



July 2021

COVID-19

VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers

Accessible Version



A Century of Non-Partisan Fact-Based Work

Why GAO Did This Study

Close to 8,000 veterans per day received nursing home care provided by VA in CLCs in fiscal year 2020. COVID-19 has posed significant risks to nursing home residents and staff, as residents are often in frail health, and residents and staff have close daily contact with each other.

The CARES Act includes a provision that GAO monitor the federal response to the pandemic. This report describes, among other objectives, guidance and training VA has issued to help CLCs respond to the pandemic and examines VA's oversight of infection prevention and control in CLCs during the pandemic.

GAO analyzed documents, including guidance, training-related materials, and CLC self-assessments of their infection prevention and control practices. GAO also interviewed VA officials and CLC staff, the latter from five facilities selected based on factors such as having been cited for infection prevention and control deficiencies prior to the pandemic.

What GAO Recommends

VA should conduct a retrospective assessment of its oversight of infection prevention and control in CLCs during the COVID-19 pandemic to identify lessons learned and be better prepared for future infectious disease outbreaks. VA concurred with GAO's recommendation in principle. VA plans to review the results of CLCs' assessments of their infection prevention and control practices and require CLCs to take any needed corrective actions.

View [GAO-21-559](#). For more information, contact Sharon Silas at (202) 512-7114 or silass@gao.gov.

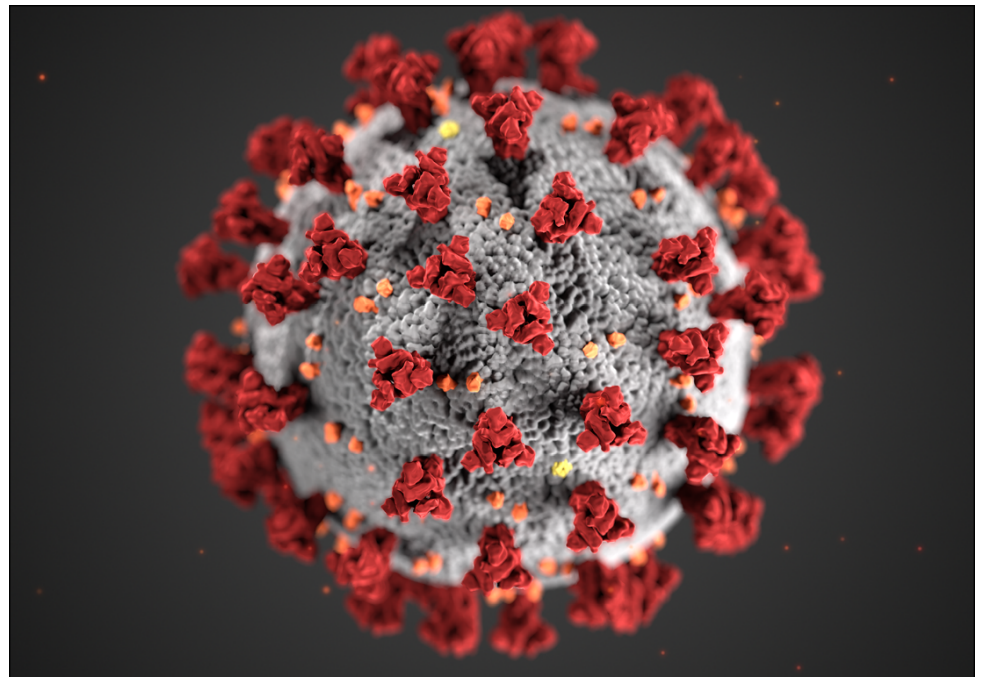
COVID-19

VA Should Assess Its Oversight of Infection Prevention and Control in Community Living Centers

What GAO Found

The Department of Veterans Affairs (VA) took steps—such as issuing guidance and trainings—to support the response to the COVID-19 pandemic in Community Living Centers (CLC), which are VA-owned and -operated nursing homes. This guidance focused on, for example, limiting CLC entry and testing residents and staff for COVID-19, while the trainings were intended to prepare staff for, among other things, a surge in cases.

However, the agency conducted limited oversight of infection prevention and control in these facilities during the first year of the pandemic, from March 2020 through February 2021. In particular, the agency suspended annual in-person inspections of CLCs before resuming them virtually in February 2021. The agency also required that CLCs conduct a one-time self-assessment of their infection prevention and control practices but did not review the results in a timely manner to make more immediate improvements.



Source: Centers for Disease Control and Prevention, Alissa Eckert, Dan Higgins. | GAO-21-559

VA officials acknowledged these shortcomings as the agency responded in real time to the rapidly evolving pandemic. As VA has described this time as a “learning period,” it could benefit from assessing its decisions and actions related to oversight of infection prevention and control during the pandemic to identify any lessons learned. Such an assessment would align with VA's plans to assess and report on the agency's overall response to the pandemic as well as its strategic goal to promote continuous quality improvement in CLCs. Results from such an assessment—which could look at both successes and missed opportunities—could help VA better prepare for future infectious disease outbreaks in CLCs.

Contents

GAO Highlights		2
	Why GAO Did This Study	2
	What GAO Recommends	2
	What GAO Found	2
<hr/>		
Letter		1
	Background	5
	VA Disseminated Evolving Guidance and Training on a Range of Topics to Help CLCs Respond to the COVID-19 Pandemic	7
	Selected CLCs Described Common Experiences Responding to the Pandemic Related to Issues Such as Evolving Guidance, Obtaining Supplies, and Staffing	11
	VA Conducted Limited Oversight of Infection Prevention and Control in CLCs during the First Year of the Pandemic	15
	Conclusions	18
	Recommendation for Executive Action	19
	Agency Comments	19
<hr/>		
Appendix I: Examples of Changes to VA Guidance for Selected CLC Services and Procedures during COVID-19, March 2020 to March 2021		23
Appendix II: VA Stages for Resuming Certain CLC Services Based on the Prevalence of COVID-19		27
Appendix III: Comments from the Department of Veterans Affairs		28
	Text of Appendix III: Comments from the Department of Veterans Affairs	31
<hr/>		
Appendix IV: GAO Contact and Staff Acknowledgments		33
	GAO Contact	33
	Staff Acknowledgments	33
<hr/>		
Tables		
	Table 1: Common Experiences Responding to the COVID-19 Pandemic among Five Selected VA Community Living Centers (CLC)	12
	Table 2: Examples of Changes to VA Guidance for Selected CLC Services and Procedures during COVID-19, March 2020 to March 2021	23

Table 3: VA Stages for Resuming Certain CLC Services Based on the Prevalence of COVID-19

27

Figure

Figure 1: Examples of Evolving VA Guidance on Selected Topics Related to CLCs' Response to the COVID-19 Pandemic, March 2020 through March 2021

9

Abbreviations

CDC	Centers for Disease Control and Prevention
CLC	community living center
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
PPE	personal protective equipment
VA	Department of Veterans Affairs
VAMC	VA medical center
VISN	Veterans Integrated Service Network

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

July 28, 2021

Congressional Addressees

Thousands of veterans rely on nursing home care provided or paid for by the Department of Veterans Affairs (VA) to help them meet their skilled nursing and personal care needs.¹ Many of these veterans—around 8,000 per day in fiscal year 2020—receive this care in one of 134 community living centers (CLC).² In contrast to the other nursing home settings in which veterans may receive nursing home care, CLCs are owned and operated by VA and are associated with, and may be located in, on the campuses of, or near VA medical centers (VAMC).³ CLCs provide nursing home care that includes short-term rehabilitation, respite care, hospice care, long-term skilled nursing, mental health recovery, dementia care, and care for spinal cord injuries and disorders to veterans in this setting.

VA's management of the response to the Coronavirus Disease 2019 (COVID-19) pandemic for CLCs is of critical importance. COVID-19 is a new and highly contagious respiratory disease causing severe illness and death, particularly among the elderly.⁴ COVID-19 has posed significant risk to the health and safety of the nation's nursing home residents, who are often in frail health and live in close proximity to one another. One of the first major outbreaks of COVID-19 reported in the United States

¹VA is required to provide nursing home care for two categories of veterans, known as mandatory veterans: (1) veterans who require nursing home care because of a service-connected disability, and (2) veterans who require nursing home care and who also have a service-connected disability rated at 70 percent or greater. A service-connected disability is an injury or disease that was incurred or aggravated while on active duty. Additionally, VA may provide nursing home care to other veterans, on a discretionary basis, as capacity and resources permit. See 38 U.S.C. §§ 1710, 1710A.

²U.S. Department of Veterans Affairs, *FY 2022 Budget Submission: Medical Programs and Information Technology Programs*, vol. 2 of 4 (June 2021).

