

# Nursing home oversight during the COVID-19 pandemic

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## Abstract

**Background/objectives:** Regulatory oversight has been a central strategy to assure nursing home quality of care for decades. In response to COVID-19, traditional elements of oversight that relate to resident care have been curtailed in favor of implementing limited infection control surveys and targeted complaint investigations. We seek to describe the state of nursing home oversight during the pandemic to facilitate a discussion of whether and how these activities should be altered going forward.

**Design and setting:** In a retrospective study, we describe national oversight activities in January–June 2020 and compare these activities to the same time period from 2019. We also examine state-level oversight activities during the peak months of the pandemic.

**Participants:** United States nursing homes.

**Data:** Publicly available Quality, Certification, and Oversight Reports (QCOR) data from the Centers for Medicare and Medicaid Services (CMS).

**Measurements:** Number of standard, complaint, and onsite infection surveys, number of deficiencies from standard and complaint surveys, number of citations by deficiency tag, and number and amount of civil monetary penalties.

**Results:** The number of standard and complaint surveys declined considerably in the second quarter of 2020 relative to the same time frame in 2019. Deficiency citations generally decreased to near zero by April 2020 with the exception of infection prevention and control deficiencies and citations for failure to report COVID-19 data to the national health safety network. Related enforcement actions were down considerably in 2020, relative to 2019.

**Conclusion:** In the months since COVID-19 first impacted nursing homes, regulatory oversight efforts have fallen off considerably. While CMS implemented universal infection control surveys and targeted complaint investigations, other routine aspects of oversight dropped in light of justifiable limits on nursing home entry. Going forward, we must develop policies that allow regulators to balance the demands of the pandemic while fulfilling their responsibilities effectively.

## KEYWORDS

COVID-19, nursing home, oversight, regulation

## 1 | INTRODUCTION

On August 17, 2020, the Centers for Medicare and Medicaid Services (CMS) announced that state survey agencies (SSAs), the entities with primary responsibility for monitoring and enforcing compliance with nursing home standards of care, could resume routine survey and certification activities.<sup>1</sup> Coming 5 months after CMS scaled back oversight efforts in response to COVID-19, the August directive recognizes the importance of nursing home oversight and the unique challenges of the pandemic, which has decimated nursing homes across the country. In pushing for states to resume standard state inspection activities, CMS acknowledges the ongoing risks, noting that on-site inspections should occur only when states “have the resources (e.g., staff and/or PPE [Personal Protective Equipment]) to do so.”<sup>2</sup>

The push to bring routine oversight activities back online reflects the key role that regulation has played historically in the nursing home sector. Since the Nursing Home Reform Act of 1987, detailed standards and ongoing monitoring and enforcement activities have aimed to protect nursing home residents and assure a minimal level of quality and focus on resident outcomes.<sup>3</sup> Most stakeholders support the need for consistent regulation in the sector, even as some argue that nursing home oversight could be more efficient and effective.<sup>4</sup> In fact, as recently as the summer of 2019, the U.S. Senate held hearings that detailed substantial lapses in quality of care and called for bolstered oversight and enforcement in the sector.<sup>5</sup>

Supported by the collection of detailed resident assessment, staffing, and ownership data, a cornerstone of nursing home oversight is the in-person presence of state and federal surveyors who assess compliance with existing care standards and investigate reported complaints and incidents.<sup>6</sup> As outlined in federal statute, government agencies (typically state departments of health) conduct nursing home recertification visits on a roughly annual basis and, when deficiencies are found, use a range of sanctions to enforce compliance, including civil monetary penalties and, less frequently, more severe sanctions like termination from the Medicare and Medicaid programs.<sup>7</sup>

In response to COVID-19, CMS made a number of changes that scaled back and re-focused nursing home oversight. On March 13, CMS restricted outside visitation into nursing homes, including family members, ombudsmen, and other volunteers who often advocate for residents.<sup>8</sup> Then, on March 23, CMS directed SSAs to limit their inspections to focus on infection control or, when necessary, respond to complaints and facility-reported incidents posing immediate jeopardy to residents.<sup>9</sup> In addition to temporary waivers granting nursing homes flexibility in areas such as submission of resident assessment and staffing data, CMS

### Key Points

- In response to COVID-19, CMS substantially curtailed traditional elements of nursing home oversight in favor of limited infection control surveys and targeted complaint investigations.
- Enhanced oversight is not a solution to help nursing homes weather the pandemic, but regulators still have an important role to play in protecting residents.
- We discuss several elements that could help support these efforts and allow regulators to balance the demands of the pandemic while fulfilling oversight responsibilities effectively.

