

Report in Brief

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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 known as nursing homes). The updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency plan that is reviewed, trained on, tested, and updated at least annually; and provisions for sheltering in place and for evacuation.

Our objective was to determine whether California 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 This Audit

Of the 1,202 nursing homes in California that participated in Medicare or Medicaid, we selected a nonstatistical sample of 20 nursing homes based on various factors, including the number of high-risk deficiencies that California reported to CMS. We conducted unannounced site visits at these nursing homes from September to December 2018 to check for life safety violations and review the nursing homes' emergency preparedness. We did not include deficiencies for one nursing home in our report because the home was destroyed by a wildfire after our site visit.

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

What OIG Found

California 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 site visits, we identified deficiencies in areas related to life safety and emergency preparedness at all 19 nursing homes that we reviewed. Specifically, we found 137 instances of noncompliance with life safety requirements related to building exits, smoke barriers, and smoke partitions; fire detection and suppression systems; hazardous storage areas; smoking policies and fire drills; and electrical equipment testing and maintenance. We also found 188 instances of noncompliance with emergency preparedness requirements related to written emergency plans; emergency power; plans for evacuation, sheltering in place, and tracking residents and staff during and after an emergency; emergency communications plans; and emergency plan training and testing. As a result, nursing home residents at the 19 nursing homes were at increased risk of injury or death during a fire or other emergency.

The identified deficiencies occurred because nursing homes lacked adequate management oversight and had high staff turnover. In addition, California did not adequately follow up on deficiencies previously cited, ensure that surveyors were consistently enforcing CMS requirements, or have a standard life safety training program for all nursing home staff (not currently required by CMS).

What OIG Recommends and California Comments

We recommend that California (1) follow up with the 19 nursing homes to ensure that corrective actions have been taken regarding the deficiencies we identified, (2) conduct more frequent site surveys at nursing homes to follow up on deficiencies, (3) ensure that all surveyors consistently enforce CMS requirements, and (4) work with CMS to develop life safety training for nursing home staff.

California concurred with our first and third recommendations and described actions that it had taken or planned to take to address the recommendations. However, California did not concur with our second and fourth recommendations. After reviewing California's comments, we maintain that our findings and recommendations are valid.