

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MISSOURI SHOULD IMPROVE ITS
OVERSIGHT OF SELECTED
NURSING HOMES' COMPLIANCE
WITH FEDERAL REQUIREMENTS
FOR LIFE SAFETY AND
EMERGENCY PREPAREDNESS**

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Office of Inspector General

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Report in Brief

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Report No. A-07-18-03230

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 Missouri 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 522 nursing homes in Missouri that participated in Medicare or Medicaid, we selected a non-statistical sample of the 20 nursing homes that had the most combined life safety and emergency preparedness deficiencies for 2015, 2016, and 2017.

We conducted unannounced site visits at the 20 nursing homes from July through November 2018. During the site visits, we checked for life safety violations and reviewed the nursing homes' emergency preparedness plans.

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

What OIG Found

Missouri 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 178 areas 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 149 areas 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 Missouri did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, Missouri did not adequately follow up on deficiencies previously cited.

What OIG Recommends and Missouri Comments

We recommend that Missouri follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the identified deficiencies. We make other procedural recommendations to Missouri regarding the development of standardized life safety training for nursing home staff, the conducting of more frequent surveys and followup at nursing homes with a history of multiple high-risk deficiencies, and updates of facility-specific plans.

Missouri did not directly agree or disagree with our first recommendation but said that it would continue to evaluate compliance with requirements and ensure that nursing homes implement corrective action for deficiencies cited in surveys. Missouri disagreed with our other recommendations and with our findings and said that it did not see the correlation between our recommendations and our stated causes (inadequate oversight and high staff turnover). We maintain that all of our findings and recommendations remain valid. More frequent surveys and expanded training of nursing home staffs will help Missouri improve its oversight of nursing homes and ensure quality of care for the vulnerable population that these facilities serve.

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INTRODUCTION

WHY WE 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). The 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.

As part of its oversight activities, the Office of Inspector General (OIG) is conducting a series of audits nation-wide (Appendix B) to assess compliance with these new life safety and emergency preparedness requirements. This audit focuses on selected nursing homes in Missouri.

OBJECTIVE

Our objective was to determine whether the Missouri Department of Health and Senior Services (State agency) ensured that selected nursing homes in Missouri that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness.

BACKGROUND

Medicare and Medicaid Coverage of Nursing Homes

The Medicare and Medicaid programs cover care in nursing homes for eligible beneficiaries. Sections 1819 and 1919 of the Social Security Act (the Act) establish requirements for CMS and States to perform surveys of nursing homes to determine whether they meet Federal participation requirements. For Medicare and Medicaid, these statutory participation and survey requirements are implemented in Federal regulations at 42 CFR part 483, subpart B, and 42 CFR part 488, subpart E, respectively.

Requirements for Life Safety and Emergency Preparedness

Nursing homes are required to comply with all Federal, State, and local laws, regulations, and codes, as well as accepted professional standards and principles (42 CFR § 483.70). Federal regulations on life safety (42 CFR § 483.90) require nursing homes to comply with standards set forth in the *Life Safety Code* (National Fire Protection Association (NFPA) 101) and *Health Care Facilities Code* (NFPA 99).¹ CMS lists applicable requirements on Form CMS-2786R, Fire Safety

¹ CMS adopted the 2012 edition of both publications in a final rule published in 81 Fed. Reg. 26872 (May 4, 2016).

Survey Report.² Federal regulations on emergency preparedness (42 CFR § 483.73) include specific requirements for nursing homes' emergency preparedness plans and reference the *Standard for Emergency and Standby Power Systems* (NFPA 110) as part of these requirements.³ CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.⁴

The *Fire Safety Survey Report* and *Emergency Preparedness Surveyor Checklist* are used when CMS or a designated agency performs a nursing home survey. The results of each survey are reported and added to CMS's Automated Survey Processing Environment (ASPEN) system.

Responsibilities for Life Safety and Emergency Preparedness

In Missouri, the State agency oversees nursing homes and is responsible for ensuring that nursing homes comply with Federal, State, and local regulations. Under an arrangement known as a "section 1864 agreement" with CMS, the State agency is responsible for completing life safety and emergency preparedness surveys not later than once every 15 months at nursing homes that participate in the Medicare or Medicaid programs.^{5, 6} However, nursing homes with repeat deficiencies can be surveyed more frequently.⁷

Management and staff at nursing homes are ultimately responsible for ensuring the safety and well-being of the nursing home's residents and for complying with Federal, State, and local regulations. They are responsible for ensuring that facility systems such as furnaces, water heaters, kitchen equipment, generators, sprinkler and fire alarm systems, elevators, and other equipment are properly installed, tested, and maintained. They are also responsible for ensuring that the nursing home is free from hazards and for ensuring that emergency plans, including fire escape plans and disaster preparedness plans, are updated and tested on a regular basis.

² Form CMS-2786R is available online at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS009335.html>.

³ CMS adopted the 2010 edition of NFPA 110 in a final rule published in 81 Fed. Reg. 63860, 63929 (Sept. 16, 2016).

⁴ CMS provides online guidance for emergency preparedness at <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertemergprep/emergency-prep-rule.html>.

⁵ The Act §§ 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii). Under the agreement, the State agency agrees to carry out the provisions of sections 1864, 1874, and related provisions of the Act.

⁶ As will be seen later in this report, the State agency sometimes refers to itself as "State survey agency."

⁷ 42 CFR § 488.308(c). The State agency generally conducts comprehensive surveys every 9 to 15 months and will follow up on deficiencies either through a site visit or documentation submission, depending on the nature and severity of the deficiency. For all 20 nursing homes we visited, the State agency conducted its 3 most recent comprehensive surveys no more frequently than every 9 to 15 months.

HOW WE CONDUCTED THIS AUDIT

As of March 2018, there were 522 nursing homes in Missouri that participated in the Medicare or Medicaid programs. We selected for review a nonstatistical sample of the 20 nursing homes that had the most combined life safety and emergency preparedness deficiencies for calendar years (CYs) 2015, 2016, and 2017.⁸ These deficiencies included multiple high-risk deficiencies reported to CMS's ASPEN system by the State agency.⁹

We conducted unannounced site visits at the 20 nursing homes from July through November 2018. During the site visits, we checked for life safety violations and reviewed the nursing homes' emergency preparedness plans.

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

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency did not ensure that selected nursing homes in Missouri 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 that we reviewed:

- We found 178 instances of noncompliance with life safety requirements related to building exits and fire barriers, fire detection and suppression systems, hazardous storage, smoking policies and fire drills, and elevator and electrical equipment testing and maintenance.
- We found 149 instances of noncompliance with emergency preparedness requirements related to written emergency plans; emergency supplies and power; plans for evacuation, sheltering in place, and tracking residents and staff; emergency communications; and emergency plan training.

