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Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes

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Why OIG Did This Review

- Nursing home residents and staff have been especially impacted by the COVID-19 pandemic. Now, it is critical to learn from what happened in nursing homes and take steps to better protect residents and staff during future infectious disease outbreaks, emergencies, or other disruptions to the health care system.
- This is the third and final report in a three-part series about the effects of the COVID-19 pandemic on nursing homes. The previous reports found that COVID-19 had a devastating impact on Medicare beneficiaries in nursing homes during 2020, as 2 in 5 residents had or likely had COVID-19 in 2020. Also, more than 1,300 nursing homes had infection rates of 75 percent or higher during surge periods.

What OIG Found



Nursing homes faced monumental and ongoing staffing challenges, including a significant loss of staff and substantial difficulties in hiring, training, and retaining new staff. Many nursing homes used outside staffing agencies to fill gaps, which had significant downsides.



Nursing homes continued to struggle with costs, testing protocols, personal protective equipment (PPE) compliance, and vaccination rates after initial challenges were resolved.



Nursing homes identified challenges with implementing effective infection control practices and opportunities for improvement.

What OIG Recommends

OIG recommends that the Centers for Medicare & Medicaid Services (CMS):

1. Implement and expand upon its policies and programs to strengthen the nursing home workforce.
2. Reassess nurse aide training and certification requirements.
3. Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic.
4. Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements.
5. Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care.

CMS did not explicitly state its concurrence or nonconcurrence for the five recommendations.

This report is the third in a series about the effects of the COVID-19 pandemic on nursing homes, their residents, and residents' families and visitors. For more information about the first two reports in this series, see below or click the title of the report to be directed to the OIG website.



COVID-19 Had a Devastating Impact on Medicare Beneficiaries in Nursing Homes During 2020, OEI-02-20-00490

We found that:

- Two in five Medicare beneficiaries in nursing homes were diagnosed with either COVID-19 or likely COVID-19 in 2020 alone.
- Almost 1,000 more beneficiaries died per day in April 2020 than in April 2019.
- Overall mortality in nursing homes increased to 22 percent in 2020 from 17 percent in 2019.
- About half of Black, Hispanic, and Asian beneficiaries in nursing homes had or likely had COVID-19 in 2020, and 41 percent of White beneficiaries did.



More Than a Thousand Nursing Homes Reached Infection Rates of 75 Percent or More in the First Year of the COVID-19 Pandemic; Better Protections Are Needed for Future Emergencies, OEI-02-20-00491

We found that:

- Nursing homes had a surge of COVID-19 cases during the spring of 2020 and a greater surge during the fall, well after nursing homes were known to be vulnerable.
- More than 1,300 nursing homes had extremely high infection rates—75 percent or more—during these surges. For-profit nursing homes made up a disproportionate percentage of these homes.
- Nursing homes with extremely high infection rates had an average overall mortality rate approaching 20 percent during the surges—roughly double that of other nursing homes.
- High COVID-19 transmission in a county did not always lead to nursing homes in that county reaching extremely high infection rates.

We recommended that CMS:

- Re-examine current nursing staff requirements and revise them as necessary.
- Improve how surveys identify infection control risks to nursing home residents and strengthen guidance on assessing the scope and severity of those risks.
- Target nursing homes in most need of infection control intervention, and provide enhanced oversight and technical assistance to these facilities as appropriate.

FINDINGS

OIG completed a three-part series of evaluations to learn more about the pandemic's impact on nursing homes. This work is crucial to understanding the experiences of residents, staff, and facilities so that improvements can be made to prevent any repeat of the widespread pain and suffering nursing home residents and staff experienced during the COVID-19 public health emergency.

The first part in the series focused on residents while the second focused on nursing homes themselves. This third part provides a more in-depth look at the experiences of nursing homes: It is based on firsthand accounts from 25 nursing home administrators about challenges with staffing and infection control practices that include supplies, testing, and vaccines. It also includes recommendations to better protect the health and safety of nursing home residents and staff.

STAFFING



Nursing homes cited monumental and ongoing staffing challenges, including a significant loss of staff and substantial difficulties in hiring, training, and retaining new staff

Every nursing home interviewed confronted staffing challenges, with most describing these challenges as significant and ongoing. Specifically, nursing homes reported difficulties with high rates of turnover, finding and hiring new staff, and training.

“Not enough staff even exists. Even if I paid all the money in the world and were fully staffed, it would only leave other nursing homes in dire straits.”

—An administrator

Nursing homes explained that at the start of the pandemic the fear of contracting COVID-19 drove some staff to retire early or leave for other jobs. Some staff went to other health care jobs at hospitals or clinics for better benefits, a better work-life balance, or a more prestigious position. These losses continued throughout the pandemic.

Nursing homes particularly struggled to find and retain staff for lower-wage positions such as certified nurse aides (CNAs), dietary services staff, and housekeeping staff. Nursing homes noted that individuals could find work in the fast-food industry, at big box stores, or with delivery services for more money and fewer physical and emotional demands than for working as a nurse aide. As one administrator explained, a nurse aide's work includes heavy lifting and caring for residents who have cognitive decline yet is compensated at only \$14 per hour at their facility. According to nursing homes, an entry-level nurse aide position no longer has a competitive advantage as wages in other industries increased even prior to the pandemic.

Nursing homes repeatedly mentioned burnout as contributing to high rates of turnover. They noted that staff felt overworked and underappreciated, adding to a sense that their work was undervalued compared to work in other health care settings.

Nursing homes also stressed that hiring was very difficult, as candidates frequently dropped out of the hiring process. Problems included candidates not coming to scheduled interviews, failing to attend orientation after being hired, or not showing up for their first day of work after completing orientation. One administrator described the experience as getting “ghosted.”

“Long-term care isn’t sought out. When people hear you work in a nursing home, people look at you as less of a nurse than someone who works in an emergency room . . . like you have less knowledge, less skill.”
—An administrator

“[Y]our staff has the market. They could leave your place at any point and go get a new job whenever they want They know they can call off and what are you going to do, fire them?” —An administrator

Nursing homes spoke of ensuing problems in managing performance even when they could hire. They feared being too strict and driving away the workers they had worked hard to onboard.

Nursing homes also faced challenges training staff because much of the training shifted to online during the pandemic. Some nursing homes reported that new staff, in particular, lacked hands-on training. They also reported that

COVID-19 protocols and procedures were so demanding that other routine training had to take a back seat. Nursing homes said that they fulfilled basic training requirements, but any additional training time had to be spent updating staff on ever-changing COVID-19 guidance.

Many nursing homes used outside staffing agencies to fill gaps, which had significant downsides

Most nursing homes turned to outside staffing agencies to fill immediate needs and meet minimum staffing requirements during the pandemic. However, using agency staff brought significant challenges.

Many nursing homes characterized the rates for agency staff as exorbitant, especially during the most intense periods of the pandemic. They explained that pandemic relief funds helped but financial strains have been considerable. One administrator said some agency costs increased by 40 percent, which was an amount the nursing home could not maintain in the long term. Another administrator noted that high agency rates put a lot of nursing facilities out of business.

Downsides of using agency staff

- High costs
- Unreliability
- Unfamiliarity with systems and residents

Nursing homes also noted that agencies pay higher wages than nursing homes, thus creating an attractive alternative for staff. One nursing home reported losing staff to higher-paying agencies. Morale also suffered: As one nursing home recounted, agency staff would talk openly about how much money they were making, upsetting permanent staff who felt agency staff were not working as hard as they were.

Problems with using agency staff were not just about costs. Nursing homes found agency staff to be unreliable and felt they had little recourse when agency staff failed to show up, arrived late, or failed to perform duties. One nursing home worried that complaining might prompt agencies to stop sending workers and leave the facility short-staffed.

“Agency staff comes in and talks about how much money they’re making and our own staff gets upset because [agency staff] aren’t working as hard.”
—An administrator

Moreover, nursing homes reported that the agency staff that showed up were less familiar than nursing home staff with the facility and residents. One administrator noted that the quality of care might be affected if, for example, agency staff did not understand a facility’s electronic health records and narcotics systems.

