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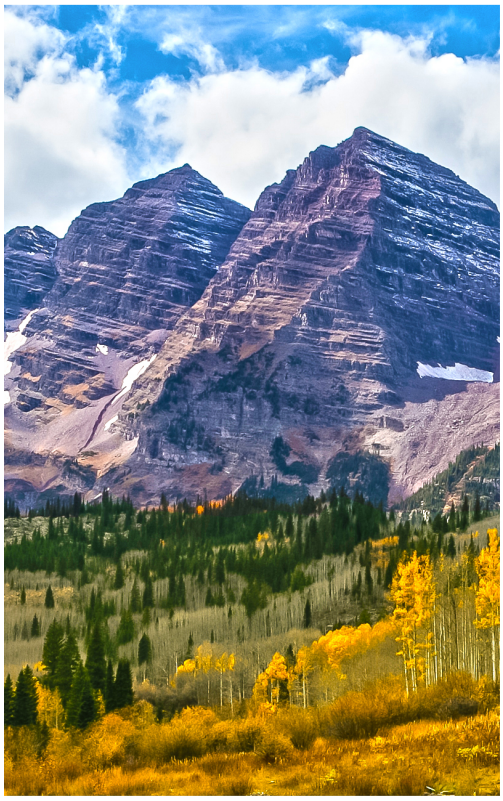
COVID-19 INFECTION PREVENTION AT THE VETERANS COMMUNITY LIVING CENTERS



OCTOBER 2021 PERFORMANCE AUDIT

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KERRI L. HUNTER, CPA
STATE AUDITOR

October 8, 2021

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of Infection Prevention at the Veterans Community Living Centers within the Department of Human Services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., which requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments for purposes of the SMART Government Act. The report presents information about the COVID-19 infection prevention efforts at the Veterans Community Living Centers and our conclusions about the effectiveness of those efforts. The Department of Human Services provided a letter outlining its views and perspectives on the report.

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REPORT HIGHLIGHTS

COVID-19 INFECTION PREVENTION AT THE VETERANS COMMUNITY LIVING CENTERS

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DEPARTMENT OF HUMAN SERVICES

CONCLUSION

Since March 2020, when the COVID-19 pandemic began, the Department of Human Services (Department) and Veterans Community Living Centers (Living Centers) have implemented required infection prevention measures to help mitigate the spread of COVID-19. During the audit period, the number of infections, deaths, and length of outbreaks at the Living Centers decreased as the measures were implemented.

KEY RESULTS AND CONCLUSIONS

- From March 2020 through June 2021, the Living Centers' infection control measures resulted in them having a lower "attack rate" (number of infections divided by the population) for both staff and residents than other similar types of residential healthcare facilities. The Living Centers had a median attack rate of 7.6 percent for staff and 4.1 percent for residents, compared to 12.1 percent for staff and 16.3 percent for residents in other similar types of facilities.
- The Living Centers conducted staff screening, and both weekly polymerase chain reaction (PCR) and daily antigen testing during our review periods, and prevented employees from working after receiving a positive test. Specifically:
  - The number of staff and residents in each facility matched the number of weekly PCR tests administered, which indicated that the Living Centers conducted required testing.
  - For a sample of 60 staff, the Living Centers provided 99 percent of their daily screening forms, and when antigen testing was in place, all sampled staff received daily antigen testing prior to working their shifts.
  - None of the 25 staff in our sample who tested positive for COVID-19 worked during the 10-day quarantine period following their positive test.
- Each Living Center and the Department communicated the required measures for limiting the spread of COVID-19 and new positive cases in the facility to staff through computer-based training, posters, emails, and swift 911 calls.
- The Living Centers conducted required monitoring activities to ensure that staff properly exercised infection prevention measures and developed plans to correct any issues identified. For example:
  - Each Living Center performed at least five and up to 16 infection control audits during the review period and provided coaching to address the deficiencies identified.
  - Each Living Center underwent at least one infection prevention survey conducted by Department Public Health and Environment (CDPHE) staff on behalf of the Centers for Medicare and Medicaid Services (CMS) and submitted correction plans to CMS for any deficiencies identified.

BACKGROUND

- There are five state-owned Living Centers in Colorado:
  - Fitzsimons in Adams County
  - Homelake in Rio Grande County
  - Bruce McCandless in Fremont County
  - Rifle in Garfield County
  - Spanish Peaks in Huerfano County
- Four of the Living Centers are operated by the Department. Spanish Peaks is operated under contract with the Huerfano County Hospital District and overseen by the Department.
- The Living Centers provide services to residents including long-term care, short-term rehabilitation, and memory care.
- The Living Centers averaged 399 residents, in total, between February 2020 and August 2021. Including:
  - 137 at Fitzsimons
  - 48 at Homelake
  - 82 at Bruce McCandless
  - 54 at Rifle
  - 78 at Spanish Peaks
- Between March 2020 and June 2021, the Living Centers experienced a total of 15 COVID-19 outbreaks.
- Between March 2020 and August 2021 the Living Centers experienced:
  - 266 staff cases of COVID-19
  - 174 resident cases of COVID-19
  - 58 deaths resulting from COVID-19 (all of which were residents).

AUDIT APPROACH

The key objective of this audit was to determine whether each Living Center implemented the federally- and state-required infection prevention measures for its staff to help mitigate the spread of the COVID-19 virus during the pandemic. To do this, we reviewed guidance from the Centers for Disease Control and Prevention, Public Health Orders issued by CDPHE, and CMS; interviewed key staff; and requested and reviewed documentation for infection prevention training, screening documents, COVID-19 testing results, signs posted in the facility, internal and external infection prevention audits and surveys, and communication to staff on new COVID-19 cases.

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CHAPTER 1

OVERVIEW OF VETERANS COMMUNITY LIVING CENTERS

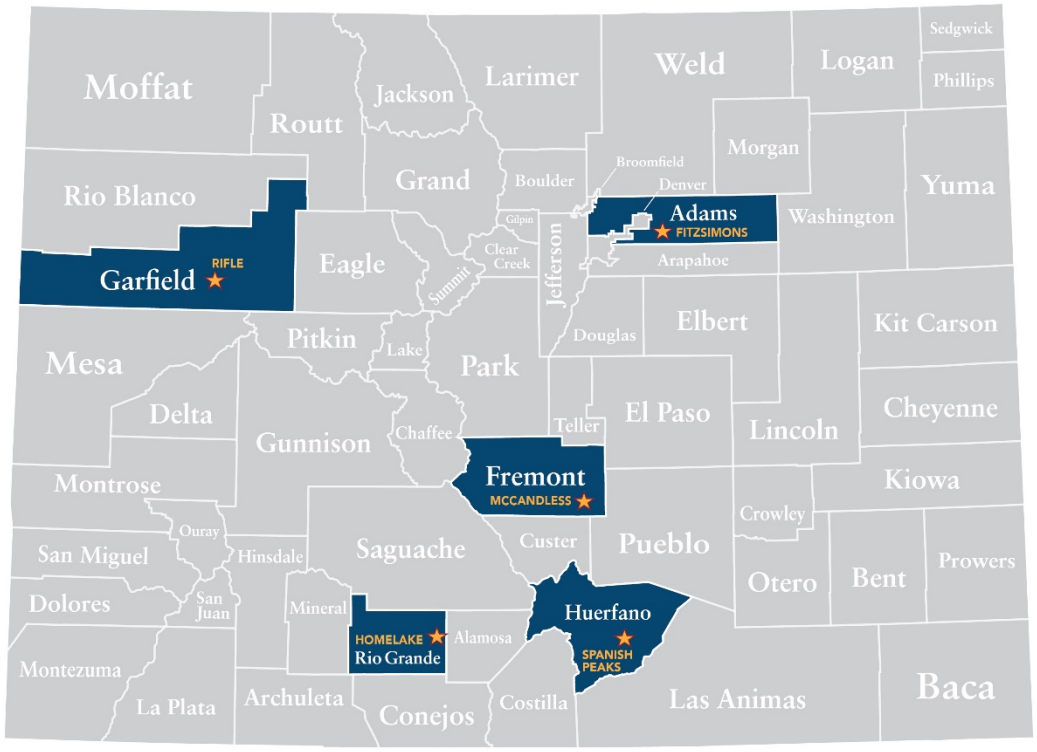
The first confirmed case of the novel coronavirus of 2019 (COVID-19) in the United States was identified on January 20, 2020, and the first case in Colorado was identified on March 5, 2020. Since that time, following the issuance of the Governor's Executive Orders D 2020 017 and 039, the Colorado Department of Public Health and Environment (CDPHE) has issued, and continues to update, dozens of public health orders intended to mitigate the spread of the virus, including, for example, mask mandates and stay-at-home orders.

