441 G St. N.W.
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January 6, 2021

The Honorable Edward J. Markey
United States Senate

The Honorable Jon Tester
United States Senate

The Honorable Elizabeth Warren
United States Senate

VA Health Care: Community Living Centers Were Commonly Cited for Infection Control Deficiencies Prior to the COVID-19 Pandemic

Thousands of veterans rely on nursing home care provided or paid for by the Department of Veterans Affairs (VA) to help meet their skilled nursing and personal care needs each day.[1] Many of these veterans—around 9,000 per day in fiscal year 2019—receive this care in the 134 community living centers (CLC) owned and operated by VA.[2] CLCs provide both short-stay (90 days or less) and long-stay services to veterans. These services include short-term rehabilitation, respite, hospice care, long-term skilled nursing, mental health recovery, dementia care, and care for spinal cord injuries and disorders.

Ensuring the quality of nursing home care provided to veterans residing in CLCs—and in all nursing homes—has become even more critical with the emergence of Coronavirus Disease 2019 (COVID-19). COVID-19 is a new and highly contagious respiratory disease causing severe illness and death, particularly among the elderly.[3] Because of this, the health and safety of the nation's nursing home residents—who are often in frail health and living in close proximity to one another—has been a concern, in particular for the disabled and elderly veterans living in CLCs who are vulnerable to infection. One of the first major outbreaks of COVID-19 reported in the United States occurred in a Washington State nursing home in February 2020. Since then, there has been a rapid increase in the number of COVID-19 cases in U.S. nursing homes, with more than 59,000 nursing home resident deaths reported as of October 2020—which is likely an undercount.[4]

[1]A veteran's eligibility for nursing home care that is fully or partially covered by VA is determined by the veteran's priority for care, which is generally based on the veteran's service-connected disability status. A service-connected disability is an injury or disease that was incurred or aggravated while on active duty.

[2]Department of Veterans Affairs, *FY 2021 Budget Submission: Medical Programs and Information Technology Programs,* vol. 2 of 4 (February 2020). VA reported that in fiscal year 2019, CLCs provided short-stay services to 2,256 residents per day and long-stay services to 6,561 residents per day, on average.

VA pays for nursing home care in two other settings: public or privately owned community nursing homes and state-owned and -operated veteran homes.

[3]A. Patel and D.B. Jernigan, "Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak—United States, December 31, 2019–February 4, 2020," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, vol. 69: 140–146 (2020).

[4]Centers for Medicare & Medicaid Services (CMS), *COVID-19 Nursing Home Data (Submitted Data as of Week*

Several news stories have prompted questions about the quality of care at individual CLCs.[5] In January 2020, we began work reviewing CLC quality at your request and related to your concerns about these stories. As part of that review, we obtained data from VA and the contractor it uses to conduct inspections of CLCs. These inspections assess CLCs against quality standards, including standards for patient care and facility condition. We reviewed data on deficiencies cited at CLCs—instances in which an inspector determined that the CLC did not meet quality standards—during regular inspections conducted prior to the COVID-19 pandemic.

Specifically, this report describes the prevalence of deficiencies related to CLCs' infection prevention and control practices prior to the COVID-19 pandemic. In addition to this report, we have ongoing work in this area. Future GAO reports will address CLC quality more broadly, and VA's response to COVID-19 in the three nursing home settings for which VA provides or pays for care.

For this report, we analyzed VA data on CLC inspection deficiencies from fiscal years 2015 through 2019.[6] Using these data, we analyzed the deficiency code used by VA's contractor when a CLC fails to meet infection prevention and control quality standards.[7] Using VA's data, we determined the most common type of deficiency among CLCs, the number of CLCs that had infection prevention and control deficiencies, as well as the number of CLCs with repeated infection prevention and control deficiencies over this 5-year period.

To determine the percentage of total CLCs with an infection control deficiency cited in any year from fiscal years 2015 through 2019, we included all CLCs that had an inspection conducted at any point during our review period for a total of 135 CLCs inspected. This count includes CLCs that may have closed or opened during the review period. To determine the percentage of CLCs

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Ending 10/04/2020), accessed October 16, 2020, https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/. We reported in September 2020 that CMS data on COVID-19 cases and deaths among residents and staff in nursing homes does not capture the early months of the pandemic. Specifically, CMS began requiring nursing homes to report COVID-19 data in May 2020 and made reporting prior to May optional. We recommended that the Department of Health and Human Services, in consultation with CMS and the Centers for Disease Control and Prevention, develop a strategy to capture more complete data on COVID-19 cases and deaths in nursing homes retroactively back to January 1, 2020. See GAO, *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions,* GAO-20-701, (Washington, D.C.: Sept. 21, 2020).