As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency.

⁸ We used 42 life safety and 4 emergency preparedness deficiency codes to select the 20 nursing homes with the most combined deficiencies.

⁹ We defined high-risk deficiencies as those that (1) were widespread and had the potential for more than minimal harm, (2) had the potential for actual harm, or (3) presented immediate jeopardy to resident health or safety.

The identified deficiencies occurred because the State agency did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, the State agency did not have a standard life safety training program for all nursing home staff (such a program is not currently required by CMS) and did not adequately follow up on deficiencies previously cited. Also, some nursing homes used templates that were not updated with facility-specific information in developing their emergency preparedness plans.

Appendix C summarizes the areas of noncompliance that we identified at each nursing home.

SELECTED NURSING HOMES DID NOT COMPLY WITH LIFE SAFETY REQUIREMENTS

CMS's *Fire Safety Survey Report*, described above, lists the Federal regulations on life safety that nursing homes must comply with and references each with an identification number referred to as a "K-Tag" (K-100 through K-933).

Building Exits and Fire Barriers

In case of fire or emergency, nursing homes are required to have unobstructed exits, self-closing doors in exit passageways that do not require tools or keys to open and are not manually propped open, discharges from exits that are free from hazards, illuminated exit signs, and sealed smoke and fire barriers (K-Tags 211, 222, 223, 271, 281, 291, 293, 372).

At each of the 20 nursing homes we visited, we identified 1 or more deficiencies related to building exits and fire barriers.¹⁰ Specifically, emergency exit doors at six facilities did not open or were difficult to open or the alarms did not sound when tested; pathways leading to exit doors at eight facilities were blocked or impeded; and, at two facilities, the discharge areas from the exit doors were impeded. In addition, 12 facilities had self-closing doors that were propped open, did not close completely, or were missing self-closing devices altogether.

At 10 of the facilities, the illumination of the exit discharges was inadequate owing to missing or burned-out lights or to the lack of any lighting. Also, at eight facilities either (1) the inspection records showing that the emergency lighting and exit signs had been properly inspected were incomplete or missing or (2) the lights and signs themselves did not illuminate when tested. Finally, 13 facilities had missing or damaged smoke and fire barriers, including broken ceiling tiles and openings that could contribute to the spread of smoke and fire. One facility (of the 13) had an unused laundry chute that was open at the bottom and not properly sealed at the top with fire-resistant caulk. The photographs on the following page depict some of the deficiencies we identified during our site visits.

¹⁰ Among the 20 nursing homes, there were a total of 67 deficiencies related to building exits and fire barriers.



**Photograph 1 (left): Top of unused laundry chute not sealed with fire caulk.
Photograph 2 (right): Unsealed bottom of unused laundry chute.**



**Photograph 3 (left): Ceiling smoke/fire barrier in facility hallway in disrepair.
Photograph 4 (center): Battery backup for emergency lighting not working.
Photograph 5 (right): Exit discharge lighting missing bulb.**

Fire Detection and Suppression Systems

Nursing homes are required to have a fire alarm system that has an alternate power supply and is tested and maintained in accordance with NFPA requirements. Sprinkler systems must be installed, inspected, and maintained in accordance with NFPA requirements. Cooking equipment, including special fire suppression systems, must be maintained and repairs performed on all components at intervals necessary to maintain good working condition. Nursing homes must also have fire watch procedures for times when the fire alarm or sprinkler system is out of service or evacuate, and portable fire extinguishers must be inspected monthly. Smoke detectors are required in spaces open to corridors (K-Tags 324, 342, 344, 345, 346, 347, 351, 352, 353, 354, 355, 421).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to their fire detection and suppression systems.¹¹ Specifically, eight facilities failed to have their fire alarm systems routinely tested and maintained, and two other facilities did not have complete listings of all

¹¹ Among the 17 nursing homes, there were a total of 43 deficiencies related to fire detection and suppression systems.

devices connected to the fire alarm systems that had been tested during their inspections.¹² In addition, nine facilities had sprinkler system heads that were blocked or obstructed, three facilities failed to have their sprinkler systems routinely tested and maintained, three had closets that were not sprinklered, and one had a service elevator shaft that was not sprinklered.

At three facilities, the exhaust hood suppression systems on cooking equipment were missing nozzle caps. Furthermore, one facility did not have documentation showing that the stovetop fire suppression system had been inspected, and one facility had a fully functional stove without an installed class K fire extinguisher.¹³ Also, six facilities had inadequate policies and procedures for fire watches.¹⁴ In addition, three facilities did not inspect all of their portable fire extinguishers on an annual or monthly basis, and three other facilities had fire extinguishers that were blocked, had inadequate pressure, or were installed at the incorrect height. The photographs below depict some of the deficiencies we identified during our site visits.



Photograph 6 (left): Functioning stove without installed class K fire extinguisher.
Photograph 7 (right): Obstructed sprinkler head in resident room closet.

Hazardous Storage Areas

In hazardous storage areas, nursing homes must install a fire barrier or an automatic fire extinguishing system with smoke-resistant partitions and self-closing doors. Hazardous chemicals must be stored in a safe manner, and general upkeep should be maintained to limit unnecessarily large amounts of combustible materials that present a fire hazard (known as fire

¹² At five facilities, some inspection and testing reports were missing. At three of these five facilities, complete device listings were also not included. We did not count these missing reports as additional deficiencies.

¹³ The 2010 edition of NFPA 10, Standard for Portable Fire Extinguishers, subsection 6.6.1, states: "Class K fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats)."

¹⁴ When fire alarms or sprinkler systems are out of service, individuals are assigned areas to patrol to watch for fire or smoke until the systems are back in service. If a fire watch is not done, the building must be evacuated. Areas not addressed in fire watch policies and procedures included articulation of the reasons to call a fire watch, the frequency with which a fire watch walkthrough is to be performed, and listings of the institutions and contact information the facility is required to call during a fire watch.

load). In addition, garbage and laundry containers must not occupy more than one-half gallon per square foot of floor space. Oxygen systems must be maintained and inspected, and rooms with oxygen cylinders must be properly placarded, including a sign indicating that the room is used for oxygen storage, a no-smoking sign, and separately labeled storage spaces for full and empty cylinders. Oxygen cylinders must be stored in a safe manner so as not to damage or tip over the cylinder, which could cause a dangerous pressurized oxygen release (K-Tags 321, 322, 500, 541, 754, 905, 908, 923).