³In addition to providing nursing home care to veterans in CLCs, VA pays for such care for veterans in two other settings: public or privately owned community nursing homes and state-owned and -operated veterans homes.

VAMCs provide two or more categories of care to veterans, such as inpatient, outpatient, residential rehabilitation, or institutional extended—that is, nursing home—care.

⁴A. 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).

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 132,000 nursing home resident deaths reported as of May 2021—which may be an undercount.⁵ Nursing home staff, who have close and personal day-to-day contact with at-risk residents, may also be at elevated risk for either contracting COVID-19 while working in these facilities or transmitting the virus to residents.⁶

Given the risk COVID-19 poses in nursing homes, VA issued guidance specific to its CLCs on COVID-19 mitigation—or infection prevention and control—and criteria for making operational decisions to protect residents and staff.⁷ A primary means through which VA oversees infection prevention and control in CLCs is through periodic inspections.

⁵Centers for Medicare & Medicaid Services, *COVID-19 Nursing Home Data (Submitted Data as of Week Ending 5/2/2021)*, accessed May 13, 2021, <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/>.

We reported in September 2020 that the Centers for Medicare & Medicaid Services' (CMS) data on COVID-19 cases and deaths among residents and staff in nursing homes may be an undercount because it does not capture the early months of the pandemic. We recommended that the U.S. 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 retroactive 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).

⁶See, for example, Kaiser Family Foundation, *COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce*, accessed January 6, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>, and M. Keith Chen, J.A. Chevalier, and E.F. Long, "Nursing Home Staff Networks and COVID-19," *Proceedings of the National Academy of Sciences of the United States of America*, vol. 118 (1): 1-7 (2021). We also reported in May 2021 that over half of the COVID-19 outbreaks that occurred among community nursing homes from May 2020 through January 2021 began with a staff member. See GAO, *COVID-19 in Nursing Homes: Most Homes Had Multiple Outbreaks and Weeks of Sustained Transmission from May 2020 through January 2021*, [GAO-21-367](#), (Washington, D.C.: May 19, 2021).

⁷See, for example, U.S. Department of Veterans Affairs Memorandum, *Coronavirus (COVID-19) Community Living Centers – Revised 03/17/20* (March 17, 2020), and U.S. Department of Veterans Affairs, *Community Living Center (CLC) Moving Forward Plan* (July 27, 2020).

In August 2020, we began work reviewing VA's response to the COVID-19 pandemic in CLCs under the CARES Act provision that GAO monitor the federal response to the pandemic.⁸ In this report, we

1. describe guidance and training that VA has provided to CLCs to help guide their response to the COVID-19 pandemic;
2. describe selected CLCs' experiences responding to the COVID-19 pandemic; and
3. examine VA's oversight of infection prevention and control in CLCs during the COVID-19 pandemic.

To describe the guidance and training VA provided to help guide CLCs' response to the COVID-19 pandemic, we reviewed guidance that VA developed and disseminated between March 2020 and March 2021 on the response and related CLC operational changes.⁹ We also reviewed documentation related to the COVID-19-specific trainings and tools that VA made available to CLC staff. We interviewed VA officials from the Office of Geriatrics and Extended Care, who are responsible for CLC strategic planning and policy development, regarding this guidance and training. We also spoke with officials from three VA research centers focused on infection prevention and control that have developed related resources for CLCs.

To describe CLCs' experiences responding to the pandemic, we interviewed staff from five CLCs and their associated VAMCs and Veterans Integrated Service Networks (VISN).¹⁰ Specifically, we interviewed staff involved in infection prevention as well as nursing staff, among others, to understand their experiences responding to the COVID-

⁸Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). We regularly issue government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Continued Attention Needed to Enhance Federal Preparedness, Response, Service Delivery, and Program Integrity*, [GAO-21-551](#) (Washington, D.C.: July 19, 2021). Our next government-wide report will be issued in October 2021 and will be available on GAO's website at <https://www.gao.gov/coronavirus>.

⁹We categorized the guidance based on topic and selected those related to CLC access and admissions; use of personal protective equipment; resident experiences pertaining to, for example, restrictions on group activities; COVID-19 screening and testing; staffing; and strategies related to handling suspected and positive COVID-19 cases to summarize for this report. This guidance may pertain to CLCs specifically or to VAMCs and Veterans Integrated Service Networks (VISNs), inclusive of CLCs.

¹⁰VISNs are regional health care networks that manage the day-to-day functions of VAMCs within their networks through, for example, administrative and clinical oversight.

19 pandemic, including their perspectives on the actions the CLCs took and the support they received from VA. We selected the five CLCs for variation in (1) their quality rating, (2) the number of cited infection prevention and control deficiencies prior to the pandemic, (3) their maximum bed capacities, (4) the complexity level of the associated VAMC, and (5) their geographic location.¹¹ We identified experiences reported by staff from a majority of (at least four) of the five CLCs, but included additional examples or exceptions from fewer CLCs for illustrative purposes. The information obtained from these interviews cannot be generalized to other CLCs or associated VAMCs and VISNs.

To examine VA's oversight of infection prevention and control in CLCs during the pandemic, we interviewed VA officials from the Office of Geriatrics and Extended Care regarding any modifications they made to the CLC oversight process in light of the pandemic as well as any additional ways they monitored CLC infection prevention and control practices in response to COVID-19. We also spoke to staff from the five selected CLCs who were responsible for quality oversight regarding these changes. We obtained and reviewed copies of self-assessments VA required CLCs to complete regarding their infection prevention and control practices. These assessments were completed by 129 of the 134

¹¹The five selected CLCs were located in Bedford, MA; Milwaukee, WI; Menlo Park, CA; Orlando, FL; and San Antonio, TX.

VA assigns CLCs a quality rating of one to five stars, where five stars indicates the highest quality and one star indicates the lowest quality. The ratings are based on data related to nurse staffing levels, quality of resident care measures, and the results of inspections. We selected two CLCs with five-star ratings and one CLC with a four-star, three-star, and two-star rating as of September 2019, the end of the most current rating period at the time of our selection, noting that there were no one-star rated CLCs as of that date.

We also identified whether CLCs were cited for an infection prevention and control deficiency during inspections VA conducted in the two fiscal years prior to the pandemic—fiscal year 2018 and fiscal year 2019. We selected two CLCs that were cited for such a deficiency in both fiscal years, one CLC that was cited for such a deficiency in one of these two fiscal years, and two CLCs that were not cited for such a deficiency in either of these two fiscal years.

Further, we divided identified CLCs' maximum bed capacity range and divided this range into thirds. We selected two CLCs in the upper third of this range, two CLCs in the middle third of this range, and one CLC in the bottom third of this range.

VA categorized VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient populations served, clinical services offered, educational and research missions, and administrative complexity. As such, we selected CLCs to approximate the percentage of VAMCs of each complexity level across the country. We also selected CLCs to ensure variation in geographic location as identified by the location of the associated VISNs.

CLCs as of July 2020.¹² We analyzed CLCs' responses to identify any self-reported gaps in these practices. We evaluated VA's oversight in the context of the agency's strategic goals for geriatrics and extended care programs, which includes CLCs, as well as federal internal control standards related to evaluating internal control issues and remediating deficiencies.¹³

We conducted this performance audit from August 2020 through July 2021 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

Within VA, the Office of Geriatrics and Extended Care is responsible for overseeing the quality of nursing home care provided to veterans residing in CLCs. VA models its oversight of CLCs on the methods used by the Centers for Medicare & Medicaid Services (CMS).¹⁴ CMS defines the quality standards that approximately 15,600 nursing homes nationwide must meet in order to participate in the Medicare and Medicaid programs.¹⁵ These include quality standards related to infection prevention and control—a critical component of preventing the spread of COVID-19 within nursing homes—as well as other matters such as delivery of care, resident outcomes, and facility conditions. The infection

¹²U.S. Department of Veterans Affairs, *Unannounced Surveys for State Veterans Homes and Community Living Centers* (July 6, 2020). According to VA officials, five of the CLCs that were closed at the time that the self-assessment was administered did not complete it. Thus, we reviewed self-assessments for 129 of the 134 CLCs.

¹³U.S. Department of Veterans Affairs, *Geriatrics and Extended Care, GEC Mission, Vision, Goals, (Updated April 8, 2016)*, accessed April 30, 2021, https://www.va.gov/GERIATRICS/GEC_Mission_Vision_Goals.asp, and GAO, *Standards for Internal Control in the Federal Government, GAO-14-704G* (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁴A VA 2016 memorandum specifies that VA will implement an unannounced inspection program modeled on the nursing home oversight conducted by CMS.