For example, a recent news report estimates deaths among nursing home staff and residents to have exceeded 77,000. See Matthew Conlen, et al., "More than 40% of U.S. Coronavirus Deaths are Linked to Nursing Homes," *The New York Times*, updated September 16, 2020.

[5]For example, see "Secret VA Nursing-home Ratings Hid Poor Quality Care from Public," *Boston Globe*, June 17, 2018 and "'They Feasted on Him': Ants at VA Nursing Home Bit Veteran 100 Times before His Death, Daughter Says," *Washington Post,* September 17, 2019.

[6]We reviewed data provided by VA and its contractor for our ongoing review of CLC quality. For the purposes of this report, we refer to the data provided by VA and its contractor as VA data.

[7]CMS's State Operations Manual provides guidance to state surveyors of nursing homes to determine compliance with federal quality standards and the deficiency codes associated with each standard, including those related to infection prevention and control program requirements. VA has adopted these CMS standards in its oversight of CLCs. We reviewed CMS documentation and a November 2018 national VA training for CLCs about infection prevention and control when determining which deficiency codes to analyze for this report. The June 2016 version of the State Operations Manual was the most recent version in use by VA's contractor during our period of review. While CMS restructured its deficiency code system beginning on November 28, 2017, VA did not implement these coding changes until the start of fiscal year 2020, which is after our review period.

with an infection control deficiency in individual fiscal years, we counted the total number of CLCs inspected in each fiscal year, rather than the total number of inspections in that fiscal year.

To provide illustrative examples of the nature of these deficiencies, we reviewed reports resulting from inspections conducted by VA's contractor at CLCs in fiscal year 2018 and fiscal year 2019 that we collected for our ongoing work on CLC quality or that were publicly available online. These reports include narratives written by VA's contracted inspectors describing the deficiencies they identified. Additionally, we reviewed and described the corresponding corrective action plans the CLCs developed to address the identified infection prevention and control deficiencies that we collected for our ongoing work on CLC quality. The examples of deficiencies and corrective action plans are illustrative and are not generalizable.

We conducted this performance audit from July 2020 through December 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA is responsible for overseeing the quality of nursing home care provided to veterans residing in CLCs. The key mechanism VA uses to assess CLC quality is regular inspections, which VA models on the methods used by the Centers for Medicare & Medicaid Services (CMS) to oversee nursing homes participating in the Medicare and Medicaid programs.[8] CLCs receive an initial inspection when they open and then unannounced inspections, which generally occur annually thereafter.[9] VA uses a contractor to conduct these inspections, and VA reviews the results of all inspections.

During these inspections, the contractor determines whether CLCs meet quality standards, which focus on the delivery of care, resident outcomes, and facility conditions. These standards require, for example, that CLCs establish and maintain infection prevention and control programs. When the contractor identifies instances in which the CLC does not meet quality standards, it can cite the CLC for deficiencies. The contractor classifies cited deficiencies according to the scope (number of residents potentially affected) and severity (the potential effect on residents, such as occurrence of harm).[10] CLCs are required to develop and

[8]CMS defines the quality standards that approximately 15,600 nursing home nationwide must meet. See 42 U.S.C. §§ 1395i-3(f)(1),1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2019). CMS oversight includes regular inspections or surveys to monitor compliance with quality standards through direct observations.

A VA 2016 memorandum specifies that VA will implement an unannounced inspection program modeled on the nursing home oversight conducted by CMS. VA oversees all CLCs; CMS has no oversight responsibility in CLCs.

[9]CLCs that have no repeat deficiencies from the previous year and no deficiencies that pose actual harm to residents are inspected every 18 months. Until 2017, CLCs with repeat deficiencies from the previous year or deficiencies above a certain severity level were inspected every 6 months. According to VA officials, the frequency of inspections was changed to every year to allow CLCs time to implement corrective actions.

[10]VA's contractor categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) a potential for minimal impact; (2) no actual harm with a potential for harm; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety.

implement corrective action plans for each deficiency the contractor identifies and must detail how the deficiency will be addressed. VA approves these plans and monitors the CLC's actions until each deficiency is addressed.

Ninety-Five Percent of Inspected CLCs Were Cited for Infection Control Deficiencies Prior to the COVID-19 Pandemic, Sometimes in Consecutive Years

Our analysis of VA data shows that infection prevention and control deficiencies were the most common type of deficiency cited in inspected CLCs from fiscal year 2015 through 2019, with 128 of the 135 CLCs inspected (95 percent) having an infection prevention and control deficiency cited in 1 or more years.[11] Over the period from 2015 through 2019, a total of 365 infection prevention and control deficiencies were cited at the inspected CLCs. The percentage of inspected CLCs with an infection prevention and control deficiency cited each fiscal year ranged from 46 percent to 70 percent. Deficiencies related to infection prevention and control included situations where CLC staff did not regularly use proper hand hygiene or wear personal protective equipment—such as gowns and gloves—to prevent the spread of infection or failed to clean reusable medical items. Many of these practices can be critical to preventing the spread of infectious diseases, including COVID-19.