On March 12, 2020, CDPHE issued Public Health Order 20-20, "Restricting Visitors at All Colorado Skilled Nursing Facilities, Assisted Living Residences and Intermediate Care Facilities," to establish infection control restrictions and requirements in all residential healthcare facilities that are licensed in Colorado. Over the course of the pandemic, these types of facilities have experienced a significant number of positive and confirmed cases of COVID-19 and resulting deaths among residents and staff, as compared to the general population. Most residential healthcare facilities are privately owned and operated. Five of these facilities, the Veterans Community Living Centers (Living Centers), are state-owned. Four of the Living Centers are operated by the Department of Human Services (Department) [Section 26-12-107(3), C.R.S.], and the fifth is operated under contract with oversight by the Department [Section 26-12-119(1), C.R.S.].

VETERANS COMMUNITY LIVING CENTERS

The five Living Centers provide long-term care, short-term rehabilitation, and memory care to residents. Four of the Living Centers—Fitzsimons (Adams County), Rifle (Garfield County), Bruce McCandless (Fremont County), and Homelake (Rio Grande County)—are operated by the Department. The fifth Living Center, Spanish Peaks (Huerfano County), is operated under a contract with the Huerfano County Hospital District. To be eligible for residency, a person must be an honorably discharged veteran, a spouse or widow or widower of an honorably discharged veteran, or a Gold Star parent of children who died while serving in the armed forces. These five facilities are located across the state, as shown in EXHIBIT 1.1.

EXHIBIT 1.1. VETERANS COMMUNITY LIVING CENTERS IN COLORADO



★ — Current Living Centers

SOURCE: Prepared by the Office of the State Auditor from data on the Department of Human Services' website.

Most of the Living Centers are in more rural areas of the state, while Fitzsimons is located in the Denver Metropolitan Area. The Living Centers provide various services to its residents, including:

- LONG-TERM CARE. Includes skilled nursing care; speech, physical, and occupational therapy; social activities; and assistance with bathing, dressing, and other daily activities.
- SHORT-TERM REHABILITATION. Temporary care for individuals who can eventually return home following rehabilitation services.
- MEMORY CARE. Specialized care for individuals with dementia.

Additionally, the Homelake Living Center has domiciliary cottages, which are for independent living with some assistance provided. Residents have their own cottage separate from the facility, but receive nursing services such as medication management and meal management. EXHIBIT 1.2 provides information about each of the five Living Centers, and shows that the average number of residents in each Living Center declined during the pandemic. According to staff, this was due to restrictions on new admissions during the pandemic, which did not allow them to readily fill vacancies when they occurred.

EXHIBIT 1.2. VETERANS COMMUNITY LIVING CENTERS
FISCAL YEAR 2021

	Fitzsimons	Homelake	Bruce McCandless	Rifle	Spanish Peaks	Total
County *(Setting)*	Adams *(Urban)*	Rio Grande *(Rural)*	Fremont *(Rural)*	Garfield *(Rural)*	Huerfano *(Rural)*	
FTE	236	95.3	135	110.6	1 [1]	577.9
Number of Licensed Beds [2]	180	60 [3]	105	89	120	554
Residents February 2020 [4]	160	53	94	63	87	457
Residents August 2021 [4,5]	114	42	69	44	68	337

SOURCE: Joint Budget Committee briefings, Veterans Community Living Centers Needs Assessment, and monthly census reports from each Living Center.
[1] Spanish Peaks is contracted to the Huerfano County Hospital District, and the Department has one FTE assigned as the contract monitor at the facility.
[2] Licensed beds include long-term care, short-term rehabilitation, and secure memory care.
[3] Homelake also has 50 domiciliary cottages.
[4] These are the average number of resident for each month.
[5] Due to restrictions implemented in response to COVID-19, when residents left the facility due to death or other circumstances, the Living Centers restricted admission of new residents.

The Living Centers are funded primarily from cash funds and federal funds including the room and board charged to private-pay residents, Medicare, Medicaid, and Veterans Administration. EXHIBIT 1.3 provides the sources of funds for all of the Living Centers for Fiscal Years 2019 through 2021.

EXHIBIT 1.3. FUNDING BY SOURCE FOR THE LIVING CENTERS
FISCAL YEARS 2019 THROUGH 2021
(IN MILLIONS)

	2019	2020	2021
Cash Funds	$30.74	$34.44	$37.14
Federal Funds	$21.43	$21.43	$21.43
General Fund	$1.05	$2.73[1]	$ 0.06
Federal COVID Funds[2]	$-	$1.69	$6.68
Total	$53.22	$60.29	$65.31

SOURCE: Office of the State Auditor compiled from Joint Budget Committee briefing documents.
[1] In Fiscal Year 2020, the General Assembly gave the Living Centers general funds for pay increases in an effort to improve staff retention.
[2] In Fiscal Years 2020 and 2021, the Living Centers received federal funds through the Coronavirus Aid, Relief, and Economic Security Act and from the U.S. Department of Veterans Affairs to assist with handling the pandemic.

COVID-19

The Centers for Disease Control and Prevention (CDC) states that, owing to the congregate nature of residential care settings, which includes the Living Centers, viruses like COVID-19 can spread quickly within them. Additionally, the residents are older and often have other underlying health issues, which increases the chances of them becoming severely ill.

From March 2020 through August 2021, the Living Centers reported a total of 440 confirmed cases of COVID-19 among residents and staff at all of the facilities combined, and 58 deaths from COVID-19, all of which were among residents. EXHIBIT 1.4 breaks down the number of cases among residents and staff by facility.

EXHIBIT 1.4. LIVING CENTERS' REPORTED COVID-19 CASES AND DEATHS BY FACILITY MARCH 2020 THROUGH AUGUST 2021

	Staff Cases	Resident Cases	Total Cases	Deaths [1]
Fitzsimons	81	71	152	26
Homelake	25	9	34	1
McCandless	37	7	44	0
Rifle	65	52	117	19
Spanish Peaks	58	35	93	12
TOTAL	**266**	**174**	**440**	**58**

SOURCE: Office of the State Auditor compiled from Department of Human Services' data.
[1] All of the COVID-19 deaths at the Living Centers were residents. None were staff.