Some nursing homes suggested ways to address agency difficulties. A few administrators noted that hiring agency staff under long-term contracts helps deepen the connection between agency staff and a nursing home. Many nursing homes called for improved regulation of staffing agencies in hopes of keeping prices down and improving the quality of care.

To retain and hire staff, nursing homes tried changing the work environment and using incentives, but success was mixed

Nursing homes tried a number of strategies to retain and hire staff. Specifically, nursing homes bolstered workforce “culture,” took steps to reduce workloads while maintaining the quality of care, and introduced a variety of incentives. Some strategies worked for some but not all nursing homes. Other strategies were minimally successful, and some strategies were not feasible for some nursing homes that lacked the necessary means. (See the box on the next page for a list of strategies that nursing homes tried.)

Facing significant staff losses, nursing homes found that fostering an “all-hands-on-deck” approach was necessary to meet staffing needs. For example, nonclinical staff distributed residents’ meals and helped submit testing and vaccination reports to authorities. Administrators filled in wherever needed, and directors of nursing were known to cover floor shifts in addition to their regular responsibilities. However, nursing homes noted that this all-hands-on-deck approach came with costs: It contributed to turnover and feelings of burnout among staff.

To maintain morale and improve retention, nursing homes leveraged workplace culture. To show appreciation to staff, nursing homes offered perks such as free meals and massages. Nursing homes stressed the importance of keeping lines of communication open, being receptive to new ideas and feedback from staff, and trying to help staff with more personal matters such as car troubles. Some nursing homes offered bonuses to staff who picked up additional shifts, had perfect attendance, or worked in a facility's COVID-19 unit.

Strategies for addressing staffing challenges

- Fostering an 'all-hands-on-deck' approach
- Showing staff appreciation
- Maintaining a lower census
- Making pertinent resident information readily available
- Taking advantage of the temporary waiver of nurse aide certification requirements
- Posting social media ads
- Offering bonuses and/or increasing wages and benefits
- Partnering with local schools or nurse aide programs

Nursing homes also described efforts to lessen workloads and provide good care. Some kept a lower census so they could ensure adequate staffing. Others tried inventive ways to maintain the quality of care when new and unfamiliar staff worked in their facilities. For example, one nursing home created an individualized, one-page care guide for each resident. Another nursing home posted icons outside each resident's door—such as a leaf icon for someone at risk of falling—so staff had pertinent information at a glance.

CMS provided the [nurse aide waiver](#) to allow nurse aides to train on the job in nursing homes without completing the standard certification requirements until the waiver period ended. This waiver permitted nurse aides to work longer than 4 months without completing training and certification provided the nurse aides demonstrated competency in the skills needed for resident care.

To bring in new staff, many nursing homes took advantage of a temporary waiver of formal testing and certification requirements for nurse aides. One facility even used this program to train existing department heads as nurse aides so that they could assist on the floor when needed. Nursing homes said that the waiver allowed them to obtain staff more quickly, but when the end of the waiver program was announced they felt rushed to have their new nurse aides tested and certified. Some nursing homes reported concerns about temporary nurse aides, such as concerns about the quality of their work and their ability to succeed on a certification exam.

Nursing homes employed a variety of other strategies to tackle hiring challenges. For example, they advertised positions across job sites and social media, and many

offered sign-on bonuses. One nursing home paid additional bonuses for new hires who stayed through a trial period. Another offered bonuses to employees who referred a new employee. Aside from incentive-based strategies, nursing homes also mentioned increasing wages and enhancing benefits, such as 401(k) plans and tuition reimbursement programs, to improve hiring.

The success of these strategies was inconsistent across nursing homes. While some found giving bonuses and using social media helpful, others did not. Furthermore, not all nursing homes could afford to try these strategies.

"We've done ads, Facebook, social media, referral programs, sign-on bonuses. We spend thousands of dollars a month, but we're not hiring anybody."
—An administrator

Nursing homes near colleges and CNA programs reported successes with recruitment. These facilities benefited from better access to new graduates. One nursing home found that some CNA students were able to learn on the job and complete clinical requirements at the same time.

Two nursing homes created their own internal "staffing agency" to fulfill staffing needs rather than retain outside agencies. These homes offered higher wages but no benefits as an option for workers. One noted that workers could make an additional \$10 to \$20 per hour by working through an internal agency, while the other noted that an internal agency allowed the home to retain staff and manage performance more directly than possible for outside agency staff.

TESTING AND PPE



While considerable difficulties related to testing and PPE were generally resolved, nursing homes still struggled with costs, testing protocols, and PPE compliance

Nursing homes reported that testing turnaround times and PPE supply issues caused significant difficulties at the beginning of the COVID-19 pandemic. While these challenges were generally resolved, difficulties with costs and compliance with testing protocols and PPE requirements remained.

Long waits for test results early in the pandemic created a host of problems for nursing homes that were alleviated with access to rapid tests

Nursing homes reported challenges with obtaining timely COVID-19 test results at the beginning of the pandemic. Only polymerase chain reaction (PCR) tests—which must

be sent to a lab for analysis—were available. As a result, there were long turnaround times for testing in the early months. One administrator recalled that the local lab could take only five tests at a time. Another administrator recalled waiting up to 18 days for results from a State lab. While waiting for results, nursing homes had to choose between exacerbating staffing shortages by keeping staff at home or having staff work and potentially spread COVID-19. One administrator noted that long turnaround times for testing extended isolation periods for residents.

Some nursing homes also mentioned that there was confusion over how labs would communicate positive test results and whether a nursing home was required to pay for testing.

“I am looking at 23 boxes of COVID [rapid] tests in my office right now. The government has been great at providing us with those tests.” —An administrator

Many of these difficulties were resolved when rapid tests became available and the Federal Government supplied nursing homes with rapid antigen test kits on a weekly basis. Nursing homes noted their appreciation for and reliance on these regular deliveries to meet testing needs.

Testing protocols continued to burden nursing homes

Nursing homes said testing protocols can be time-consuming and pull staff from regular duties. At the time of our interviews, facilities had to conduct routine testing on schedules that varied based on local positivity rates and outbreaks.¹ One administrator of a large facility noted that 220 staff and about 160 residents had to be tested twice a week during outbreaks. The administrator said testing takes so much time and so many resources that other activities, such as floor supervision and routine surveillance of new nurses and nurse aides, became secondary. Some nursing homes said that they trained nonclinical office staff to conduct tests to take the burden off clinical staff.

Testing also presented logistical challenges. In particular, nursing homes reported difficulties coordinating routine testing for part-time staff, agency staff, and student workers.

Although PPE supplies stabilized, nursing homes reported that PPE costs remained high and staff experienced ‘PPE fatigue’

Nursing homes described extremely difficult experiences with obtaining PPE at the beginning of the pandemic. Staff spent a lot of time searching for PPE and resorted to using alternative, unregulated items instead of PPE, such as rain ponchos and painters’ clothes. One administrator described the beginning of the pandemic as “absolutely chaos” and recalled driving hours to pick up a couple of cases of gowns, which provided enough gowns for only one day.

As the pandemic continued, nursing homes struggled to acquire sufficient PPE, at times competing with other health care facilities. Some nursing homes said vendors shipped to them a fixed PPE allotment based on previous orders, which was a smaller allotment than necessary for a pandemic. In addition, nursing homes recalled that hospitals received priority treatment for PPE supplies. One administrator lamented that at the start of the pandemic nursing homes were at “the back of the line” and unable to get PPE.

Based on these experiences, many nursing homes reported they have created PPE stockpiles for their facilities and generally have a dependable supply of PPE. However, at the time of our interviews some nursing homes said PPE costs remained high. One administrator reported that a case of gloves cost more than \$600, up from \$95 pre-pandemic.