### Why Does this Paper Matter?

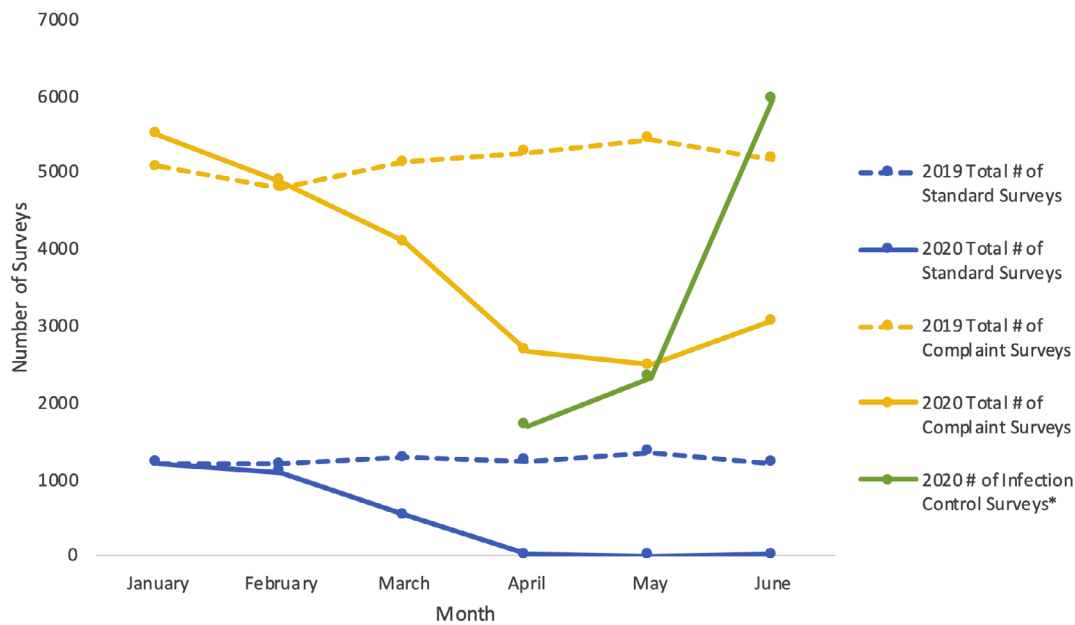
Regulatory oversight has been a central component of assuring nursing home quality of care for decades. We describe how COVID-19 curtailed oversight activities and discuss strategies to balance oversight concerns with the distinct challenges of the pandemic.

pointed to these changes as a strategy to focus resources on resident care and not “routine paperwork.”<sup>10</sup> CMS also directed states to complete targeted infection control surveys at all nursing homes by July 31, 2020.<sup>11</sup> Most states reported meeting this deadline, although some stakeholders have questioned the thoroughness of these inspections in light of the relatively low rate of deficiency citations compared to previous, non-pandemic years.<sup>12</sup> Beginning in June, CMS gave states discretion to resume some onsite survey activities, provided that local case rates were sufficiently low,<sup>11</sup> followed by the resumption of routine inspections from August 17th forward, again with some state discretion.<sup>2</sup> In light of these changes, we sought to describe the state of nursing home oversight during the COVID-19 pandemic and to stimulate discussion of how best to approach these activities as the current crisis evolves and to prepare for future emergencies that might present similar challenges.

## 2 | METHODS

### 2.1 | Overview

We used publicly available Quality, Certification, and Oversight Reports (QCOR) data from CMS to document nursing



**FIGURE 1** Number of standard, complaint, and infection control surveys from January to June in 2019 and 2020. \*The number of infection control surveys is derived by subtracting the number of complaint and standard surveys in QCOR data from the total number of on-site surveys in other publicly-reported data. The number of infection control surveys we present is a lower bound, as some infection control surveys might occur on the same day as another type of survey in the data [Color figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.com)]

home oversight activities in the first half of the 2020 calendar year. In doing so, we seek to describe survey activities during the course of the pandemic thus far, compare these activities to the same months of 2019, and examine cross-state differences. Given the ongoing pandemic, our goal is to describe the state of nursing home oversight during the pandemic's early months and facilitate consideration of whether these activities should be altered in the face of continued challenges.

