Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Report in Brief
Date: September 2023
Report No. A-04-22-08093

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

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

Why OIG Did This Audit

In 2016, CMS updated its life safety and emergency preparedness regulations for health care facilities to improve protections for individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. In addition, facilities were required to implement an infection control program.

Our objective was to determine whether Georgia ensured that selected nursing homes in Georgia that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

How OIG Did This Audit

Of the 358 nursing homes in Georgia that participated in Medicare and Medicaid, we selected a nonstatistical sample of 20 nursing homes for our audit based on certain risk factors, including multiple high-risk deficiencies Georgia reported to CMS.

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

What OIG Found

Georgia could better ensure that nursing homes in Georgia that participate in Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During our onsite inspections, we identified deficiencies related to life safety, emergency preparedness, or infection control at 19 of the 20 nursing homes we audited, totaling 155 deficiencies. Specifically, we found 71 deficiencies related to life safety, 66 deficiencies related to emergency preparedness, and 18 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at 19 of the 20 nursing homes are at an increased risk during a fire or other emergency or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Georgia had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Georgia does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

What OIG Recommends and Georgia Comments

We recommend that Georgia follow up with the 19 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions. We also make procedural recommendations for Georgia to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

In written comments on our draft report, Georgia concurred with our first recommendation and indicated that our other procedural recommendations were beyond its scope and authority. After reviewing Georgia's comments, we revised one of our procedural recommendations and maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its requirements related to health care facilities to improve protections for all individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems and smoke detector coverage to better protect residents, staff, and visitors from fire hazards. In addition, existing emergency preparedness plan requirements were expanded to include sheltering in place and evacuation provisions. Facilities were also required to update and test their emergency preparedness plans annually and train staff on them. Finally, facilities were required to develop an infection control program. CMS subsequently issued guidance to State survey agencies and nursing homes to help prevent the spread of COVID-19.

As part of our oversight activities, the Office of Inspector General (OIG) is reviewing this area because many residents of nursing homes have limited or no mobility and are particularly vulnerable in the event of a fire or other emergency. Nursing homes are also communal living environments; therefore, residents are susceptible to infectious diseases. In July 2022, we issued a report summarizing the results of a series of audits we previously conducted in eight States[1] to assess compliance with CMS's new life safety and emergency preparedness requirements.[2] This audit, which focuses on selected nursing homes in Georgia, is the second in a series of audits that also assesses compliance with CMS's infection control requirements.

OBJECTIVE

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

BACKGROUND

Medicare and Medicaid Nursing Home Survey Requirements

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

[1] We conducted audits in New York, California, Texas, Florida, Missouri, Illinois, North Carolina, and Iowa. Appendix B contains a list of these audits.

[2] *Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services To Improve Resident, Visitor, and Staff Safety* (A-02-21-01010), July 15, 2022. Available online at https://oig.hhs.gov/oas/reports/region2/22101010.asp.

perform surveys of nursing homes to determine whether they meet Federal participation requirements. For Medicare and Medicaid, these statutory participation and survey requirements are implemented in Federal regulations at 42 CFR part 483, subpart B, and 42 CFR part 488, subpart E, respectively.

Requirements for Life Safety, Emergency Preparedness, and Infection Control

Nursing homes are required to comply with all Federal, State, and local laws, regulations, and codes, as well as accepted professional standards and principles (42 CFR § 483.70), including:

- *Life Safety Requirements*: Federal regulations for life safety (42 CFR § 483.90) require nursing homes to comply with standards set forth in the National Fire Protection Association's (NFPA) *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99).[3] CMS lists applicable requirements on Form CMS-2786R, Fire Safety Survey Report.[4]

- *Emergency Preparedness Requirements*: Federal regulations for emergency preparedness (42 CFR § 483.73) include specific requirements for nursing homes' emergency preparedness plans and reference the *Standard for Emergency and Standby Power Systems* (NFPA 110)[5] as part of these requirements. CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.[6]

- *Infection Control Requirements*: Federal regulations for infection control (42 CFR § 483.80) require nursing homes to comply with specific requirements for infection prevention and control programs (IPCPs) and with policies and procedures for influenza, pneumococcal, and COVID-19 immunizations. CMS lists applicable requirements on its *Infection Prevention, Control, and Immunizations Surveyor Checklist* and *COVID-19 Focused Survey Checklist* (Infection Control Surveyor Checklists).

[3] CMS adopted the 2012 edition of both publications in a final rule published in 81 FR 26872 (May 4, 2016).

[4] Form CMS-2786R is available online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009335.html. Accessed on Feb. 21, 2023.

[5] CMS adopted the 2010 edition of NFPA 110 in a final rule published in 81 FR 63860, 63929 (Sept. 16, 2016).

[6] CMS provides online guidance for emergency preparedness at https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/emergency-prep-rule.html and https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Surveyor-Tool-EP-Tags.xlsx. Accessed on Feb. 21, 2023.

CMS uses these survey documents when CMS or a designated agency performs a nursing home survey. The results of each survey are reported and added to CMS's Automated Survey Processing Environment (ASPEN) system.[7]

Responsibilities for Life Safety, Emergency Preparedness, and Infection Control

Federal law requires nursing homes to protect the health, safety, welfare, and rights of nursing home residents and to comply with requirements for participating in Medicare and Medicaid.[8] CMS is the Federal agency responsible for certifying and overseeing all of the Nation's 15,600 Medicare- and Medicaid-certified nursing homes. To monitor nursing home compliance with Medicare and Medicaid participation requirements, CMS enters into agreements with States under Section 1864 of the Act (Section 1864 Agreements).[9, 10] Pursuant to these Section 1864 Agreements, State survey agencies are responsible for completing life safety, emergency preparedness, and infection control surveys (known as standard surveys) at least once every 15 months at nursing homes that participate in the Medicare or Medicaid programs.[11] Nursing homes with repeat deficiencies can be surveyed more frequently. In Georgia, the State agency is the State survey agency that oversees nursing homes and is responsible for ensuring that nursing homes comply with Federal, State, and local regulations. Through a contract between the Georgia Office of Commissioner of Insurance and Safety Fire (OCI) and the Georgia Department of Human Resources, OCI's State Fire Marshal's Office (SFMO) conducts the federally required life safety and emergency preparedness surveys for the State agency.

Between 2017 and 2019 (prior to the COVID-19 pandemic), the State agency conducted standard surveys at least every 15 months at all 20 of the nursing homes we visited in Georgia. In response to CMS's March 2020 COVID-19 guidance, the State agency shifted its oversight to infection control surveys and suspended standard surveys in nursing homes during the COVID-19 public health emergency. The State agency resumed standard surveys in June 2020. However, between 2020 and 2022, the State agency did not conduct standard surveys at least every 15 months at all 20 nursing homes we visited because the State agency lacked the staff resources to do so.

Management and staff at nursing homes are ultimately responsible for ensuring the safety and well-being of their residents and for complying with Federal, State, and local regulations. For

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

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

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

[10] The Act §§ 1819(g) and 1919(g).