Nursing homes reported that, after many months of the pandemic, staff grew tired of the nearly constant use of PPE. As a result, nursing homes started seeing problems with compliance. Administrators felt torn between enforcing PPE requirements and maintaining adequate staffing levels. They feared losing staff who were disciplined over PPE issues. Administrators also said that they tried to boost compliance with reminders and training but found that these steps did not overcome what they called “PPE fatigue.” In addition, administrators noted that residents, especially those with dementia, struggled with wearing masks. They further noted that masks created communication challenges for hard-of-hearing residents as they could no longer read lips.

VACCINES



Nursing homes reported success with the initial vaccine rollout, but challenges remained with subsequent vaccine doses for staff

Most nursing homes reported ready access to COVID-19 vaccines. Many were able to partner with a local pharmacy to administer the vaccines to residents and staff, usually at the nursing home. In addition to pharmacies, nursing homes said that government entities and corporations played a crucial role in accessing vaccines. One administrator was particularly impressed with the nursing home’s State health department that helped with rapid response teams and all documentation associated with vaccinations. One nursing home said it received vaccines from its parent corporation that had made long-term care staff a priority.

“We had all doses for residents and staff when rollout began Rollout has been great.”
—An administrator

Vaccine challenges mainly involved staff vaccination, especially booster doses. At the time of our interviews, nursing home staff were required to have received the primary vaccination series or an exemption. Subsequent booster doses were encouraged but optional.² Other OIG work published in June 2022 estimated that 91 percent of nursing home staff nationwide received the required primary vaccination series and 56 percent received a booster dose.³ The nursing homes we interviewed confirmed that the percentage of staff who received the primary vaccination series was high, but that the percentage of staff who were “up to date” with all boosters was lower.⁴ Some administrators talked about “vaccine fatigue” concerning booster doses, which were more of a challenge than primary doses. Administrators said that false information on social media made some staff more hesitant to get vaccinated. Nursing homes also described confusion regarding changing guidance as contributing to hesitancy. For example, administrators found it difficult to convey the evolving requirements, such as those related to the definition of “up to date” and the need for booster doses.

“[S]ome people do not believe the vaccine is safe. That’s one hurdle They get information from wrong sources.”
—An administrator

Nursing homes that reported few challenges with vaccine hesitancy attributed this lack of hesitancy to culture and trust. One nursing home noted that its director of nursing was well-respected in the nursing home, which made residents and families more comfortable with the vaccines. Other nursing homes reported using education and financial incentives to encourage vaccination among staff. Some administrators reported bringing in cultural leaders and medical professionals from the community to answer questions, emphasize vaccine safety, and address concerns. Administrators also held town hall meetings and one-on-one discussions to discuss hesitations and reaffirm facts about the vaccine. Other nursing homes offered financial incentives and raffles to encourage vaccination. One facility offered a \$100 bonus to each staff member who got vaccinated.

Despite these efforts, some nursing homes found that some staff simply refused vaccinations. One administrator concluded that staff who were already leaning toward getting vaccinated could be persuaded by incentives, but staff who were “hard no’s” were unmoved. This administrator was convinced that even an incentive of \$1,000 would not have made a difference.

In addition, administrators pointed out that unvaccinated visitors could pose an infection control risk to residents. They noted that nursing homes could not hire unvaccinated staff but had to allow unvaccinated visitors into the facilities.



Nursing homes identified challenges with implementing effective infection control practices and opportunities for improvement

The COVID-19 pandemic created substantial challenges for infection control in nursing homes. Preventing and controlling infections was a monumental task due to the novelty of the virus and the characteristics of the nursing home setting. Administrators described instances when COVID-19 spread through their facilities. Two administrators said it spread like “wildfire.” Reflecting on the rapid spread, some administrators questioned the efficacy of certain infection control measures they implemented.

Nursing homes had trouble identifying and implementing the most effective infection control practices. For instance, nursing homes had difficulty developing designated COVID-19 units.⁵ Administrators noted that they lacked private rooms or space for designated units. They also said that residents, especially those with dementia, had trouble adjusting to unfamiliar surroundings. Some administrators even questioned whether moving residents to COVID-19 units inadvertently spread the disease. Moreover, nursing homes felt as if these practices had been developed without feedback or input from nursing homes themselves. Specifically, some administrators were concerned that the guidance did not sufficiently consider what practices were feasible in the nursing home setting.

As the pandemic continued, CMS worked with the Centers for Disease Control and Prevention (CDC) to update infection control guidance.⁶ However, nursing homes recounted the significant challenges of interpreting this changing guidance and disseminating the guidance to staff. While revisions to guidance are necessary when more is learned about a novel virus, the pace of changes—occurring as often as several times a day at the beginning of the pandemic—created practical challenges for nursing homes. For several administrators, simply reading guidance became a full-time job. They said incoming guidance was often unclear, which made effective implementation difficult.

“Put things in simple terms. It should say ‘this replaces memo X’ and highlight the changes . . . Make it simple, quick, and easy to read.”

—A director of nursing

Administrators said they wanted concise and explicit guidance on effective infection control measures. They emphasized the importance of consistency in guidance from Federal, State, and local entities. In their view, guidance was sometimes conflicting. Particularly conflicting, in their view, was guidance from CMS, CDC, and State and local departments of health. This left nursing homes unsure about which actions to take to remain in compliance with Federal requirements.

Nursing homes noted the importance of having access to resources that answered their questions about infection control. For example, some nursing homes found State and local health departments or corporate offices helpful with interpreting and implementing new requirements. They described regular calls or webinars with State and local health departments and industry associations. Some administrators found in-person assistance beneficial. One recounted a team of State epidemiologists walking through the nursing home and explaining where to put hand sanitizer and plexiglass as well as additional infection control information staff should know, such as “how quickly certain chemicals could clean.”

While some nursing homes had such resources, others did not know where to turn for assistance or were unable to get clear answers. One administrator explained that the health department only shared website links for fear of incorrectly interpreting guidance. Another administrator said the health department “left us to fend for ourselves.”

Throughout the pandemic, CMS hosted recurring stakeholder calls for nursing homes during which CMS explained relevant guidance and Quality Improvement Organizations (QIOs) provided technical assistance to nursing homes.⁷ However, none of the nursing homes we interviewed mentioned turning to QIOs as a resource.

TOLL ON RESIDENTS AND STAFF



Nursing homes conveyed the dire physical, mental, and emotional toll the COVID-19 pandemic took on residents and staff

As nursing homes reflected on their challenges and struggles, a common theme emerged: The pandemic took a tremendous toll on residents and staff. Nursing homes described isolation, loneliness, and a decrease in quality of life among residents during the pandemic. They also described the extreme emotional burden carried by staff, who were often the residents’ only human interaction.

Nursing homes recounted how residents were isolated from their spouses, family members, and other loved ones, some of whom had visited daily prior to the pandemic. They said residents’ daily routines were upended due to short staffing and the absence of loved ones. And for long periods during the pandemic, residents were restricted to their rooms, unable to eat together in common rooms or participate in social activities. Nursing homes described the loneliness felt by the residents whose only source of human interaction

“[I]t was heartbreaking seeing residents die alone . . . without someone to hold their hand.”

—An acting administrator

was with staff hidden behind masks, goggles, gowns, and gloves. Some administrators recalled trying to comfort family members who were upset about being unable to visit residents in what would likely be their final months.

“I think depression took over and we lost a lot of people because they gave up hope.” —An acting administrator

Some nursing homes said that the loneliness and isolation contributed to depression and premature death. Several administrators described their facilities as prisons during the pandemic—not the homes residents deserved. They pointed to an increase in depression among residents, as well as in the use of medication to treat depression. Some told heartbreaking stories of residents deprived of physical touch, smiles, and comfort from loved ones and caretakers, and tragic stories of residents who died alone.

Administrators lamented that while they took necessary and required actions to stem exposure to the potentially deadly virus, these actions had dire consequences for residents and staff. Administrators described how serving as a sole source of comfort to residents weighed heavily on staff. One spoke of the unprecedented amount of death that staff witnessed, and another described staff as experiencing post-traumatic stress disorder after functioning as the residents’ substitute family during the peak of the pandemic.