## 2.2 | Data sources

CMS maintains the QCOR website,<sup>13</sup> which includes information for Medicare- and Medicaid-certified providers, such as nursing homes, home health and hospice agencies, and hospitals. QCOR imports data from CMS's CASPER data platform and provides summarized survey and certification data, including on-site inspection reports. For nursing homes in particular, QCOR includes 10 years of information on active provider counts; infection control, recertification, and complaint survey activity; deficiency frequency, type, and severity; and enforcement actions, including civil monetary penalties (CMPs). Information is uploaded to the QCOR website weekly, but there is a roughly 2-month lag between the survey and its appearance on QCOR.<sup>14</sup> Our analyses use data extracted on October 15, 2020, with the exception of one element on infection control surveys extracted on July 7, 2020.

## 2.3 | Analyses

Our analyses focus on nursing home oversight activities in calendar year 2020; we generally examine January 1–June 30 and use the same time period of 2019 for reference. We first assess the number and percent of facilities with standard and complaint surveys for 2019 and 2020 between January and June, by month, at both the national and state levels. For 2020, we add in the CMS-mandated infection control surveys. We further examine the number of care-related deficiencies identified in these surveys nationally, by month, to compare the results to trends over the same months in 2019. We then describe the types of deficiencies that were cited in the first half of 2020 to give an indication of how this evolved during the year. Given the pause in standard survey activities after March 23 and the increased reliance on complaint surveys to identify general quality concerns, we assess the number and percent of nursing homes that had a complaint survey, by month and state. Finally, to examine enforcement, we assess CMP trends by month for the first half of 2020 and compare these trends to 2019.

## 2.4 | Limitations

Some have noticed discrepancies between CMS public statements and elements of the QCOR data, in particular around the number of deficiencies.<sup>15</sup> It is unclear whether these

**TABLE 1** Onsite infection, standard, and complaint nursing home surveys by state

State	Onsite infection surveys			Standard surveys		Complaint surveys	
	March 1–June 26			March 1–June 30		Total # of surveys	Average % NHs surveyed
	Number of NHs surveyed	Number of NHs in state	% of NHs surveyed	Total # of surveys	Average % NHs surveyed		
Alabama	94	228	41%	8	1%	9	1%
Alaska	9	19	47%	2	3%	5	6%
Arizona	145	146	99%	4	1%	14	2%
Arkansas	220	227	97%	20	2%	165	17%
California	1155	1194	97%	43	1%	4622	45%
Colorado	206	225	92%	2	0%	91	10%
Connecticut	214	216	99%	0	0%	22	2%
Delaware	47	47	100%	2	1%	12	6%
District of Columbia	14	18	78%	0	0%	1	1%
Florida	683	698	98%	36	1%	517	17%
Georgia	131	358	37%	6	0%	49	3%
Hawaii	38	45	84%	2	1%	7	4%
Idaho	48	82	59%	3	1%	3	1%
Illinois	656	721	91%	29	1%	224	7%
Indiana	509	533	95%	25	1%	306	13%
Iowa	283	434	65%	2	0%	89	5%
Kansas	201	331	61%	19	1%	112	8%
Kentucky	282	285	99%	9	1%	100	8%
Louisiana	278	278	100%	15	1%	73	7%
Maine	64	93	69%	2	1%	30	8%
Maryland	56	226	25%	4	0%	39	4%
Massachusetts	237	376	63%	0	0%	10	1%
Michigan	438	441	99%	18	1%	181	10%
Minnesota	327	368	89%	10	1%	313	17%
Mississippi	140	204	69%	7	1%	20	2%
Missouri	475	522	91%	25	1%	175	8%
Montana	67	71	94%	0	0%	6	2%
Nebraska	115	201	57%	6	1%	38	4%
Nevada	66	66	100%	4	2%	14	5%
New Hampshire	63	74	85%	2	1%	7	2%
New Jersey	224	363	62%	17	1%	34	2%
New Mexico	44	71	62%	0	0%	15	5%
New York	536	619	87%	12	0%	700	26%
North Carolina	419	428	98%	14	1%	248	14%
North Dakota	79	80	99%	5	2%	79	24%
Ohio	953	953	100%	41	1%	202	5%
Oklahoma	234	298	79%	5	0%	9	1%
Oregon	130	130	100%	1	0%	23	4%
Pennsylvania	217	695	31%	25	1%	341	11%

(Continues)

TABLE 1 (Continued)

State	Onsite infection surveys			Standard surveys		Complaint surveys	
	March 1–June 26			March 1–June 30			
	Number of NHs surveyed	Number of NHs in state	% of NHs surveyed	Total # of surveys	Average % NHs surveyed	Total # of surveys	Average % NHs surveyed
Rhode Island	80	80	100%	4	1%	63	18%
South Carolina	135	190	71%	10	1%	27	4%
South Dakota	104	104	100%	5	1%	6	1%
Tennessee	292	316	92%	19	2%	232	17%
Texas	1191	1219	98%	58	1%	2021	36%
Utah	80	98	82%	3	1%	7	2%
Vermont	29	35	83%	0	0%	9	6%
Virginia	189	287	66%	2	0%	16	1%
Washington	206	205	100%	9	1%	936	68%
West Virginia	55	123	45%	2	0%	0	0%
Wisconsin	245	355	69%	17	1%	87	6%
Wyoming	36	37	97%	2	1%	7	5%
Total	12,739	15,413	83%	556	1%	12,316	10%