All five Living Centers have experienced COVID-19 outbreaks. At the start of the pandemic, CDPHE defined an outbreak as two or more confirmed cases among residents and staff with onset in a 14-day period. In December 2020, CDPHE expanded the definition of an outbreak, which could also be defined as one confirmed case and two or more probable cases among residents and staff in a facility with onset in a 14-day period. Generally, CDPHE considers an outbreak resolved when there are no new cases 28 days after the last case's onset or with multiple rounds of negative test results of all residents and staff. When a facility goes into outbreak status, infection prevention measures change, including tighter restrictions on visitation and an increase in the rate of testing.

CDPHE outbreak data does not include individual cases within a facility if they are resolved before the onset of another case, which would constitute an outbreak. Between March 2020 and June 2021, CDPHE reported a total of 397 cases among residents and staff and 53 deaths during outbreaks in the Living Centers from the data reported by the facilities. EXHIBIT 1.5 lists all of the outbreaks occurring at the Living Centers from March 2020 through June 2021 in chronological order and the respective number of COVID-19 cases and deaths at each facility.

EXHIBIT 1.5. OUTBREAK LENGTH, CASES, AND DEATHS AT THE LIVING CENTERS OUTBREAKS BEGINNING MARCH 2020 THROUGH JUNE 2021

	Start of Outbreak	Date Outbreak Resolved	Outbreak Length (Days)	Resident Cases	Staff Cases	Total Cases	Total/Resident Deaths
Fitzsimons	4/29/2020	7/16/2020	79	68	30	98	26
Fitzsimons	8/3/2020	9/1/2020	30	2	3	5	0
Rifle	11/3/2020	1/25/2021	84	42	51	93	15
Spanish Peaks	11/19/2020	4/1/2021	134	33	41	74	12
Homelake	12/6/2020	2/26/2021	83	7	18	25	0
McCandless	12/7/2020	1/8/2021	33	3	6	9	0
Fitzsimons	12/10/2020	2/9/2021	62	4	22	26	0
McCandless	1/14/2021	2/18/2021	36	0	5	5	0
Fitzsimons	2/24/2021	3/12/2021	17	0	3	3	0
Fitzsimons	4/1/2021	5/24/2021	54	2	8	10	0
Rifle	4/8/2021	7/9/2021	93	5	8	13	0
McCandless	4/13/2021	6/23/2021	72	3	16	19	0
Spanish Peaks	4/29/2021	5/24/2021	26	2	10	12	0
Homelake	5/24/2021	6/9/2021	17	0	2	2	0
Fitzsimons	6/22/2021	7/9/2021	18	2	1	3	0
TOTAL [1]			838	173	224	397	53

SOURCE: Colorado Department of Public Health and Environment, Outbreak Fusion Center.

[1] The numbers in this table only include cases and deaths that occurred during outbreaks, and therefore, do not reflect the same numbers reported in EXHIBIT 1.4.

FEDERAL AND STATE OVERSIGHT

FEDERAL OVERSIGHT. The Living Centers are required to follow Centers for Medicare and Medicaid Services (CMS) regulations and standards that apply to all licensed skilled nursing facilities, and are subject to CMS inspections. CMS regulations and inspections tend to focus on safety in the facilities, quality of care, and infection prevention. The Living Centers are also subject to certification by the U.S. Department of Veterans Affairs, which sets standards of care, conducts annual surveys to determine compliance with those standards, and determines who is eligible to be a resident. According to Department staff, the Living Centers have looked to CMS, as well as to the CDC, for updated guidance and requirements related to the COVID-19

pandemic. Staff have stated that, in general, federal guidance related to COVID-19 has been less stringent than the state level guidance, but that they follow the strictest guidance regardless of the source.

COLORADO DEPARTMENT OF HUMAN SERVICES. The Department has a Chief Medical Officer who is responsible for providing healthcare expertise and interpretation in the development of healthcare-related policy for all of the Department's facilities that provide residential care or rehabilitation services. During the COVID-19 pandemic, the Chief Medical Officer has worked with CDPHE and the Living Centers to communicate changes in guidance and to advise on infection prevention measures. In addition, each of the Living Centers has its own administrator, and the Department has one on-site observer at the contracted facility who acts as the contract monitor. The Department's Division of Veterans Community Living Centers (Division), which is located within the Office of Adult, Aging, and Disability Services, oversees the Living Centers. The Division includes a director, deputy director, and clinical operations director who administer the Living Centers as a group by submitting the annual budgets for each facility, maintaining the facility buildings, and administering any grants or gifts given to the facilities. During the pandemic, the Division also coordinated information sharing of infection prevention guidance and case reporting.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI). As required by the Federal Code of Regulations [42 CFR 483.75(g)], each of the Living Centers has a QAPI committee responsible for ensuring that the facility management provides proper care and quality of life for its residents. The committees have to include, at a minimum, the facility's director of nursing, medical director (or designee), administrator, and infection preventionist. The QAPI committees meet monthly to discuss operations and strategies for improvement.

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT. At the state level, CDPHE is the primary rule-making and coordinating body for infection control, both for the general public and within all residential healthcare facilities, including the Living Centers. CDPHE may enforce its Public Health Orders by fine or imprisonment. CDPHE's first COVID-19 Public Health

Order 20-20, issued on March 12, 2020, restricted activities at residential healthcare facilities. These measures included restricting visitation by non-Living Center staff (e.g., family members of residents, healthcare providers, or transportation providers), requiring everyone who entered a facility to be screened for signs and symptoms of COVID-19 or fever, establishing measures for handling and reporting suspected or confirmed COVID-19 cases, and establishing policies for how facility staff should interact with third parties (e.g., vendors, volunteers, Department staff). Public Health Order 20-20 has been revised a number of times since the pandemic began to provide further restrictions and requirements related to infection control at residential healthcare facilities. Key dates and revisions include:

- APRIL 20, 2020—Required residential healthcare facilities, including the Living Centers, to create a Prevention and Response Plan to implement infection prevention strategies, including how staff are trained and competencies are tested. The order also set isolation timeframes for people who test positive for COVID-19 or who have compatible symptoms.

- JULY 30, 2020—Required residential healthcare facilities, including the Living Centers, to report daily to CDPHE regarding their resources available to respond to COVID-19, including information about personal protective equipment (PPE). This reporting began August 5, 2020.

- SEPTEMBER 3, 2020—Defined conditions under which indoor visitation at residential healthcare facilities, including the Living Centers, could be allowed, with guidance dependent upon infection rates in the county where a facility is located. It also updated isolation requirements for new or readmitted residents and timeframes required for isolation.

- NOVEMBER 10, 2020—Required residential healthcare facilities, including the Living Centers, to implement surveillance testing (i.e., testing all staff demonstrating symptoms or who have a suspected exposure). CDPHE required that surveillance testing be conducted on all staff at least once every 7 days and for all residents who had left the facility and interacted with people outside of the facility.

- MARCH 22, 2021—Required that any facility report all COVID-19 test results to CDPHE and clarified that staff or residents who had tested positive within the last 90 days and are no longer symptomatic were excluded from ongoing testing. It also clarified that newly admitted or readmitted residents do not need to quarantine for 14 days if they are fully vaccinated and that visitation does not stop for other residents if a resident tests positive for COVID-19.

- MAY 31, 2021—Required that facilities establish and maintain a COVID-19 mitigation plan that promotes vaccine confidence and acceptance, and that facilities continue to offer vaccinations to all consenting staff and residents. It also required that facilities submit to CDPHE a plan detailing how the facility ensures vaccinations are offered.