¹⁵See 42 U.S.C. §§ 1395i-3(f)(1), 1396r(f)(1); 42 C.F.R. Part 483, Subpart B (2020).

prevention and control standards pertain to, for example, hand hygiene, appropriate use of personal protective equipment (PPE), and other infectious disease transmission-based precautions.¹⁶ The Centers for Disease Control and Prevention's (CDC) guidance on preventing the spread of COVID-19 in nursing homes identified the need to reinforce and monitor resident and staff adherence to hand hygiene and the use of PPE during the pandemic.¹⁷

To monitor compliance with these standards, CMS enters into agreements with state survey agencies to conduct inspections of each nursing home. During these inspections, a state survey agency might identify deficiencies—or instances in which the nursing home does not meet an applicable quality standard.¹⁸ Similarly, VA enters into an agreement with a contractor to conduct regular unannounced inspections—generally occurring annually—that determine the extent to which CLCs meet quality standards.¹⁹ VA reviews the results of all inspections and requires that CLCs develop and implement corrective action plans for each deficiency identified that detail how it will be addressed. VA approves these plans and monitors CLCs' actions until each deficiency is addressed.

¹⁶CMS requires that nursing homes establish and maintain infection prevention and control programs that include (1) a system to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff, volunteers, visitors, and others providing services in the home; (2) written standards, policies, and procedures for their infection prevention and control program; (3) antibiotic use protocols and a system to monitor antibiotic use; and (4) a system for recording incidents identified under the home's infection prevention and control program and any corrective actions taken. See 42 C.F.R. § 483.80(a)(1)-(4) (2020).

¹⁷Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (Updated March 29, 2021)*, accessed May 19, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

¹⁸Surveyors classify cited deficiencies into categories according to scope (the number of residents potentially affected) and severity (the potential for or occurrence of harm to residents).

¹⁹CLCs receive an initial inspection when they open and then periodic, unannounced inspections thereafter. The frequency of these inspections depends on the number and severity of deficiencies identified during the prior year's inspection, but they generally occur every 11 to 13 months.

VA Disseminated Evolving Guidance and Training on a Range of Topics to Help CLCs Respond to the COVID-19 Pandemic

VA disseminated numerous guidance documents, trainings, and other resources to CLCs to help staff manage the response to the COVID-19 pandemic. Throughout the first year of the pandemic, VA frequently shared new and updated guidance with CLC staff to help mitigate the spread of COVID-19. VA also made trainings and other resources available to help CLC staff manage their duties and help improve their knowledge of COVID-19.

Guidance on COVID-19. During the first year of the pandemic, from March 2020 through March 2021, VA developed and disseminated over 70 pieces of guidance that evolved along with information about COVID-19 to help CLCs respond to the pandemic.²⁰ VA's early guidance outlined safeguards designed to mitigate the introduction and spread of COVID-19 within CLCs, such as guidance on assigning dedicated staff to CLCs, limiting the number of staff entering the facility, and the use and conservation of PPE.²¹ This guidance also suspended certain regular operations, such as visitor entry and new veteran admissions.²² VA distributed this guidance frequently, in some cases sharing multiple pieces of guidance on a single day early in the response.

VA continued to issue new and updated guidance throughout the pandemic as new information became available about how COVID-19 spreads and as access to supplies increased. (See fig. 1 and app. I.) For example, VA revised its isolation guidance for infectious residents from a test-based strategy to a symptom-based strategy in response to changing

²⁰This includes guidance for CLCs specifically as well as VAMCs and VISNs, inclusive of CLCs. VA shared approximately 45 percent of this guidance with CLC staff during the first two months of the pandemic.

²¹See, for example, U.S. Department of Veterans Affairs, *Coronavirus (COVID-19) Community Living Centers – Revised 03/17/20* and U.S. Department of Veterans Affairs, *Coronavirus (COVID-19) Personal Protective Equipment (PPE) Use* (March 15, 2020).

²²See, for example, U.S. Department of Veterans Affairs, *Coronavirus (COVID-19) Community Living Centers – Revised 03/17/20*.

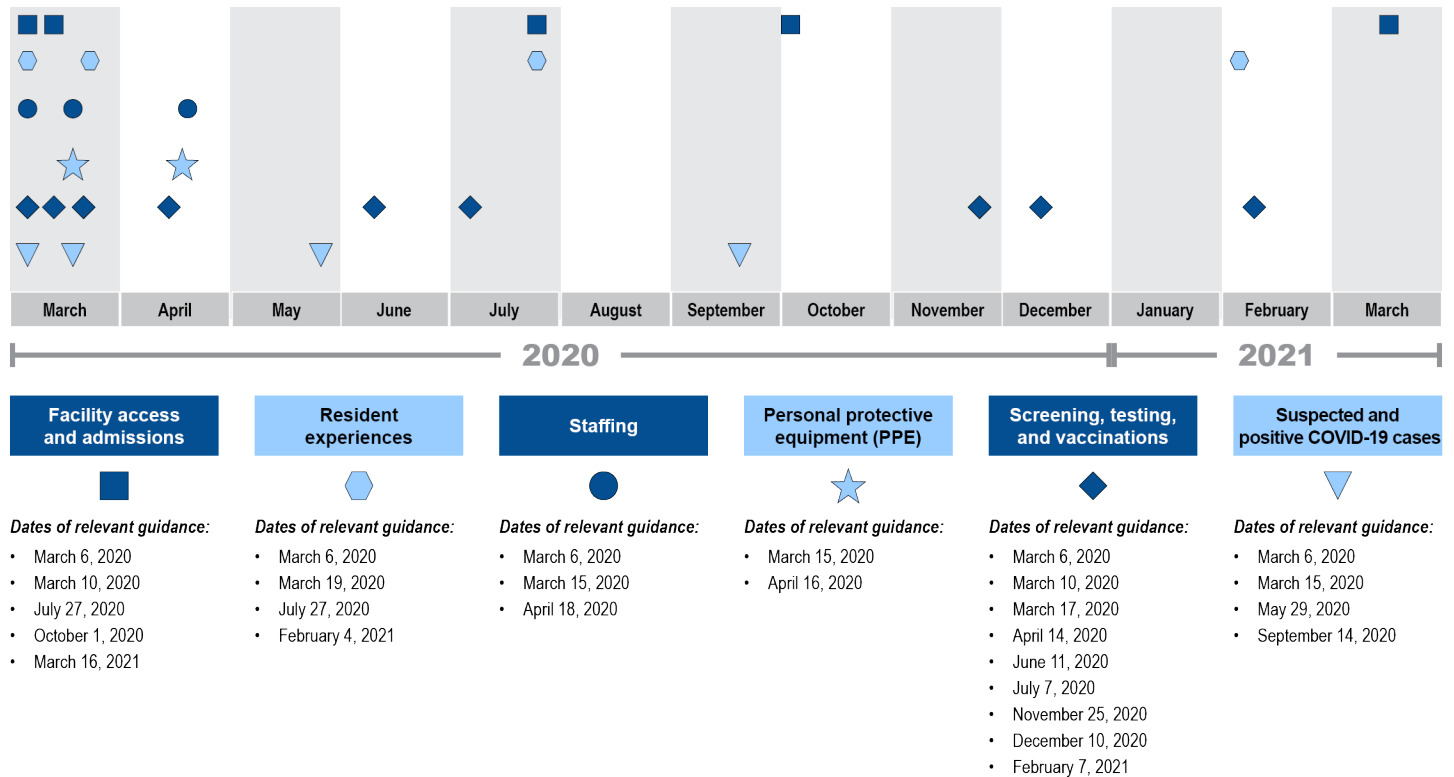
information from CDC.²³ VA guidance also evolved as access to supplies increased. For example, in March 2020, VA guidance indicated that the agency could not meet the demand for PPE, and its use should be limited to procedures likely to increase aerosols.²⁴ Subsequently, in April 2020, VA released guidance stating the agency had received adequate PPE to remove some restrictions on PPE use.²⁵

²³U.S. Department of Veterans Affairs, *Discontinuation of Transmission-Based Precautions for Patients with Confirmed COVID-19 in Healthcare Settings* (May 29, 2020), and U.S. Department of Veterans Affairs, *Update to 052920 Discontinuation of Transmission-Based Precautions for Patients with Confirmed COVID-19 in Healthcare Settings* (September 14, 2020). Since the beginning of the COVID-19 pandemic, CDC has focused on improving its knowledge of COVID-19; updating and sharing related guidance accordingly; and coordinating with agencies, such as VA, on the pandemic response. VA regularly revised guidance throughout the pandemic to align with updated CDC information.

²⁴U.S. Department of Veterans Affairs, *Coronavirus (COVID-19) Personal Protective Equipment (PPE) Use*.