VA data show that CLCs frequently had infection prevention and control deficiencies cited in consecutive fiscal years, which may indicate persistent problems.[12]

- Specifically, 84 of the 135 CLCs (62 percent) inspected in fiscal years 2015 through 2019 had infection prevention and control deficiencies cited in consecutive fiscal years.
- An additional 25 of the 135 CLCs (19 percent) inspected had an infection prevention and control deficiency cited in multiple, nonconsecutive fiscal years. (See fig. 1.)

[11]After infection prevention and control deficiencies, the next most common deficiencies cited in CLCs from fiscal years 2015 through 2019 were related to ensuring that the environment is free from accidents (about 52 percent of inspected CLCs in each year) and quality of care (about 37 percent of CLCs per year). In our May 2020 report, we similarly found that most nursing homes that participate in the Medicare and Medicaid programs were cited with infection prevention and control deficiencies in 1 or more years prior to the COVID-19 pandemic (82 percent of all nursing homes inspected from 2013 through 2017). GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to the COVID-19 Pandemic,* GAO-20-576R, (Washington, D.C.: May 20, 2020).

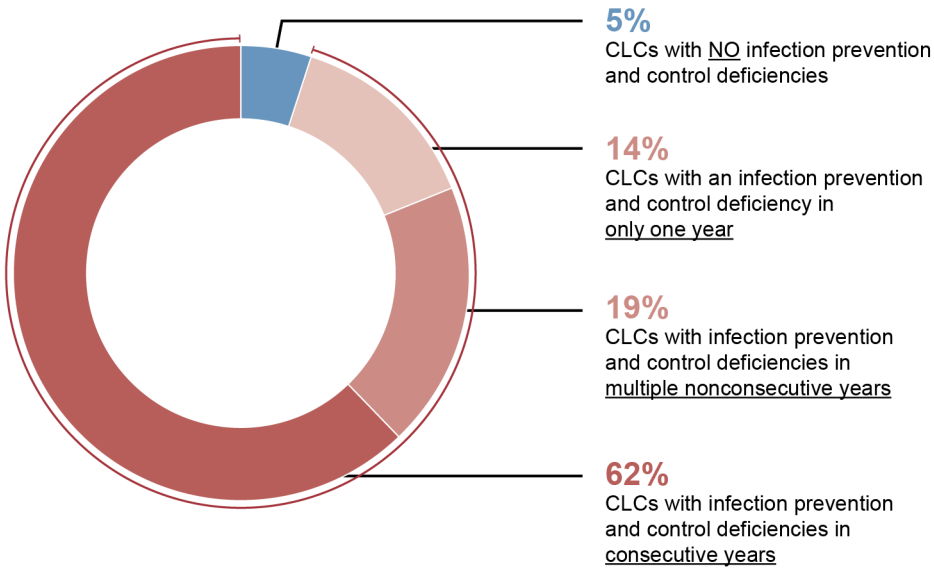
We included all CLCs that had an inspection conducted at any point during our review period, from fiscal years 2015 through 2019, for a total of 135 CLCs. This count includes CLCs that may have closed or opened during the review period.

[12]We reviewed infection prevention and control deficiencies by CLC by fiscal year. Due to the timing of repeat inspections or the timing of the annual, unannounced inspections and the contract year, some CLCs were inspected more than once in a fiscal year, and not all CLCs had an inspection in each fiscal year. As a result, CLCs with infection prevention and control deficiencies cited in consecutive inspections that occurred in the same fiscal year would not be included in our count. From fiscal year 2015 through 2019, 22 CLCs had infection prevention and control deficiencies cited on consecutive inspections that occurred within the same fiscal year. Similarly, CLCs with infection prevention and control deficiencies in consecutive fiscal years would be included in our count, even if they did not have such deficiencies cited on consecutive inspections due to multiple inspections in a single fiscal year.

In our analysis, CLCs with infection prevention and control deficiencies cited in multiple years were categorized as having deficiencies cited in either consecutive years or multiple nonconsecutive years, not both. CLCs with deficiencies cited in any consecutive years during the review period are included in the consecutive years count only, even if they had an additional deficiency cited in an inspection in a nonconsecutive year.

- Furthermore, 40 of the 135 CLCs (30 percent) had these deficiencies cited in at least 3 consecutive fiscal years, 13 of these 40 CLCs (10 percent of the 135 inspected) had these deficiencies cited in at least 4 consecutive fiscal years, and five of these 40 CLCs (4 percent of the 135 inspected) had these deficiencies cited in all 5 fiscal years.