Additionally, within CDPHE, the Division of Health Care Facilities is responsible for conducting the inspections of residential healthcare facilities like the Living Centers, as required by CMS—referred to as surveys. These surveys review whether the facilities are meeting state licensing standards, state Medicaid standards, and federal Medicare standards. Surveys must be completed at least once every 12 to 15 months, but they can occur more often, for instance if a resident or family member files a complaint, or, as was the case with COVID-19, more frequent infection prevention surveys are warranted. Due to the COVID-19 pandemic, beginning in March 2020, these surveys have focused on infection prevention measures within the residential healthcare facilities. In Calendar Year 2020, each Living Center received at least one survey focused on their adherence to infection prevention guidance and procedures. Survey results are submitted to the facility as well as the State's Medicaid agency. The facility must submit a plan of correction for any identified issues within 10 calendar days from the time the facility receives the report. The severity level of a deficiency is dependent upon whether there was clear harm done as well as the history of the facility with the deficiency identified.

OUTBREAK FUSION CENTER. CDPHE created the Outbreak Fusion Center on June 1, 2020, to collect and compile comprehensive and timely statewide

COVID-19 outbreak data. The Center consists of three units (data, outbreak response, and acute response) that gather information from the local public health agencies, case surveillance, and laboratory test results as well as from changing public policy. CDPHE then uses this information to monitor and communicate statewide COVID-19 outbreaks, data, new variants, and any emerging issues.

RESIDENTIAL CARE STRIKE FORCE TEAM. In April 2020, the Governor created this interdisciplinary team to help long-term care facilities mitigate the spread of COVID-19. The Strike Force Team has been responsible for communicating changes in federal and state guidance to residential healthcare facilities, coordinating changes in laboratory testing, providing infection control education, and providing PPE to facilities.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this performance audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government, and Section 2-7-204(5), C.R.S., the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act. This audit reviewed control measures implemented at each Living Center in response to the COVID-19 pandemic, including testing and screening activities, monitoring activities, and staff training and communication activities. Audit work was performed from February 2021 through October 2021. We appreciate the cooperation and assistance provided by the Department, each of the Living Centers, and CDPHE.

We conducted this audit 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 conclusion based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objectives.

The scope of the audit is limited to a compliance review of the COVID-19 infection prevention measures taken by each Living Center, specifically with respect to staff. The overall testing period covered March 2020 through March 2021 and the audit work focused on the activities of Living Center management and staff with respect to their compliance with safety protocols within the facilities; ongoing screening of visitors and staff and testing of staff and residents; and response when an outbreak occurred within a facility. Due to the fact that management and staff are responsible for implementing and exercising infection control activities within the facility and provide the highest risk of introducing COVID-19 into a facility, the audit only looked at infection prevention efforts taken by Living Center staff and did not include a review of resident compliance with infection prevention protocols within the facilities. Additionally, due to COVID-19 regulations and precautions in effect during this audit, we did not conduct site visits at the Living Centers, and all interviews were conducted virtually.

The key objective of this audit was to determine whether each Living Center implemented the state-required infection prevention measures for staff and facility visitors in response to the COVID-19 pandemic. To accomplish our audit objective, we performed the following audit work:

- Reviewed state statutes and rules, Department policies and procedures, Living Center policies and procedures, CMS rules, CDC guidance, Colorado's statewide public health orders, and CDPHE guidance to identify the measures that were put in place to help control the spread of COVID-19 in the Living Centers and other similar types of facilities.

- Interviewed Department staff to determine the processes the Department implemented across the Living Centers to track COVID-19 cases and communicate changes in guidance as issued by the CDC, CMS, and CDPHE.

- Interviewed key Living Center staff to determine how they implemented infection prevention methods, the challenges the facilities faced in trying to prevent COVID-19 from occurring within a facility and controlling it

when it did occur within a facility, and any concerns they had with how the Department or the facility handled COVID-19 prevention.

- Interviewed CDPHE staff to determine how positive COVID-19 cases were identified within a Living Center, the COVID-19 data collected and reported for each Living Center, and how Division of Health Facilities' staff conducted CMS-directed infection prevention surveys at the Living Centers.

- Surveyed Living Center staff to gather information about infection prevention efforts, and to provide staff with an opportunity to communicate any issues or concerns that they had with infection prevention measures taken at the Living Centers, as well as about any successes that they had with preventing the spread of COVID-19 within the facilities. EXHIBIT 1.6 shows the response rate for the survey.

EXHIBIT 1.6. RESPONSE RATE FOR LIVING CENTER STAFF SURVEY

	Fitzsimons	Homelake	McCandless	Rifle	Spanish Peaks	Totals
Estimated # of staff [1]	247	90	138	109	158	742
# of respondents	39	12	23	24	11	109
Response Rate	16%	13%	17%	22%	7%	15%

SOURCE: Office of the State Auditor analysis of Living Center staff survey data.
[1] The link to the survey was sent to universal email addresses at each Living Center, so the auditors could not be sure how many staff received it. Additionally one Living Center reported that not all staff had an email address associated with the facility, and therefore, they posted it to their education website so that all could have access.

- Requested and reviewed Infection Prevention Plans submitted to CDPHE in April and May 2020 by each of the five Living Centers to determine if they submitted them timely and included all of the elements and the associated policies required by CDPHE's Public Health Order 20-20.

- Reviewed communication and training materials from each of the five Living Centers to determine what and how infection prevention measures were communicated to staff, such as putting on and taking off PPE, handwashing, environmental disinfection, social distancing, and not working when expressing symptoms or having received a positive COVID-19 test.

- Reviewed the infection prevention surveys conducted by CDPHE at each of the Living Centers between January 2020 and March 2021 to determine whether each center had submitted a plan of correction to remedy any issues identified in the surveys.

We relied on sampling to support our testwork related to infection control audits, screening questionnaires of staff, and COVID-19 testing of staff. We based our sampling on a timeframe of 2 weeks prior to, and 1 week after, the declaration of an outbreak within a facility. We requested documentation of all infection control audits, screening questionnaires, and testing of staff that occurred during those periods. We sampled two periods for Fitzsimons and one for each of the other four Living Centers. EXHIBIT 1.7 shows the periods selected for this testing.

EXHIBIT 1.7. SAMPLED DATE RANGES BASED ON THE START OF AN OUTBREAK

	Date of Outbreak Start	Sampled Date Ranges
Fitzsimons	Apr. 29, 2020	Apr. 15 - May 6, 2020
Fitzsimons	Dec. 10, 2020	Nov. 26 - Dec. 17, 2020
Homelake	Dec. 6, 2020	Nov. 22 - Dec. 13, 2020
McCandless	Dec. 7, 2020	Nov. 23 - Dec. 14, 2020
Rifle	Nov. 3, 2020	Oct. 20 - Nov. 10, 2020
Spanish Peaks	Nov. 19, 2020	Nov. 5 - Nov. 26, 2020

From these periods we conducted the following work:

- Reviewed all 70 internal infection control audits conducted during the sampled 3-week periods to determine whether the Living Centers used the audit results, as required, to identify staff not following proper use of PPE, social distancing, handwashing, and environmental disinfection, and whether there was indication of staff receiving training for any issues identified during the audit.

- Reviewed a sample of 60 total staff, including 20 from Fitzsimons (10 from each outbreak) and 10 from each of the other four Living Centers to determine whether they were screened in accordance with CDPHE

requirements on days they reported for work, and when daily antigen testing was in place, to determine if they had been tested.

- Reviewed all 25 staff in these sampled periods who tested positive for COVID-19 to determine if they worked within 10 days of their first positive test result.