[11] State survey agencies oversee nursing homes in their respective States and are responsible for ensuring that nursing homes comply with Federal, State, and local regulations.

example, management and staff are responsible for ensuring that facility systems (e.g., furnaces, water heaters, kitchen equipment, generators, sprinkler and alarm systems, and elevators) are properly installed, tested, and maintained. They are also responsible for ensuring that: (1) nursing homes are free from hazards, (2) emergency preparedness plans (e.g., fire evacuation and disaster preparedness plans) are updated and tested regularly, and (3) IPCPs are updated as necessary.

Nursing Home Surveys During the COVID-19 Public Health Emergency

In March 2020, CMS suspended standard surveys in nursing homes to reduce surveyors' time onsite and modified deadlines for completing surveys during the COVID-19 public health emergency. Consequently, State survey agencies (including Georgia's) experienced a backlog of standard surveys. During this period, CMS shifted its oversight to infection control surveys, which are more limited in scope than standard surveys.[12] States, including Georgia, also continued to conduct surveys for more serious nursing home complaints. In August 2020, CMS authorized States to resume standard surveys "as soon as they have the resources (e.g., staff and/or Personal Protective Equipment) to do so."[13]

HOW WE CONDUCTED THIS AUDIT

As of June 2022, 358 nursing homes in Georgia participated in the Medicare or Medicaid programs. We selected for audit a nonstatistical sample of 20 of these nursing homes based on risk factors, including multiple high-risk deficiencies the State agency reported to CMS's ASPEN system for calendar years 2017 through 2019.[14, 15]

We conducted unannounced site visits at each of the 20 nursing homes from June through September 2022. During each site visit, we checked for life safety violations, reviewed the nursing home's emergency preparedness plan, and reviewed the nursing home's policies and procedures for infection control and prevention. We considered noncompliance with a Federal requirement to be a deficiency, regardless of the number of instances of noncompliance we observed. For example, if we found three fire extinguishers at one nursing home to be in noncompliance with the requirement for monthly testing, we considered it a single deficiency for reporting purposes.

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

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

[14] All 20 nursing homes had multiple high-risk deficiencies.

[15] We defined deficiencies as high-risk if they: (1) were widespread and had the potential for more than minimal harm, (2) involved actual harm that was not immediate jeopardy, or (3) presented immediate jeopardy to resident health or safety.

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

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency could better ensure that nursing homes in Georgia that participate in the Medicare or Medicaid programs comply with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During our site visits, we identified deficiencies related to life safety, emergency preparedness, or infection control at 19 of the 20 nursing homes that we audited, totaling 155 deficiencies. Specifically:

- We found 71 deficiencies with life safety requirements related to building exits, fire barriers, and smoke partitions (29); fire detection and suppression systems (23); hazardous storage areas (5); smoking policies and fire drills (4); and electrical equipment (10).

- We found 66 deficiencies with emergency preparedness requirements related to emergency preparedness plans (10); emergency supplies and power (5); plans for evacuations, sheltering in place, and tracking residents and staff during an emergency (5); emergency communications plans (23); and emergency preparedness plan training and testing (23).

- We found 18 deficiencies with infection control requirements or guidance related to IPCPs (8), influenza and pneumococcal immunizations (4), COVID-19 immunizations (5), and COVID-19 testing (1).

The identified deficiencies occurred because of frequent management and staff turnover at the nursing homes, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, the State agency had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than required by CMS (i.e., every 15 months). Finally, although not required by CMS, the State agency does not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

As a result, the health and safety of residents, staff, and visitors at the 19 nursing homes are at an increased risk of injury or death during a fire or other emergency, or in the event of an infectious disease outbreak.

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

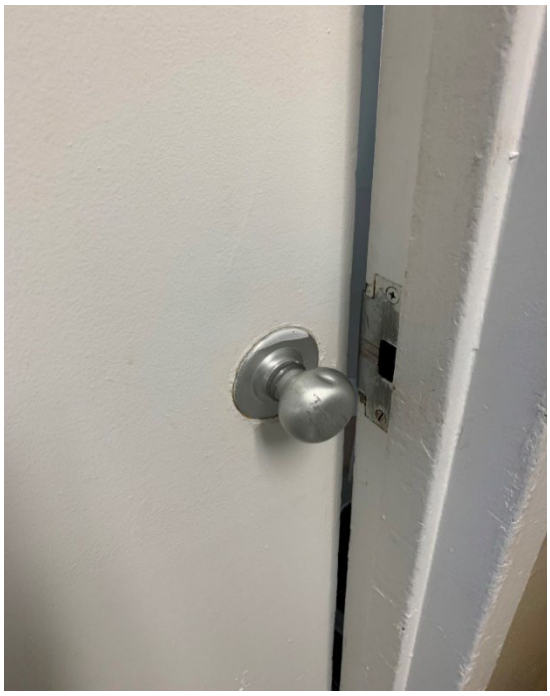
SELECTED NURSING HOMES DID NOT COMPLY WITH LIFE SAFETY REQUIREMENTS

CMS's Fire Safety Survey Report form, described on page 2, lists the Federal regulations on life safety that nursing homes must comply with and references each with an identification number, known as a K-Tag (numbered K-100 through K-933).

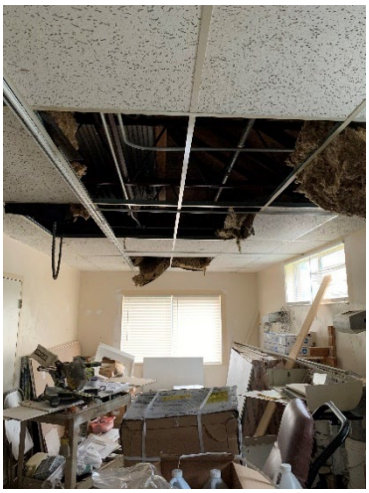
Building Exits, Fire Barriers, and Smoke Partitions

In case of fire or emergency, nursing homes are required to have unobstructed exits, self-closing doors in exit passageways that do not require tools or keys to open and are not manually propped open, pathways leading to exit doors that are not blocked or impeded, discharges from exits that are free from hazards, and fire-stopped smoke and fire barriers. In addition, corridor doors are required to latch and should seal the room from smoke or fire (K-Tags 211, 223, 271, 363, 372, 374).

Of the 20 nursing homes we visited, 18 had 1 or more deficiencies related to building exits, fire barriers, and smoke partitions, totaling 29 deficiencies. Specifically, we found deficiencies related to missing or damaged smoke and fire barriers (14 nursing homes), including broken ceiling tiles and openings that could contribute to the spread of smoke and fire. In addition, we found deficiencies related to corridor doors that were impeded from closing, would not latch, or did not fully seal (seven nursing homes); smoke barrier doors that were impeded from closing or did not fully seal (four nursing homes); and self-closing doors that would not fully seal (two nursing homes). Finally, we found deficiencies related to blocked or impeded pathways leading to exit doors (one nursing home) and blocked or impeded exit door discharge areas (one nursing home). The photographs that follow depict some of the deficiencies we identified during our site visits.