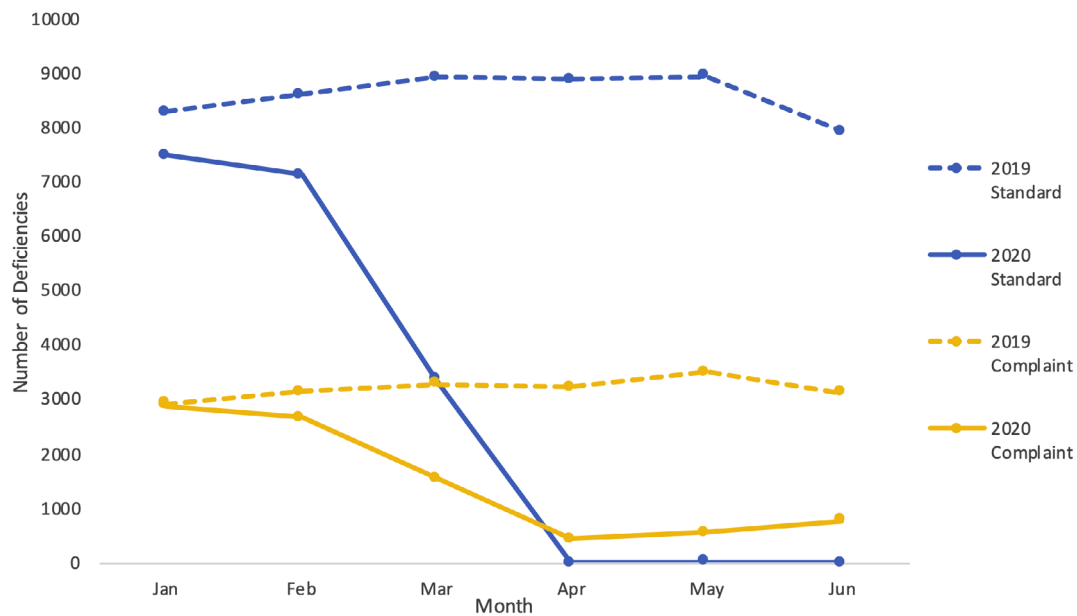


FIGURE 2 Number of deficiencies in standard and complaint surveys in 2019 and 2020 [Color figure can be viewed at wileyonlinelibrary.com]

result from inaccuracies in one data source or the other or if they result from the aforementioned lag in the posting of QCOR data. Additionally relevant for our analyses is that the infection control surveys file CMS posted publicly includes all survey types, not just infection control surveys. We attempt to minimize this potential overlap by subtracting the number of standard and complaint surveys in QCOR from the on-site surveys listed in this file. This likely results in an

undercount of infection control surveys, as these surveys could coincide with standard or complaint investigations. Similarly, some deficiencies from the targeted infection control surveys might not be included in the QCOR deficiency data, although these exclusions seem minimal. Though we are able to assess the number of complaint surveys and the resulting number of deficiencies, QCOR data do not include information on all complaints that are received by state