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to hazardous storage areas.¹⁵ Specifically, we found two facilities with doors to hazardous storage areas that did not close properly, five facilities with doors that accessed hazardous storage areas and that either did not have self-closing devices installed on the doors or had self-closing devices that were disconnected, and five facilities with gasoline cans or other hazardous chemicals that were not stored in approved flammable storage cabinets. Also, we found two facilities with oxygen cylinders stored in rooms that were not properly labeled. The following photographs depict some of the deficiencies we identified during our site visits.



**Photograph 8 (left): Hazardous area enclosure’s self-closing device not closing properly.
Photograph 9 (right): Hazardous area enclosure’s self-closing device disconnected.**



**Photograph 10 (left): Unsecured gasoline cans not stored in a flammables storage cabinet.
Photograph 11 (right): Oxygen storage room lacking a posted “NO SMOKING” sign or symbol.**

¹⁵ Among the 10 nursing homes, there were a total of 14 deficiencies related to hazardous storage.

Smoking Policies and Fire Drills

Nursing homes are required to establish smoking policies for residents and staff. Smoking is permitted only in authorized areas where ash receptacles are provided. Further, no-smoking areas must include signage. Nursing homes are also required to conduct fire drills each calendar quarter that cover each work shift. Participation by staff members is required, and the drills must be planned and conducted by a qualified individual designated by the nursing home. The drills may be announced or unannounced; they include the transmission of a fire alarm signal and simulation of emergency fire conditions (K-Tags 712, 741, 925).

Of the 20 nursing homes we visited, 18 had 1 or more deficiencies related to smoking policies or fire drills.¹⁶ Specifically, three facilities were not following their smoking policies, such as banning smoking except in allowable marked areas, and another three facilities had ash cans with trash in them. In addition, we found that 15 facilities did not conduct fire drills each quarter covering all work shifts, did not document fire drill attendance to verify staff participation, or did not document fire drills at all. The following photograph depicts one of the conditions we identified during our site visits.



Photograph 12: Cigarette butts and trash in a cigarette ash can.

Elevator and Electrical Equipment Testing and Maintenance

If a nursing home has an elevator, it must be tested and maintained on a regular basis. Nursing homes must also keep a record of tests and repairs of other electrical equipment, such as patient beds and lifts. If power strips, extension cords, and portable space heaters are used, they must meet Underwriters Laboratories (UL) requirements and be used in a safe manner (K-Tags 531, 781, 920, 921).

¹⁶ Among the 18 nursing homes, there were a total of 21 deficiencies related to smoking policies and fire drills.

At all 20 nursing homes we visited, we identified 1 or more deficiencies related to elevator or electrical equipment testing and maintenance.¹⁷ Specifically, at all 20 facilities, we found no records of patient beds and lifts and no records of repairs made to these devices. Additionally, 13 facilities used power strips and extension cords that did not meet UL requirements (photograph below) or were unsafely connected to appliances or other power strips.



Photograph 13: “Daisy-chained” power strips (one power strip plugged into another power strip).

Life Safety Training

While conducting our onsite inspections, we found that there was a frequent turnover of nursing home management and staff. We noted that, although not required by CMS, there was no existing State agency training program that nursing home management could use to educate newly hired staff on how to comply with CMS requirements for life safety. For example, there was no standardized training program to teach newly hired maintenance staff about fire extinguisher inspections, fire alarm and sprinkler maintenance, the proper way to conduct and document fire drills, or how to test and maintain electrical equipment.

SELECTED NURSING HOMES DID NOT COMPLY WITH EMERGENCY PREPAREDNESS REQUIREMENTS

CMS’s *Emergency Preparedness Surveyor Checklist*, described earlier, lists the Federal regulations on emergency preparedness that nursing homes must comply with, and references each with an identification number referred to as an “E-Tag” (E-0001 through E-0042).

¹⁷ Of the 20 nursing homes we visited, 1 had a service elevator that was not used by residents. None of the other 19 nursing homes had any type of elevator. Among the 20 nursing homes with findings, there were a total of 33 deficiencies related to elevator or electrical equipment testing and maintenance.

Emergency Plan

Nursing homes are required to have an emergency plan in place, and the plan must be easily located. Nursing homes are also required to update the plan at least annually, include a facility and community all-hazards risk assessment, address emergency events and resident population needs, include a continuity of operations plan, address coordination with Federal, State, and local government emergency management officials, and have policies and procedures for emergency events based on the risk assessment (E-Tags 0001, 0004, 0006, 0007, 0009, and 0013).

At all 20 nursing homes we visited, we identified 1 or more deficiencies related to their emergency plans.¹⁸ Specifically, we found that seven facilities did not update their emergency plans annually. In addition, the plans at 4 facilities did not include a completed a risk assessment or did not address all risk assessment elements, 5 facilities' plans did not address resident population needs or continuity of operations, and 18 facilities' plans did not provide for coordination with all government emergency management officials.

Emergency Supplies and Power

Nursing homes must have an emergency plan that addresses emergency supplies and power and are required to have adequate supplies of emergency food, water, and pharmaceuticals readily available. (As a best practice, the Federal Emergency Management Agency (FEMA) considers 3 days of emergency supplies to be sufficient.)¹⁹ Nursing homes are also required to provide an alternate source of energy (usually a generator) to maintain temperatures to protect residents' health and safety, as well as for food storage, emergency lighting, fire protection, and sewage disposal (if applicable). Further, facilities must establish policies and procedures that determine how required heating and cooling of their facility will be maintained during an emergency situation, if there were a loss of the primary power source. Nursing homes that have generators must have them installed in a safe location and are required to perform weekly maintenance checks, monthly load tests, and annual fuel quality tests (if the generator operates on diesel fuel). Generators that operate on diesel fuel or propane gas are generally designed with a minimum fuel tank capacity to last for 3 days at half load, which factors in an emergency fuel stock and lead time for refueling with time built in for unanticipated delays. Nursing homes should also have a plan in place to keep generators fueled "as necessary" and an evacuation plan if emergency power is lost (E-Tags 0015 and 0041).

¹⁸ Among the 20 nursing homes, there were a total of 38 deficiencies related to emergency plan requirements.

¹⁹ The 3-day standard is a best-practice recommendation, as CMS does not have a specific standard regarding what constitutes a sufficient amount of emergency supplies to have on hand. We did not audit compliance to this standard. Rather, our findings regarding a sufficient amount of generator fuel or other emergency supplies are based on a totality of the applicable criteria.