Photograph 1 (left): Exit door obstructed by boxes.
Photograph 2 (right): Corridor door would not latch or seal.



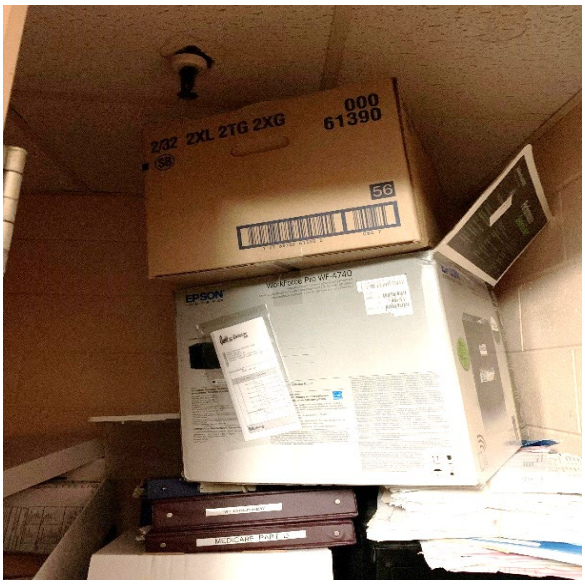
Photograph 3 (left): Self-closing door would not fully seal.
Photograph 4 (center): Electrical room smoke barrier would not seal.
Photograph 5 (right): Missing and damaged ceiling tiles.

Fire Detection and Suppression Systems

Every nursing home is required to have sprinkler systems that are installed, inspected, and maintained according to NFPA requirements. Cooking equipment and its related fire suppression systems must be maintained, and repairs must be performed on all components at intervals necessary to maintain good working condition. Nursing homes must also have fire watch policies and procedures for when fire alarms or sprinkler systems are out of service (or

evacuate its residents if a fire watch is not instituted), and portable fire extinguishers must be inspected monthly (K-Tags 324, 346, 351, 354, 355).

Of the 20 nursing homes we visited, 14 had 1 or more deficiencies related to their fire detection and suppression systems, totaling 23 deficiencies. Specifically, we found deficiencies related to blocked or obstructed sprinkler heads (12 nursing homes). We also found deficiencies related to cooking equipment fire suppression systems that were not checked monthly (two nursing homes). Finally, we found inadequate fire watch policies and procedures that should be effective during periods when the fire alarm or sprinkler system is out of service (two nursing homes)[16] and deficiencies related to monthly portable fire extinguisher inspections (seven nursing homes). The photographs that follow depict some of the deficiencies we identified during our site visits.



Photograph 6 (left): Fire extinguisher did not have monthly inspections.
Photograph 7 (right): Sprinkler head obstructed by storage boxes.

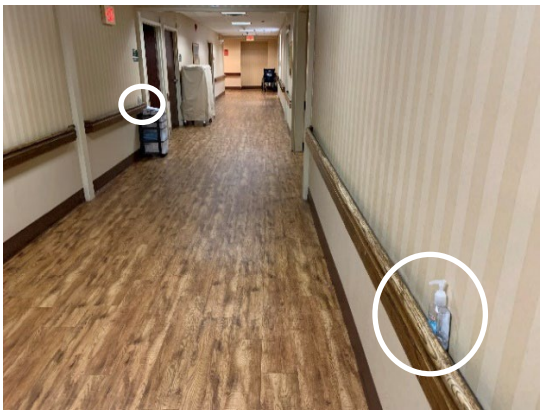
Hazardous Storage Areas

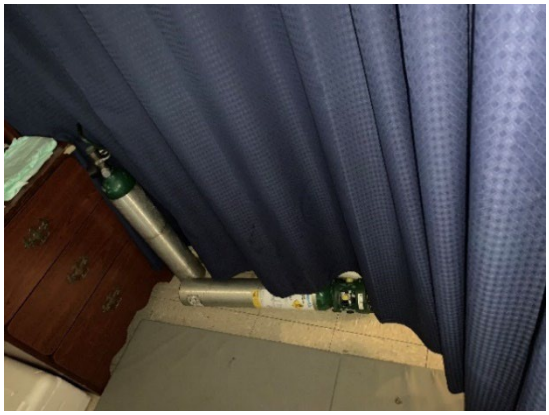
Every nursing home is required to store oxygen cylinders in a safe manner (e.g., in a storage rack and not laying on the ground in a patient's room). In addition, alcohol-based hand rub dispensers must be installed in a manner that adequately protects against inappropriate access (K-Tags 325, 923).

Of the 20 nursing homes we visited, 5 had 1 deficiency related to hazardous storage, totaling 5 deficiencies. Specifically, we found deficiencies related to oxygen cylinders that were stored in

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

an unsecure manner (four nursing homes). In addition, we found deficiencies related to alcohol-based hand rub dispensers that were installed in a manner that did not adequately protect against inappropriate access (one nursing home). The photographs that follow depict some of the deficiencies we identified during our site visits.





Photograph 8 (left): Unsecured hand rub dispensers.
Photograph 9 (right): Oxygen cylinders stored in an unsafe manner.

Smoking Policies and Fire Drills

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

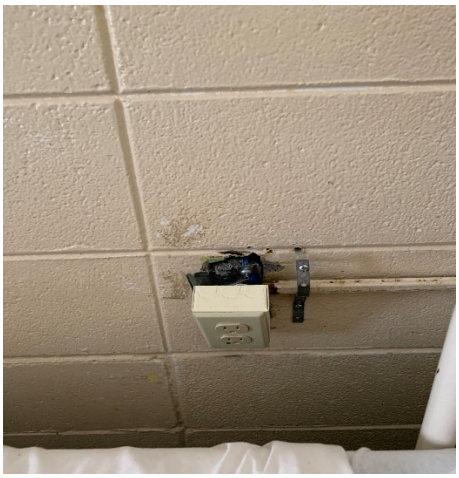
Of the 20 nursing homes we visited, 3 had 1 or more deficiencies related to smoking policies or fire drills, totaling 4 deficiencies. Specifically, we found two nursing homes whose smoking policies were not being followed (e.g., smoking in banned areas). In addition, we found two nursing homes whose fire drills were not conducted each calendar quarter covering all work shifts according to the facility's fire drill log. The photograph on the next page depicts a deficiency we identified during our site visits.

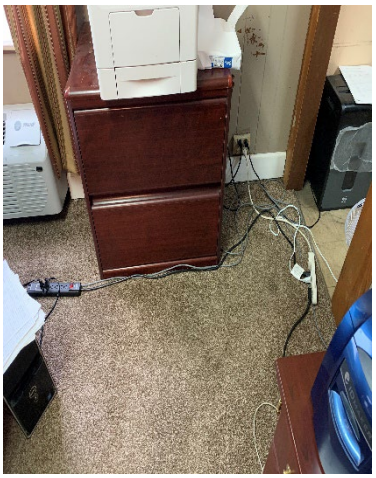
Photograph 10: Cigarette butts in no-smoking designated area.

