

## Report in Brief

Date: February 2021

Report No. A-07-19-03238

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term care facilities (commonly referred to as nursing homes). Updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency preparedness plan that is reviewed, trained on, tested, and updated at least annually; and provisions for sheltering in place and evacuation.

Our objective was to determine whether Iowa ensured that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness.

### How OIG Did Audit

Of the 437 nursing homes in Iowa that participated in Medicare or Medicaid, we selected a nonstatistical sample of the 20 nursing homes that had the most combined life safety and emergency preparedness deficiencies for 2016, 2017, and 2018.

We conducted unannounced site visits at the 20 nursing homes from July through November 2019. During the site visits, we checked for life safety violations and reviewed the nursing homes' emergency preparedness plans.

## Iowa Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness

### What OIG Found

Iowa did not ensure that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness. During our onsite inspections, we identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes. We found 122 instances of noncompliance with life safety requirements related to building exits, fire detection and suppression systems, hazardous storage, smoking policies, and electrical equipment maintenance, among others. We also found 133 instances of noncompliance with emergency preparedness requirements related to written plans, emergency power, emergency communications, and training, among others. As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency.

The identified areas of noncompliance occurred because Iowa did not have a standardized life safety training program for all staff (not currently required by CMS). In addition, Iowa did not adequately follow up on deficiencies previously cited or require nursing homes or inspection contractors to: (1) tag systems that are critical to the health and safety of nursing home residents when these systems may not work as required and (2) notify the State.

### What OIG Recommends and Iowa Comments

We recommend that Iowa follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the deficiencies identified in this report. We make other procedural recommendations to Iowa regarding the development of standardized life safety training for nursing home staff, the conduct of more frequent surveys and followup at nursing homes with a history of multiple high-risk deficiencies, and the tagging of critical systems.

Iowa concurred "with limitations" with our first three recommendations and the associated findings and described corrective actions. Iowa did not concur with our recommendation regarding the tagging of critical systems. After reviewing Iowa's comments, we revised our findings to remove three deficiencies related to instances of noncompliance with life safety requirements and six deficiencies related to instances of noncompliance with emergency preparedness requirements. We maintain that our findings, as revised, and all our recommendations are valid.