²⁵U.S. Department of Veterans Affairs, *Update: Coronavirus (COVID-19) Return to a Contingency Strategy for Facemask and N95 Respirator Use* (April 16, 2020). Specifically, this guidance states the amount of PPE available was adequate for CDC PPE contingency strategies. CDC PPE contingency strategies include temporary measures during periods of anticipated supply shortages where current supply may meet the current or anticipated utilization rate, but where there may be uncertainty about adequacy of future PPE supply. Strategies include extended use of facemasks for staff encounters with multiple patients.

Figure 1: Examples of Evolving VA Guidance on Selected Topics Related to CLCs' Response to the COVID-19 Pandemic, March 2020 through March 2021



Source: GAO review of selected Department of Veterans Affairs (VA) guidance. | GAO-21-559

Note: We categorized VA guidance based on topic and selected those related to Community Living Centers (CLC) access and admissions; resident experiences pertaining to, for example, restrictions on group activities; staffing; use of personal protective equipment; Coronavirus Disease 2019 (COVID-19) screening, testing, and vaccinations; and strategies related to handling suspected and positive COVID-19 cases as examples. This guidance may pertain to CLCs specifically or to VA medical centers and Veterans Integrated Service Networks, inclusive of CLCs.

While VA initially standardized its guidance across all CLCs, over time VA issued guidance that allowed CLCs to adapt their response to the pandemic based on the local spread of COVID-19. For example, VA released guidance in July 2020 permitting leadership at individual CLCs, as well as the associated VAMCs and VISNs, to resume certain CLC services in three stages based on the prevalence of COVID-19 within the individual CLC.²⁶ (See app. II.) Specifically, individual CLCs are allowed to transition from one stage to another after meeting certain criteria and

²⁶U.S. Department of Veterans Affairs, *Community Living Center (CLC) Moving Forward Plan*.

must revert to a prior stage should a resident or staff member be diagnosed with COVID-19.

VA primarily relied upon national phone calls and emails with CLC and VISN staff to share new and updated guidance and clarify information during the pandemic.²⁷ For instance, VA officials told us they set up monthly national phone calls with CLCs to discuss the COVID-19 response and compiled CLC frequently asked questions collected from phone calls and emails to clarify guidance.

Trainings and other resources. Since March 2020, VA has compiled numerous trainings and other resources related to COVID-19, which they circulated to CLC staff to help them manage the pandemic.²⁸ (See sidebar for one example of these resources.) VA provided skills-based training for CLC staff on a variety of topics, including the following:

- Training on infection prevention and control, such as the proper donning and doffing of PPE to mitigate the spread of COVID-19. One such training used an interactive avatar to demonstrate the appropriate order to remove jewelry, perform hand hygiene, and don protective gown, N95 respirator, face shield, and gloves prior to a healthcare provider entering the room of suspected or confirmed COVID-19 cases.²⁹
- Training on certain clinical care or services that CLC staff may not typically perform. For example, VA provided online trainings for CLC nursing staff on how to perform an electrocardiogram.³⁰ As CLC access was limited to essential staff during the pandemic, CLC

²⁷According to VA officials, these national phone calls served as a forum to share information related to the COVID-19 response broadly, including discussing guidance, sharing challenges and leading practices, and offering opportunity for feedback.

²⁸VA shared over 250 trainings, tools, and other resources to help staff manage their response to the pandemic. See, for example, U.S. Department of Veterans Affairs, *Clinical Crisis Skills Training for Community Living Centers*, (Updated April 9, 2020), accessed April 5, 2021, <https://www.va.gov/covidtraining/clc.html>. Some of these trainings were developed by VA, while others were developed by CDC or other healthcare organizations.

²⁹U.S. Department of Veterans Affairs, *Donning and Doffing: Interactive Training*, accessed April 26, 2021, <https://emergencytraining.azureedge.net>.

³⁰An electrocardiogram is a test that detects and records the heart's activity, including heart beat rhythm and strength.

VA Temperature Dashboard Tool for COVID-19

In addition to guidance and training, VA officials told us they developed and shared tools with Community Living Center (CLC) staff to support their response to the pandemic. For example, VA officials involved in research on infection prevention and control told us they developed a Temperature Dashboard Tool that allowed CLC staff to track residents' daily temperatures over time. According to officials, collecting and comparing data on a resident's daily temperature can predict the probability that a resident has Coronavirus Disease 2019 (COVID-19) one week before testing positive for the virus that causes the disease. A higher body temperature--even one defined by smaller deviations from a resident's baseline than a typical fever--can be a leading indicator of COVID-19 among the elderly, according to officials. VA officials told us that they introduced the dashboard in CLCs nationwide in March 2020 after piloting it in three Veterans Integrated Service Networks.

Source: GAO interviews with Department of Veterans Affairs (VA) officials. | GAO-21-559

nursing staff told us they were trained to perform procedures, such as electrocardiograms, which are typically performed by specialists.³¹

- Training to help CLC staff prepare for a potential surge in cases. For example, VA officials told us they conducted a series of field trainings on acute care and post-acute care for COVID-19 cases for CLC nursing staff and staff temporarily reassigned to CLCs from other departments of the associated VAMC who typically did not work in acute-care settings.

VA officials told us that they shared these trainings with CLCs by posting them on VA's website, incorporating information on, and links to, certain trainings in guidance documents and discussing them on national phone calls with CLC staff. Officials also told us that staff were encouraged to take these trainings, but that they were not mandatory.

Selected CLCs Described Common Experiences Responding to the Pandemic Related to Issues Such as Evolving Guidance, Obtaining Supplies, and Staffing

Staff from the five selected CLCs described common experiences responding to the COVID-19 pandemic, such as experiences with evolving guidance, obtaining supplies, and staffing issues. (See table 1.) For example, as described earlier, staff from all five selected CLCs told us that VA provided them with frequent, rapidly evolving guidance to inform their response to the pandemic, which at times necessitated implementation on very short notice. Many of the experiences described

³¹See, for example, U.S. Department of Veterans Affairs, *Coronavirus (COVID-19) Community Living Centers – Revised 03/17/20* regarding limitations on CLC access.

by CLC staff are experiences that we and others have reported that other nursing homes also experienced during the pandemic.³²

Table 1: Common Experiences Responding to the COVID-19 Pandemic among Five Selected VA Community Living Centers (CLC)

Common experience	Description	Examples
Evolving guidance	Implementing rapidly-evolving guidance, at times on very short notice	<ul style="list-style-type: none"> Staff at the five CLCs told us it was difficult to keep up with VA’s frequent and evolving guidance on Coronavirus Disease 2019 (COVID-19). Some staff explained that because some guidance was effective immediately, they had to, for example, determine related responsibilities or ensure that staff were trained and ready to implement the changes very quickly.
Obtaining supplies	Obtaining necessary supplies, such as personal protective equipment (PPE)	<ul style="list-style-type: none"> Staff at four CLCs told us that, early in the pandemic, they had difficulty obtaining some necessary supplies, such as COVID-19 testing kits or appropriate masks to protect both CLC staff and residents from transmitting COVID-19. For example, some staff described limited amounts of COVID-19 testing kits early in the pandemic that may have made it difficult to track such transmissions.
Staffing issues	Addressing issues related to staff on sick leave or under quarantine and additional staff responsibilities	<ul style="list-style-type: none"> Staff at the five CLCs reported taking on additional responsibilities, such as feeding residents, conducting lab draws, or taking residents to medical appointments, in part because family caregivers or auxiliary staff who typically perform these tasks were not allowed in the CLC. In addition, staff at some of the CLCs described increased demand for staff—particularly during surges of COVID-19 cases—such as when nurses and other staff became ill or were required to quarantine. However, staff at one CLC told us that their staff-to-resident ratio had improved since the beginning of the pandemic because the CLC significantly reduced the capacity of the CLC by limiting the number of residents, in part so residents could each have their own room, while the number of staff remained the same.

³²For example, GAO previously reported that community nursing homes and State Veterans Homes faced similar experiences related to supplies, staffing, resident isolation, or vaccinations. See GAO, *COVID-19 In Nursing Homes: HHS Has Taken Steps In Response To Pandemic, but Several GAO Recommendations Have Not Been Implemented*, [GAO-21-402T](#) (Washington, D.C: March 17, 2021), and GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020).

A CMS Commission on COVID-19 in nursing homes made similar observations on guidance, staffing, building changes and resident isolation; see MITRE, *Coronavirus Commission on Safety and Quality in Nursing Homes: Commission Final Report*, PRS Release Number 20-2382 (McLean, Va: September 2020).

VA’s Office of Inspector General also reported similar experiences among CLC staff related to guidance, supplies, moving residents, and resident isolation. See Department of Veterans Affairs, Office of Inspector General, *Comprehensive Healthcare Inspection of Facilities’ COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, Report #21-01116-98 (March 16, 2021).

