

GAO@100 Highlights

Highlights of [GAO-21-559](#), a report to congressional addressees

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.

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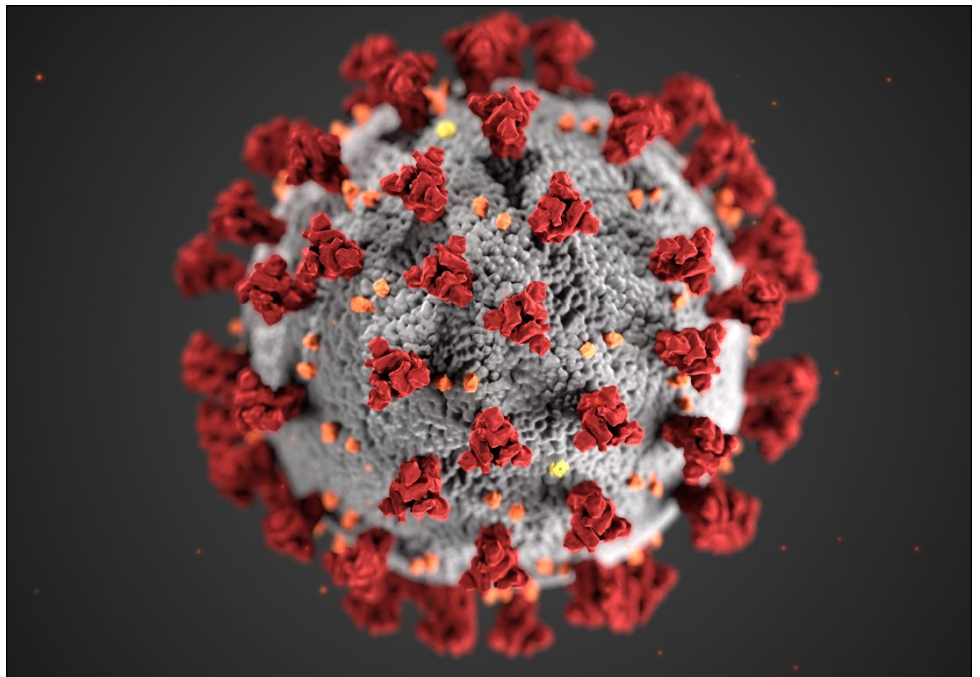
COVID-19

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.