RECOMMENDATIONS

COVID-19 was devastating for nursing home residents. It also highlighted longstanding issues with staffing and infection control that negatively impact nursing home safety and quality of care. To learn from what happened and better prepare for future public health emergencies, OIG completed a three-part series of reports assessing the pandemic's impacts on nursing homes. This report is the third and final part in that series. Our combined findings illuminate the outsized toll the pandemic exacted on nursing home residents and staff and identify the urgent need for improvement. We found that nursing homes were not prepared for this scale of infectious disease, nor could they adapt effectively. Cases surged in spring 2020, and there was a greater surge in the fall. We determined that 2 in 5 Medicare beneficiaries in nursing homes were diagnosed with either COVID-19 or likely COVID-19 during the year. Residents were not impacted equally, however, as COVID-19 rates were higher among Black, Hispanic, and Asian beneficiaries than among White beneficiaries.

More than 1,300 nursing homes had extremely high infection rates during these surges, with at least 3 out of every 4 of their Medicare beneficiaries diagnosed with COVID-19 or likely COVID-19 in a matter of weeks. We found that just because a nursing home was located in a county with a high transmission level, it was not inevitable that the nursing home would have an extremely high infection rate. The effects of these high rates reached beyond those residents diagnosed with COVID-19. Nursing homes with extremely high infection rates experienced dramatic increases in overall mortality.

This OIG work has raised pivotal questions about existing oversight, such as whether current staffing requirements are sufficient to protect residents from infectious disease and how effective the survey process is in preventing and mitigating its spread in nursing homes. We found that even though nearly all nursing homes had multiple surveys during 2020, the majority of those with extremely high infection rates were not cited with any deficiencies in infection control, and few were cited with serious deficiencies. OIG has made important recommendations for CMS to re-examine and revise current nursing staff requirements, improve the survey process, and provide enhanced oversight and technical assistance to nursing homes most in need. The findings in this final report reinforce the urgency of these prior recommendations.

This final report examines the challenges that nursing homes faced during the pandemic and the strategies they used to address those challenges through the lens of the nursing homes themselves. The need for improvement is clear. The recommendations in this report, combined with recommendations from the prior reports, offer a path for CMS to help improve nursing home performance both overall and during crises.

The COVID-19 pandemic was a call to action not just for CMS but for all nursing home stakeholders. Significant change is needed to better protect the health and safety of residents, and this change will require broad collaboration with partners and stakeholders across Government, the nursing home sector, and the broader health care industry. The findings in this report can inform stakeholder collaborations and improvement efforts.

Part of that change has begun, as the administration has made improving safety and quality of care in nursing homes a priority. Both the Department of Health and Human Services (HHS) and CMS are playing key roles in developing and executing initiatives aimed at this goal. The administration outlined steps to address staffing shortages by, for example, investing more than \$75 million in scholarships and tuition reimbursements for nursing workers through a partnership between CMS and the Health Resources and Services Administration (HRSA), and by streamlining entry to career opportunities in nursing homes.⁸ In addition, after conducting an extensive study, CMS has proposed new minimum staffing standards for nursing homes.⁹

Still, our findings in this report and other OIG work demonstrate that nursing homes face challenging and entrenched problems across multiple dimensions, including workforce and infection control. Beyond the initial steps CMS is taking, more must be done to strengthen the nursing home workforce and enhance infection control practices. OIG offers several recommendations to do so.

These issues are complex and cannot be resolved by CMS alone. However, as the primary payer of nursing home care and the agency that sets quality and safety standards for nursing homes, CMS plays a critical role. CMS can use existing methods and search for new ones in its efforts to protect the health and safety of nursing home residents. For instance, CMS can partner with other agencies and nursing homes working to expand the nursing home workforce. Collaboration and creative problem-solving involving CMS, other Federal agencies, States, and the industry are essential to improving nursing homes' ongoing quality and safety efforts as well as their preparedness to handle public health crises. Moreover, although CMS does not regulate staffing agencies, it can help identify potential strategies for nursing homes facing challenges with staffing agencies.

To strengthen staffing in nursing homes, CMS should:

Implement and expand upon its policies and programs to strengthen the nursing home workforce

Qualified staff are essential to ensuring that nursing homes provide safe and quality care. During the pandemic, however, nursing homes described substantial, multifaceted staffing challenges. One of the biggest and most difficult challenges was the shortage of qualified staff. Staffing shortages can also have negative consequences for existing staff, such as burnout, which can affect retention. Nursing

home staffing challenges are massive, complex, and have continued past the end of the public health emergency.

CMS is an integral part of the administration's nursing home priority and initiatives to support, strengthen, and grow the health workforce. CMS recently announced that it will partner with HRSA to lead nursing home workforce development by investing more than \$75 million in financial incentives, such as scholarships and tuition reimbursements, for individuals entering nursing home careers.¹⁰ This planned initiative has the potential to meaningfully build a pipeline for qualified nursing home staff. Achieving these goals will require sustained attention from CMS and sustained partnerships with HRSA and potentially other Federal agencies such as the Labor and Education Departments. Given its vast experience overseeing nursing homes, CMS is uniquely positioned to both lead major initiatives like the one it recently announced and to support other agencies in their related efforts to strengthen the nursing home workforce.

Furthermore, CMS should explore which additional tools it can bring to help alleviate nursing home staffing shortages and related challenges. For example, CMS could explore demonstration workforce development programs through the Center for Medicare and Medicaid Innovation (CMMI). CMMI is ideally suited to exploring innovative strategies to strengthen the nursing home workforce and address staffing challenges, and has previously run demonstration programs recognizing the impact of staffing on outcomes, such as quality of care and cost savings for Medicare.¹¹ CMS should seek statutory authority if needed to run such programs.

Reassess nurse aide training and certification requirements

CMS should reassess existing nurse aide training and certification requirements in light of nursing homes' experiences during the COVID-19 public health emergency, including experiences with the temporary nurse aide waiver. The waiver allowed nurse aides to train on the job in nursing homes without completing the standard certification requirements until the waiver period ended. It provided enhanced flexibilities at a time when increased staffing was essential but opened a door to potential nurse aide qualification concerns. It is important that CMS take advantage of the rich learning opportunity presented by the waiver and engage with nursing homes about their experiences.

Effective training and certification requirements for nurse aides are critical to ensuring the health and safety of residents while expanding and supporting the nurse aide workforce. As CMS considers new minimum staffing requirements for nursing homes that emphasize the essential role of nurse aides, it is more important than ever to update training and certification requirements when appropriate to promote a strong and qualified workforce. CMS should seek statutory authority if needed to make these changes.

To enhance infection control practices and better protect nursing home residents, CMS should:

Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic

The spread of COVID-19 among nursing home residents reflects failures to control and prevent infection. Since the beginning of the pandemic, much has been learned about mitigating the spread of COVID-19, and this information must now be used to protect nursing home residents. Specifically, CMS should update the nursing home requirements for infection control using what was learned during the pandemic about the most effective infection control practices.

CMS conducted this type of update before the pandemic. A periodic update is an important step to take as knowledge evolves. Given all that has been learned, we recommend that CMS undertake this work again. In doing so, CMS should collaborate with experts including Federal partners such as the CDC, infectious disease experts, industry groups, and resident advocacy groups. CMS also should take into account nursing homes' insights by, for example, conducting "listening sessions," soliciting written comments, or convening a panel or council that includes nursing home practitioners, among others.

The findings in this series of reports and the devastating toll that the pandemic took on nursing homes demonstrate the need for updated infection control requirements. Nursing homes were not prepared for the sweeping health emergency that COVID-19 created. Now that the public health emergency has ended, it is time to assess the information learned and improve infection control practices.

Once the requirements are updated, they should be incorporated into the survey process. Surveys are periodic, onsite inspections of nursing homes to determine compliance with Federal requirements. In the second part of this series, we recommended that CMS improve the survey process. Updating the requirements for infection control can be a part of that improvement.