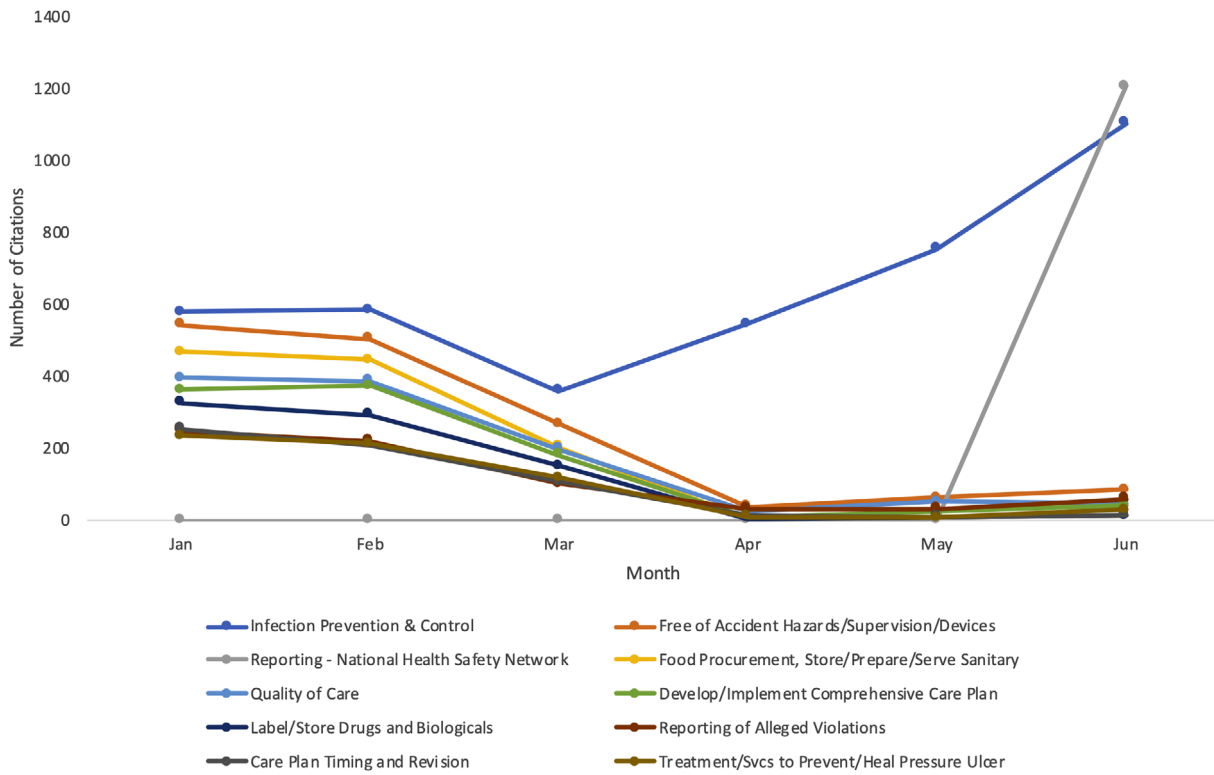


FIGURE 3 Number of citations for top 10 deficiency tags in 2020

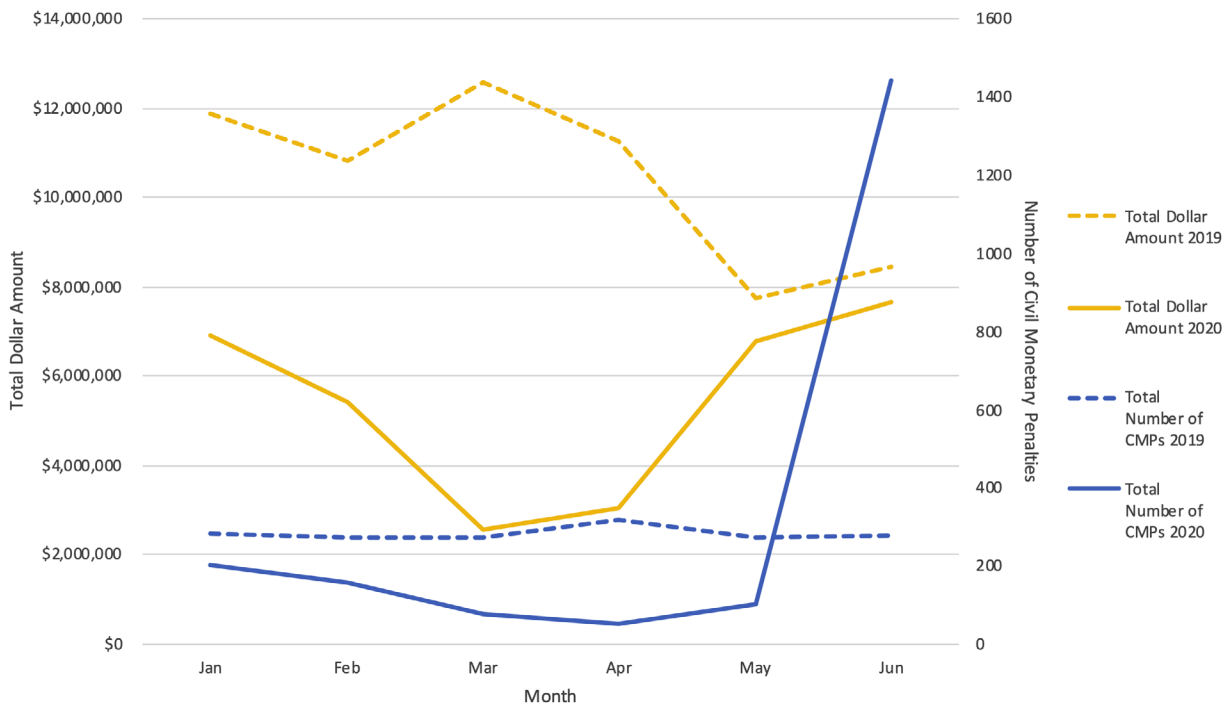


FIGURE 4 Number of civil monetary penalties and total dollar amounts in 2019 and 2020 [Color figure can be viewed at wileyonlinelibrary.com]