Figure 1: VA Community Living Centers (CLC) with Infection Prevention and Control Deficiencies Cited in Multiple Years, Fiscal Years 2015 through 2019



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-21-195R

Note: We reviewed infection prevention and control deficiencies by CLC by fiscal year. We included all CLCs inspected at any point from fiscal years 2015 through 2019, a total of 135 CLCs. Due to repeat inspections or the timing of the annual unannounced inspections, some CLCs were inspected more than once, and not all were inspected, in a fiscal year. Thus, the count of deficiencies reflects citations in consecutive fiscal years but does not reflect deficiencies cited on consecutive inspections that occurred in the same fiscal year (22 CLCs had infection and prevention control deficiencies cited on consecutive inspections in the same fiscal year). Each inspected CLC was placed in only one category. That is, CLCs with deficiencies cited in any consecutive years during the review period are included in the consecutive years count only, even if they had an additional deficiency cited in an inspection in a nonconsecutive year.

For additional information on specific CLCs, see enclosure I.

When we reviewed example inspection records, we identified some repeat instances of problems with infection prevention and control deficiencies. For example, in fiscal years 2018 and 2019, inspectors identified nine situations at one CLC where CLC staff did not use proper precautions—such as appropriately wearing personal protective equipment or performing hand hygiene—when working with residents who were documented as being at high risk of transmitting infection. To address these deficiencies, as part of its corrective action plan, the CLC developed new policies related to infection transmission precautions and provided training to staff on these new policies, among other actions. For examples of the types of infection control deficiencies cited in CLCs and the steps taken to address them, see table 1.

Table 1: Illustrative Examples of Infection Prevention and Control Deficiency Narratives and Related Corrective Actions in Community Living Centers (CLC) in Fiscal Years 2018 and 2019

Summary of inspection narrative	CLC corrective action[a]
At one CLC, inspectors observed a total of nine situations across fiscal years 2018 and 2019 where CLC staff did not take proper precautions when they interacted with residents for whom enhanced infection transmission precautions were to be followed. These proper precautions include appropriately wearing personal protective equipment (PPE)—gowns or gloves—or performing hand hygiene. In fiscal year 2018, seven residents were affected, five of whom were positive for methicillin-resistant *Staphylococcus aureus* (MRSA).[b] Across both years these situations involved, for example, nursing staff administering medications to residents without appropriately wearing such PPE.	In fiscal year 2018, the CLC • developed new policies and signage related to infection transmission precautions; • educated staff on these policies through daily rounds and educational materials; • installed over-the-door PPE equipment holders; and • collected real-time data on hand hygiene compliance. In fiscal year 2019, the CLC • identified infection control champions from each neighborhood, or unit; and • reviewed infection transmission precaution policies with staff.
At a second CLC, inspectors observed a situation in both fiscal years 2018 and 2019 where nursing staff administered medications without appropriately wearing PPE to a MRSA-positive resident for whom enhanced infection transmission precautions were to be followed. In fiscal year 2018, maintenance staff also entered the same resident's room without performing hand hygiene or wearing PPE. In fiscal year 2019, nursing staff also failed to clean a vital sign machine or discard a disposable cuff after taking the resident's blood pressure.	In fiscal year 2018, the CLC • educated nurses on medication cart use and infection transmission precautions, hand hygiene, and PPE requirements; and • trained engineering staff on infection transmission precautions and hand hygiene. In fiscal year 2019, the CLC • cleaned all vital sign machines and replaced all blood pressure cuffs in the neighborhood, or unit.
A resident at a third CLC with a diagnosis of *Clostridium difficile* was observed by surveyors using a deck of playing cards to perform exercises during an occupational therapy (OT) session in fiscal year 2018.[c] Afterwards, an OT assistant placed the cards in the box without cleaning or sanitizing the cards—despite the fact that enhanced infection transmission precautions were to be followed given the resident's diagnosis—and did not appropriately perform hand hygiene while cleaning other therapy equipment.	• The OT supervisor conducted in-service training with OT staff on the policies on cleaning reusable medical equipment and hand hygiene; and • the OT supervisor conducted weekly monitoring of a random sample of OT staff to ensure compliance.
Inspectors observed three situations at a fourth CLC where nursing staff did not appropriately wear PPE or perform hand hygiene while providing care to residents in fiscal year 2019. This included a nursing assistant who was helping a resident with hygiene care, which included changing the resident's adult brief; one registered nurse who was administering intravenous therapy to a resident with chronic obstructive pulmonary disease (COPD); and one registered nurse who was providing wound care to another resident with COPD and pneumonia.[d]	• The CLC educated staff on maintaining infection control while assisting residents with activities of daily living, administering intravenous therapy, and providing wound care and conducted audits to ensure compliance.

Source: GAO analysis of CLC inspection reports and corrective action plans. | GAO-21-195R

[a]VA requires that CLCs develop and implement corrective action plans to address cited deficiencies and tracks CLCs' progress in resolving each deficiency.