Of the 20 nursing homes we visited, 16 had 1 or more deficiencies related to emergency supplies and power.²⁰ Specifically, four of the facilities did not adequately address the availability of emergency supplies or emergency power in their emergency plans. In addition, eight facilities did not have sufficient water on hand (FEMA recommends 1 gallon per person, per day, for 3 days),²¹ four facilities did not have a working generator onsite,²² and one facility did not have a generator system sufficient to power their heating or air conditioning systems (or other alternate means of heating or cooling the facility or a plan that specified at which indoor air temperature the facility should be evacuated if it is too cold or too hot). Also, 12 facilities had not properly tested and maintained their generators. Eight facilities did not have sufficient generator fuel on hand to last 3 days, or sufficient plans to obtain emergency fuel or evacuate the facility when fuel levels reached a specified low level.

Plans for Evacuations, Sheltering in Place, and Tracking Residents and Staff During and After an Emergency

Nursing homes are required to have a plan for evacuations, sheltering in place, and tracking residents and staff during and after an emergency. Nursing homes must also have a plan for transferring medical records, using volunteers, and transferring residents, and procedures for waivers when providing care at alternate sites during emergencies (E-Tags 0018, 0020, 0022, 0023, 0024, 0025, 0026, 0033).

Of the 20 nursing homes we visited, 6 had 1 or more deficiencies related to their emergency plans for evacuations, sheltering in place, and tracking residents and staff during and after emergencies.²³ Specifically, we found that emergency plans for four facilities did not address sheltering in place and that plans for three facilities did not address tracking residents and staff.

Emergency Communications Plans

Nursing homes are required to have a communications plan that includes names and contact information for staff, entities providing services, residents' physicians, other nearby nursing homes, volunteers, government emergency management offices, and the State agency, among others. The plan must be updated at least annually. Nursing homes are also required to have primary and alternate means of communication, such as cell phones or radios; a means to communicate residents' condition information and location in the event of an evacuation; and

²⁰ Among the 16 nursing homes, there were a total of 37 deficiencies related to emergency supplies and power.

²¹ As noted earlier, this 3-day standard is a best practice recommendation, as CMS does not have a specific standard regarding what constitutes a sufficient amount of water to have on hand.

²² One facility had a generator onsite that had not been properly serviced and that did not have a transfer switch installed to properly connect it to the facility in the event of an emergency. Facility personnel told us that ownership's plans were to be able to put the generator on a trailer and take it to other nursing homes they owned whenever it was needed and to connect it with extension cords.

²³ Among the six nursing homes, there were a total of seven deficiencies related to tracking residents and staff.

methods to share emergency plan information with residents and their families (E-Tags 0029, 0030, 0031, 0032, 0034, 0035).

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to the adequacy of the emergency communications plans.²⁴ Specifically, we found that two facilities did not have an official emergency communications plan but had contact information in other locations. We found that 10 facilities did not have required name and contact information, 7 did not update their plans annually, and 2 did not have alternate means of communication.

Emergency Plan Training

Nursing homes are required to have a training and testing program related to their emergency plan and to provide updated training at least annually. Initial training must be provided to new staff members, independent contractors (e.g., contracted cleaning staff), and volunteers. The training, as well as annual refresher training required for all staff, must be designed to demonstrate knowledge of emergency procedures and must be documented. Nursing homes must also conduct an annual community-based, full-scale testing exercise.²⁵ In addition, a second training exercise (full-scale testing exercise, facility-based exercise, or “tabletop” exercise) must be completed annually. An analysis of all training exercises (and actual events) must be completed and documented and the emergency plan revised, if necessary (E-Tags 0036, 0037, 0039).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to emergency plan training.²⁶ Specifically, 3 facilities did not have an emergency preparedness training and testing program or did not update it annually, 3 did not maintain adequate documentation that new staff had received initial training in emergency preparedness policies and procedures, 3 provided annual refresher training that was not adequate because not all emergency plan elements were included or documented in the training, 2 did not conduct annual full-scale training exercises, 3 did not conduct a second training exercise, and 10 did not conduct either of these training exercises or analyses of them.

We also noted during our site visits that the staffs at many of the nursing homes were in some cases using templates to incorporate CMS requirements into their emergency plans. Several of the facilities used generic entries rather than facility-specific information in their emergency plans. For example, several facilities had the following statement in their emergency plans to document the planned use of a backup generator in the event of a power outage: “We also have a rigorously maintained generator.” One of the nursing homes whose emergency plan included this statement did not have a backup generator.

²⁴ Among the 11 nursing homes, there were a total of 21 deficiencies related to emergency communications.

²⁵ The exercise can be facility-based if a community-based exercise is not possible. Further, nursing homes are exempt from this requirement if they activated their emergency plan during the year.

²⁶ Among the 17 nursing homes, there were a total of 46 deficiencies related to emergency plan training.

CONCLUSION

At the conclusion of our inspections, we shared the deficiencies we identified with nursing home management and staff so that immediate corrective actions could be taken. We also shared the identified deficiencies with the State agency and CMS for followup, as appropriate.

While nursing home management and staff are ultimately responsible for ensuring resident safety, we maintain that the State agency can reduce the risk of resident injury or death by improving its oversight. For example, the State agency could explain CMS requirements for life safety and emergency preparedness to nursing homes by providing standardized life safety training and conducting more frequent comprehensive life safety and emergency preparedness surveys at facilities with a history of multiple high-risk deficiencies.²⁷ State agency oversight could also include training of nursing home staffs in how to update the available templates with facility-specific information to assist the staffs in preparing and refining their own emergency preparedness plans.

RECOMMENDATIONS

We recommend that the Missouri Department of Health and Senior Services:

- follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report,
- work with CMS to develop standardized life safety training for nursing home staff,
- conduct more frequent surveys at nursing homes that have a history of multiple high-risk deficiencies and follow up to ensure that corrective actions have been taken, and
- expand training of nursing home staffs with specific attention to the updating of emergency preparedness plan templates to address facility-specific preparations.