oversight agencies. A final important limitation of QCOR data is that this system does not necessarily capture all activities in which SSAs engage. For instance, if SSAs engaged in extra-survey activities such as providing consultation,

delivering PPE, or providing supplemental staffing, it would not be visible in QCOR data. Similarly, QCOR data do not include information about the amount of time surveyors spend in facilities, what SSA staff disciplines are making

these in-person visits, or about off-site activities agencies might conduct.

### 3 | RESULTS

In calendar year 2020, the numbers of standard and complaint surveys were similar to those conducted in 2019 in the first few months of the year before dropping considerably (Figure 1). Compared to the roughly 1250 standard surveys each month in 2019 (ranging from 1195 to 1355), the number of standard surveys conducted in 2020 was similar in January and February (1209 and 1089 surveys, respectively) before declining in light of CMS's March 23 directive to suspend routine surveys, with 534 surveys conducted in March and only 9, 4, and 9 surveys during April, May, and June. Complaint surveys show a similar downward trend, as CMS's March 23 memorandum also directed states to focus on complaints and incidents posing immediate jeopardy to residents. Compared to the roughly 5000 complaint surveys conducted monthly in 2019, 5485 and 4882 complaint surveys were conducted by states in January and February, before dropping to 4095 in March and around 2700 per month in April–June. Finally, infection control surveys, which CMS began to prioritize in March with subsequent direction for states to conduct these for all facilities by July 31, numbered around 4500 per month in April–May, before increasing to over 9000 on-site inspections in June. These surveys continued into July 2020, although these are not shown.

Table 1 displays state-level information from March 1st roughly through June. After March 2020, oversight elements that followed clear CMS directives were generally consistent across states while other dimensions varied more widely. As of June 26th, 83% of facilities nationwide had received an onsite infection control survey, and only six states (Alabama, Alaska, Georgia, Maryland, Pennsylvania, and West Virginia) had visited fewer than 50% of all facilities for these directed surveys. Of note, by the July 31, 2020 deadline, all states had conducted infection control surveys at 97% or more of its facilities, except for Maryland (76%) and Alaska (85%) (not shown). Similarly, following CMS's instructions to suspend routine survey activities, most states conducted very few standard surveys between March 1st and June 30th (1% nationally and between 0 and 3% at the state level). In contrast, the percent of facilities that were subject to a complaint survey over this time was 10% nationally and ranged from 0 to 68% at the state level. With a few exceptions (e.g., Washington at 68% and California at 45%), most states conducted complaints surveys at fewer than 10% of all facilities between March 1st and June 30th. The five states that conducted the most complaint surveys (California, Texas, Washington, New York, and

Florida) accounted for almost three-quarters of all complaint surveys nationally.

Health-related deficiency trends in 2020 were consistent with the overall survey activity presented above (Figure 2). In particular, standard and complaint surveys were close to 2019 levels in January (7480 and 2877, respectively), dipped slightly in February (7124 and 2662) and further in March (3360 and 1542), before dropping considerably in April–June (between 5 and 13 standard survey deficiencies and 431–771 complaint deficiencies each month). As noted above, it is difficult to assess with precision the number of deficiencies arising specifically from the targeted infection control surveys, as these are not distinguishable from the complaint or standard survey deficiencies in our data.

Figure 3 shows trends in the number of deficiencies among the top 10 deficiency types in January–June of 2020. With the exception of two deficiencies—Infection prevention and control and reporting to the national health safety network—all of the top deficiency citations declined from the beginning of the year toward almost zero by April, remaining at these levels through the end of June. Infection control deficiencies declined from January–March, before increasing in number each successive month in April–June. Finally, reflecting the requirement that facilities report COVID data to the National Health Safety Reporting Network starting in May, 1205 deficiencies were issued in June for facilities' failure to do so.