[b]MRSA is a bacteria that is difficult to treat because of resistance to several antibiotics. In healthcare settings, such as nursing homes, MRSA is usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers, and can cause severe problems such as bloodstream infections or pneumonia. It can also be spread through shared equipment and supplies.

[c]*Clostridium difficile*, also known as *Clostridioides difficile* or *C. diff*, is a bacteria that causes diarrhea and inflammation of the colon. More than 80 percent of deaths caused by *C. diff* occur in people age 65 and older. *C. diff* is spread, for example, when individuals touch contaminated surfaces or do not perform hand hygiene. Extended stays in healthcare settings, including nursing homes, increase the risk of infection.

[d]COPD refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.

Finally, our analysis of VA data shows that that inspectors classified all 365 infection prevention and control deficiencies cited at CLCs as "not severe"—meaning the inspector determined that residents were not harmed—in fiscal years 2015 through 2019.[13] Infection prevention and control deficiencies were also categorized by scope—whether the incident was an isolated occurrence, part of a pattern of behavior, or a widespread behavior—with 58 percent categorized as isolated, 41 percent categorized as a pattern of behavior, and 1 percent categorized as widespread in fiscal years 2015 through 2019.

- **Pattern.** One CLC was cited with an infection prevention and control deficiency of this scope when inspectors found that there was no information on transmission-based precautions in care plans or other care documentation for several residents with MRSA colonization.[14] Inspectors also observed nursing staff failing to properly conduct hand hygiene as required to prevent spread of infection during medication administration for three residents with active infections.

- **Widespread.** One CLC was cited with an infection prevention and control deficiency of widespread scope after inspectors observed nursing, food and nutrition, or environmental management services staff fail to properly use personal protective equipment or perform hand hygiene in a way that would prevent the transmission of disease and infection from nine residents with active infections. Further, according to the inspection report, staff were inconsistent in describing to inspectors the CLC's policy related to required precautions to take with these residents.

[13]For the purposes of this report, a classification of "not severe" means that surveyors determined that the deficiency posed either 1) no actual harm with a potential for minimal harm or 2) no actual harm with a potential for more than minimal harm but not immediate jeopardy.

In our May 2020 report, we similarly found that nearly all infection control deficiencies (99 percent in each year from 2013 through 2017) identified in nursing homes that participate in the Medicare and Medicaid programs were classified as "not severe." GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to the COVID-19 Pandemic,* GAO-20-576R, (Washington, D.C.: May 20, 2020).

[14]MRSA or methicillin-resistant *Staphylococcus aureus* is a bacteria that is difficult to treat because of resistance to several antibiotics. In healthcare settings, such as nursing homes, MRSA is usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers, and can cause severe problems such as bloodstream infections or pneumonia. It can also be spread through shared equipment and supplies.

Agency Comments

We provided a draft of this report to VA for review and comment. In the agency's comments, reproduced in enclosure II, VA noted that the term "widespread" in our draft title could be interpreted according to the technical definition of a deficiency categorization of the scope. To eliminate potential confusion, we revised our title.

As agreed with your offices, unless you publicly announce the contents of this report, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of VA and other interested parties. In addition the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at SilasS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Karin Wallestad (Assistant Director), Summar C. Corley (Analyst-in-Charge), and Karen Belli. Also contributing were Laurie Pachter, Ethiene Salgado-Rodriguez, and Jennifer Whitworth.

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Enclosures - 2

Enclosure I: Inspections Conducted and Infection Prevention and Control Deficiencies Cited at Department of Veterans Affairs' Community Living Centers, Fiscal Years 2015 through 2019

Table 2: Inspections Performed and Infection Prevention and Control Deficiencies (IPC) Cited, by Community Living Center (CLC), Fiscal Years (FY) 2015 through 2019

Legend: ✓= inspection conducted, ■ = infection prevention and control deficiencies (IPC) cited during inspection, □ = no IPC cited during inspection, - = no inspection occurred, no opportunity for an IPC to be cited.