To the extent possible, infection control requirements should reflect the latest knowledge about infection prevention for COVID-19 and other dangerous, infectious diseases. We encourage CMS to explore ways in which it can continuously and quickly update requirements as needed. These updates may be needed to respond to novel infectious diseases or to incorporate new information about existing infectious diseases.

Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements

After the nursing home requirements are updated, CMS should provide guidance and assistance to nursing homes to implement the new requirements. As part of this

recommendation, CMS should solicit and consider feedback from nursing homes about the types of guidance, assistance, or other resources—such as webinars or written materials—that may be most useful. We note that some nursing homes we interviewed did not know where to turn for assistance or were unable to get clear answers to questions during the pandemic.

CMS should also offer individualized assistance with implementation, such as on-site technical assistance with infection control experts or QIOs. Nursing homes we interviewed noted that on-site technical assistance from State and local organizations, when available, was invaluable for implementing changing guidance, but not all of the nursing homes had access to such assistance. By first identifying the most effective practices, CMS can best use resources such as QIOs.

To further support nursing homes in addressing current and future challenges, CMS should:

Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care

Facing unprecedented challenges posed by the COVID-19 pandemic, nursing homes developed a number of strategies to strengthen their workforces, address testing delays and PPE shortages, and reduce vaccine hesitancy. They also struggled with challenges that came with relying on staffing agencies, such as high costs and unreliability. While some nursing homes expressed that they developed networks to learn from, other nursing homes—particularly those without corporate support—were more isolated and struggled to identify the most effective strategies.

To facilitate information sharing on these and other topics and further support nursing homes in addressing current and future challenges, CMS should develop methods for CMS and nursing homes to exchange strategies and ideas. These methods could include an online platform, open forums, roundtables, or other approaches that CMS deems appropriate. CMS currently has some nursing home websites and resources available that largely function in only one direction—from CMS to nursing homes.¹² There are limited mechanisms for nursing homes to give feedback to CMS or to ask CMS questions, or for nursing homes to assist each other.

The methods that CMS develops should be easy for nursing homes to access and use. Having methods for sharing information will help nursing homes address challenges based on effective, on-the-ground strategies used by other facilities rather than having to “reinvent the wheel.” CMS should also include resources and information that nursing homes might find helpful and connect nursing homes with contacts, such as QIOs, that can provide additional insight into effective practices. CMS could work with the nursing home industry or other stakeholders to develop these methods to facilitate this information sharing. Furthermore, CMS should use these forums or other methods it develops to not only share information but also to learn more about

the challenges nursing homes are facing and identify potential strategies for addressing these challenges.

One priority issue that CMS should focus on is sharing strategies and information about nursing homes' challenges related to staffing agencies. CMS could use the forums or other methods it develops to learn more about these challenges and to help identify potential strategies for addressing these challenges. For example, nursing homes may be able to share strategies they found effective such as using longer-term contracts, navigating State regulations, and holding agency staff accountable. CMS could also use forums to share information about staffing agency challenges learned from its recent engagement with nursing homes as part of its staffing study.¹³

AGENCY COMMENTS AND OIG RESPONSE

CMS did not explicitly state its concurrence or nonconcurrence for the five recommendations. For two of the five recommendations, CMS's response generally conveyed agreement. CMS agreed with the intent of the remaining three recommendations and indicated that it has implemented them, suggesting that they be removed from the report. OIG is aware of and has considered all of the actions that CMS has taken, proposed, or planned. While these are positive and necessary actions, we stand by our recommendations, as we continue to see both the need and the opportunity for CMS to do more.

The magnitude of the issues we identified makes clear that additional work must be done to improve care for nursing home residents. The findings from this series demonstrate that COVID-19 was devastating for nursing home residents. We found that 2 in 5 Medicare beneficiaries in nursing homes had or likely had COVID-19 in 2020. More than 1,300 nursing homes had extremely high infection rates during surge periods in spring 2020 and fall 2020, and these nursing homes had dramatic increases in mortality. In this third report, we examined the challenges that nursing homes faced as described by the nursing homes themselves. The recommendations in this report are based on the combined findings of this series.

Regarding the first recommendation to implement and expand upon its policies and programs to strengthen the nursing home workforce, CMS noted that it issued a proposed rule for minimum staffing requirements and will invest \$75 million in financial incentives for individuals to enter careers in nursing homes. CMS suggested that OIG remove this recommendation; however, we maintain its merit. While we appreciate the importance of these two actions and support them, neither has taken effect yet. Furthermore, as stated in the recommendation, we are looking for CMS to implement a process that allows for sustained attention to the crucial issue of the nursing home workforce and for CMS to explore additional tools it can bring to alleviate nursing home staffing shortages and related challenges.

Regarding the second recommendation to reassess nurse aide training and certification requirements, CMS stated that it monitored and evaluated all emergency waivers through the course of the public health emergency, making updates as appropriate. CMS suggested that OIG remove this recommendation; however, we maintain its merit. This recommendation is for CMS to reevaluate the requirements based on the experiences of facilities during the pandemic and consider what changes may be appropriate in the future. As CMS considers new minimum staffing requirements for nursing homes that emphasize the essential role of nurse aides, it is more important than ever to ensure that training and certification requirements promote a strong and qualified workforce.

Regarding the third recommendation to update the nursing home requirements for infection control to incorporate lessons learned from the pandemic, CMS stated that it engages with other agencies that have expertise in emergency preparedness and infection control, such as the Administration for Strategic Preparedness and Response and the CDC. CMS is considering the lessons learned from the COVID-19 public health emergency, which includes infection prevention and control during emergency periods, as a part of an expected emergency preparedness proposed rule that will revise and update national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers. We look forward to hearing more about these updated requirements. We note two potential concerns with this approach. First, this recommendation is for updated infection control requirements generally—and not limited to during emergency periods—given the devastating spread of COVID-19 among nursing home residents. Second, requirements for all participating providers may not sufficiently address the circumstances of the nursing home setting and the ways in which nursing home residents are uniquely vulnerable to infection.

Regarding the fourth recommendation to provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements, CMS cited infection control guidance it issued prior to the pandemic and the work of QIOs to support facilities during the pandemic. CMS suggested that OIG remove this recommendation; however, we maintain its merit. We believe it is worth a retrospective look at all that happened and was learned during the pandemic to determine what is needed in the future with respect to guidance and assistance. Accordingly, we recommend that CMS solicit and consider feedback from nursing homes about the types of guidance, assistance, and/or other resources that may be most useful. Furthermore, implementation of this recommendation necessarily follows the implementation of the previous recommendation to update nursing home requirements for infection control.

Regarding the fifth recommendation to facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care, CMS described actions it has taken to share information with nursing homes. These actions include regular stakeholder listening sessions and publishing all memorandums and guidance publicly online. While CMS makes information available to nursing homes, there are limited mechanisms for nursing homes to give feedback to CMS or to ask CMS questions, or for nursing homes to assist each other. Our recommendation is for CMS to develop methods for CMS and nursing homes to exchange strategies and ideas.

OIG is committed to protecting the health and safety of nursing home residents and staff and will continue to work with CMS to promote additional actions to achieve that outcome.

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

METHODOLOGY

This study is based on 25 indepth, structured interviews that we conducted with nursing home administrators. We asked them about their experiences during the pandemic, specifically their challenges and strategies related to staffing and infection control, including COVID-19 testing and PPE, COVID-19 vaccines, and other infection control practices.

Sample Selection

We used data collected and analyzed for the second evaluation in this series to select 30 nursing homes for the sample. We selected these nursing homes to represent a diversity of characteristics, including geographic location, size, profit status, and the prevalence of COVID-19 in a facility, among others. We then contacted each of the 30 nursing homes by telephone and email to explain the study, answer questions, and schedule interviews. Ultimately, we interviewed 25 of the nursing homes, while 4 chose not to participate and 1 was excluded based on the short tenure of its administrator.