Civil monetary penalties against nursing homes dropped considerably in 2020 relative to 2019 (Figure 4), except in the month of June. In January–June of 2019, the monthly CMP count ranged from 271 to 316, with associated monthly fines of between \$7.7 and \$12.6 million and a six-month total of \$62.7 million. In 2020, the number and dollar amount of CMPs was lower to start the year (204 and 156 CMPs for \$6.9 and \$5.4 million in January and February, respectively), declining in the subsequent months (with between 54 and 101 CMPs in March–May) until there was a spike in CMPs in June. In that month alone, over 1400 nursing homes were fined, with more than three-quarters receiving modest per-diem CMPs for their lack of reporting COVID-19 data to the National Health Safety Reporting Network (F-0884). A total of \$32.4 million in fines were issued to nursing homes in the first half of 2020.

### 4 | DISCUSSION

In many ways, our results demonstrate what could have been predicted based on initial federal guidance to state survey agencies during the COVID-19 pandemic. Following the March CMS directive to cease standard survey operations, the number of standard nursing home surveys fell to almost zero in April–June. Similarly, at CMS's

direction, states began conducting onsite infection control surveys around that same time, with almost all states reportedly meeting the July 31st deadline to conduct abbreviated in-person infection control surveys in all nursing homes.

It was harder to predict what would happen with complaint surveys, which occurred about half as often in the second quarter of 2020 as over the same time period of 2019 and had substantial state-level variation. In particular, without routine recertification surveys, CMS guidance directed states to prioritize investigating complaints and incidents involving immediate jeopardy to residents. Nonetheless, these investigations depend largely on third-party reports,<sup>16,17</sup> something curtailed by the absence of family members, ombudsman, and other resident advocates from nursing homes during the COVID-related lockdowns. Consistent with the overall trends we identified, deficiency citations and enforcement actions were substantially lower in the first half of 2020, relative to the same period in 2019. In the first half of 2020, standard and complaint deficiencies combined were around 40% of 2019 levels, and the total dollar amount of CMPs was around 50% as much as in the prior year.

With the notable exception of the targeted infection control surveys, the bottom line from our findings is that on-site nursing home oversight activities in the first half of 2020 were well below what they would have been in a typical year. During a year that has been far from typical, however, one response to these trends might be a shrug of the shoulders. Indeed, SSAs (generally) were doing as they were directed by CMS. Moreover, restricting the flow of non-essential personnel into nursing homes was an explicit policy priority reflecting the clinical urgency of the pandemic.

Nonetheless, these trends raise two issues that are critical for nursing home oversight and the health of residents going forward—first, how can SSAs maintain effective oversight during a pandemic especially if in-person visits, viewed as an essential component of that oversight, are a point of clinical concern; second, and more broadly, what role should oversight play during a crisis and how can SSAs best protect nursing home residents at such a time?

#### 4.1 | In-person visits

Periodic in-person inspections have been a core part of survey activities since the passage of Omnibus Budget Reconciliation Act of 1987 (OBRA '87). To assess the care a particular facility delivers, there is no substitute for seeing and speaking with residents in person, visually inspecting facility and clinical operations, and engaging nursing home staff and others in dialogue. Because of concerns about COVID's transmissibility and to focus

CMS and facility resources on resident safety,<sup>10</sup> nursing home entry for inspectors—like that of others—has been limited since March 2020. Although these concerns have not abated, CMS announced in August that states may resume regular in-person surveys, provided they have the resources (PPE, testing, and willing survey staff) to do so.

With uncertainty about the trajectory of COVID-19, not to mention the possibility of future infectious disease outbreaks, CMS must develop contingency plans that allow in-person monitoring activities to occur in scenarios where access to facilities might be limited. As a first step, the federal government should ensure that SSAs have access to adequate PPE and testing, just as it should for nursing home personnel and residents.<sup>18</sup> A related point is that safe visitation plans for residents' family, friends, and advocates should be viewed as essential for bolstering care oversight, residents' mental and physical health, and delivering high quality care.

Contingency plans should also address potential gaps created by restrictions on in-person visits. In the initial months of the COVID-19 pandemic, CMS prioritized on-site visits for allegations posing immediate jeopardy to residents and compelled states to conduct infection control surveys in all facilities. The latter strategy in particular was an effective mechanism to get surveyors into facilities, in addition to lessening provider burden from elements of routine inspections. At present, it is unclear how effective these targeted visits have been in spurring nursing homes to meet minimum standards for infection control and other care they provide. Yet, some advocates point to the relatively small number of deficiencies identified during these targeted inspections compared to deficiency data from previous years (e.g., a recent Government Accountability Office analysis found that 82% of facilities had at least one infection control deficiency between 2013 and 2017, with almost half of facilities having citations in multiple years<sup>19</sup>)<sup>12</sup> in questioning the thoroughness of these inspections. More recently, as states are being asked to expand oversight activities going forward, CMS has directed SSAs to prioritize nursing homes with previous allegations or noncompliance on abuse and neglect, infection control, insufficient staffing, and other quality issues. Finally, although not a substitute for in-person visits, states might consider whether virtual monitoring activities could provide supplemental information during times where facility access is limited, as some accrediting organizations have reportedly done.<sup>20</sup>