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Albany, NY	✓	□	✓	□	-	-	✓	■	✓	■
Albuquerque, NM	✓	■	✓	■	✓	□	✓	■	-	-
Altoona, PA	✓	□	✓	■	✓	□	✓	■	✓✓	■□
Amarillo, TX	✓	■	✓	■	✓	□	✓	■	✓	□
Ann Arbor, MI	✓	■	✓	□	✓	□	✓	□	✓	■
Asheville, NC	✓	■	✓✓	■□	✓	□	-	-	✓	□
Augusta, GA	✓	■	-	-	✓✓	■□	✓	■	✓	□
Augusta, ME	✓	□	✓	■	✓	■	✓✓	■■	✓	□
Baltimore, MD	✓	□	✓	□	✓	■	✓	■	✓	■
Batavia, NY	✓	■	-	-	✓	□	✓	□	✓	□
Bath, NY	✓	■	✓	□	✓	□	✓	■	✓	■
Battle Creek, MI	✓	□	-	-	✓	■	✓✓	■□	✓	■
Bay Pines, FL	✓	□	✓✓	□■	✓	□	✓	■	-	-
Beckley, WV	-	-	✓	□	✓	□	✓	□	✓✓	■□
Bedford, MA	✓	■	✓	■	✓	■	✓	■	✓	■
Big Spring, TX	✓	□	✓	■	✓	□	✓	□	✓	□
Biloxi, MS	✓	■	✓	■	✓	□	✓✓	□■	-	-
Boise, ID	✓	□	✓	□	✓	■	✓	■	✓	□

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Bonham, TX	✓	■	-	-	✓✓	■□	✓	■	✓	■
Brockton, MA	✓	■	✓	□	✓	■	✓	■	✓	□
Bronx, NY	✓	■	-	-	✓✓	■□	-	-	✓	□
Buffalo, NY	✓	■	✓	□	✓	■	✓	□	✓	■
Butler, PA	✓	■	-	-	✓	■	✓✓	□■	-	-
Canandaigua, NY	✓	□	✓	■	✓✓	■■	✓	■	✓	■
Carrollton, GA	✓	□	✓	□	✓	■	-	-	✓	□
Castle Point, NY	✓	■	-	-	✓✓	■■	✓	□	✓	■
Charleston, SC	✓	■	✓	□	✓	■	✓	■	✓	□
Cheyenne, WY	✓	■	-	-	✓	□	✓	■	✓	■
Chicago, IL	✓	□	✓	□	✓	■	✓	■	✓	■
Chilicothe, OH	✓	■	✓	□	✓	□	✓✓	□■	✓	□
Cincinnati, OH	✓	■	-	-	✓	■	✓	□	✓✓	■■
Clarksburg, WV	✓	■	✓	■	✓	■	✓	■	✓	■
Cleveland, OH	✓	■	✓	□	✓	□	✓	■	✓	□
Coatesville, PA	✓	□	✓	□	-	-	✓	□	✓	□
Columbia, MO	✓	■	✓	□	-	-	✓	■	✓✓	□■
Columbia, SC	✓	■	✓	■	✓✓	□□	✓	■	✓	□
Dallas, TX	✓	■	✓	■	✓	■	✓	□	✓	■
Danville, IL	✓	■	✓	□	✓	□	✓✓	■■	✓	□
Dayton, OH	✓	■	✓	□	✓✓	□■	✓	■	✓	■

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Decatur, GA	✓	□	✓	□	✓	■	✓	□	✓	■
Denver, CO	-	-	✓	■	✓	■	-	-	-	-
Des Moines, IA	✓	■	✓	□	✓	■	✓	■	✓	■
Detroit, MI	✓	■	✓	□	✓	■	✓✓	■■	✓	□
Dublin, GA	✓	■	✓	■	✓	■	✓	□	✓	□
Durham, NC	-	-	✓	■	✓✓	□■	-	-	✓	□
Erie, PA	✓	■	✓	■	-	-	✓	□	✓	■
Fargo, ND	✓	□	✓	□	✓	□	-	-	✓	□
Fayetteville, NC	✓	□	✓	□	✓	□	✓	■	✓	□
Fort Meade, SD	✓	□	✓	□	-	-	✓✓	■□	✓	■
Fresno, CA	✓	■	✓	■	✓	□	✓	■	✓	□
Gainesville, FL	✓	■	✓	□	✓	■	✓	■	✓	■
Grand Island, NE	✓	□	✓	□	✓	□	✓	■	✓	■
Grand Junction, CO	✓	□	✓	■	✓	□	✓	■	✓	■
Hampton, VA	✓	□	-	-	✓	■	✓	■	✓	■
Hines, IL	✓	■	-	-	✓	□	✓✓	■■	✓	□
Honolulu, HI	-	-	✓	■	✓	□	✓	□	✓	■
Hot Springs, SD	✓	■	✓	■	-	-	✓✓	□■	✓	□
Houston, TX	✓	■	✓	■	✓	□	✓	■	✓	□
Iron Mountain, MI	✓	□	-	-	✓	■	✓	■	✓	□
Jackson, MS	✓	■	✓	□	✓	■	✓✓	■■	✓	■