²⁷ While CMS does not specifically require this type of comprehensive life safety training, under the State agency's section 1864 agreement with CMS (described earlier in "Responsibilities for Life Safety and Emergency Preparedness"), the State agency agreed to perform certain functions, including explaining Federal requirements to providers to enable them to maintain standards of health care consistent with Medicare and Medicaid participation requirements (CMS *State Operations Manual* § 1010). Also, as mandated by §§ 1819(g)(1)(B) and 1919(g)(1)(B) of the Act, States must conduct periodic educational programs for the staff and residents of nursing homes to present current regulations, procedures, and policies.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our findings and with our last three recommendations. The State agency did not directly agree or disagree with our first recommendation but said that it would continue to evaluate compliance with requirements and ensure that nursing homes implement corrective action for deficiencies cited in surveys. The State agency also stated that it did not see “the correlation between the OIG recommendations and the impact on inadequate management oversight and high staff turnover at nursing homes, nor does the OIG provide a standard of practice for evaluating either area.”²⁸

After reviewing the State agency’s comments, we maintain that all of our findings and recommendations remain valid. Nursing homes and other long-term-care facilities serve a vulnerable population; ensuring quality of care in these facilities is undeniably challenging. The nursing home regulatory process is designed to hold providers accountable for meeting certain performance standards, and in Missouri the State agency is one of the primary entities responsible for doing so. More frequent surveys and expanded training of nursing home staffs would be likely to improve the performance of facilities with a history of multiple high-risk deficiencies.

The State agency’s mission statement states: “To be the leader in promoting, protecting and partnering for health.”²⁹ This report offers well-supported recommendations for ways in which the State agency can improve its oversight of nursing homes in direct support of its stated mission.

A summary of the State agency’s comments and our responses appears below. The State agency’s comments, from which we have redacted information identifying individual facilities, appear as Appendix D.

OFFICE OF INSPECTOR GENERAL RECOMMENDATIONS ON TRAINING

State Agency Comments

The State agency did not concur with our second and fourth recommendations. For both recommendations, the State agency said that training is already available through CMS, NFPA, and other organizations. The State agency described some of the training opportunities provided by these entities and added that the State agency itself would continue to provide training in life safety and emergency preparedness “as requested by nursing homes and provider associations.”

²⁸ The State agency also provided comments on our “Other Matters” section; we summarize and respond to those comments in that section.

²⁹ At <https://health.mo.gov/about/index.php> (accessed Dec. 9, 2019).

The State agency also stated that “[t]raining does not always result in fewer deficiencies. . . . Additionally, [F]ederal regulations do not require nursing home staff to attend standardized training.”

Office of Inspector General Response

We agree that training does not *always* result in fewer deficiencies. However, we believe that more frequent training would generally result in fewer high-risk deficiencies and, more importantly, in reduced risks to the health and safety of nursing home residents. Although Federal requirements do not speak explicitly in terms of standardized training, relevant provisions of the Act, the CMS *State Operations Manual*, and the section 1864 agreement require cognizant State agencies to conduct training that (1) explains Federal requirements to providers to enable them to maintain standards of healthcare and (2) includes periodic educational programs (footnote 27).

The State agency’s comments on these two recommendations focused primarily on the availability of training offered by CMS, NFPA, and other outside organizations and by the State agency itself. These comments placed the responsibility for taking advantage of outside training opportunities on nursing home management and staff. Similarly, the State agency essentially suggested that nursing homes and provider associations are responsible for requesting training that the State agency offers. We believe that by relying on nursing home employees to take training that is not required of them, and by waiting for nursing homes and provider associations to request this training, the State agency did not take advantage of an opportunity to be more proactive in leveraging life safety and emergency preparedness training to help safeguard the health and safety of nursing home residents.

OFFICE OF INSPECTOR GENERAL RECOMMENDATIONS ON FREQUENCY OF SURVEYS

State Agency Comments

The State agency did not concur with our third recommendation. The State agency said that in Federal fiscal year 2019, for example, it had used nearly all of the funds provided by CMS to conduct required nursing home surveys and complaint investigations. The State agency added that “[c]urrent funding by CMS does not support the hiring of additional surveyors. . . . Without proper funding and commitment of additional survey staff, more frequent surveys cannot be completed unless other workload priorities are compromised, including the investigation of complaints.” The State agency also said that it had requested additional funding for Federal fiscal year 2020.

The State agency also stated that “[s]urveys that are more frequent do not always result in a nursing home having fewer deficiencies.” To support this statement, the State agency cited as examples three nursing homes and described dates of surveys and our own onsite visits, as well as deficiencies noted, for each.

Office of Inspector General Response

We agree that more frequent surveys do not *always* result in fewer deficiencies. However, we believe that more frequent surveys would generally result in fewer high-risk deficiencies and, more importantly, in reduced risks to the health and safety of nursing home residents.

We recognize the effect of the funding constraints that the State agency described, and we acknowledge that it has requested additional funding.

Regarding the three examples that the State agency cited to support its comment that more frequent surveys do not always result in fewer deficiencies, we note that the first example (“Nursing Home 1” in this report (Appendix C)) showed that the more frequent surveys that the State agency described did in fact result in fewer deficiencies.³⁰ For the other two examples that the State agency cited, it is not clear what conclusions the State agency expected us to draw. In its discussion of the second example, for instance, the State agency mentioned a deficiency that it said we had identified during our onsite visit, but we did not note that deficiency during our visit to that nursing home. In its discussion of the third example, the State agency referred to a CMS inspector but acknowledged that the individual was at the nursing home to conduct a training exercise rather than an actual inspection.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING OUR FINDINGS

State Agency Comments

The State agency said that it disagreed with our findings and stated that we “did not identify or report to the [S]tate agency any instances where [OIG] identified resident harm or immediate jeopardy in any of the sampled nursing homes.” In addition, the State agency said that 2 of the 20 nursing homes we reviewed had not been surveyed by the State agency “to determine compliance with the new emergency preparedness regulations” before our audit. The State agency asked us to remove these two facilities from our findings because it had not completed its evaluations of these facilities’ emergency preparedness programs before our audit.

The State agency also stated that our draft report included findings that are not required by Federal or State regulations; the State agency added that it “is required to ensure nursing homes follow regulations, and cannot go beyond our scope and authority.” To support this statement, the State agency cited considerations pertaining to generators, shelter-in-place plans, alternative communication means, and fire watch policies. For example, according to the State agency, if a nursing home’s emergency plan shows that residents and staff will evacuate rather than sheltering in place during a power loss, that facility is not required to have a

³⁰ The October 10, 2017, survey of this nursing home identified 15 life safety deficiencies; the March 22, 2019, survey of the same facility identified 2 life safety deficiencies. Emergency preparedness deficiencies at this nursing home showed a similar decline over time.

generator or a shelter-in-place plan. The State agency also said that use of a hand-held or citizens' band radio as an alternative communication means is a best practice, not a requirement. Further, the State agency said that insurance company information is not required under the fire watch policy in NFPA 101.