#### 4.2 | Role of SSAs during crisis

Policy discussions about how to mitigate the impact of COVID-19 on nursing homes have focused most urgently on strategies to navigate the immediate crisis, including



bolstered testing, distribution of PPE, infection control practices, and the timely reporting of cases and deaths. Reflecting this focus, the ensuing policy discussions have centered on the roles of the federal government and of individual nursing homes. Notwithstanding the substantial progress still needed in these key areas, discussions about the most effective role for SSAs, entities with considerable on-the-ground experience in nursing homes, have been minimal.<sup>21</sup> In fact, the prospect of SSA visits to nursing homes during the pandemic has been portrayed by some as a distraction from—as opposed to a safeguard for—high quality resident care.<sup>22</sup>

One potential explanation for why SSAs have been mostly left out of nursing home COVID-19 policy discussions is the poor fit between the tools typically at SSAs' disposal and the type of assistance nursing homes have needed most during the pandemic. Although one might respond by encouraging state surveyors to partner with facilities as they navigate this crisis,<sup>23</sup> federal statute largely precludes SSAs from consulting with or guiding the same providers they oversee. In support of this restriction, some stakeholders have expressed concern that if surveyors become too collegial with particular nursing homes, they might be less likely to cite deficiencies or issue sanctions for non-compliance.<sup>24,25</sup>

As survey agencies identify nursing homes that are falling short on infection control practices or experiencing COVID-19 outbreaks, SSAs can instead use their oversight authority to see that nursing homes develop and implement action plans to support residents. Where appropriate, SSAs could strongly encourage nursing homes to engage reputable quality improvement or accrediting organizations to help identify root causes of emerging problems and develop strategies to address them quickly and effectively. This orientation would be consistent with CMS's efforts to deploy QIOs to NHs in COVID-19 hotspots.<sup>26</sup> Similarly, SSAs could help target deployment of supplemental staff to facilities (e.g., "strike teams") where temporary staffing crises have emerged.<sup>27</sup>

Additionally, a tough question to answer during the pandemic is what role enforcement should play. To date, CMS has been somewhat inconsistent about this component, most notably around civil monetary penalties. In August 2020, for instance, Administrator Verma noted first that, "We are here to help you and support you [nursing homes]. This isn't a time of fines and being punitive," followed the next day with a statement that CMS would be "taking aggressive enforcement action against Medicare and Medicaid certified nursing homes that fail to implement proper infection control practices."<sup>28</sup> On the surface at least, these statements are at odds; yet, they also reflect a tension of wanting to hold nursing homes accountable (a deterrence approach to

regulation) while also aiming to provide support (or at least not drain further resources) during a time of crisis (a compliance approach to regulation). Policymakers should recognize that there are tradeoffs to each of these approaches and that a middle ground might consider nursing homes' previous quality performance in setting the bar on enforcement (a more responsive form of regulation), at least during the pandemic.<sup>29</sup>

## 5 | CONCLUSION

Over the several months that COVID-19 has devastated nursing homes, regulatory oversight efforts have fallen off considerably. While CMS implemented universal infection control surveys and targeted complaint investigations in response to the pandemic, other more routine aspects of oversight fell considerably in light of justifiable limits on nursing home entry. Enhanced oversight is not a solution to help nursing homes weather the pandemic successfully; regulators generally do not have the skills or the authority to achieve what quality improvement experts can accomplish. Nonetheless, regulators have an important role to play in assuring that nursing homes comply with standards of care and that residents are as safe as possible. Several elements could help support these efforts, such as ensuring adequate PPE access for inspectors and family members to enter nursing homes and visit with residents safely; developing contingency plans for when in-person visits are not possible; engaging outside clinical and quality improvement expertise to assist facilities as needed; and focusing oversight activities on their most central components. As COVID-19 continues to impact communities across the country, we must develop and implement policies that allow regulators to be responsive in balancing the competing demands of an ongoing pandemic and fulfilling their oversight responsibilities effectively.

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### CONFLICT OF INTEREST

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### AUTHOR CONTRIBUTIONS

David G. Stevenson led this investigation. Acquisition, analysis, and interpretation of data and preparation of

manuscript was done jointly by David G. Stevenson and Audrey Cheng.

## SPONSOR'S ROLE

No sponsors.

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