residents and staff to the CDC's National Healthcare Safety Network.⁷ Thereafter, in September of 2021, CMS began posting nursing home staff and resident

COVID-19 vaccination data in a user-friendly format on its Nursing Home Care Compare website. Subsequently, in February 2022, CMS began posting staff and resident booster shot data to the website.⁸ To further enhance the information available to consumers, residents, and families and to help support their healthcare decisions and incentivize quality improvement among nursing homes, CMS began posting weekend nurse staffing levels as well as nursing home staff turnover data.⁹

These data are also used in the coordinated effort between CMS and CDC to provide detailed information to state and local health departments and nursing homes to inform infection

4 QSO-22-02-All: Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes.

5 QSO-22-02-All: Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes.

6 QSO-21-08-NLTC: COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care Providers and Suppliers.

7 QSO-20-26-NH Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes.

8 CMS Makes Nursing Home COVID-19 Booster Vaccination Online Increasing Transparency, CMS News Alert, Feb. 09, 2022.

9 QSO-22-0-08-NH: Nursing Home Staff Turnover and Weekend Staffing Levels.

prevention and control policies and strategies across the country to further support nursing home residents. These data are also used by CMS when it is considering adjusting or introducing new policies. They have informed CMS's national policies as to when to implement, revise, or terminate waivers, and they have allowed CMS to target specific nursing homes for assistance with infection control or vaccine uptake. Specifically, through the work of the Quality Improvement Organization (QIO) program, CMS assists nursing homes in strengthening infection control practices to reduce and prevent transmission of COVID-19.

The QIOs provide educational activities, including frontline training of nursing home staff and management on infection prevention practices to reduce the spread of infection and manage outbreaks effectively, as well as providing individualized training resources based on the nursing homes' specific needs through toolkits, resource materials, guides, webinars, and clinician office hours to provide expert consultation on the particular challenges nursing homes face. CMS collects best practices and lessons learned from each of the QIOs and coordinates the sharing of that information across QIOs nationally for rapid deployment. Additionally, CMS partners with Federal agencies such as the CDC and ASPR, who are the national leaders in disease prevention and control and public health emergency response to ensure coordination of services and alignment of guidance for nursing homes.

As we continue to emerge from the COVID-19 pandemic, ensuring that residents in nursing home receive safe, high-quality care is critical. CMS is continuing the work it started before the COVID-19 pandemic to strengthen its health and safety requirements that protect residents' rights and improve the quality of care they receive. Based on lessons learned from the pandemic, CMS released guidance related to the requirement for all nursing homes to have an Infection Preventionist (IP) who has specialized training to effectively oversee the facility's infection prevention and control program. With emerging infectious disease such as COVID-19, CMS believes the role of the IP is critical in nursing homes' efforts to mitigate the onset and spread of infections. CMS recently revised guidance to clarify its expectations for infection control and prevention.¹⁰

HHS and CMS thank GAO for its efforts on this important issue and look forward to working with GAO on this and other issues in the future. GAO's recommendations and CMS' responses are below.

GAO Recommendation 1

Establish minimum infection preventionist training standards.

HHS Response

CMS concurs with this recommendation. CMS will consider this recommendation when proposing new requirements. We note that any proposed regulation requires notice and comment rulemaking. Currently, the regulation at 42 C.F.R. § 483.80(b) states that the IP who is responsible for the facility's infection prevention and control program must 1) have primary

10 QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide.

professional training in nursing, medical technology, microbiology, epidemiology, or another related field; 2) be qualified by education, training, experience or certification; 3) have completed specialized training in infection prevention and control.¹¹ Additionally, CDC and CMS developed specialized IP training to include topics such as transmission based precautions and antibiotic stewardship programs.¹² While CMS does not dictate which specialized training in infection prevention and control is required, the IP would be expected to have completed specialized training prior to being hired or being designated as an IP.

GAO Recommendation 2

Collect infection preventionist staffing data and use these data to determine whether the current infection preventionist staffing requirement is sufficient.

HHS Response

CMS will consider this recommendation when proposing new requirements. We note that any proposed regulation requires notice and comment rulemaking. CMS recently revised guidance for implementing Phase 3 regulations, among which requires nursing homes to have an IP who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program.¹³ With emerging infectious diseases such as COVID-19, CMS believes the role of the IP is critical in a facility's efforts to mitigate the onset and spread of infections. Currently, the regulation at 42 C.F.R. § 483.70(f) states all LTC facilities are responsible for employing full-time, part-time, or on a consultant basis those professionals necessary to carry out the provisions of the LTC requirements.¹⁴ Thus, LTC facilities

are currently required to have at least a part-time IP, which should be seen as a minimum for LTC facilities needing an IP for a longer time, as the IP must meet the needs of the facility. SSAs are responsible for ensuring nursing homes are complying with this and other Federal requirements.

Further, the current regulation at 42 C.F.R. § 483.70 requires LTC facilities to submit complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, which is currently done through the Electronic Staffing Data Submission Payroll-Based Journal.¹⁵ CMS must consider the ability to audit the staffing data in order to be consistent with the statutory requirement. CMS will evaluate the feasibility of collecting this information, and will take appropriate actions based on this evaluation.

GAO Recommendation 3

Provide additional guidance in the State Operations Manual on making scope and severity determination for IPC-related deficiencies

11 See also, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 (Nov. 28, 2016).

12 CDC Train, Nursing Home Infection Preventionist Training Course.

13 QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide.

14 Requirements for States and Long-Term Care Facilities, 42 CFR Part 483.70.

15 S&C: 17-45-NH Electronic Staffing Submission - Payroll-Based Journal (PBJ)

HHS Response

In June 2022, CMS updated Appendix PP of the State Operations Manual to, among other things, provide additional guidance for infection prevention and control (IPC)-related deficiencies.¹⁶ The new guidance includes additional examples surveyors can use to assess the scope and severity of IPC-related deficiencies. For example, CMS provided deficiency categorization examples at each of the four severity levels for both the infection control deficiency F-880 and the infection preventionist deficiency F-883. Given this additional information, CMS believes it met the recommendation requirements prior to the report publication and requests that GAO remove this recommendation.

**Appendix VI: Comments from the Department
of Health and Human Services**

16 QSO-22-19-NH Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phase 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Sarah-Lynn McGrath (Analyst-in-Charge), Elise Pressma, Kathryn Richter, Elaina Stephenson, and Julianne Flowers. Also contributing were Isabella Guyott, Laurie Pachter, and Jennifer Whitworth.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its [website](#) newly released reports, testimony, and correspondence. You can also [subscribe](#) to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [Email Updates](#). Listen to our [Podcasts](#).
Visit GAO on the web at <https://www.gao.gov>.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: <https://www.gao.gov/about/what-gao-does/fraudnet>

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548



Please Print on Recycled Paper.