Electrical Equipment

Power strips and extension cords must meet Underwriters Laboratories (UL) requirements and be used in a safe manner (e.g., extension cords are not used as a substitute for fixed wiring of a structure) (K-Tag 920).

Of the 20 nursing homes we visited, 10 had 1 deficiency related to electrical equipment, totaling 10 deficiencies. Specifically, we found 10 nursing homes with unsafe connections of appliances to extension cords instead of fixed wiring or with electrical outlets that were not secured. The photographs that follow depict some of the deficiencies we identified during our site visits.





Photograph 11 (left): Electrical outlet pulled off the wall exposing electrical wires.
Photograph 12 (center): Extension cord in a patient's room.
Photograph 13 (right): Daisy-chained power strips were observed in an office.

Life Safety Training for Nursing Home Management and Staff

Under section 1864 Agreements with CMS, State agencies agree to perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS's *State Operations Manual* § 1010). CMS has a publicly accessible online learning portal related to such life safety training.[17] Both CMS and State agency surveyors are required to receive standardized life safety training such as the training available through CMS's online learning portal.[18] Also, as mandated by subsections 1819(g)(1)(B) and 1919(g)(1)(B) of the Act, States must conduct periodic educational programs for staff and residents of nursing homes to present current regulations, procedures, and policies.

Participation by all nursing home management and staff in State-conducted periodic education programs is not mandatory. In addition, although not required by CMS, the State agency does not require newly hired nursing home management and staff to receive standardized life safety training such as the training available through CMS's online learning portal. During our onsite inspections, we found that there was frequent nursing home management and staff turnover. Combined, these factors may have contributed to a lack of awareness of, or failure to address, Federal requirements, potentially resulting in deficiencies similar to those detailed in our report.

SELECTED NURSING HOMES DID NOT COMPLY WITH EMERGENCY PREPAREDNESS REQUIREMENTS

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

Emergency Preparedness Plans

Nursing homes are required to develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The emergency preparedness plan must: (1) include a facility and community all-hazards risk assessment; (2) address emergency events and resident population needs; (3) include a continuity of operations plan/succession plan; and (4) address coordination with Federal, State, and local emergency management officials (E-Tags 0001, 0004, 0006, 0007, 0009).

Of the 20 nursing homes we visited, 3 had 1 or more deficiencies related to their emergency

[17] Learning portal available online at https://qsep.cms.gov/pubs/CourseMenu.aspx?cid=0CMSLSCPR_WBT. Accessed on Mar. 30, 2023.

[18] No State or Federal surveyor shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary of Health and Human Services (The Act §§ 1819(g)(2)(E)(iii) and 1919(g)(2)(E)(iii)).

preparedness plan, totaling 10 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that were not updated at least annually (three nursing homes). In addition, we found deficiencies related to all-hazard risk assessments that were not completed (one nursing home) and risk assessments that did not address all risks (one nursing home). We also found deficiencies related to emergency preparedness plans that did not address resident population needs (e.g., the plan was not specific to the facility or its residents) or consider continuity of operations (two nursing homes), emergency preparedness plans that did not include a delegation of authority/succession plan (two nursing homes), and emergency preparedness plans that did not provide for coordination with all government emergency management officials (one nursing home).

Emergency Supplies and Power

Nursing homes' emergency preparedness plans must address emergency supplies and power, and nursing homes are required to have adequate, readily available supplies of emergency food, water, and pharmaceuticals. As a best practice, the Federal Emergency Management Agency considers 3 days of emergency supplies to be sufficient.[19] Nursing homes are also required to provide an alternate source of energy (usually a generator) to maintain temperatures to protect residents' health and safety, as well as for food storage, emergency lighting, fire protection, and sewage disposal (if applicable). Further, nursing homes with generators must perform weekly maintenance checks, monthly load tests, and annual fuel quality tests if fueled with diesel[20] (E-Tags 0015, 0041).

Of the 20 nursing homes we visited, 5 had 1 deficiency related to emergency supplies and power, totaling 5 deficiencies. Specifically, we found four nursing homes with deficiencies related to insufficient emergency food and/or water supplies. In addition, we found one nursing home with a deficiency related to a generator that was not properly tested and maintained.

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

Nursing homes are required to have a plan for evacuations, sheltering in place, and tracking residents and staff during and after an emergency. Nursing homes must also have a plan for transferring medical records and using volunteers (E-Tags 0018, 0020, 0022–0024, 0033).

Of the 20 nursing homes we visited, 2 had 1 or more deficiencies related to their emergency preparedness plans for evacuations, sheltering in place, and tracking residents and staff during

[19] The 3-day standard is a best practice recommendation, as CMS does not require a specific standard. (We did not audit for compliance with this standard.) Our findings regarding a sufficient amount of generator fuel or other emergency supplies were based on a totality of the applicable criteria.

[20] Generators that operate on diesel fuel or propane gas are generally designed with a minimum fuel tank capacity to last for 3 days at half load, which factors in an emergency fuel stock and lead time for refueling.

and after emergencies, totaling 5 deficiencies. Specifically, we found deficiencies related to emergency preparedness plans that did not address evacuations (one nursing home), sheltering in place (one nursing home), tracking residents and staff (one nursing home), maintaining the availability of medical records (one nursing home), and volunteers (one nursing home).

Emergency Communications Plans

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

Of the 20 nursing homes we visited, 7 had 1 or more deficiencies related to the adequacy of the emergency communications plans, totaling 23 deficiencies. Specifically, we found 12 deficiencies related to nursing homes whose emergency communications plans did not include various categories of required names and contact information,[21] 6 deficiencies related to nursing homes whose emergency communications plans were not updated annually, 1 deficiency related to a nursing home whose emergency communications plan had insufficient alternate means of communication, 1 deficiency related to a nursing home whose emergency communications plan did not include a method of sharing information with other facilities in the event of an evacuation, 1 deficiency related to a nursing home that did not have procedures for sharing emergency preparedness plan information with residents and their families, and 1 deficiency related to a nursing home that did not have a means to provide information about the facility to emergency management officials. In addition, one nursing home did not have an emergency communications plan.

Emergency Preparedness Plan Training and Testing

Nursing homes are required to have training and testing programs related to their emergency preparedness plans and to provide updated training at least annually. Initial training must be provided to new staff members, independent contractors (e.g., contracted cleaning staff), and volunteers. The training, as well as annual refresher training, is required for all staff, must be designed to demonstrate knowledge of emergency preparedness procedures, and must be documented. Nursing homes must also conduct an annual community-based, full-scale testing

[21] The 12 deficiencies were related to nursing homes whose emergency communications plans did not include the following various categories of required names and contact information: staff (2), entities providing services (1), residents' physicians (2), other nearby nursing homes (1), volunteers (1), government emergency management offices (1), the State licensing agency (1), the ombudsman program (1), and other various required entities (2).

exercise.[22] In addition, a second training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise[23]) must be completed annually. An analysis of all training exercises (and actual events) must be completed and documented, and the emergency preparedness plan revised, if necessary (E-Tags 0036, 0037, 0039).