In our testing of communication to staff of new cases and outbreaks, we sampled a period of 4 days following the declaration of an outbreak. During these periods we requested all documentation of communication. We sampled two periods for Fitzsimons and one for each of the other four Living Centers. EXHIBIT 1.8 shows the periods selected for this testing.

EXHIBIT 1.8. SAMPLED DATE RANGES FOR OUTBREAK TESTING BASED ON THE START OF AN OUTBREAK

	Date of Outbreak Start	Dates of Testing Window
Fitzsimons	Apr. 29, 2020	Apr. 30 - May 3, 2020
Fitzsimons	Dec. 10, 2020	Dec.11 - Dec. 14, 2020
Homelake	Dec. 6, 2020	Dec. 7 - Dec. 10, 2020
McCandless	Dec. 7, 2020	Dec. 8 - Dec. 11, 2020
Rifle	Nov. 3, 2020	Nov. 4 - Nov. 7, 2020
Spanish Peaks	Nov. 19, 2020	Nov. 20 - Nov. 23, 2020

- We reviewed all documentation provided to determine whether the Living Centers communicated the new cases or outbreak status to facility staff, whether staff were informed of the response actions that they should take, and whether the Living Center had documentation of the isolation of residents, as needed.

As required by auditing standards, we planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Details about the audit work supporting our conclusions are described in the remainder of this report.

A draft of this report was reviewed by the Department and the Living Centers. We have incorporated their perspective into the report where relevant. APPENDIX C contains a letter from the Department with its comments.

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CHAPTER 2

COVID-19 INFECTION PREVENTION AT THE LIVING CENTERS

According to the Centers for Disease Control and Prevention (CDC), the COVID-19 virus commonly spreads when someone who is infected has close contact with others by means of respiratory droplets when coughing and sneezing, and, in some cases, when the infected person contaminates surfaces they touch. Because of this, preventative practices recommended by the CDC and the Colorado Department of Public Health and Environment (CDPHE) include wearing masks to prevent the dispersion of droplets containing the virus, washing hands, and disinfecting surfaces regularly.

Prevention measures also include practicing social distancing, which is defined as staying at least 6 feet apart from others at all times, and quarantining individuals who test positive for the virus or are demonstrating symptoms. Symptoms of the virus include, but are not limited to, fever, cough, and difficulty breathing.

Department of Human Services (Department) management and Veterans Community Living Centers (Living Centers) staff indicated that one of their greatest challenges during the pandemic in mitigating the spread of COVID-19 has been being aware of, and implementing changing guidance from the CDC, as it publishes updates on appropriate infection control measures. The Department updated its requirements as new CDC, Centers for Medicare and Medicaid Services (CMS), and CDPHE guidance has been made available to reflect infection control measures that are based on the most up-to-date information learned about mitigating the transmission of COVID-19. The requirements from the CDC, CMS, and CDPHE apply to infection prevention within all five of the Living Centers, including Spanish Peaks, as CMS-licensed skilled nursing facilities. Additionally, while Spanish Peaks is operated by the Huerfano County Hospital District under contract with the Department, the Department's contract with the facility states that it shall operate in accordance with state and federal rules and regulations, and during the audit period, Spanish Peaks was included on Division communications and coordination efforts.

Our audit reviewed the infection prevention guidance and requirements established by the CDC, CMS, and CDPHE, and implemented by the Department and Living Centers between March 2020 and March 2021, and evaluated Living Center management and staff's compliance with the guidance and required activities. The infection prevention guidance and requirements addressed the following areas:

SCREENING AND TESTING REQUIREMENTS. Beginning in March 2020, CDPHE began requiring that residential healthcare facilities, including Living Centers, screen all persons, including staff, at the door of a facility prior to entry. Screening includes inquiring whether the person has any possible COVID-19 symptoms, has been exposed to someone who had COVID-19, or has

engaged in an activity that might have exposed them to COVID-19 (e.g., traveled to a location with a high infection rate, or worked at a facility or business with known cases.) Additionally, beginning in November 2020, CDPHE began requiring facilities to conduct COVID-19 testing of all staff, and any residents who left the facility and returned at any point, for instance to attend a medical appointment. Testing requirements have evolved over time as new testing protocols have been developed and improved, but have generally included testing any individuals who are experiencing symptoms to determine if they are positive for COVID-19, as well as routinely testing all individuals regardless of whether they are experiencing symptoms.

COMMUNICATION TO STAFF OF PREVENTATIVE PRACTICES. CDC and CDPHE requirements and guidance identified the following key practices that all staff should follow to prevent the spread of the COVID-19 virus:

- USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE). This includes, in part, wearing a mask that covers the nose and mouth, is made of two layers of tightly woven fabric, or is surgical grade. In March 2020, CMS and Public Health Order 20-20 required healthcare staff to wear masks, gloves, and gowns. Additionally, the Living Centers reported that during an outbreak, all staff are required to wear N-95 masks and face shields at all times.

- HANDWASHING/SANITIZING. This includes vigorously washing hands with soap and water for a minimum of 20 seconds. Alternatively, hand sanitizer can be used and must be allowed to remain on the skin to dry for 20 seconds. For Living Center staff, hand sanitizing is required when entering the Living Centers, entering and exiting a resident's room, and before assisting residents with meals.

- SOCIAL DISTANCING. This requires maintaining a physical distance of at least 6 feet from residents and other staff, when possible.

- ENVIRONMENTAL DISINFECTION. This requires wiping down high-touch surfaces, using an Environmental Protection Agency (EPA)-certified disinfectant and leaving it on contact with the surface for the length of time stated in the manufacturer's instructions. High-touch areas can

include counter-tops, telephones, shared computers, door knobs, and light switches.

- NOTIFICATION OF ACTIVE CASES IN A FACILITY. In April 2020, Department and CDPHE policy required that staff, residents, and family be informed within 12 hours of a positive case for a staff person or a positive or highly suspected case for a resident.

MONITORING ACTIVITIES. For all of these preventative practice areas, Living Center nursing staff and CDPHE conduct ongoing internal and external monitoring to ensure that staff comply with the requirements as they are implemented and updated. These monitoring activities include internal infection control audits, reporting to the facility's Quality Assurance and Performance Improvement (QAPI) Committee, and external surveys—or inspections—conducted by CDPHE on behalf of CMS.

For each of the five Living Centers, we reviewed COVID-19 screening and testing processes, training, and other forms of communication provided to staff regarding infection mitigation and monitoring activities conducted by both internal staff through infection control audits and by external CDPHE staff through infection control surveys on behalf of CMS—from March 2020 through March 2021—to determine whether each Living Center implemented the state-required infection prevention measures for staff and facility visitors in response to the COVID-19 pandemic.

AUDITOR CONCLUSIONS

Overall, we found that the Department and Living Centers implemented infection prevention measures for staff to help mitigate the spread of COVID-19. During the audit period, the number of infections for both staff and residents, deaths, and the length of outbreaks at the Living Centers decreased as these measures were implemented and improved with updated guidance. We did not identify any findings related to the Living Centers' implementation of infection prevention measures.

We also looked at information for the Living Centers compared to the 648 other residential healthcare facilities in Colorado that are comparable to the Living Centers in that they provide inpatient care to populations that have a high risk of infection. EXHIBIT 2.1 compares the number of facilities and outbreaks that occurred from March 2020 through June 2021 for the five Living Centers, including Spanish Peaks, which is operated under contract, with these other similar residential healthcare facilities. The exhibit also compares the "attack rate," which is the number of infections divided by the population, for the Living Centers and the other facilities. As shown, compared to the other facilities, the Living Centers have had a lower attack rate for both staff and residents.