Data Collection and Analysis

We conducted interviews with the 25 nursing homes by telephone from December 2021 through July 2022. We interviewed the administrator at each nursing home, and some interviews also included additional staff (e.g., a director of nursing or infection preventionist) at the administrator's discretion. We developed a structured interview guide that was organized by five main topic areas: staffing, testing, PPE, vaccines, and other infection control practices. Within each topic area, we asked about nursing homes' challenges and strategies used to address those challenges.

We analyzed the interview data using NVivo qualitative analysis software. We organized interview responses and categorized the themes that emerged related to each of the five topic areas. We examined results to identify significant challenges faced by nursing homes and strategies they employed to address the challenges.

We reviewed CMS's applicable policies, procedures, and guidance, as well as other related documents and studies, for background and context.

Limitations

Our analysis is limited to challenges and strategies as reported by the 25 nursing homes at the time of the interviews. The information reported in this study does not represent the views and experiences of all nursing homes. In addition, we identified and reported the most significant themes; the report does not reflect every challenge or strategy mentioned during interviews.

Standards

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

APPENDIX

Agency Comments

Following this page are the official comments from CMS.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: December 15, 2023

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure *Chiq B LaS*
Administrator

SUBJECT: Office of Inspector General Draft Issue Brief: Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes (OEI-02-20-00492)

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

CMS thanks the OIG for their review in this area and is similarly committed to transparency, which we have used to highlight the disproportionate impact of COVID-19 on patient populations, including individuals residing in nursing homes.¹ In the first year of the COVID-19 pandemic, nursing homes were severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population combined with the inherent risks of living in a congregate health care setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes. Given the continued high incidence of COVID-19 and the likelihood that new variants and other infectious agents may cause future outbreaks, CMS sought to understand the relationship between nursing homes and the COVID-19 public health emergency and published data and several analyses. This includes an in-depth look at the impact of COVID-19 on Medicare beneficiaries residing in nursing homes during 2020² and a CMS-funded study to analyze the relationship between quality ratings and COVID-19 infections, published in May 2021.³

Even 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, "Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers," which noted the need for nursing homes to prepare for infectious disease threats.⁴ 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 (LTC)," which was the impetus for the requirement

¹ CMS, [CMS COVID-19 Data Products](#), Updated on November 05, 2021

² CMS, [The Impact of COVID-19 on Medicare Beneficiaries](#), 2021

³ Williams, C., Zheng, Q., White, A., Bengtsson, A., Shulman, E., Herzer, K., Lee F., [The Association of Nursing Home Quality Ratings and Spread of COVID-19](#), Vol. 6, Is. 8, Journal of the American Geriatrics Society, May 31, 2021

⁴ [Medicare and Medicaid Programs: Emergency Preparedness Requirements](#), 81 Fed. Reg. 63860, 63862 (Sept. 16, 2016)

that nursing homes develop an infection prevention and control program that includes an antibiotic stewardship program.⁵

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.⁶ CMS reiterated the importance of longstanding infection control guidelines and guidelines on screening processes and the use of personal protective equipment (PPE). CMS has held regular calls with stakeholders, nursing home associations, and State Survey Agencies (SSAs) to keep them up to date on the latest information to respond to COVID-19 and listened to the challenges faced by nursing homes, such as access to PPE, continuing staffing issues, and a lack of availability of testing and vaccinations during the first year of the public health emergency.

In an effort to support surveillance of COVID-19 cases and increase transparency, CMS in collaboration with the Centers for Disease Control and Prevention (CDC) developed a system to conduct COVID-19 surveillance and collect COVID-19 data within the CDC's National Healthcare Safety Network (NHSN) system for response activities. These data were used to strengthen surveillance locally and nationally, monitor trends in infection rates, and help local, state, and federal authorities get help to nursing homes faster.

Furthermore, in an effort to focus on controlling the spread of COVID-19, CMS provided SSAs, who conduct onsite surveys to assess compliance with federal requirements and investigate facility complaints, with a streamlined review tool to conduct focused infection control surveys of providers identified through collaboration with the CDC and the Administration for Strategic Preparedness & 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 development and transmission of COVID-19 and other communicable diseases and infections. By July 2020, over 99 percent of Medicare and Medicaid certified 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 as appropriate. 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 catalog of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19.⁷ CMS continues to review and revise guidance as needed.

Throughout the pandemic, CMS used data from the CDC's NHSN, in part, to identify which nursing homes may need targeted help through the Quality Improvement Organizations (QIOs) to strengthen infection control practices to reduce and prevent transmission of COVID-19. Throughout the course of the public health emergency, QIOs have helped facilities address many COVID-19 challenges related to staffing, PPE, infection prevention and control activities, COVID-19 testing, and vaccine uptake. The QIOs connect nursing homes with local resources, provide educational activities, and train nursing home staff and management. Currently, QIOs continue to focus on vaccination and infection prevention and control practices to reduce the spread of infection and manage outbreaks effectively, as well as provide individualized training

⁵ [Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 \(October 4, 2016\)](#). [Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 \(Nov. 28, 2016\)](#) [Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 \(Nov. 28, 2016\)](#)

⁶ [QSO 20-09-ALL Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness \(2019-nCoV\)](#)

⁷ [QSO-21-08-NLTC: COVID-19 Focused Infection Control Survey Tool for Acute and Continuing Care Providers and Suppliers \(Revised\)](#)

resources based on the nursing home's 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, which are the agencies tasked with national leadership of disease prevention and control and public health emergency response, to ensure coordination of services and alignment of guidance for nursing homes.

As nursing homes continue to deal with COVID-19, ensuring that residents receive safe, high-quality care is a high priority for the agency. 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 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 diseases 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.⁸ For example, CMS is urging providers to consider making changes to their physical environment to allow for a maximum of double occupancy in each room to improve infection control and prevention by reducing the risk associated with multiple residents in the room and making it easier to isolate or quarantine residents who are infectious.

Ensuring that nursing homes maintain sufficient staffing to allow for safe, reliable, and high-quality nursing home care is a critical function of the Medicare and Medicaid programs and a top priority of CMS. In September 2023, CMS issued the "Minimum Staffing Standards for Long Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" proposed rule (88 FR 61352),⁹ which seeks to establish comprehensive nurse staffing requirements to hold nursing homes accountable for providing safe and high-quality care for the over 1.2 million residents receiving care in Medicare and Medicaid certified LTC facilities each day. The proposed rule results from a multi-faceted approach aimed at determining the minimum level and type of staffing needed to enable safe and quality care in LTC facilities. This effort included issuing a Request for Information in the FY 2023 Skilled Nurse Facility Prospective Payment System Proposed Rule (87 FR 22720),¹⁰ hosting listening sessions, and extensive engagement with various interested parties, conducting a 2022 Nurse Home Staffing Study, which builds on existing evidence and research studies using multiple data sources, and reviewing recent years of Payroll-Based Journal Systems staffing data. CMS also considered how the proposed minimum staffing requirements would align or interact with ongoing CMS initiatives and programs that impact the LTC community. Information gathered from each of these facets was used by CMS in the development of the proposed requirements that aim to ensure all nursing home residents are provided safe, high-quality care.¹¹

⁸ [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](#)

⁹ [Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting](#), 88 Fed. Reg. 61352 (Sept. 6, 2023)

¹⁰ [Medicare Program; Prospective Payment Consolidated Billing for Skilled Nursing Facilities; Fed. Reg. 22720, Updates to the Quality Reporting Program and Value Program for Federal Fiscal Year 2023; Request for Information Requirements for Long-Term Care Facilities Mandatory Minimum Staffing Levels](#), April 15, 2022

¹¹ CMS Fact Sheet, [Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting \(CMS 3442-P\)](#), September 1, 2023

Additionally, CMS announced it is developing a national campaign to support staffing in nursing homes.¹² CMS will work with the Health Resources and Services Administration (HRSA) and other partners to make it easier for individuals to enter careers in nursing homes. For example, CMS is investing over \$75 million in financial incentives such as scholarships and tuition reimbursement, using money collected from monetary fines against nursing homes for non-compliance with federal regulations. This staffing campaign builds on other actions through the HHS Health Workforce Initiative. For example, separate from CMS, in August 2023 HRSA awarded more than \$100 million to five HRSA nursing workforce programs to train more nurses and grow the workforce.¹³

Although CMS appreciates OIG's review, it is important to note that OIG's findings are based on 25 interviews with administrators that took place almost two years ago (beginning in December 2021). Since then, CMS has taken numerous actions to further strengthen infection prevention and control within nursing homes. CMS acknowledges that administrators can provide valuable insight. However, there are many other stakeholders whose views are not represented, such as residents, resident advocates, and federal and state oversight entities. OIG's recommendations and CMS's responses are below.