In addition, the State agency addressed the causes that we identify in this report: inadequate management oversight, high staff turnover, and inadequate followup on deficiencies previously cited. The State agency characterized our stated causes as "misleading. The . . . audit findings presume that any potential non-compliance [the auditors] observed while at the nursing home was present at the time of the most recent [S]tate agency survey and was a direct result of inadequate management oversight and high turnover." The State agency added that the checklists we gave to it "did not provide specific information on which homes [OIG] identified as having inadequate management oversight and high turnover."

Office of Inspector General Response

The objective of this audit was to determine whether the State agency ensured that the nursing homes we reviewed complied with CMS requirements for life safety and emergency preparedness. We used these requirements to evaluate the extent to which the nursing homes' life safety and emergency preparedness procedures eliminated or minimized the *risk* to the health and safety of their residents. It was not necessary for us to identify instances of harm or immediate jeopardy for us to conclude that the deficiencies we identified increased the risk to residents.

With respect to the State agency's request that we remove two nursing homes from our findings, CMS's requirements for emergency preparedness (42 CFR § 483.73) became *effective* on November 15, 2016, with an *implementation* date of November 15, 2017—that is, 1 year later. Therefore, we disagree with the State agency's assertion that the timing of our audit did not allow it enough time to determine whether these two nursing homes complied with CMS requirements for emergency preparedness. In addition, we note that the State agency surveyed both of these nursing homes after the November 15, 2016, effective date and before we performed our review of the emergency preparedness procedures.

Furthermore, the State agency found no deficiencies in its first (December 2018) surveys of these two nursing homes' compliance with the new emergency preparedness regulations. (The State agency conducted these two surveys approximately 3 months after our onsite visits to those facilities.) Moreover, State agency surveyors found no deficiencies in the first surveys of nursing homes' compliance with the new regulations for 18 of the 20 nursing homes in our sample. Our onsite visits to the nursing homes—all but 2 of which we visited *after* the State agency's first surveys—identified deficiencies in compliance with the new emergency preparedness regulations at all 20 facilities. This fact reinforces our statement earlier in this report (in "Conclusion") that the State agency can improve its oversight of the nursing homes' management and staff.

Moreover, we disagree with the State agency's characterization that our draft report included findings that are not required by Federal or State regulations. Each of the examples that the State agency cited in this regard—generators, shelter-in-place plans, alternative communication means, and fire watch policies—is clearly addressed in regulatory language. Federal regulations require an alternate source of energy (usually a generator) that meets the subsistence needs for staff and residents, whether those individuals evacuate or shelter in place (42 CFR § 483.73(b)(1)(ii)). These regulations also require nursing homes to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code (42 CFR § 483.73(e)(2)). Explanatory material (Annex A) to section 4.6.12.3 of NFPA 101 also suggests that if these life safety features are not maintained, they be removed as they would otherwise create a “reasonable expectation” that they are functional. “When systems are inoperable or taken out of service but the devices remain, they present a false sense of security.”

Additionally, shelter-in-place plans are not required to be long-term in nature or to be implemented solely as the result of a power outage. Other events to which a shelter-in-place plan would apply include, but are not limited to, an active shooter, tornado, or civil uprising, as well as instances in which a section of the facility is damaged, and residents are moved to an unaffected section or to another building. Regarding alternative communication means, our findings (in “Emergency Communications Plans”) do not specify that any type of radio is required as an alternative communication means and do not count the absence of a particular type of radio as a deficiency. Finally, the State agency was correct in stating that insurance company information is not required under NFPA 101. However, notification of insurance companies is required under NFPA 25 when a facility's fire alarm and sprinkler system out-of-service policies are combined into one fire watch policy.

We disagree with the State agency's characterization of our stated causes as “misleading.” Although we acknowledge that a nursing home can sustain new life safety deficiencies shortly after a survey or onsite visit had found no such deficiencies, that fact does not pertain to many emergency preparedness deficiencies (such as evacuation plans and shelter-in-place plans). In this regard, we identified significant challenges in key personnel turnover at the 20 nursing homes we reviewed. At 10 of those facilities, the Maintenance Director had less than 1 year of time in service in that position; at 2 other facilities, that position was vacant. This position is primarily responsible for maintaining facilities' sprinkler systems, fire alarms, emergency lighting, and other life safety systems. Accordingly, the high turnover in this position that we observed at the majority of the nursing homes increased the risk to the health and safety of the residents of these facilities.

In addition, employees at 18 of the 20 nursing homes we visited stated that they were short-staffed, with average to frequent staff turnover. Nursing staff shortages and turnover would also affect the experience level of staff familiar with facility life safety and emergency preparedness procedures as well as the facility itself. Staffing shortages and turnover, particularly with respect to positions calling for experienced staff who are familiar with a facility and its emergency procedures, could affect the health and safety of residents of these facilities.

In this regard, the issues of inadequate oversight and high turnover that this report identifies can be recognized for what they are: causes rather than findings. The checklists that we gave to the State agency focused on findings: they identified the deficiencies we found while performing our site visits at these nursing homes. Inadequate management oversight and high turnover are not deficiencies in and of themselves that we would have listed on these checklists. After we provided these checklists to the State agency, it did not respond to our offer to review the checklists with its staff.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING OUR OBJECTIVE, SCOPE, AND THE STRUCTURE OF THIS AUDIT

State Agency Comments

The State agency said that “From the date of the entrance conference to the exit conference on July 12, 2019, the objective of the audit changed considerably”—a change, according to the State agency, that we did not communicate to it. The State agency also said that at the exit conference, “the auditors stated they did not have any concerns related to the state agency ensuring corrective action was taken to correct deficient practice identified during inspections. This is in direct conflict with the statement made that Missouri did not adequately follow up on deficiencies previously cited.”

In addition, the State agency pointed to our reference to Federal regulations at 42 CFR § 488.308(c) (footnote 7), which “makes no mention of surveying nursing homes with repeat deficiencies more often.” The State agency also pointed to our statement that management and staff at nursing homes are ultimately responsible for ensuring the safety and well-being of the nursing homes’ residents and for complying with Federal, State, and local regulations, “[y]et,” the State agency added, “the [draft] report faults the state survey agency for not ensuring the sampled nursing homes were in compliance.” The State agency said that its role is “to conduct surveys within required timeframes and utilize the survey process to determine if nursing homes are in compliance with federal and state regulations and to ensure identified deficiencies are corrected.”

Office of Inspector General Response

We reserve the right to change the audit objectives that we communicate in our engagement letters to auditees. We make such changes only after careful consideration, and we communicate these decisions to auditees expeditiously, while still engaged in our audit work. For this audit, we communicated this change in objective to the State agency at the entrance conference, noting that this is an audit of Missouri’s oversight of the nursing homes and that the report would be written to the State agency.