EXHIBIT 2.1. COMPARISON OF OUTBREAKS AND ATTACK RATES AT THE LIVING CENTERS AND OTHER RESIDENTIAL HEALTHCARE FACILITIES IN COLORADO MARCH 2020 THROUGH JUNE 2021

Facility Type	Number of Facilities	Number of Outbreaks	Median Staff Attack Rate (range)	Median Resident Attack Rate (range)
State-owned Living Centers	5	15	7.6%	4.1%
Other Comparable Residential Healthcare Facilities	648	1,094	12.1%	16.3%

SOURCE: Colorado Department of Public Health and Environment, Outbreak Fusion Center.

The remainder of this chapter provides information on the Living Centers' processes, the work we conducted, and our conclusions. Additionally, in APPENDIX A, we provide data on the vaccination rates at the Living Centers. As the available COVID-19 vaccines were under emergency authorization during our audit period, and therefore not mandatory, we did not include test work on the Living Centers' use of them as an infection prevention measure. APPENDIX B contains a timeline of events that identify some of the key dates that had some effect on the infection prevention controls at the Living Centers, including changes in infection prevention guidance, dates of outbreaks, and surges in infection rates.

COVID-19 SCREENING AND TESTING

In March 2020, CDPHE required that residential healthcare facilities have all staff complete a screening form before entering the facility to report whether they were having any COVID-19 symptoms (e.g., coughing, headache, sore throat, fever), had recently visited a high risk location, or had been exposed to someone who was infected. CDPHE also required facilities to record temperatures for all staff. If the staff person indicated any symptoms or risks on the screening form, CDPHE directed the facility to not allow the individual to enter the building until certain protocols had been followed. For example, the facility could have medical personnel at the facility review the case to make a determination as to whether any symptoms that had been reported might be related to another, non-COVID-19 malady (e.g., allergies, ear infection). If the staff's case could not be cleared by medical personnel or the screener, then the screener was instructed not to let the individual into the facility until a COVID-19 test could be administered and a negative result received.

In November 2020, CDPHE added the requirement that all skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes—which includes the Living Centers—conduct surveillance testing for COVID-19 using a polymerase chain reaction (PCR) test, which is considered to be the most reliable COVID-19 test, once a week for all staff. Surveillance testing is regular testing of a population regardless of whether they report experiencing symptoms or not. Additionally, CDPHE required that a facility increase surveillance testing to twice weekly during an outbreak. All five of the Living Centers used medical personnel within the facility to administer PCR tests on site, and all of the tests were sent to the state laboratory at CDPHE to be processed. Generally, PCR test results are received within 24 hours. However, due to transportation of the test and the volume of tests the state laboratory was processing during peaks in infections, results could take longer to be received. For example, we found in one of the cases that we sampled that it took 16 days to get results for a test conducted at one of the Living Centers based on the date the test was administered and the date the Living Center received the results.

In addition to the PCR surveillance testing, in November 2020, the Department required the four state-operated Living Centers to conduct daily antigen testing for staff within their facility at the beginning of their shifts to the extent that testing supplies were available. The contracted Living Center, Spanish Peaks, began daily antigen testing in January 2021. Antigen tests look for the presence of a viral antigen, which indicates possible current infection. Living Center staff were able to administer and process antigen tests on site. The results for antigen tests are available within about 15 minutes, but they are not considered to be as reliable as the PCR test results. In practice, the Living Centers have confirmed that staff have tested negative on an antigen test, but later found that they had COVID-19 through the more reliable PCR test. If a staff person tests positive during a daily antigen test, the Living Center performs a PCR test and sends the staff member home until it receives the test results and the person is confirmed negative for COVID-19. Staff who test positive from a PCR test are required to remain away from the facility for 10 days from the time the test was administered.

WHAT AUDIT WORK WAS PERFORMED AND WHAT DID WE FIND?

We reviewed daily screening documentation and testing results from each Living Center for dates surrounding an outbreak within the facility between March and December 2020. Specifically, we sampled two date ranges for the Living Center at Fitzsimons and one date range for each of the other four Living Centers. The documentation included screening forms completed by staff who entered the facility during the time period reviewed, PCR tests administered and results, and, when applicable, antigen tests and results. We also compared timecard reports and staff rosters for each Living Center with the daily screening forms and tests completed. Overall, we found that the Living Centers conducted screening and both weekly PCR and daily antigen testing in accordance with requirements during the periods we reviewed, and prevented employees from working after receiving a positive PCR test.

We performed three analyses to determine whether each Living Center conducted screening and testing in accordance with CDPHE requirements

during the periods we reviewed, and whether they prevented employees from working after receiving a positive PCR test. We found:

- SURVEILLANCE TESTING. First, we compared the number of PCR tests administered by each facility during our review period with the number of staff working and residents present in the facilities during this time to determine if the number of tests administered matched the number of staff and residents in the facilities, which would indicate that everyone received surveillance testing. We found that the number of PCR tests administered during this time period matched the number of staff and residents present in the facilities, indicating that they all underwent surveillance testing at least once every 7 days, in accordance with CMS and CDPHE requirements.

- DAILY SCREENING AND ANTIGEN TESTING. Second, we sampled a total of 60 random staff (20 staff for Fitzsimons and 10 staff for each of the other four facilities) over 5 random days in the 3-week period around the outbreaks included in our sample. We reviewed each staff person to determine if they had completed a screening form, and, when applicable, if there was a log for a daily antigen test for those staff who clocked into work. We found that, for the most part, all 60 staff members in our sample completed screening forms prior to clocking into work for each of the 5 days reviewed, and that they either did not indicate experiencing any symptoms, or there was an explanation other than COVID-19 for the symptoms reported (e.g., allergies, ear infection). In total we found that there should have been 145 total screening forms for the days employees clocked into work. The Living Centers provided 143 screening forms (99 percent).

  Only three of the facilities (Fitzsimons, Homelake, and McCandless) had started to conduct daily antigen testing during the periods we sampled; the other two facilities (Rifle and Spanish Peaks) had not yet started conducting the daily testing. Therefore, we only analyzed daily antigen testing data for the 30 staff in our sample from the three facilities that were conducting antigen testing during our sampled review periods. We found that the facilities provided antigen tests to all 30 staff in our sample

who clocked into work during the review period. None of these 30 staff had a positive antigen test in this period.

- STAFF WHO TESTED POSITIVE. Third, we identified 25 employees from all five facilities who tested positive for COVID-19 through a PCR test within the time period for which we requested screening and testing documentation. We reviewed documentation for each of the 25 employees to determine whether they had (1) completed a screening form prior to clocking into work and what information was reported on that form, and (2) clocked into work within 10 days of the date that they had taken the COVID-19 test that returned a positive result. This included:

  - Two employees each at the Rifle, Spanish Peaks, Bruce McCandless and Homelake (eight employees total) facilities.

  - 17 employees at the Fitzsimons facility.

For these 25 employees, we found that all of them were screened into work in accordance with screening requirements, and none of them worked at a Living Center facility within the 10-day quarantine period following the date of their positive PCR test.

TRAINING AND COMMUNICATION

Some of the restrictions put into place across Colorado during the COVID-19 pandemic made it challenging for the Living Centers to communicate infection prevention information and changing guidance. Specifically, social distancing restrictions meant that Living Centers could not hold in-person training with staff and they could not always hold beginning- and end-of-shift staff huddles, as they had normally done, to provide important information and updates to staff.

WHAT AUDIT WORK WAS PERFORMED AND WHAT DID WE FIND?