OIG Recommendation (1)

Implement and expand upon its policies and programs to strengthen the nursing home workforce.

CMS Response

CMS agrees with the need to strengthen the nursing home workforce, and in fact, has already implemented activities prior to this report (for those actions that are within our scope and authority). Other agencies within HHS are also leading efforts in this area. Therefore, since the actions have been implemented within CMS's authority, we suggest OIG remove it. As always, CMS will continue to assess our policies for improvements in this area moving forward.

As mentioned above, CMS has issued a proposed rule that, among other things, would set a national minimum nurse staffing standard in nursing homes, the adoption of a 24/7 RN requirements, and enhanced facility assessment requirements.¹⁴ However, we note these proposed requirements are subject to the comment and rule-making process. Although CMS's scope and authority focus on a facility's compliance with federal requirements, staffing in nursing homes has remained a persistent concern, especially among low-performing facilities that are at the most risk for providing unsafe care. In addition, CMS announced a national campaign to support staffing in nursing homes, which will invest over \$75 million in financial incentives such as scholarships and tuition reimbursement.¹⁵ This staffing campaign builds on other actions through the HHS Health Workforce Initiative led by HRSA, whose scope includes workforce development. CMS will continue to partner with HHS and HRSA as appropriate as they work to strengthen the nursing workforce.

OIG Recommendation (2)

Reassess nurse aide training and certification requirements.

CMS Response

Although CMS agrees with the intent of the recommendation, we have already implemented it prior to the issuance of this report. Therefore, since the actions have been implemented, CMS

¹² CMS Press Release, <https://www.cms.gov/newsroom/press-releases/hhs-proposes-minimum-staffing-standards-enhance-safety-and-quality-nursing-homes>

¹³ Id

¹⁴ Fact Sheet, [Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting \(CMS 3442-P\)](#), September 2023

¹⁵ Id

suggests OIG remove it. As always, CMS will continue to assess our policies for improvements in this area moving forward. CMS believes training is extremely important to ensure staff have the appropriate skills and competencies to meet residents' needs. The existing regulations enable this to occur, while also providing states and facilities flexibility on how to conduct the training.

Since the beginning of the COVID-19 pandemic, CMS monitored and evaluated all emergency waivers through the course of the public health emergency, making updates as appropriate. Additionally, CMS has participated in regular stakeholder feedback calls, including with nursing homes, nurses, nurse aides, and advocates.

We note that existing regulations allow facilities to employ nurse aides while they are undergoing state-approved training and competency evaluation programs.¹⁶ Additionally, federal requirements allow states to use a variety of means for their state-approved Nurse Aide Competency Evaluation Program training curriculum, including online, classroom, or onsite training.¹⁷

Considering nursing homes' experiences during the COVID-19 public health emergency, CMS did reassess existing nurse aide training and certification requirements. We reiterate that the current requirements allow nursing homes the flexibility to train onsite as explained above.

OIG Recommendation (3)

Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic.

CMS Response

CMS agrees with OIG that, to the extent possible, infection control requirements should reflect the latest knowledge about infection prevention for COVID-19 and other dangerous, infectious diseases. As such, CMS engages with other agencies that have expertise in emergency preparedness and infection control, such as ASPR and the CDC. Additionally, CMS is considering the lessons learned from the COVID-19 public health emergency, which includes infection prevention and control during emergency periods, as a part of an expected emergency preparedness proposed rule that will revise and update national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers.¹⁸ CMS believes it has provided extensive information to the nursing home community about infection control but ultimately defers to colleagues at the CDC for the development of infection control and prevention standards.

ASPR, CDC, and CMS have a long history of working together to protect Americans from emerging infectious diseases (EID), including Ebola, and other health security threats. CDC develops evidence-based guidelines and recommendations, along with expert interim guidance and strategies to inform actions healthcare facilities, such as nursing homes, and healthcare professionals should take. These guidelines and recommendations are developed based on years of fieldwork, emergency responses and exercises, and deep clinical and scientific expertise. CDC's expert guidelines, interim guidance, and technical assistance to health care providers and facilities, in conjunction with ASPR's coordination and hospital preparedness activities and CMS's implementation processes drives improvements in healthcare preparedness and response to EID threats. A year before the public health emergency, CMS and CDC collaborated on the development of a free, online training course in infection prevention and control for nursing

¹⁶ 42 CFR §483.35(d)(3)(i)

¹⁷ CMS QSO-22-15-NH & NLTC & LSC, [Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers](#), August 7, 2022

¹⁸ Office of Information and Regulatory Affairs, Office of Management and Budget [RIN: 0938-AV21](#)

home staff in LTC settings. Originally, it comprised 23 modules and took 19 hours to complete.¹⁹ Now, the free LTC infection prevention and control training course is 24 modules and takes approximately 20 hours to complete.

At the start of the public health emergency, CMS and CDC formed the “COVID-19 Nursing Home Task Force” to align CMS policies and CDC guidance. During the public health emergency, CMS, CDC, and ASPR met several times a week to discuss all providers and suppliers impacted by COVID-19. Activities and issuances included but were not limited to a variety of information sharing, including updated guidance by the CDC, updated data presented by the CDC, resources presented by ASPR, as well as CMS guidance to healthcare facilities and surveyors responsible for determining compliance. In addition, the infection control survey tool that SSAs used to conduct focused infection control surveys at the beginning of the public health emergency, and that CMS shared with facilities to use as a voluntary self-assessment tool, was developed in concert with the CDC. As the public health emergency continued, the infection control survey was revised to incorporate new infection control requirements to address the spread of COVID-19. CMS continues to engage with other agencies and rely on its federal partners’ expertise for emergency preparedness and infection control and prevention.

OIG Recommendation (4)

Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements.

CMS Response

CMS agrees with the intent of the recommendation, and in fact, implemented new guidance prior to this report. Therefore, since the actions have been implemented, CMS suggests OIG remove it. Additionally, as always, CMS will continue to assess our work in this area to promote effective technical assistance to the nursing home community.

CMS agrees with the importance of effective guidance for nursing homes and in June 2022, which CMS notes is after OIG’s audit period, CMS released the Revised LTC Surveyor Guidance, which included new guidance for phases 2 and 3 of the 2019 “Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care” Final Rule (84 FR 51732)²⁰ which in part, requires nursing homes to employ an Infection Preventionist and implement an effective infection prevention and control program.²¹ The new guidance also strengthened general infection control guidance to address frequently cited issues such as hand hygiene, transmission-based precautions, and surveillance of infectious diseases.

Additionally, CMS uses data to target support for nursing homes most in need and deploys QIOs to provide expedited, data-driven Quality Improvement interventions to support facilities. In the earliest stages of the pandemic, CMS prioritized providing QIO technical assistance to facilities with a history of infection control deficiencies. Subsequently, and as the pandemic evolved, CMS incorporated other criteria, such as high COVID-19 incidence among residents, or high community spread of the virus, to direct QIOs to high-risk facilities.

¹⁹ QSO-19-10-NH, [Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long Term Care Setting is Now Available](#), March 2019

²⁰ [Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital \(CAH\) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care](#)

²¹ CMS QSO-22-19-NH, [Revised Long-Term Care Surveyor Guidance](#), June 29, 2022

When a nursing home is referred to the QIO, the QIO conducts a root cause analysis and assists nursing home leadership with developing an improvement plan. The QIO then guides the nursing homes to implement the plan and provides coaching where needed. The QIOs monitor the nursing home's progress to ensure improvement is occurring. Once CMS has made nursing home referrals to the QIOs, and after the QIOs have begun training and offering technical assistance, CMS regularly reviews and monitors QIO progress in the referred nursing homes, reviews the incoming data from the QIOs on a weekly basis, and monitors the performance of the QIOs in improving vaccine rates and managing COVID-19 outbreaks in nursing homes. As of November 2023, QIOs have assisted over 13,000 nursing homes with infection prevention and control activities.