Letter

Common experience	Description	Examples
Moving residents	Moving residents to and from other facilities to accommodate infection surges	<ul style="list-style-type: none"> Staff at four of the CLCs described moving residents between facilities, such as between CLCs or between the CLC and its associated VA medical center (VAMC), to accommodate infection surges or because the CLC did not provide care for residents with COVID-19. Staff at one CLC described residents' challenges with these moves as an upheaval being in a new and unfamiliar environment, particularly for those with dementia who rely on the familiarity of their surroundings. Some staff also described their own challenges related to moving residents, including managing much longer commutes or the inability to work in the new location due to family obligations.
Building changes	Building limitations necessitated adjustments to prevent the transmission of COVID-19	<ul style="list-style-type: none"> Staff at the five CLCs described building limitations that necessitated adjustments, such as the need for more single occupancy rooms or air circulation improvements in building ventilation systems, to prevent the airborne transmission of COVID-19 within enclosed spaces. Some staff also described challenges with providing access to adequate space for residents who needed physical therapy or for residents with dementia.
Staff stress	Staff stress caring for residents during the pandemic, and fears of infecting their families	<ul style="list-style-type: none"> Staff at the five CLCs described the stress they experienced related to caring for residents, especially those at the end of life, or fears of bringing the virus home to their families during the pandemic. For example, some staff described the burden of supporting residents near death whose families were unable to be there due to the visitor restrictions and the grief they experienced related to residents' deaths. Further, staff at one CLC told us about fears of transmitting the virus to their family members, including their children or elderly parents.
Resident isolation	Residents isolated from family and friends due to visitation restrictions	<ul style="list-style-type: none"> Staff at the five CLCs told us that, over time, prohibitions on resident gatherings and restrictions on in-person visits with family and friends caused residents to feel isolated. Some staff described how the lack of visitors was difficult for residents, and how they also missed opportunities to socialize with each other or participate in activities outside the CLC. Some staff also told us that it could be difficult to tell when residents were close to dying as their health could change very quickly—especially among residents near the end of life during the pandemic—so the residents may have missed opportunities for families to say goodbye to their loved ones.
Vaccine rollout	Vaccinating CLC residents and staff as VA's highest priority	<ul style="list-style-type: none"> Staff at five of the CLCs described having sufficient vaccines for all the staff or residents who chose to receive them and did not indicate any problems with their administration. Some staff also described vaccine reluctance among staff but stated that some of the staff who initially declined subsequently agreed to be vaccinated.

Source: GAO analysis of interviews with staff at five selected Department of Veterans Affairs (VA) CLCs. | GAO-21-559

Note: We selected the five CLCs to provide variation in their quality ratings, the number of cited infection prevention and control deficiencies they received in the 2 years prior to the pandemic, their maximum bed capacities, the complexity level of the associated VAMCs, and their geographic locations.

Staff from the CLCs described how they or VA responded to each of these experiences; these responses ranged from receiving training from VA to shifting staff resources. For example:

- CLC staff told us that the training they received from VA, as well as the CLCs' associated VAMCs or VISNs, helped them implement the rapidly evolving COVID-19 guidance.
- CLC staff also said that they communicated regularly with officials from the associated VAMCs and VISNs about supplies and staffing needs. For example, staff at four CLCs explained that the VAMCs or VISNs reassigned staff to their CLCs during the pandemic, including moving nurses from outpatient clinics because of the lower demand for those services and hiring additional staff to meet increased demand at CLCs.³³
- CLC staff also noted that VA's efforts to vaccinate CLC residents and staff had been going well. VA officials told us that, as of June 6, 2021, 87 percent of CLC residents had received at least one dose of vaccine, and 84 percent had been fully vaccinated.³⁴

³³For example, VA activated its Disaster Emergency Medical Personnel System to respond to the pandemic, which was developed to deploy existing clinical and non-clinical staff to reinforce existing staff levels where needed due to an emergency or disaster. VA reported in April 2021 that it also continued to recruit and orient new personnel.

³⁴VA officials stated that the percentage of residents who have been vaccinated may change, primarily due to resident movement and also indicated that there may be CLC residents for whom vaccinations are not clinically appropriate or who decline vaccinations.

VA guidance indicates that visitors may be allowed in CLCs under certain conditions, including if more than 70 percent of residents are vaccinated for COVID-19 and the most recent positive COVID-19 case was more than 14 days prior, which will help to end residents' extended isolation. See U.S. Department of Veterans Affairs, *COVID-19: Visitations to Veterans Health Administration (VHA) Community Living Centers (CLC) and Spinal Cord Injury & Disorder (SCID) Neighborhoods* (March 16, 2021).

VA's Office of Inspector General found that VA facilities had not consistently documented or managed the COVID-19 vaccinations of CLC residents, based on its analysis of national data on vaccinations from December 14, 2020, when vaccinations began, through January 19, 2021. For example, the Inspector General found that some CLCs had used a locally developed tracking system to document why residents had not been vaccinated, such as those who refused or for whom it was medically inappropriate, and had not entered this information into the national data system. The Inspector General also found that some CLCs were unclear about whether to vaccinate certain residents, such as residents staying less than 21 days who may not have been given a first dose of the vaccine because the CLC had not yet determined how to schedule the second dose after these residents had left the CLC. VA agreed to identify and evaluate these gaps and develop a corrective action plan to resolve the concerns. See VA Office of Inspector General, *Veterans Health Administration: Inconsistent Documentation and Management of COVID-19 Vaccinations for Community Living Center Residents*, Report #21-00913-91 (April 14, 2021).

CLC staff also explained how they shared practices with each other, so that CLCs that faced later outbreaks of COVID-19 were able to learn from those who had experienced earlier waves of the pandemic.

VA Conducted Limited Oversight of Infection Prevention and Control in CLCs during the First Year of the Pandemic

VA conducted limited oversight of infection prevention and control in CLCs during the first year of the pandemic, suspending its annual inspections of CLCs and taking limited, alternative actions to ensure that CLCs were best able to prevent the spread of COVID-19. VA officials acknowledged these shortcomings.³⁵ VA described this year as a “learning period,” as the agency took important steps to limit the number of individuals entering CLCs and helped CLCs respond to a rapidly evolving pandemic in real time.

Specifically, to oversee infection prevention and control in CLCs between March 2020 and February 2021, VA did the following:

- **Suspended annual inspections of CLCs until the agency was able to conduct them virtually.** In March 2020, VA suspended its annual inspections of CLCs, periodically reevaluating the state of the pandemic to determine whether this suspension should continue.³⁶ These inspections are VA’s primary means of CLC oversight, which the agency uses to evaluate CLCs on a broad range of quality standards, including those relevant to COVID-19 mitigation. VA suspended these inspections, which the agency’s contractor typically

³⁵CMS experienced similar limitations related to its oversight of community nursing homes during the pandemic. In March 2020, the agency suspended comprehensive in-person inspections of such nursing homes. Instead, CMS required state survey agencies to conduct targeted infection prevention and control inspections and high-priority complaint investigations as long as surveyors had access to adequate PPE. Subsequently, in August 2020, CMS authorized comprehensive in-person inspections to resume as soon as state agencies had adequate resources, such as staff and PPE. See GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020).

³⁶See, for example, U.S. Department of Veterans Affairs, *Postponement of Long-Term Care Surveys* (March 6, 2020), and U.S. Department of Veterans Affairs, *Unannounced Surveys for State Veterans Homes and Community Living Centers*.

conducts in person, because of the risk of contracting or transmitting COVID-19 to CLC residents and staff as well as to inspectors.³⁷

According to VA officials, they considered conducting virtual inspections early in the pandemic, but the agency first had to modify its contract with the organization that conducts the inspections to allow for this. Once this modification was complete, VA resumed inspections virtually in February 2021.³⁸

- **Required CLCs to assess their own infection prevention and control practices related to the pandemic but did not review them in a timely manner.** In July 2020, VA required that CLCs complete a one-time self-assessment specific to their practices to prevent the transmission of COVID-19, such as hand hygiene, the appropriate use of PPE, and restrictions on visitor entry.³⁹ Many of the practices assessed align with those described in VA's guidance to help CLCs respond to the pandemic. In our review of the self-assessments, we found that CLCs identified gaps in their infection prevention and control practices.⁴⁰ For example, one CLC reported that staff were observed not conducting hand hygiene after patient care and that non-critical reusable medical equipment was observed to be visibly dirty between uses. Another CLC reported that the facility had not

³⁷According to VA guidance, while these inspections are essential for continued oversight and monitoring of CLCs, a temporary suspension to mitigate the potential spread of COVID-19 was considered to be in the best interest of residents, staff, and inspectors. See U.S. Department of Veterans Affairs, *Postponement of Long-Term Care Surveys*.