We examined various methods of communication (e.g., training, memos, and signage) that the Living Centers used during our review period to determine whether the facilities had communicated relevant CDC and CDPHE guidance and requirements to staff related to five key infection prevention measures to help mitigate the introduction and spread of COVID-19 within the facilities: (1) proper use of PPE, (2) handwashing and sanitizing, (3) social distancing and not working when ill, (4) environmental disinfection, and (5) alerting staff to new cases within the facility.

Overall, we found that each Living Center and the Department communicated relevant CDC and CDPHE guidance and requirements to staff on each of the five measures recommended to limit the spread of COVID-19 in the facilities. Specifically, we found that the Department's Chief Medical Officer, and Division staff responsible for overseeing the Living Centers, regularly communicated with the Living Centers to update and inform staff about changes in infection prevention guidance and requirements, such as changes in PPE use, visitation policies, testing requirements, and notification of new cases. For example, the Department's Chief Medical Officer sent an April 2020 email that clarified requirements related to hand-washing and sanitizing, surface disinfection, and informing staff to stay home when ill. The Chief Medical Officer also sent a letter to all Living Center staff in October 2020 informing them that COVID-19 cases were climbing and providing guidance on how to celebrate the upcoming holidays safely. Additionally, the Division Director sent a November 2020 memo communicating to staff how daily antigen testing—in addition to the weekly PCR testing—would be performed for timely identification of COVID-19, in accordance with CDC and CMS guidelines.

We also found that the Living Centers provided information and reminders to staff on infection prevention measures through ongoing training, emails, posters, and texts. EXHIBIT 2.2 shows that all five Living Centers

communicated to staff using at least one of these methods for each of the five infection prevention measures that we reviewed.

EXHIBIT 2.2. INFECTION PREVENTION COMMUNICATION METHODS

	Fitzsimons	Homelake	McCandless	Rifle	Spanish Peaks
Personal Protective Equipment	Training Posters	Training Posters	Training	Training Posters	Training Posters
Handwashing and Sanitizing	Training Posters	Posters	Posters	Posters	Posters
Social Distancing and Not Working When Ill	Training Emails Posters	Emails Posters	Posters Texts	Emails Posters	Training Emails Posters
Environmental Disinfection	Training Emails Posters	Training Memos	Training	Training	Training Emails Posters
New Cases	Emails	Swift 911 Calls	Emails Swift 911 Calls	Emails	Emails

SOURCE: Office of the State Auditor analysis of information compiled from documents provided by the Living Centers and the Department.

MONITORING

Federal regulations [42 CFR 483.80] require facilities that receive funds from Medicare or Medicaid, which includes the Living Centers, to implement an infection control program "designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." To comply with federal requirements related to infection control programs, each of the Living Centers has designated an infection preventionist for their facility, who is generally a nurse responsible for overseeing infection prevention policies and practices, and implemented policies and procedures for preventing, identifying, and reporting infections. Additionally, the Living Centers' infection control programs include various monitoring activities that are to occur within each facility. Specifically:

- INTERNAL INFECTION CONTROL AUDITS. These are generally completed by the Living Center's Director of Nursing and/or the infection preventionist and involve walking the facility to observe whether staff are exercising various infection prevention practices such as properly putting on and taking off PPE, engaging in social distancing, handwashing, and

performing environmental disinfection. If the auditor observes staff who are not properly demonstrating these activities, they will provide coaching to the staff on the spot.

- QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) COMMITTEES. Federal regulations [42 CFR 483.75] require residential healthcare facilities, including the Living Centers, to have a QAPI Committee. These committees are tasked with monitoring all areas of care and services within a facility, including monitoring adverse events and developing methods for tracking, investigating, and handling those events.

- EXTERNAL INFECTION CONTROL SURVEYS. On behalf of CMS, CDPHE staff conduct "surveys" at residential care facilities, including the Living Centers, that are essentially inspections of the operation of the facilities and the measures that staff within the facility are taking to prevent the spread of diseases such as COVID-19. If the surveyors identify problems, they will issue a "tag" and the facility must then present and implement a plan of correction for each tag. If problems are serious enough and/or repeatedly identified at the same facility, CMS has the authority to issue financial penalties against the facility.

WHAT AUDIT WORK WAS PERFORMED AND WHAT DID WE FIND?

We reviewed documentation from all five Living Centers for three areas of monitoring, including infection control audits conducted internally for the date ranges we sampled based on the start of an outbreak at the facilities, monthly QAPI meeting minutes for March 2020 through March 2021, and CMS survey results and the associated facility plans of correction from January 2020 through March 2021. The purpose of our review was to determine if the Living Centers were conducting the required monitoring activities and taking steps to address any problems identified. Overall, we found that all of the Living Centers did conduct required monitoring activities and developed plans to correct any problems identified.

- INFECTION CONTROL AUDITS. We found that each Living Center regularly conducted infection prevention audits, and provided corrections to staff for any problems identified. Living Centers staff conducted a total of 70 audits during our 22-day sampled review periods surrounding an outbreak (two periods for Fitzsimons and one each for the other four facilities), and the number conducted per facility ranged from five to 16 audits. Four of the facilities conducted broader-scoped audits that covered all aspects of infection prevention, while one facility conducted smaller-scoped separate audits for individual aspects of infection prevention (i.e., audits specifically concerning PPE, hand hygiene, or storage of personal items). EXHIBIT 2.3 shows the number and type of audits conducted at each Living Center during the 22-day sampled review periods for each facility surrounding an outbreak at the facility.

EXHIBIT 2.3. TOTAL NUMBER AND TYPES OF INTERNAL INFECTION CONTROL AUDITS CONDUCTED AT EACH LIVING CENTER WITHIN SAMPLED REVIEW PERIODS

	Number of Audits	Prevention Practices Covered
Fitzsimons (sample period #1)	5	All
Fitzsimons (sample period #2)	16	All
Homelake	12	4—Use of PPE 4—Hand Hygiene 4—Storage of Personal Items
McCandless	16	All
Rifle	5	All
Spanish Peaks	16	All
Total	70	

SOURCE: Office of the State Auditor analysis of infection prevention documentation.

- QAPI MEETING MINUTES. We reviewed QAPI monthly meeting minutes for March 2020 through March 2021 for each of the Living Centers. In general, we found that the minutes documented that the QAPIs reviewed and discussed infection control issues routinely, including the infection control audits, rates of infection, and any reoccurring issues or areas needing additional staff training or education.

- CMS Infection Control Surveys. We reviewed all seven infection control surveys conducted by CMS surveyors on each of the five Living Centers from January 2020 through March 2021. While most of the surveys identified problems with infection control measures, the Living Centers provided documentation to us during the audit to show that they had developed and submitted correction plans, which CMS accepted, to address the problems identified in the surveys. For instance, one April 2020 survey of the Fitzsimons Living Center identified problems with staff not properly sanitizing their hands and not ensuring the proper use of PPE. Fitzsimons' correction plan indicated that staff would be trained in these areas by June 2020 and that its director of nursing or infection preventionist would conduct an increased number of internal infection control audits during the 3 months following the survey. In another instance, a May 2020 CMS survey at the Rifle Living Center identified a problem with staff not using an EPA-registered, hospital-grade disinfectant consistently to clean shared resident care equipment in between uses. The facility's associated correction plan indicated that the director of nursing would be increasing monitoring for 3 months, the signage on the carts related to disinfectant protocols would be updated, and the QAPI would continue monitoring staff progress in addressing the problem. CMS accepted these correction plans as a remedy for the problems.