Of the 20 nursing homes we visited, 8 had 1 or more deficiencies related to emergency preparedness plan training, totaling 23 deficiencies. Specifically, we found one deficiency related to a nursing home that did not establish a training and testing program, two deficiencies related to nursing homes that did not update their training plan annually, and one deficiency related to a nursing home that did not conduct an initial training. In addition, we found two deficiencies related to nursing homes that did not provide annual training, six deficiencies related to nursing homes that did not conduct an annual full-scale testing exercise, five deficiencies related to nursing homes that did not conduct a second annual training exercise (a full-scale testing exercise, a facility-based exercise, or a "tabletop" exercise), and six deficiencies related to nursing homes that did not conduct an analysis of their training exercises.

SELECTED NURSING HOMES DID NOT COMPLY WITH INFECTION CONTROL REQUIREMENTS

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

Infection Prevention and Control Program

Nursing homes are required to have a facilitywide IPCP that includes when and how to isolate individuals. Nursing homes must also conduct an annual review of their IPCP and update it as necessary (F-Tag 880).

Of the 20 nursing homes we visited, 8 had 1 deficiency related to their IPCP, totaling 8 deficiencies. Specifically, we found deficiencies related to nursing homes that did not complete an annual review of their IPCP (seven nursing homes). In addition, we found deficiencies related to IPCP policies and procedures that did not include when and how isolation should be used (one nursing home).

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

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

During our site visits, mpox was declared a public health emergency from August 4, 2022, through January 31, 2023. We recontacted the 20 nursing homes to determine if they: (1) received guidance from CMS or the State agency related to mpox, (2) updated their IPCP to mitigate mpox, and (3) experienced any cases of mpox among residents or staff.

Of the 20 nursing homes, 14 indicated that they received or accessed guidance related to mpox, 16 indicated that they updated their IPCP, and 3 reported experiencing cases of mpox among residents or staff.

Influenza and Pneumococcal Immunizations

Nursing homes are required to develop policies and procedures so that each resident is offered influenza and pneumococcal immunizations unless an immunization is medically contraindicated or the resident has already been immunized. These policies and procedures must also ensure that, before offering the immunizations, each resident or resident's representative receives education regarding the benefits and potential side effects of the immunizations and has the opportunity to refuse them. Nursing homes are also required to ensure that the resident's medical record includes documentation that indicates whether education was provided and that the resident either received or did not receive these immunizations (F-Tag 883).

Of the 20 nursing homes we visited, 1 had 4 deficiencies related to medical records documentation of influenza and pneumococcal immunizations, totaling 4 deficiencies. Specifically, we found deficiencies related to medical records that lacked documentation that: (1) the facility provided required education regarding the influenza and pneumococcal immunizations and (2) a resident did or did not receive an influenza or pneumococcal immunization.

COVID-19 Immunizations

Nursing homes are required to develop policies and procedures to ensure that each resident and staff member is offered COVID-19 vaccination (unless the immunization is medically contraindicated, or the resident or staff member has already been immunized) and that staff (except exempt staff) are fully vaccinated for COVID-19.[24, 25] These policies and procedures must also ensure that, before offering the immunizations, all staff and each resident or resident's representative receive education regarding the benefits and potential side effects of COVID-19 vaccination, and the facility documents this education and the immunization status of staff and residents. The policies and procedures must also provide each resident or resident's

[24] Staff are considered fully vaccinated if it has been 2 or more weeks since they completed a primary vaccine series for COVID-19 (i.e., a single-dose vaccine or all required doses of a multidose vaccine).

[25] The policies and procedures do not apply to staff who exclusively provide telehealth, telemedicine, or support services outside of the facility setting (exempt staff). The Final Rule published in 88 FR 36485 withdraws regulations pertaining to staff vaccination effective Aug. 4, 2023.

representative the opportunity to accept or refuse COVID-19 vaccination (F-Tags 887, 888).

Of the 20 nursing homes we visited, 3 had 1 or more deficiencies related to COVID-19 immunizations, totaling 5 deficiencies. Specifically, we found two deficiencies related to the lack of required elements in the nursing homes' COVID-19 immunization policies and procedures. The nursing homes' policies and procedures did not have a process by which staff may request an exemption from COVID-19 vaccination requirements (one nursing home) and did not have a process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from COVID-19 vaccination requirements (one nursing home). We also found three nursing homes with deficiencies related to their documentation of COVID-19 vaccination requirements. Specifically, at two nursing homes, one medical record did not include documentation that the resident or resident's representative was provided education regarding the benefits or potential risks of immunization. In addition, for one nursing home, one medical record did not include documentation indicating whether each COVID-19 vaccine dose was received or refused.

COVID-19 Testing

Nursing homes are required to test residents and staff, including contractors and volunteers, for COVID-19. Nursing homes are also required to document in each resident's record that testing was offered and completed, as well as the results of each test (F-Tag 886).

Of the 20 nursing homes we visited, only 1 had a deficiency related to COVID-19 testing. Specifically, the nursing home did not document in a resident's medical record that testing was offered and completed, and it did not provide the results of each test.

CONCLUSION

At the conclusion of our inspections, we shared the deficiencies we identified with nursing home management and staff so that they could take immediate corrective action. We also shared the identified deficiencies with the State agency and CMS for followup, as appropriate.

Although nursing home management and staff are ultimately responsible for ensuring resident safety, the State agency could better ensure that nursing homes comply with Federal health and safety requirements.

RECOMMENDATIONS

We recommend that the Georgia Department of Community Health:

- follow up with the 19 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective actions;

- work with CMS to develop a risk-based approach to identify nursing homes where surveys should be conducted more frequently than once every 15 months, such as those with a history of multiple high-risk deficiencies or frequent management turnover;

- develop a plan with CMS to address the foundational issues preventing more frequent surveys at nursing homes with a history of multiple high-risk deficiencies; and

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our first recommendation and indicated that our second, third, and fourth recommendations were beyond the State agency's scope and authority. The State agency's response also included comments from SFMO. Although it was not our direct auditee, SFMO operates in collaboration with the State agency to conduct surveys at nursing facilities. After reviewing the State agency's comments, we revised our third recommendation and maintain that our findings and recommendations, as revised, are valid. See Appendix D for the complete State agency response.

State Agency and State Fire Marshal Comments

The State agency agreed with our recommendation to follow up with the 19 nursing homes regarding the deficiencies noted in this report. The State agency will work collaboratively with the OCI's SFMO to ensure that qualified health safety surveyors conduct these surveys. As of the date of the State agency's response, the State agency has conducted followup onsite investigations in 10 of the 19 facilities with infection control deficiencies and has begun to conduct followup investigations of the remaining 9 nursing homes.