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Kerrville, TX	✓	■	-	-	✓	■	✓✓	□■	✓	■
Lake City, FL	✓✓	■■	-	-	✓	■	✓	■	✓	■
Leavenworth, KS	✓	■	✓✓	□□	✓	□	✓	□	✓	□
Lebanon, PA	✓	□	✓	□	✓	□	-	-	✓	■
Leeds, MA	✓	□	✓	□	-	-	✓	■	✓	■
Lexington, KY	✓	■	✓	■	✓	□	✓	■	✓	■
Livermore, CA	✓	□	✓	□	✓	□	✓	■	✓	■
Loma Linda, CA	✓	□	✓	■	✓	□	✓	■	✓	■
Long Beach, CA	✓	■	✓	□	✓	■	✓	■	✓	■
Los Angeles, CA	✓	□	✓	□	✓	■	✓	■	✓	□
Lyons, NJ	✓✓	■■	✓	□	✓	□	✓✓	■□	-	-
Madison, WI	✓	□	-	-	✓	□	✓	■	✓	□
Manchester, NH	✓	■	✓	■	✓	□	✓	□	✓	□
Marion, IL	✓	□	✓	■	✓	□	✓	■	✓	■
Marion, IN	✓	□	✓	□	✓	□	✓	□	✓	■
Martinez, CA	✓	□	✓✓	■■	✓	■	✓	■	✓	■
Martinsburg, WV	✓	□	✓	□	-	-	✓✓	□■	✓	■
Menlo Park, CA	✓	■	✓	□	✓	■	✓	■	✓✓	■■
Miami, FL	✓	□	✓	□	✓	■	✓	■	✓	□
Miles City, MT	✓	□	✓	□	✓	□	✓	□	-	-
Milwaukee, WI	✓	□	-	-	✓	■	✓	□	✓	■
Minneapolis, MN	-	-	✓	□	✓	■	-	-	✓	■
Montrose, NY	-	-	✓	□	✓	□	✓	□	✓	□

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Mountain Home, TN	✓	■	✓	■	✓	□	✓	□	✓	■
Murfreesboro, TN	✓✓	□□	-	-	✓✓	□■	✓	■	✓	■
New Orleans, LA	-	-	-	-	-	-	✓	□	-	-
North Chicago, IL	✓	■	✓	□	✓	■	✓	■	✓	□
North Little Rock, AR	-	-	✓	□	✓	□	✓	■	✓	■
Northport, NY	✓	■	✓	□	✓	□	✓	□	-	-
Oklahoma City, OK	✓	□	✓	□	✓✓	□■	-	-	✓	■
Orlando, FL	✓	■	✓	■	✓	■	✓	□	✓	□
Palo Alto, CA	✓	■	✓	□	✓	■	-	-	✓	□
Perry Point, MD	✓	■	✓✓	■■	✓	■	✓	□	✓	■
Philadelphia, PA	✓	■	✓	□	✓	■	✓	□	✓	□
Phoenix, AZ	✓	□	-	-	✓	□	✓	□	✓	□
Pineville, LA	✓	□	✓	■	✓	□	✓	■	✓	□
Pittsburgh, PA	✓✓	□□	-	-	✓	□	✓✓	■■	✓	□
Poplar Bluff, MO	✓	□	✓	■	✓	■	✓	■	✓	■
Prescott, AZ	✓	■	-	-	✓	■	✓	■	✓	■
Pueblo, CO	✓	□	✓	□	✓	■	✓	■	✓✓	■■
Reno, NV	✓	■	✓	■	✓	■	✓✓	□■	✓	□
Richmond, VA	✓	□	-	-	✓	□	✓	■	✓	■
Roseburg, OR	✓	■	✓	■	✓✓	■□	-	-	✓	□
Saginaw, MI	✓	■	✓	□	✓	■	✓	□	✓	■

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Salem, VA	✓	■	✓	■	✓	■	✓	■	✓✓	■■
Salisbury, NC	✓	■	✓	□	✓	□	✓	□	✓	□
San Antonio, TX	✓	□	-	-	✓	■	✓	□	✓	□
San Diego, CA	✓	□	✓	■	✓	■	✓	■	✓	■
San Francisco, CA	✓	■	-	-	✓✓	■□	✓	■	✓	■
San Juan, PR	✓	■	✓	■	✓	■	✓	■	✓	□
Seattle, WA	✓	■	✓	■	✓	■	✓	□	✓	■
Sepulveda, CA	✓✓	■■	✓	□	✓	□	✓	■	✓	□
Sheridan, WY	✓	□	-	-	✓✓	□■	✓	□	-	-
Sioux Falls, SD	✓	■	✓	■	✓	□	✓	■	✓	□
Spokane, WA	-	-	✓	□	✓	□	✓	■	✓	□
St. Albans, NY	✓	□	✓	■	✓	■	✓	■	✓	■
St. Cloud, MN	✓	■	✓	□	✓	■	-	-	✓	□
St. Louis, MO	✓✓	■□	✓	■	-	-	✓✓	■■	✓	■
Syracuse, NY	✓	□	✓	■	✓	□	✓	■	✓	□
Tacoma, WA	✓	□	✓✓	□■	-	-	✓	■	✓	□
Tampa, FL	✓✓	□■	✓	■	✓	■	✓	■	✓	■
Temple, TX	✓	□	-	-	✓	□	✓	■	✓	□
Tomah, WI	✓	□	✓	■	✓	□	-	-	✓	□
Topeka, KS	-	-	✓	□	✓	■	✓	□	-	-
Tucson, AZ	✓	□	-	-	✓	■	✓✓	■□	✓	■
Tuscaloosa, AL	✓	□	✓	□	✓	□	✓	□	✓	□