³⁸U.S. Department of Veterans Affairs, *Virtual Survey Process for Department of Veterans Affairs (VA) Community Living Centers (CLC) and Spinal Cord Injury/Disorders (SCI/D) Long Term Care Unites (VIEWS 4420960)* (February 2, 2021).

³⁹U.S. Department of Veterans Affairs, *Unannounced Surveys for State Veterans Homes and Community Living Centers*. CMS developed the self-assessment tool for use by community nursing homes, and VA adapted it for its own use. The self-assessment includes questions related to standard and transmission-based precautions, including hand hygiene and PPE; resident care; infection prevention and control standards, policies, and procedures; infection surveillance; visitor entry; education, monitoring, and screening of staff; and staffing in emergencies.

⁴⁰GAO previously found that 95 percent of CLCs were cited for infection control deficiencies prior to the pandemic, with some CLCs cited in consecutive years. These deficiencies often pertained to the same gaps we identified in our review of the self-assessments—such as hand hygiene and appropriate use of PPE. See GAO, *VA Health Care: Community Living Centers Were Commonly Cited for Infection Control Deficiencies Prior to the COVID-19 Pandemic*, [GAO-21-195R](#) (Washington, D.C.: Jan. 6, 2021). In addition, GAO previously found that prior to COVID-19 most nursing homes that participate in Medicare and Medicaid had infection control deficiencies, with more than half of the nursing homes having persistent problems. See GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, [GAO-20-576R](#) (Washington, D.C.: May 20, 2020).

conducted the appropriate screening, restriction, and education for visitors entering the CLC. According to VA officials, although they reviewed the results of the self-assessments with CLCs, they did not do so in a timely manner, which would have allowed CLCs to make more immediate improvements. Specifically, CLCs were required to complete the self-assessment in July 2020; in September of that year, VA officials told us they had not reviewed the results, but indicated they had done so by December. VA officials told us they do not have plans to require that CLCs complete the self-assessment again now that annual inspections have resumed.

- **Relied on informal communications not designed to assess infection prevention and control.** VA officials told us they relied on informal communications with CLC staff to discuss their COVID-19 status as well as infection prevention and control practices—including monthly phone calls established in response to the pandemic and pre-established quarterly phone calls that included VISN leadership. During these phone calls, which officials said have continued beyond VA’s resumption of annual inspections, CLC staff can ask questions and obtain real-time information about the pandemic response broadly, including but not limited to infection prevention and control. Given the informal nature of these calls, they were not designed to allow VA to assess CLC infection prevention and control practices in a standardized and comprehensive manner.

VA could benefit from assessing the decisions and actions related to its oversight of infection prevention and control in CLCs during the first year of the pandemic. When asked in May 2021 whether the agency had plans for assessing its oversight of infection prevention and control in CLCs during the pandemic, VA officials told us that they had discussed conducting such an assessment in the future, including some ideas of what an assessment could include. Officials indicated they would develop a plan for conducting such an assessment by August 2021. Such an assessment would align with VA’s plans to assess and report on the agency’s overall response to the pandemic, which the agency stated is essential as a learning organization.⁴¹ In addition, it would be consistent

⁴¹In October 2020, VA issued an initial report evaluating the agency’s response between January 2020 and June 2020, covering a period prior to, as well as approximately the first four months of, the pandemic. See U.S. Department of Veterans Affairs, *Veterans Health Administration (VHA) Coronavirus Disease 2019 (COVID-19) Response Report* (October 27, 2020). The report states that these types of assessments are essential to VA as a learning organization and that the agency plans to continue them and consider strategic follow-up actions informed by the agency’s experiences.

with the agency's strategic goal to promote continuous quality improvement among its geriatrics and extended care programs, which include CLCs, as well as federal standards for internal control, which require that agencies evaluate internal controls issues and address identified deficiencies.⁴²

By conducting a retrospective assessment of its oversight of infection prevention and control in CLCs during the pandemic, VA could better prepare to help CLCs mitigate future infectious disease outbreaks among this vulnerable population, rather than having to react in real time as it often did during the pandemic. VA's first two reports on the agency's overall response to the pandemic, covering the period January 2020 through December 2020, describe the COVID-19-specific actions the agency took to protect CLC residents and staff by, for example, restricting access and admissions, suspending group activities, and testing and vaccinating residents and staff, as outlined in VA guidance.⁴³ However, these reports do not indicate whether the agency oversaw CLCs' implementation of these actions or how officials determined their effectiveness, and do not include an assessment of VA's oversight of infection prevention and control broadly in the absence of annual inspections.⁴⁴ The results of a more comprehensive and retrospective assessment of VA oversight of infection prevention and control in CLCs could help the agency identify any lessons learned and needed changes. Further, it could also help VA identify successful decisions and actions taken to protect CLC residents and staff.

Conclusions

VA's management of the COVID-19 pandemic for CLCs is of critical importance, given that veterans who receive care and staff who work in

⁴²U.S. Department of Veterans Affairs, *Geriatrics and Extended Care, GEC Mission, Vision, Goals*, accessed April 30, 2021, https://www.va.gov/GERIATRICS/GEC_Mission_Vision_Goals.asp, and [GAO-14-704G](#).

⁴³U.S. Department of Veterans Affairs, *Veterans Health Administration (VHA) Coronavirus Disease 2019 (COVID-19) Response Report*, and U.S. Department of Veterans Affairs, *Veterans Health Administration (VHA) Coronavirus Disease 2019 (COVID-19) Response Report – Annex A* (May 10, 2021).

⁴⁴VA found that the agency effectively participated in monitoring and dissemination of evolving guidelines to prevent, diagnose, and treat COVID-19 to protect CLC residents, but the report did not define or otherwise indicate a standard for evaluating this statement. See U.S. Department of Veterans Affairs, *Veterans Health Administration (VHA) Coronavirus Disease 2019 (COVID-19) Response Report – Annex A*.

this nursing home setting are at increased risk of contracting or transmitting the disease. Although VA was active in generating guidance, training, and other support for CLCs, the agency conducted limited oversight of infection prevention and control in CLCs during the first year of the pandemic. Between March 2020 and February 2021, VA suspended annual, in-person CLC inspections—which the agency uses to determine whether CLCs meet infection prevention and control quality standards and have since resumed virtually—and implemented alternative means of oversight that were limited in different ways.

It is understandable that VA faced challenges that affected its ability to oversee nursing homes during the pandemic, as information about COVID-19 and its mitigation rapidly evolved, and the agency had to respond in real time. Assessing its decisions and actions related to its oversight during this period—looking at both successful decisions and actions as well as missed opportunities to protect this vulnerable population—would align with VA’s plans to review the agency’s overall response to the pandemic and better prepare the agency to help CLCs mitigate future infectious disease outbreaks.

Recommendation for Executive Action

The Department of Veterans Affairs Under Secretary for Health should conduct a retrospective assessment of VA’s oversight of infection prevention and control in CLCs during the COVID-19 pandemic to identify lessons learned and be better prepared for future infectious disease outbreaks. (Recommendation 1)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in Appendix III, VA concurred with our recommendation in principle. VA stated that by January 2022, it will review the results of CLCs’ July 2020 assessments of their infection prevention and control practices to identify any trends and require that CLCs develop related corrective action plans. We agree this may help CLCs improve their infection prevention and control practices and be better prepared for future infectious disease outbreaks. Our recommendation intended that VA conduct a broader assessment of its decisions and actions related to its oversight of infection prevention and control in CLCS during the COVID-19 pandemic; that this assessment

potentially include, but not be limited to, decisions that affected the timeliness of the agency's review of CLCs' assessments; and that VA's broader assessment identify lessons learned for the future. We encourage VA to conduct such an assessment as well.

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

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

A handwritten signature in black ink, appearing to read "Sharon Silas". The signature is fluid and cursive, with the first name "Sharon" and the last name "Silas" clearly distinguishable.

Sharon M. Silas
Director, Health Care

List of Addressees

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

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

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

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

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate

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

The Honorable Frank Pallone, Jr.

Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy and Commerce
House of Representatives

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

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

The Honorable Mark Takano
Chairman
Committee on Veterans' Affairs
House of Representatives

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

The Honorable Julia Brownley
Chairwoman
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Edward J. Markey
United States Senate

The Honorable Elizabeth Warren
United States Senate

Appendix I: Examples of Changes to VA Guidance for Selected CLC Services and Procedures during COVID-19, March 2020 to March 2021

Table 2: Examples of Changes to VA Guidance for Selected CLC Services and Procedures during COVID-19, March 2020 to March 2021

Guidance topic	Summary of guidance and date issued
Facility access and admissions	<p>March 6, 2020</p> <ul style="list-style-type: none"> • New admissions to CLCs will be based on priority system and will be placed under quarantine and observation for COVID-19 symptoms for 14 days. • CLCs should limit entry of visitors and staff, who should be screened prior to entry. <p>March 10, 2020</p> <ul style="list-style-type: none"> • New admissions to CLCs will be suspended except for those already in another VA facility. • No visitors allowed entry except at the end of a resident's life. <p>July 27, 2020</p> <ul style="list-style-type: none"> • Based on the prevalence of COVID-19, CLCs may permit entry to community admissions and limited visitors. <p>October 1, 2020</p> <ul style="list-style-type: none"> • While visitors should remain limited, CLCs should regularly reassess their visitation plans to balance resident welfare with infection control risks. <p>March 16, 2021</p> <ul style="list-style-type: none"> • Visitors allowed in CLCs under certain conditions, including if more than 70 percent of residents are vaccinated for COVID-19, and the most recent positive COVID-19 case was more than 14 days prior.

**Appendix I: Examples of Changes to VA
Guidance for Selected CLC Services and
Procedures during COVID-19, March 2020 to
March 2021**

Guidance topic	Summary of guidance and date issued
Resident experiences	<p>March 6, 2020</p> <ul style="list-style-type: none"> • CLCs should limit social activities, such as meals and field trips. • Medical visits outside the CLC should be rare and telehealth should be used instead. <p>March 19, 2020</p> <ul style="list-style-type: none"> • Residents with necessary medical appointments outside the CLC should be placed under COVID-19 observation for 14 days after returning to the CLC. <p>July 27, 2020</p> <ul style="list-style-type: none"> • Based on the prevalence of COVID-19, residents are allowed to attend in-person activities with certain precautions. • Based on the prevalence of COVID-19, residents may attend medical appointments in VA Medical Center under certain precautions and without 14-day observation. <p>February 4, 2021</p> <ul style="list-style-type: none"> • To mitigate COVID-19 social isolation, CLCs can request VA funding to enhance safe, small-group activities.
Staffing	<p>March 6, 2020</p> <ul style="list-style-type: none"> • Where possible, the number of staff entering the CLC should be limited and dedicated CLC staff should be used. <p>March 15, 2020</p> <ul style="list-style-type: none"> • Asymptomatic staff who are exposed to COVID-19-positive patients can continue to work. <p>April 18, 2020</p> <ul style="list-style-type: none"> • Staff suspected or confirmed to have COVID-19 should either be tested or wait until symptoms resolve—at least seven days after symptoms appeared—before returning to work.
Personal Protective Equipment (PPE)	<p>March 15, 2020</p> <ul style="list-style-type: none"> • When PPE supplies cannot meet demand, PPE should be prioritized for high-risk procedures likely to produce aerosols. <p>April 16, 2020</p> <ul style="list-style-type: none"> • VA recently received a large supply of N95 respirators. Staff caring for COVID-19-positive residents should use N95 respirators. • VA should have plans for extended use or decontamination of masks in the event of disrupted supply chains.

**Appendix I: Examples of Changes to VA
Guidance for Selected CLC Services and
Procedures during COVID-19, March 2020 to
March 2021**

Guidance topic	Summary of guidance and date issued
Screening, testing, and vaccinations	<p>March 6, 2020</p> <ul style="list-style-type: none"> Residents should be screened daily for COVID-19 symptoms. <p>March 10, 2020</p> <ul style="list-style-type: none"> Staff should be screened for COVID-19 symptoms. <p>March 17, 2020</p> <ul style="list-style-type: none"> Residents should be screened for temperatures higher than 100.4 degrees. <p>April 14, 2020</p> <ul style="list-style-type: none"> With recent increases in testing kits, staff and residents should undergo baseline COVID-19 testing. <p>June 11, 2020</p> <ul style="list-style-type: none"> CLC residents should be tested upon admission to a CLC. Residents who leave the CLC for outside medical appointments should be tested weekly. Residents and staff should be tested as soon as a new case is identified at the facility. Those who initially test negative should continue to be tested weekly until 14 days have passed since the most recent positive case in the facility. <p>July 7, 2020</p> <ul style="list-style-type: none"> Residents should be screened for temperatures higher than 99 degrees. <p>November 25, 2020</p> <ul style="list-style-type: none"> Staff should be tested based on risk. Residents who leave the CLC for outside medical appointments should be tested based on risk rather than weekly. Residents and staff should be tested as soon as a new case is identified at the facility. Those who initially test negative should be tested twice weekly until 14 days have passed since the most recent positive case in the facility. <p>December 10, 2020</p> <ul style="list-style-type: none"> Residents and staff will be among the first vaccinated by VA. <p>February 7, 2021</p> <ul style="list-style-type: none"> CLCs must continue prevention activities against COVID-19, including testing and screening procedures, regardless of the vaccination status of residents.
Suspected and positive COVID-19 cases	<p>March 6, 2020</p> <ul style="list-style-type: none"> CLC residents with suspected cases of COVID-19 should be isolated. <p>March 15, 2020</p> <ul style="list-style-type: none"> Staff with COVID-19 symptoms should cease patient care and leave work. <p>May 29, 2020</p> <ul style="list-style-type: none"> It is recommended that certain COVID-19-positive patients be tested before discontinuing isolation.^a <p>September 14, 2020</p> <ul style="list-style-type: none"> Using the time since symptoms first appeared and resolved is the preferred way to determine the infectiousness of certain patients.^b

Source: GAO review of select Department of Veterans Affairs (VA) guidance. | GAO-21-559

Note: We categorized VA guidance based on topic and selected those related to Community Living Center (CLC) access and admissions; resident experiences pertaining to, for example, restrictions on group activities; staffing; use of personal protective equipment; Coronavirus Disease 2019 (COVID-19) screening, testing, and vaccinations; and strategies related to handling suspected and positive COVID-19 cases as examples. This guidance may pertain to CLCs specifically or to Veterans Affairs Medical Centers or Veterans Integrated Service Networks, inclusive of CLCs.

**Appendix I: Examples of Changes to VA
Guidance for Selected CLC Services and
Procedures during COVID-19, March 2020 to
March 2021**

^aThis guidance aligns with Centers for Disease Control (CDC) recommendations and pertains to symptomatic patients for whom testing should be considered if the timing of symptom onset is unclear, as well as to symptomatic and asymptomatic patients who are severely immunocompromised. Otherwise, using a time-based or symptom-based strategy is preferred.

^bThis guidance aligns with CDC recommendations and pertains to patients with mild to moderate illness who are not severely immunocompromised, and patients with severe or critical illness who are severely immunocompromised. A test-based strategy is no longer recommended, with some exceptions, because in the majority of cases it results in prolonged isolation of patients who continue to shed detectable virus but are no longer infectious.

Appendix II: VA Stages for Resuming Certain CLC Services Based on the Prevalence of COVID-19

Appendix II: VA Stages for Resuming Certain CLC Services Based on the Prevalence of COVID-19

Table 3: VA Stages for Resuming Certain CLC Services Based on the Prevalence of COVID-19

CLC service	Stage 1 (most restrictive) ^a	Stage 2 ^b	Stage 3 (least restrictive) ^c
Admissions and Screening	No community admissions except in rare circumstances 14-day observation upon admission to CLC	No community admissions except for veterans needing hospice care 14-day observation upon admission to CLC	Admission from community allowed with a negative COVID-19 test 14-day observation upon admission to CLC
Visitors	No visitors unless resident is actively dying	One adult visitor allowed at a time, per resident, in an outdoor area	Visitation allowed indoors; no more than two visitors per resident
Activities and Dining	COVID-19 positive residents must stay in their room COVID-19 negative residents can join activities with social distancing and the use of face masks	Less than 10 COVID-19 negative residents can join activities with social distancing and the use of face masks Communal dining limited by social distancing	More than 10 residents can attend group activities
Appointments	All appointments outside the CLC should be conducted virtually as able 14-day observation upon re-entry to CLC	Necessary appointments in VA medical center (VAMC) can be scheduled 14-day observation not needed if certain precautions are followed Necessary appointments off campus still require 14-day observation upon return to CLC	No restrictions