SFMO indicated it will initiate an immediate internal review of all nursing homes involved in the audit and will provide a written response within 90 days. However, SFMO indicated that OIG's facility reports do not provide enough information to confirm that the cited incidences of noncompliance were present. SFMO provided examples of OIG life safety and emergency preparedness deficiencies cited in the report that may have been wrongly viewed as a violation. Those examples include the following:

- One facility had a hole in the drywall in a utility closet. If the hole is in an exterior wall the hole may be nothing more than a cosmetic repair, as the wall may not require a fire rating. A similar hole in a corridor wall may require a minor repair to maintain the wall's smoke rating, but it may not require a fire-rated repair.

- Discarded cigarette butts outside an exterior door were cited. Per CMS, all fire code violations are required to trace back to NFPA 101 or NFPA 99. These references do not

address nonresidents' handling of tobacco products, only residents. The presence of the discarded cigarettes alone is not a violation.

- OIG cited a facility for a door having a gap; however, no specific dimensions were provided and, therefore, SFMO will attempt to locate the door and verify the condition for compliance.

- Some facilities were cited for not performing their mandatory emergency preparedness program (EPP) drills. Nursing homes are permitted to claim an EPP as a full-scale exercise or drill if it occurred within the preceding year, and because the public health emergency exceeded a year, they are allowed to claim it for multiple years with documentation of the implementation. OIG cited a facility in March 2022 for not having a full-scale exercise within the last year even though it was only 1 month after the end of the COVID-related public health emergency. SFMO stated that it will determine if this was a documentation error or if the auditors failed to give the facility credit for the EPP implementation during the public health emergency.

The State agency indicated that our second, third, and fourth recommendations are beyond the State agency's scope and authority. Its explanations concerning those recommendations are as follows:

- Regarding the second recommendation, the State agency indicated that survey frequency is set by Federal law and provided to the State agency annually in a Mission and Priorities Document (MPD). The State agency regularly participates in meetings and forums with CMS and will continue to utilize opportunities for engagement to provide input on potential future Federal changes to policy and/or law in this area.

- Regarding the third recommendation, the State agency indicated that CMS allocates resources based on budget information submitted by the State agency in response to the annual MPD. Additional resources, if available, may be requested only for work that is within the scope of the MPD and consistent with the survey schedule outlined by CMS in accordance with Federal laws and regulations.

- Regarding the fourth recommendation, the State agency indicated that developing standardized life safety training for nursing home staff is not currently included as part of the MPD. However, the State agency indicated that upon invitation, it welcomes an opportunity to participate in a joint dialogue with CMS to discuss life safety training standardization for nursing home staff that will address training curriculum in theory and practicum, survey regulations processes and procedures, and interpretive guidance.

Office of Inspector General Response

We are pleased that the State agency concurred with our first recommendation and, along with SFMO, has begun to or will follow up with the 19 nursing homes. Although SFMO asserts that

the OIG facility reports do not always provide enough information to permit confirmation that the cited incidences of noncompliance were present, they also do not state these were not incidences of noncompliance. Regarding the examples cited above, we maintain that our findings are accurate for the following reasons:

- Nursing homes are required to have fire-stopped smoke and fire barriers. The nursing homes cited had a hole in a fire-rated utility closet that contained electrical equipment. If this hole was not properly sealed, it could contribute to the spread of smoke and fire throughout the building, thereby endangering the lives of the occupants.

- Nursing homes are required to establish smoking policies for residents and staff that indicate smoking may be permitted only in authorized areas and provide signage for no-smoking areas. The nursing homes we cited clearly indicated these were no-smoking areas and failed to disallow smoking in no-smoking areas by either residents, staff, or other individuals.

- Nursing homes are required to have fire-stopped smoke and fire barriers as well as corridor doors that latch and should seal the room from smoke or fire. The nursing homes we cited had multiple corridor doors or smoke barrier doors that would not latch or fully seal and would not prevent the room from smoke or fire.

- Nursing homes must conduct an annual community-based, full-scale testing exercise. As noted in footnote 22 above, we understand nursing homes are exempt from this exercise if they activated their emergency preparedness plan during the year. We confirmed, and agreed with the State agency, that we would ask each nursing home if they activated their emergency plan due to the public health emergency and obtain support of their activation. If the nursing homes provided support for emergency plan activation, then we gave them credit. The nursing homes we cited did not activate their emergency plans due to the public health emergency and did not have a full-scale testing exercise documented during the preceding 24-month period. Therefore, we determined they did not meet the requirements for this E-Tag.

We held meetings with the State agency and SFMO to discuss our findings and indicated that we have photographic evidence available if needed to verify the identified deficiencies. Furthermore, the nursing homes we cited agreed with our findings and in most cases were able to fix the identified deficiencies while we were onsite.

Regarding our second recommendation, for which the State agency neither offered concurrence or nonconcurrence, the findings in our report show that multiple nursing homes

had significant deficiencies and could benefit from more frequent surveys.[26] We reiterate the importance that the State agency work with CMS to develop a risk-based approach to identify nursing homes for more frequent surveys.

We revised our third recommendation in response to the State agency's comments. However, we maintain that the State agency should work with CMS to address the foundational issues preventing more frequent surveys at nursing homes with a history of multiple high-risk deficiencies. Addressing these issues will allow the State agency to focus surveys on facilities most likely to have deficiencies, which will reduce the risk of injury or death during a fire or other emergency or in the event of an infectious disease outbreak.

Regarding our fourth recommendation to work with CMS to develop standardized life safety training for nursing home staff, we do not believe the State agency needs an invitation from CMS to participate in a joint dialogue with CMS to discuss life safety training standardization. For example, the State agency could begin a dialogue with CMS in CMS's capacity as the action officials responsible for clearing the recommendations in this report. Absent a standardized training program that includes mandatory participation, nursing home management and staff may be unaware of critical life safety requirements.

[26] Survey agencies are not restricted by law from conducting surveys more frequently. The survey agency may conduct a survey as frequently as necessary to: (1) determine whether a facility complies with the participation requirements and (2) confirm that the facility has corrected deficiencies previously cited (42 CFR 488.308(c)). In addition, CMS's *State Operations Manual* adds that "There is no required minimum time which must elapse between surveys" (Ch. 7 § 7205.2).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of October 2019, 358 nursing homes in Georgia participated in Medicare or Medicaid programs. Of these 358 nursing homes, we selected a nonstatistical sample of 20 nursing homes for our audit based on risk factors, including multiple high-risk deficiencies the State agency reported to CMS's ASPEN system for calendar years 2017 through 2019.

We did not assess the State agency's overall internal control structure. Rather, we limited our assessment of internal controls to those applicable to our audit objective. Specifically, we assessed the State agency's policies, procedures, and practices applicable to monitoring nursing homes' compliance with life safety, emergency preparedness, and infection control requirements. Our assessment would not necessarily disclose all material weaknesses in the State agency's internal controls.