CMS has provided updated infection prevention and control guidance based on insights gained during the COVID-19 pandemic and the QIOs continue to provide nursing homes individualized assistance based on the most effective practices.

OIG Recommendation (5)

Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care.

CMS Response

CMS agrees that the sharing of information with nursing homes is an important measure to assist nursing homes with challenges. As described throughout this response, CMS holds regular stakeholder listening sessions for nursing homes and advocates and often provides updates based on feedback received. In March 2020, CMS issued a Nursing Home Best Practices toolkit to combat COVID-19, and regularly updated it with additional guidance as necessary. Further, CMS notes that all quality, safety, and oversight memorandums, guidance, clarification, and instructions are available publicly online.²² CMS contends that the agency has therefore met this recommendation. It is important to note, however, that creating individualized communication with over 15,000 nursing homes is not feasible with CMS's available resources.

Additionally, CMS contracted with QIOs to work with providers, community partners, beneficiaries, and caregivers on data-driven quality improvement initiatives designed to improve the quality of care for nursing home residents. The QIOs have been strategically refocused to assist nursing homes in combating COVID-19 through such efforts as education and training, creating action plans based on infection control problem areas, and recommending steps to establish a strong infection control surveillance program. As of November 2023, the QIOs have assisted more than 14,000 nursing homes with staffing, emergency preparedness, PPE, infection prevention and control activities, COVID-19 testing, and vaccine uptake through providing targeted education, best practices, technical assistance, and identifying root causes to find long-term solutions.

²² [Nursing Homes: Policy & Memos to States and CMS Locations](#)

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York Regional Office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

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ENDNOTES

¹ Although these requirements have since changed, at the time of our interviews facilities' routine testing schedules varied from once per month if the county positivity rate was less than 5 percent to twice per week if the county positivity rate was higher than 10 percent. Outbreak testing protocols require testing all staff and residents every 3 to 7 days while there are cases in a facility until there have been no cases for at least 14 days. See CMS, *Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool: QSO-20-38-NH*, Apr. 27, 2021.

² At the time of our interviews, CMS required that nursing home staff be fully vaccinated against COVID-19. Staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The regulations allow nursing homes to grant staff exemptions from the vaccination requirements based on Federal law (e.g., for specific medical or religious reasons). The regulations also require nursing homes to track and securely document the vaccination status of staff and exemptions, including each type of exemption and supporting documentation. CMS is also urging facilities to communicate with their fully vaccinated staff members and residents about the importance of staying up to date with COVID-19 shots to protect the nursing home population. CMS requires that nursing homes educate their residents and staff and offer the COVID-19 vaccine, which includes the booster, but does not currently require booster doses. See 42 CFR § 483.80; CMS, *Long-Term Care and Skilled Nursing Facility, Attachment A: QSO-22-07-ALL*. Accessed at <https://www.cms.gov/files/document/qso-22-07-all-attachment-ltc.pdf> on Mar. 7, 2023. See also CMS, *CMS Makes Nursing Home COVID-19 Booster Vaccination Data Available Online, Increasing Transparency for Consumers*, Feb. 9, 2022. Accessed at <https://www.cms.gov/newsroom/news-alert/cms-makes-nursing-home-covid-19-booster-vaccination-data-available-online-increasing-transparency> on Aug. 7, 2023.

³ As of the week ending Mar. 27, 2022, an OIG report estimated that 91 percent of nursing home staff members nationwide had received the required vaccine doses, 56 percent of staff nationwide had received a booster dose, and 6 percent of staff nationwide had been granted a religious exemption. See OIG, *An Estimated 91 Percent of Nursing Home Staff Nationwide Received the Required COVID-19 Vaccine Doses, and an Estimated 56 Percent of Staff Nationwide Received a Booster Dose (A-09-22-02003)*, June 2022. Accessed at <https://oig.hhs.gov/oas/reports/region9/92202003.pdf> on Aug. 31, 2023.

⁴ We note that our interviews occurred prior to the availability of the bivalent booster or the updated COVID-19 vaccine.

⁵ On Apr. 2, 2020, CMS and CDC issued recommendations to nursing homes to create COVID-19-positive units to separate residents who have COVID-19 from residents who do not have COVID-19 or have an unknown status. CMS reiterated this guidance to nursing homes in a subsequent memorandum (QSO-20-25-NH). See CMS, *COVID-19 Long-Term Care Facility Guidance*, Apr. 2, 2020. Accessed at <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf> on Feb. 21, 2023. See also CMS, *2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios: QSO-20-25-NH*, Apr. 13, 2020. Accessed at <https://www.cms.gov/files/document/qso-20-25-nh.pdf> on Mar. 15, 2023.

⁶ For example, see CMS, *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes: QSO-20-14-NH*, Mar. 9, 2023. Accessed at <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> on Aug. 31, 2023. See also CMS, *Revised Long-Term Care Surveyor Guidance: Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide: QSO-22-19-NH*, June 29, 2022. Accessed at <https://www.cms.gov/files/document/qso-22-19-nh-revised-long-term-care-surveyor-guidance.pdf> on Aug. 11, 2023. See also CMS, *Strengthened Enhanced Enforcement for Infection Control Deficiencies and Quality Improvement Activities in Nursing Homes: QSO-23-10-NH*, Mar. 30, 2023. Accessed at <https://www.cms.gov/files/document/qso-23-10-nh.pdf> on Aug. 11, 2023.

⁷ A QIO is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare.

⁸ The White House, *FACT SHEET: Biden-Harris Administration Takes Steps to Crack Down on Nursing Homes that Endanger Resident Safety*, Sept. 1, 2023. Accessed at <https://www.whitehouse.gov/briefing-room/statements-releases/2023/09/01/fact-sheet-biden-harris-administration-takes-steps-to-crack-down-on-nursing-homes-that-endanger-resident-safety/> on Sept. 5, 2023.

⁹ CMS, *Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes*, Aug. 22, 2022. Accessed at <https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes> on May 11, 2023. See also CMS, *HHS Proposes Minimum Staffing Standards to Enhance Safety and Quality in Nursing Homes*, Sept. 1, 2023. Accessed at <https://www.cms.gov/newsroom/press-releases/hhs-proposes-minimum-staffing-standards-enhance-safety-and-quality-nursing-homes> on Sept. 5, 2023.

¹⁰ CMS, *HHS Proposes Minimum Staffing Standards to Enhance Safety and Quality in Nursing Homes*, Sept. 1, 2023. Accessed at <https://www.cms.gov/newsroom/press-releases/hhs-proposes-minimum-staffing-standards-enhance-safety-and-quality-nursing-homes> on Sept. 5, 2023.

¹¹ CMMI, *Graduate Nurse Education Demonstration*, November 2019. Accessed at <https://www.cms.gov/priorities/innovation/innovation-models/gne> on Mar. 7, 2023. See also CMMI, *Nursing Home Value-Based Purchasing Demonstration*, July 1, 2009. Accessed at <https://www.cms.gov/priorities/innovation/innovation-models/nursing-home-value-based-purchasing> on Aug. 3, 2023.

¹² For example, see QIOs, *Tools and Resources*. Accessed at https://qioprogram.org/tools-and-resources?combine=&created%5Bmin%5D=&created%5Bmax%5D=&field_tags_target_id%5B106%5D=106&page=0 on Aug. 11, 2023. See also CMS, *Welcome to the Nursing Home Resource Center!* Accessed at <https://www.cms.gov/nursing-homes> on Aug. 11, 2023.

¹³ CMS, *Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes*, Aug. 22, 2022. Accessed at <https://www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes> on May 11, 2023.