APPENDIX A

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VACCINATIONS

In December 2020, the Food and Drug Administration gave emergency authorization to the first COVID-19 vaccine. Adults over the age of 75 and those living and working in congregate care facilities, including the Living Centers, were prioritized for getting vaccinated. In December 2020 the first vaccines were administered in the Living Centers, as follows.

- Fitzsimons: December 18, 2020
- McCandless: December 22, 2020
- Spanish Peaks: December 22, 2020
- Rifle: December 23, 2020
- Homelake: December 28, 2020

EXHIBIT A.1 shows the number and percentage of residents and staff who had received at least one dose of one of the three approved vaccines, as of September 1, 2021.

EXHIBIT A.1. VACCINATION RATES FOR STAFF AND RESIDENTS AT EACH LIVING CENTER AS OF SEPTEMBER 2021 [1]

	Percentage of Staff	Percentage of Residents
Fitzsimons	94.3%	98.3%
Homelake	72.0%	97.3%
McCandless	86.8%	95.4%
Rifle	65.3%	95.7%
Spanish Peaks	76.6%	99.0%

SOURCE: Office of the State Auditor's analysis of data provide by the Division of Veterans Community Living Centers.

[1] Residents were initially encouraged, but not required, to be vaccinated. However, on August 17, 2021, the Department informed staff that all Living Center staff must be vaccinated, and that the first dose must be received by September 30, 2021.

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APPENDIX B

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TIMELINE OF EVENTS

COVID-19 Colorado Timeline

March 5, 2020	The Governor announces Colorado's first confirmed COVID-19 cases.
March 10, 2020	The Governor declares state of emergency to give officials access to resources to better contain the outbreak and protect the most vulnerable.
March 11, 2020	The World Health Organization declares COVID-19 outbreak a pandemic.
March 12, 2020	Public Health Order (PHO) 20-20 for all Colorado skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes restricted visitation of non-essential individuals. Facilities must screen all essential individuals entering the building. Staff must wear the appropriate personal protective equipment (PPE)—gowns, gloves, masks.
March 14, 2020	Health officials announce restricted visitation to skilled nursing, assisted living, and intermediate care facilities to protect health care workers and those most vulnerable.
March 26, 2020	Colorado stay-at-home order enacted.
March 28, 2020	Nine Colorado nursing homes have COVID-19 outbreaks.
March 31, 2020	COVID-19 outbreak hits 14 nursing home facilities statewide.
April 3, 2020	All Coloradans wear non-medical masks when they leave the house.
April 11, 2020	Nearly 40 percent of COVID-19 deaths in Colorado linked to nursing homes and long-term care facilities. Aurora assisted living center has 8 COVID-19 related deaths as statewide deaths reach 274.

April 15, 2020	COVID-19 outbreak at Fitzsimons lasting through May 6, 2020.
April 20, 2020	Update to PHO 20-20 requires all Living Centers to submit a Prevention and Response Plan to CDPHE by May 1, 2020, detailing COVID-19 prevention strategies and isolation plans for residents that have tested positive, or have compatible symptoms.
April 22, 2020	Residents of nursing homes and assisted living facilities account for 64 percent of Colorado's COVID-19 deaths.
April 27, 2020	Colorado's stay-at-home order lifts and shifts to safer-at-home.
May 17, 2020	Colorado's COVID-19 hospitalizations reach lowest point since late March.
May 21, 2020	Colorado nursing homes to test all employees weekly to prevent outbreaks.
June 19, 2020	COVID-19 outbreaks at Colorado nursing homes prompted emergency push to inspect all of them.
July 30, 2020	Update to PHO 20-20 requires that beginning August 5, 2020, all Living Centers must report daily to CDPHE their available resources (e.g., PPE, staff, and facility bed capacity) to respond to the COVID-19 pandemic. Facilities may allow outdoor visitation in accordance with CDPHE guidance.
September 3, 2020	PHO 20-20 amended for facilities to allow indoor visitation for their residents in accordance with the guidance published by CDPHE.
October 20, 2020	COVID-19 outbreak at Rifle Living Center lasting through November 10, 2020.
October 30, 2020	COVID-19 cases begin to increase again and CDPHE issues order limiting private gatherings to 10 individuals from no more than two households.

November 2020	Daily antigen testing begins at all Living Centers for staff and residents.
November 5, 2020	COVID-19 outbreak at Spanish Peaks through November 26, 2020.
November 10, 2020	Updates to PHO 20-20 states that effective November 20, 2020, all Living Centers must implement COVID-19 ongoing surveillance testing, and outbreak testing as needed, for all staff and residents. At a minimum, facilities must implement weekly PCR testing for all staff and for residents who have left the facility premises in the last 14 days.
November 22, 2020	COVID-19 outbreak at Homelake lasting through December 13, 2020.
November 23, 2020	COVID-19 outbreak at Bruce McCandless lasting through December 14, 2020.
November 26, 2020	COVID-19 outbreak at Fitzsimons lasting through December 17, 2020.
December 2020	COVID-19 vaccine administration begins for high-risk health care workers and the staff and residents of long-term care facilities. Statewide mask mandate extended.
February 8, 2021	Individuals 65 and older and school staff are eligible for COVID-19 vaccinations.
May 14, 2021	The Governor ended statewide mask mandate, although masks still required for unvaccinated visitors to nursing homes and hospitals.
August 17, 2021	Living Center staff vaccine mandate per the Governor.

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APPENDIX C

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COLORADO
Department of Human Services

September 29, 2021

Ms. Kerri Hunter
State Auditor
Office of the State Auditor
1525 Sherman Street, 7th Floor
Denver, Colorado 80203

Dear Auditor Hunter:

The Colorado Department of Human Services (Department) has completed its review of the Infection Prevention at the Veterans Community Living Centers (VCLCs or Division) Performance Audit. COVID-19 (Virus) infection prevention is a critically important issue and CDHS encourages any discussion on ways to improve the support of Veterans Community Living Centers across our state.

The Virus has permanently changed the way the VCLCs operate each day. Throughout the pandemic, in collaboration and in alignment with the overall Department efforts, the VCLCs identified ways to address, communicate and mitigate the challenges created by the on-going evolution of the virus and its impacts on long-term care communities. The VCLCs had emergency preparedness plans in place with steps to deploy during a pandemic and over the course of the pandemic, the Division proactively approached critical topics such as the availability of supplies, sufficient technology, and strategies to manage the ever-changing guidelines for communications and management. Additionally, the Division along with leadership worked tirelessly to maintain the highest quality of life for the residents during long stretches of quarantine and isolation. Infection prevention was at the forefront of priorities and continues to be the primary focus, as well as the psychosocial well-being of residents and the overall safety and well-being of VCLC staff.

The Virus was particularly challenging because of the wide incubation period of 2-14 days and asymptomatic infection. The Department believes that the audit accurately reflects the actions that were taken to implement infection prevention measures for staff and facility visitors in an effort to help mitigate the spread of the virus. Specifically, the audit report accurately lays out how quickly guidance was changing from the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and the Colorado Department of Public Health and Environment and summarizes how the Department and VCLCs continually implemented this guidance. The audit shows the steps taken by the Department and the Division to ensure screening and testing requirements were being met, and that communication to staff regarding preventative practices and outbreak management were initiated and monitored consistently. It is the Department's belief that the audit met its key stated objectives and the Department appreciates the Office of the State Auditor for highlighting all of this hard work during very trying times.

Sincerely,

Michelle Barnes

Michelle Barnes, Executive Director