We conducted unannounced site visits at the 20 nursing homes throughout Georgia from June through September 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS and State agency officials to gain an understanding of the process for conducting nursing home life safety, emergency preparedness, and infection control surveys;
- obtained from CMS a list of all 358 active nursing homes in Georgia that participated in the Medicare and Medicaid programs as of April 2022;
- obtained from CMS's ASPEN system a list of 76 nursing homes that had 1 or more deficiencies during calendar years 2017 through 2019 that were considered high-risk because they: (1) were widespread and had the potential for more than minimal harm, (2) had actual harm that was not immediate jeopardy, or (3) presented immediate jeopardy to resident life and safety;[27]

[27] Deficiencies that the State agency enters into the ASPEN system are uploaded to CMS's Certification and Survey Provider Enhanced Reports system and are available to the public through the Quality, Certification and Oversight Reports online reporting system. Available online at https://qcor.cms.gov/.

- selected 20 nursing homes for onsite inspections from the 76 nursing homes identified in ASPEN and, for each of the 20 nursing homes:

    - reviewed deficiency reports prepared by the State agency for the nursing home's 2017 through 2019 surveys and

    - conducted unannounced site visits at the nursing home to check for life safety violations, review the nursing home's emergency preparedness plan, and review the nursing home's infection control policies and procedures; and

- discussed the results of our inspections with the selected nursing homes, the State agency, and CMS officials.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

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

APPENDIX C: DEFICIENCIES AT EACH NURSING HOME

Table 1: Summary of All Deficiencies by Nursing Home

Nursing Home	Life Safety Deficiencies	Emergency Preparedness Deficiencies	Infection Control Deficiencies	Total
1	6	27	1	**34**
2	4	4	-	**8**
3	3	4	1	**8**
4	3	1	-	**4**
5	-	-	-	**0**
6	2	2	1	**5**
7	2	-	-	**2**
8	3	-	3	**6**
9	4	-	-	**4**
10	4	-	-	**4**
11	3	2	-	**5**
12	9	13	8	**30**
13	3	-	1	**4**
14	5	-	1	**6**
15	4	1	-	**5**
16	1	-	-	**1**
17	3	-	1	**4**
18	3	2	-	**5**
19	5	10	1	**16**
20	4	-	-	**4**
Total	**71**	**66**	**18**	**155**

Table 2: Life Safety Deficiencies

Nursing Home	Building Exits, Fire Barriers, and Smoke Partitions	Fire Detection and Suppression Systems	Hazardous Storage Areas	Smoking Policies and Fire Drills	Electrical Equipment	Total
1	1	4	-	-	1	**6**
2	2	1	1	-	-	**4**
3	1	-	1	-	1	**3**
4	2	-	-	-	1	**3**
5	-	-	-	-	-	**-**
6	1	-	-	-	1	**2**
7	1	-	-	-	1	**2**
8	1	1	-	-	1	**3**
9	1	1	1	-	1	**4**
10	1	1	1	-	1	**4**
11	1	2	-	-	-	**3**
12	3	3	-	2	1	**9**
13	2	1	-	-	-	**3**
14	3	2	-	-	-	**5**
15	2	1	-	1	-	**4**
16	-	1	-	-	-	**1**
17	2	-	1	-	-	**3**
18	2	1	-	-	-	**3**
19	2	3	-	-	-	**5**
20	1	1	-	1	1	**4**
Total	**29**	**23**	**5**	**4**	**10**	**71**

Table 3: Emergency Preparedness Deficiencies

Nursing Home	Emergency Preparedness Plans	Emergency Supplies and Power	Plans for Evacuations, Sheltering in Place, and Tracking Residents and Staff During an Emergency	Emergency Communications Plans	Emergency Preparedness Plan Training and Testing	Total
1	6	1	4	15	1	**27**
2	-	-	-	1	3	**4**
3	-	-	-	1	3	**4**
4	-	-	-	1	-	**1**
5	-	-	-	-	-	**-**
6	-	1	-	1	-	**2**
7	-	-	-	-	-	**-**
8	-	-	-	-	-	**-**
9	-	-	-	-	-	**-**
10	-	-	-	-	-	**-**
11	-	-	-	-	2	**2**
12	3	1	1	2	6	**13**
13	-	-	-	-	-	**-**
14	-	-	-	-	-	**-**
15	-	-	-	-	1	**1**
16	-	-	-	-	-	**-**
17	-	-	-	-	-	**-**
18	-	1	-	-	1	**2**
19	1	1	-	2	6	**10**
20	-	-	-	-	-	**-**
Total	**10**	**5**	**5**	**23**	**23**	**66**

Table 4: Infection Control Deficiencies

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

***** Influenza and pneumococcal immunizations.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

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Georgia Department of Community Health
Healthcare Facility Regulation Division HHS-
OIG CMS Report Number A-04-22-8093
Emergency Preparedness, Life Safety and Infection Control
June 15, 2023

Overview

Enclosed is the Georgia state survey agency's response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) audit for emergency preparedness, life safety and infection control. The OIG visits were unannounced. Facilities audited were based on the OIG nonstatistical sample of 20 nursing homes based on certain risk factors previously reported to CMS. Additionally, the Georgia state survey agency recommended to the OIG high risk facilities with deficiencies applicable to the scope of the OIG audit. There are four bulleted recommendations from the OIG audit conducted June through September 2022.

The Georgia Department of Community Health, Healthcare Facility Regulation Division (hereafter referred to as HFRD) is the state survey agency responsible for conducting health and life safety inspections in all of Georgia's nursing homes. The Georgia state survey agency seeksto ensure optimal health and safety oversight for our most vulnerable population and appreciates this opportunity to respond to the audit. Also included as Appendix A is the response from the State Fire Marshal inspectors who are state contractors through the Georgia Office of Commissioner of Insurance and Safety Fire that conduct Life Safety Code and Emergency Preparedness surveys in Georgia's nursing homes.

The OIG recommended the state survey agency follow up with the 19 facilities with identified deficiencies. HFRD reviewed each finding and projects all follow up surveys will be completed within three (3) months from the date of this response. A review of the OIG deficiencies included: 18 infection control deficiencies, 66 deficiencies related to emergency preparedness and 71 deficiencies related to life safety.

Concurrences with recommendations were restricted to deficient practices, the scope of the state survey agency's regulatory authority, and Georgia's contractual obligation to CMS.

Corrective Actions

It is the responsibility of HFRD to ensure that nursing homes comply with CMS requirements for life safety, emergency preparedness, and infection control.

Response to OIG Final Draft Report (pages 16-17)

Recommendation Bullet 1:

- Follow up with the 19 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they have taken corrective action.