Because we were aware at all times that we were auditing the State agency rather than the nursing homes, we did not say, and would not have said, that we had no concerns about the State agency’s actions to ensure that nursing homes took corrective actions. The only

discussion at the exit conference that touched on corrective actions occurred when a State agency official asked us if we were aware of plans of correction that the nursing homes had submitted after previous State agency surveys. Our reply that we were aware of those plans of correction did not, and does not, constitute a statement that we had no concerns related to the State agency's actions after it received those plans.

The concerns that this audit report conveys regarding State agency oversight are fully supported by the Federal regulations at 42 CFR § 488.308(c), which state: "The survey agency may conduct a survey as frequently as necessary to—(1) Determine whether a facility complies with the participation requirements; and (2) Confirm that the facility has corrected deficiencies previously cited." This regulation firmly underpins our statement (in "Responsibilities for Life Safety and Emergency Preparedness") that nursing homes with repeat deficiencies *can* be surveyed more frequently.

Federal regulations, as well as the section 1864 agreement and the Act itself, speak more broadly about the depth and extent of the State agency's oversight responsibilities toward the nursing homes under its purview. The section 1864 agreement between the Federal Government and the State of Missouri, which "includes the State survey agency," specifies that the State is responsible for certifying that a nursing home complies with all requirements in the Act and implementing regulations. Although it is true that management and staff at nursing homes have direct responsibility for their residents, this does not relieve the State agency of its oversight responsibility to ensure that nursing homes not only meet Federal participation requirements, but also provide safe environments, "including standards for life safety" (section 1864 agreement), for their residents. In this regard, when the State agency described its "role" in terms of surveys and the survey process, it was not acknowledging other aspects of its oversight responsibility, which must ultimately focus on the health and safety of the residents of the nursing homes in the State.

OTHER MATTERS

We note that the Missouri Code of State Regulations (CSR) does not require the installation of carbon monoxide detectors in nursing homes; however, the fire safety requirements for facility-based day habilitation and employment service settings at 9 CSR 45-5.110(7)(H) state: "Facilities using any equipment or appliances using wood or fossil fuel that pose a potential carbon monoxide risk . . . shall install a carbon monoxide detector(s)." In addition, the fire safety requirements for family day care homes at 19 CSR 30-61.086(10)(D) and those for group day care homes and child day care centers at 19 CSR 30-62.087(12)(A) state: "Facilities using equipment or appliances that pose a potential carbon monoxide risk . . . shall install a carbon monoxide detector(s)."

In its comments on our draft report, the State agency said that "this information is not relevant to this audit, has no relation to the objective or the findings and should be stricken from the report."

After reviewing the State agency's comments, we maintain that this discussion is worth including in this report. The purpose of "Other Matters" is to include issues for the auditee's consideration but for which we do not make a formal recommendation. As we acknowledge above, the State of Missouri does not have regulations mandating the use of carbon monoxide detectors in nursing homes. We believe, though, that this issue deserves attention and is relevant to any audit that evaluates State-level oversight of the health and safety of nursing home residents.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

As of March 2018, there were 522 nursing homes in Missouri that participated in the Medicare or Medicaid programs. Of these 522 nursing homes, we selected for review a nonstatistical sample of the 20 nursing homes that had the most combined life safety and emergency preparedness deficiencies for CYs 2015, 2016, and 2017.

We did not assess the State agency's or nursing homes' overall internal control structures. Rather, we limited our review of internal controls to those applicable to our audit objective.

We performed our fieldwork at the State agency's offices in Jefferson City, Missouri, and conducted unannounced site visits at the 20 nursing homes throughout Missouri from July through November 2018.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS and State agency officials to gain an understanding of the process for conducting nursing home life safety and emergency preparedness surveys;
- obtained from CMS's ASPEN system a list of all 522 active nursing homes in Missouri that participated in the Medicare or Medicaid programs as of March 2018;
- compared the list obtained from CMS with the State agency Directory of Nursing Homes to verify completeness and accuracy;
- obtained from the nursing homes identified in ASPEN a listing of facilities that had 1 or more deficiencies in the previous 3 years that were considered high-risk because they (1) were widespread and had the potential for more than minimal harm, (2) had the potential for actual harm, or (3) presented immediate jeopardy to resident health or safety;
- selected for onsite inspections the 20 nursing homes in Missouri with the most combined life safety and emergency preparedness deficiencies for CYs 2015, 2016, and 2017 and, for each:
 - reviewed the deficiency reports prepared by the State agency for the nursing home's 3 most recent surveys and

- conducted unannounced onsite inspections to check for life safety violations and review the emergency preparedness plan; and
- discussed the results of our inspections with nursing home, CMS, and State agency officials on July 12, 2019.

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Life Safety and Emergency Preparedness Deficiencies Found at 18 of 20 Texas Nursing Homes</i>	<u>A-06-19-08001</u>	2/5/2020
<i>California Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>	<u>A-09-18-02009</u>	11/13/2019
<i>New York Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>	<u>A-02-17-01027</u>	8/20/2019

APPENDIX C: AREAS OF NONCOMPLIANCE AT EACH NURSING HOME

Life Safety Deficiencies

Nursing Home	Building Exits and Fire Barriers	Fire Detection and Suppression Systems	Hazardous Storage	Smoking Policies and Fire Drills	Elevator and Electrical Equipment Testing and Maintenance	Total
1	2	3	0	1	1	7
2	2	3	0	1	1	7
3	2	2	0	1	1	6
4	3	2	1	1	2	9
5	4	2	2	1	2	11
6	4	1	0	2	1	8
7	1	0	0	1	1	3
8	1	4	1	1	1	8
9	6	2	0	0	1	9
10	5	2	1	1	2	11
11	3	3	2	1	2	11
12	6	3	2	1	2	14
13	2	0	0	1	2	5
14	1	2	0	1	2	6
15	4	1	0	1	2	8
16	3	3	1	1	2	10
17	5	3	2	2	2	14
18	2	0	0	0	2	4
19	5	5	1	2	2	15
20	6	2	1	1	2	12
Total	67	43	14	21	33	178

Emergency Preparedness Deficiencies

Nursing Home	Emergency Plan	Emergency Supplies and Power	Evacuations, Sheltering in Place, and Tracking Residents and Staff During and After an Emergency	Emergency Communications	Emergency Plan Training	Total
1	1	3	0	2	5	11
2	3	2	0	3	3	11
3	5	1	1	3	7	17
4	2	2	1	2	1	8
5	1	2	0	0	1	4
6	5	2	0	2	6	15
7	1	1	0	0	1	3
8	1	4	1	2	3	11
9	2	1	0	2	0	5
10	1	0	0	0	0	1
11	4	3	1	2	3	13
12	1	2	0	0	3	6
13	1	0	0	1	0	2
14	2	3	2	0	1	8
15	1	0	0	0	3	4
16	2	4	0	0	3	9
17	2	3	0	1	3	9
18	1	0	0	1	1	3
19	1	2	1	0	1	5
20	1	2	0	0	1	4
Total	38	37	7	21	46	149

Notice: Under separate cover, we provided to the State agency and CMS the detailed inspection worksheets for each of the nursing homes we reviewed.