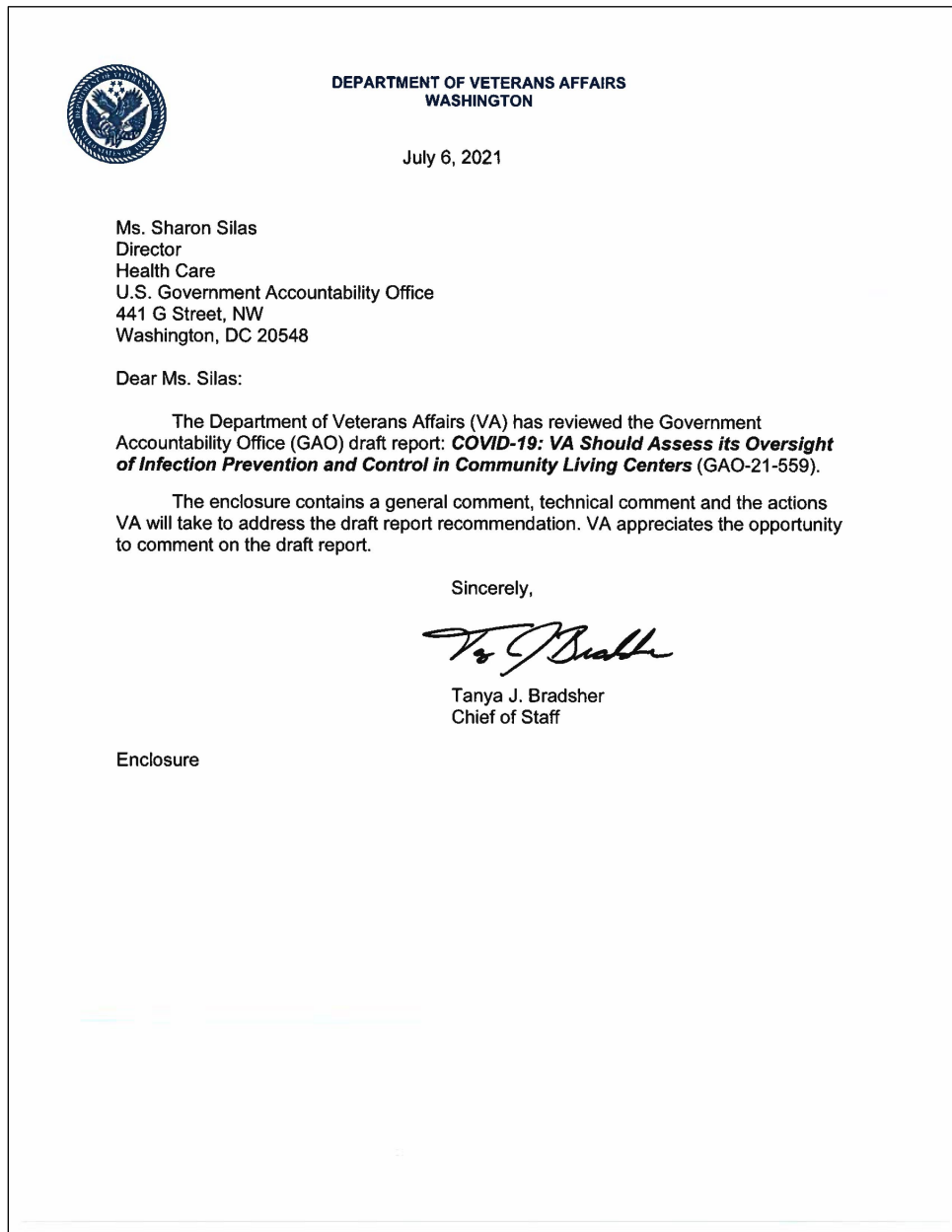
Source: U.S. Department of Veterans Affairs (VA), Community Living Center (CLC) Moving Forward Plan (July 27, 2020). | GAO-21-559

^aVA guidance requires that VAMCs follow a separate phased approach to resume normal operations, with phase 1 having the most restrictions and phase 3 having the least restrictions. CLCs must remain in stage 1 while the associated VAMC is in phase 1 or phase 2. During this stage, CLCs should minimize movement within the facility regardless of Coronavirus Disease 2019 (COVID-19) transmission within the local community.

^bCLCs may transition to this stage after no new cases of COVID-19 among residents or staff have occurred for 21 days while operating under stage 1, and if the associated VAMC is also operating under the lowest level of restrictions. However, the CLC must return to stage 1 if a new confirmed or suspected case of COVID-19 is identified among residents or staff.

^cCLC may transition to this stage after no new cases of COVID-19 among residents or staff have occurred for 21 days while operating under stage 2. However, the CLC must return to stage 1 if a new confirmed or suspected case of COVID-19 is identified among residents or staff.

Appendix III: Comments from the Department of Veterans Affairs



**Appendix III: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***COVID-19: VA Should Assess its Oversight of Infection Prevention and
Control in Community Living Centers***
(GAO-21-559)

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should conduct a retrospective assessment of VA's oversight of infection prevention and control in CLCs during the COVID-19 pandemic to identify lessons learned and be better prepared for future infectious disease outbreaks.

VA Comment: Concur in principle. The Veterans Health Administration's (VHA) Office of Geriatrics and Extended Care (GEC) will continue to assess the completed self-assessments distributed to Community Living Centers (CLC) in July 2020 to identify trends in self-reported deficiencies of infection control practices. Identified trends will be communicated to VHA Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) leadership who will be required to develop a corrective action plan within 30 days of notification. Corrective action plan(s) will be monitored by GEC Program Office until completion.

Target Completion Date: January 31, 2022

**Appendix III: Comments from the Department
of Veterans Affairs**

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***COVID-19: VA Should Assess its Oversight of Infection Prevention and
Control in Community Living Centers***
(GAO-21-559)

General Comments:

VHA monitored the distribution of grant funds which were awarded to CLCs to decrease social isolation and facilitate the use of tools and equipment to reduce deconditioning.

To address social isolation, VHA GEC provided individualized consultation with each VISN and collaborated with the Office of Connected Care to leverage technology to promote routine opportunities that keep Veterans connected with families via non face to face methods, such as telephone and video visits.

GEC provided education in a timely manner for immediate implementation of care practices, such as temperature screening and a coronavirus disease 2019 (COVID-19) nursing template.

VHA's infection prevention and control approaches, monitoring of CLC COVID-19 cases and rapid COVID-19 vaccination administration has significantly protected the lives and health of the highly vulnerable residents residing in VA CLCs.

Veterans residing in CLCs and the CLC staff were among the first in VA to be offered the Food and Drug Administration-Emergency Use Authorized COVID-19 vaccines. VA rapidly distributed COVID-19 vaccines to protect CLC residents.

Text of Appendix III: Comments from the Department of Veterans Affairs

July 6, 2021

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: COVID-19: VA Should Assess its Oversight of Infection Prevention and Control in Community Living Centers (GAO-21-559).

The enclosure contains a general comment, technical comment and the actions VA will take to address the draft report recommendation. VA appreciates the opportunity to comment on the draft report.

Sincerely,

Tanya J. Bradsher Chief of Staff

Enclosure

Recommendation 1: The Department of Veterans Affairs Under Secretary for Health should conduct a retrospective assessment of VA's oversight of infection prevention and control in CLCs during the COVID-19 pandemic to identify lessons learned and be better prepared for future infectious disease outbreaks.

VA Comment: Concur in principle. The Veterans Health Administration's (VHA) Office of Geriatrics and Extended Care (GEC) will continue to assess the completed self- assessments distributed to Community Living Centers (CLC) in July 2020 to identify trends in self-reported deficiencies of infection control practices. Identified trends will be communicated to VHA Veterans

Integrated Service Network (VISN) and VA Medical Center (VAMC) leadership who will be required to develop a corrective action plan within 30 days of notification. Corrective action plan(s) will be monitored by GEC Program Office until completion.

Target Completion Date: January 31, 2022

General Comments:

VHA monitored the distribution of grant funds which were awarded to CLCs to decrease social isolation and facilitate the use of tools and equipment to reduce deconditioning.

To address social isolation, VHA GEC provided individualized consultation with each VISN and collaborated with the Office of Connected Care to leverage technology to promote routine opportunities that keep Veterans connected with families via non face to face methods, such as telephone and video visits.

GEC provided education in a timely manner for immediate implementation of care practices, such as temperature screening and a coronavirus disease 2019 (COVID-19) nursing template.

VHA's infection prevention and control approaches, monitoring of CLC COVID-19 cases and rapid COVID-19 vaccination administration has significantly protected the lives and health of the highly vulnerable residents residing in VA CLCs.

Veterans residing in CLCs and the CLC staff were among the first in VA to be offered the Food and Drug Administration-Emergency Use Authorized COVID-19 vaccines. VA rapidly distributed COVID-19 vaccines to protect CLC residents.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas, (202) 512-7114 or silass@gao.gov

Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Karen Belli (Analyst-in-Charge), Kye Briesath, and Naomi Joswiak made key contributions to this report. Also contributing were Laurie Pachter, Jeffrey Tamburello, and Jennifer Whitworth.

GAO's Mission

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

Obtaining Copies of GAO Reports and Testimony

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

Order by Phone

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

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

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

Connect with GAO

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

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

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

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

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

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

Strategic Planning and External Liaison

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



Please Print on Recycled Paper.