DCH Response to Recommendation

The Department agrees to follow-up with the 19 audited nursing homes regarding the deficiencies noted within this report. Each of the OIG's recommendations for infection control were under the state survey agency's regulatory authority. HFRD will conduct a follow-up review of the 19 nursing homes with cited deficiencies. Qualified health safety surveyors shall conduct these surveys and work collaboratively with the State Fire Marshal as indicated (see Appendix A). The state survey agency will use the OIG's reports as a baseline to assess whether corrective actions are required. For the findings that required corrective action, the state survey agency will subsequently assess for continued non-compliance with regulatory requirements and the nursing home(s) will be subject to relevant citations and enforcement action. As of the date of this report, follow-up on-site investigations were conducted in 10 of the 19 facilities with infection control deficiencies prior to the state survey agency receiving the final OIG report. The state survey agency has begun to conduct follow-up investigations of the remaining nine facilities.

Recommendation Bullet 2:

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

DCH Response to Recommendation

This recommendation is beyond the authority and scope of HFRD's role. Survey frequency for nursing homes is set by federal law and regulation, 42 C.F.R. § 488.308, and provided to the states annually in a Mission and Priorities Document (hereinafter "MPD"). HFRD regularly participates in meetings and forums with CMS to offer feedback on operations, workload, and survey activity. HFRD will continue to utilize opportunities for engagement to provide input on potential future federal changes to policy and/or law in this area.

Recommendation Bullet 3:

- Work with CMS to obtain additional resources to implement more frequent surveys using this risk-based approach.

DCH Response to Recommendation

This recommendation is beyond the scope and authority of HFRD as it is not currently included as part of the MPD. In furtherance of the response to Recommendation Bullet 2 above, CMS allocates resources based on budget information submitted by the states in response to the annual MPD. Additional resources, if available, may be requested only for work that is within the scope of the MPD and consistent with the survey schedule outlined by CMS in accordance with federal law and regulation.

Recommendation Bullet 4:

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

DCH Response to Recommendation

This recommendation is beyond the scope and authority of HFRD as it is not currently included as part of the MPD.

See additional remarks in the referenced Appendix A for the State Fire Marshal Office response.

In concurrence with this recommendation and upon invitation, HFRD welcomes an opportunity to participate in a joint dialogue with CMS to discuss life safety training standardization for nursing home staff that will address training curriculum in theory and practicum, survey regulations process and procedures, and interpretive guidance.

The Healthcare Facility Regulation Division respectfully submits to the Office of Inspector General our response to the audit report conducted in 20 state nursing homes. Please know that we will share this response with our Region 4 CMS partners. You may contact me directly with any questions.

Respectfully,

Lisa Davies Digitally signed by Lisa Davies
Date: 2023.06.15 17:31:41 -04'00'

Lisa Davies
Deputy Executive Director
Healthcare Facility Regulation Division

Office of Commissioner of Insurance and Safety Fire
Protect | Enforce | Educate | Inform

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Commissioner of Insurance and Safety Fire

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APPENDIX A

State Fire Marshals Office Review & Response
OIG CMS Report Number A-04-22-08093
Life Safety Code and Emergency Preparedness Plan
June 12, 2023

The Insurance and Safety Fire Commissioner considers matters of safety in our state's nursing homes a top priority. Any suugestion of the Georgia's survey program being less than effective raises significant concerns and evaluation. After careful review of the audit findings presented in OIG Report, at the direction of the Safety Fire Commissioner, the State Fire Marshal will initiate an immediate internal review of all facilities involved in the audit. Within ninety days, this office will survey all of the audited facilities and provide a written response. Response will include detailed explanations addressing the K or E tags identified in the report. In cases where violations are of a K and E category of the NFPA and CMS guidelines, a detailed explanation will be provided. Where K and E tags are not confirmed violations, detailed explanations will be provided along with substantiating code references and or CMS documentation.

It was determined during the review of the audit findings that the facility reports do not provide enough information to permit confirmation that the cited incidences of non-compliance were present. Site visits will be necessary. To the untrained individual a condition observed in one area of a building might be a bonafide fire code violation and when present in another area of the building be considered compliant. Unless an inspector is knowledgable in CMS practices and protocols, certain observations would appear to be non-compliant, however they may not be. Many auditors may not be familiar with the various exceptions and special conditions that apply to all aspects of fire code enforcement.

The majority of Life Safety Code K-tags issued, depending upon circumstances and certain factors, may be wrongly viewed as a violation. For example, in one facility it was noted that a hole existed in the drywall in a utility closet. If this hole is located in an exterior wall the hole may be nothing more than a cosmetic repair as the wall may not require a fire rating. A similar hole in a corridor wall may require a minor repair to maintain the walls smoke-rating, but not require a fire-rated repair. In another example discarded cigarette butts outside an exterior door were cited. Per CMS, all fire code violations are required to trace back to NFPA 101, 2012 edition Chapter 18 or 19 or NFPA 99. Those references do not adddress non-residents handling of tobacco products. They only address smoking of tobacco performed by residents. The presence of the discarded cigarettes is not a violation. Similarly, in the area of Emergency Preparedness Programs (EPP), some facilities were cited for not performing their mandatory EPP drills. The Public Health Emergency (PHE) related to the pandemic ended for Nursing Homes in April 2022. Facilities are permitted to claim an EPP as a full scale exercise or drill if it occurred within the proceeding year. Since the PHE exceeded a year, they are allowed to claim it for multiple years with documentation of the implementation. The auditors cited a facility in March 2022 for not having a full-scale exercise within the last year even though it was only one month after the end of the PHE. The State Fire Marshal's Office will determine if this was a documentation error or if the auditors failed to give

the facility credit for the EPP implementation during the PHE. In many cases CMS has provided Survey and Certification (S&C) letters providing specific direction to surveying agencies. The information in the S&C letters may permit conditions that the Life Safety Code or other NFPA reference codes might deem a violation. For example, inspection of any acceptable gap around a patient room corridor door. In some cases CMS allows up to one half of an inch if the door still positively latches. The auditors cited a facility for a door having a gap, however, no specific dimensions were provided and, therefore, we will attempt to locate the door and verify the condition for compliance. In the many cases, the violations may not have been present during the previous surveys.

Lastly, of the three areas referenced in the cover letter provided by the "Report In Brief" none are under the direct responsibility of the Insurance and Safety Fire Commissioner's Office. The document provides three observations that they conclude contributed to the non-compliant conditions they observed during the audit. Here is a brief description of their observations:

1. Staff turn-over leading to a lack of awareness of the federal requirements.

2. Georgia did not conduct surveys as required in facilities within the required maximum time allowed between surveys.

3. Failed to "requiring" nursing home staff to take Life Safety Code training.

The first two observations are outside the control of the Georgia State Fire Marshal's Office and CMS Survey Program. The last, is not required in accordance with CMS guidelines, and would have to be implemented external to the CMS survey process.

In closing the State Fire Marshal's Office will diligently investigate the concerns identified and, where appropriate, implement policy revisions and staff training to ensure measurable improvements in our survey program. This will be illustrated more fully in subsequent reports.

Respectfully,

Mark Revenew
Deputy Commissioner of Insurance
Safety Fire