CLC location	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited	Inspection conducted	IPC cited
Tuskegee, AL	✓	□	✓	□	✓	■	✓✓	■■	✓	□
Vancouver, WA	-	-	✓	□	✓	□	✓	□	✓	■
Waco, TX	✓✓	■□	-	-	✓✓	■■	✓	■	✓	■
Washington, DC	✓	■	✓	■	✓	■	✓	■	✓	□
West Haven, CT	✓	□	-	-	✓	■	✓	■	✓	□
West Palm Beach, FL	✓	■	✓	■	✓	■	✓	■	✓	■
Wichita, KS	✓	■	✓✓	■■	✓	■	✓	□	✓	■
Wilkes-Barre, PA	✓	■	✓	□	✓	■	✓	□	✓	□
Wilmington, DE	-	-	✓✓	■□	-	-	✓	■	✓✓	■■

Legend: ✓= inspection conducted, ■ = infection prevention and control deficiencies (IPC) cited during inspection, □ = no IPC cited during inspection, - = no inspection occurred, no opportunity for an IPC to be cited.

Source: GAO analysis of Department of Veterans Affairs data. | GAO-21-195R

Enclosure II: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

December 14, 2020

Ms. Sharon Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report ***VA Health Care: Infection Control Deficiencies Were Widespread in Community Living Centers Prior to the COVID-19 Pandemic*** (GAO-21-195R).

The enclosure contains general comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Brooks D. Tucker
Assistant Secretary for Congressional and Legislative Affairs Performing the Delegable Duties of the Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA Health Care: Infection Control Deficiencies Were Widespread in Community Living Centers Prior to the COVID-19 Pandemic
(GAO-21-195R)

General Comments:

The Department of Veterans Affairs (VA) is committed to ensuring quality and safe infection control practices for our Nation's Veterans in its 134 VA Community Living Centers (CLC). Infection control deficiencies identified from the unannounced surveys are immediately addressed by each facility through corrective action plans. VA's Office of Geriatrics and Extended Care (GEC) follows up with facilities on their corrective action plans to ensure deficiencies are addressed and sustainable improvements in infection control processes are in place. The proactive efforts and readiness to enhance infection control processes contributes to VA's containment and mitigation of Coronavirus Disease 2019 (COVID-19) within CLCs.

Of the 365 infection control deficiencies cited within VA CLC Unannounced Surveys during fiscal years (FY) 2015 through 2019, 100% were deemed not severe, and no Veterans were harmed. During FY 2015 through 2019, 58% of the infection control deficiencies were isolated in scope; 41% were categorized as a pattern and 1% had widespread scope. VA objects to the Government Accountability Office's (GAO) characterization of infection control deficiencies as "widespread" in the report title because it is inconsistent with the data and unnecessarily misleads the reader. VA asks GAO to consider removing the word "widespread" from the title of the report for purposes of accuracy.

At the onset of the COVID-19 pandemic, VA immediately activated infection prevention and control safeguards geared to prevent entry, detect cases and minimize spread of severe acute respiratory syndrome coronavirus 2 (or SARS-CoV-2) virus in CLCs. VA GEC continued follow-up with facility corrective action plans and emphasized vigilant infection control practices. VA's priority to protect highly-vulnerable Veterans within CLCs and implement infection prevention and control measures promoted VA's response to COVID-19.

We would like to point out that significant improvements and changes have been implemented at VA CLCs since the article, "Secret VA Nursing Home Rating Hid Poor Quality Care from Public," was printed in June 2018. For example, VA no longer has any overall one-star rated CLCs. While we can appreciate the article's findings, much progress has been made at our CLCs since then, and we are very pleased with that progress.

The report title and supporting references can be misinterpreted to imply that findings from unannounced surveys could have determined whether a CLC was at risk for spread of COVID-19 to residents. The unannounced surveys conducted from

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
VA Health Care: Infection Control Deficiencies Were Widespread in Community Living Centers Prior to the COVID-19 Pandemic
(GAO-21-195R)

FY 2015 to 2019 would never have identified infection control deficiencies that could prevent introduction of COVID-19 into a CLC, simply because COVID-19 did not exist at that time.

Department of Veterans Affairs
December 2020

(104561)