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Randall W. Williams, MD, FACOG
 Director

Michael L. Parson
 Governor

November 12, 2019

 Patrick J. Cogley
 Regional Inspector General for Audit Services, Region VII
 601 East 12th Street, Room 0429
 Kansas City, MO 64106

Dear Mr. Cogley:

Thank you for providing the Department of Health and Senior Services (DHSS) with an opportunity to provide written comments on the information provided in the Office of Inspector General's (OIG) draft audit report entitled *Missouri Should Improve Its Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness*.

In addition to responding to the recommendations in the report, we would like to offer the following information:

The Objective of the Audit Changed Between the Entrance and Exit

During the entrance conference on July 10, 2016, the objective of the audit provided on the entrance conference agenda stated, "The objective of our audit is to determine if long term care facilities that received Medicare and/or Medicaid funds for the period May 2, 2016 through November 15, 2017 are complying with federal requirements for Life Safety and Emergency Preparedness." From the date of the entrance conference to the exit conference on July 12, 2019, the objective of the audit changed considerably to, "Our objective was to determine whether the Missouri Department of Health and Senior Services (State agency) ensured that selected nursing homes in Missouri that participate in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness". Prior to the exit conference, the change in the objective of the audit was not communicated to DHSS.

Background: Requirements for Life Safety and Emergency Preparedness

The Final Rule for Emergency Preparedness was released by the Centers for Medicare and Medicaid Services (CMS) on Friday, September 16, 2016. Nursing homes were required to comply with the Emergency Preparedness Rule by November 15, 2017. State agencies began surveying nursing homes for compliance with the emergency preparedness rule on November 15, 2017.

Two of the homes selected by the OIG were not surveyed by the state agency to determine compliance with the new emergency preparedness regulations, prior to the OIG's audit. DHSS requests the following two homes be removed from the findings, since the state agency had not completed an evaluation of the homes emergency preparedness program prior to the OIG review.

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³⁰
[REDACTED] had a survey prior to implementation on 10/20/2017. The OIG review was completed from 9/4-9/6/2018. DHSS conducted a full survey in accordance with timeframes required by CMS, including the emergency preparedness requirements on 12/7/2018.

[REDACTED] had a survey prior to implementation on 11/02/2017. The OIG review was completed from 9/10-9/11/2018. DHSS conducted a full survey in accordance with timeframes required by CMS, including the emergency preparedness requirements on 12/7/2018.

Background: Responsibilities for Life Safety and Emergency Preparedness

A statement is made that nursing homes with repeat deficiencies can be surveyed more frequently. The footnote references 42 CFR 488.308(c). This particular footnote makes no mention of surveying nursing homes with repeat deficiencies more often. Additionally, this particular section states that management and staff at nursing homes are ultimately responsible for ensuring the safety and well-being of the nursing home's residents and for complying with Federal, State, and local regulations. Yet, the report faults the state survey agency for not ensuring the sampled nursing homes were in compliance.

DHSS' role is to conduct surveys within required timeframes and utilize the survey process to determine if nursing homes are in compliance with federal and state regulations and to ensure identified deficiencies are corrected. There is no evidence presented or conclusion drawn in the report indicating DHSS did not fulfill this role.

How We Conducted This Review: Findings

DHSS disagrees with the OIG findings. The report states that residents at the sampled nursing homes were at increased risk of resident injury or death during a fire or other emergency. The OIG did not identify or report to the state agency any instances where they identified resident harm or immediate jeopardy in any of the sampled nursing homes.

The OIG report states, "The identified areas of noncompliance occurred because Missouri did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, Missouri did not adequately follow up on deficiencies previously cited." This statement is misleading. The OIG audit findings presume that any potential non-compliance they observed while at the nursing home was present at the time of the most recent state agency survey and was a direct result of inadequate management oversight and high turnover. The audit checklists provided by the OIG did not provide specific information on which homes they identified as having inadequate management oversight and high turnover, or the standard for which they measured the homes, including the regulation that should have been cited.

The OIG developed their sample for this audit, by selecting "a nonstatistical sample of the 20 nursing homes that had the most combined life safety and emergency preparedness deficiencies for 2015, 2016, and 2017." The OIG audit did not evaluate whether the state agency appropriately cited deficient practice in the nursing homes, ensured corrective action was made by the nursing home using the requirement for submission of a plan of correction, or if the state agency verified corrective measures were in place and ongoing. Rather, during the exit conference with the state agency, the auditors stated they did not have any concerns related to the state agency ensuring corrective action was taken to correct deficient practice identified during inspections. This is in direct conflict with the statement made that Missouri did not adequately follow up on deficiencies previously cited.

³⁰ Office of Inspector General Note – The deleted text in this Appendix has been redacted because it identifies an individual facility.

Selected Nursing Homes Did Not Comply with Life Safety Requirements

Findings Not Supported in the Regulations

Throughout the evaluations, the auditors included findings that are not required by state or federal regulations. DHSS is required to ensure nursing homes follow regulations, and cannot go beyond our scope and authority. Examples of this practice included:

Generators

- If a nursing home's emergency plan shows they will not shelter in place during an evacuation event, a generator is not required for the nursing home. If a generator is not required, then they did not have to meet the testing and inspection requirements in the NFPA 110 standard.
- A nursing home may have a generator that does not meet NFPA 110/99 as long as they do not use it during an emergency instead of completing a total evacuation, or use it to fulfill LSC requirements.

Shelter in Place

If a nursing home's emergency plan shows they will conduct a full evacuation in the event of a power loss, they are not required to have a plan to shelter in place, as they do not have a generator compliant with NFPA 110. The nursing home would be noncompliant if they did have a plan that showed they would shelter in place during an extended power outage, where E-0041 could not be met.

Communication

Nursing homes are not required to use a hand held or CB radio as an alternative communication means. It is a best practice, not a requirement.

Fire Watch Policy

Insurance company information is not required under the fire alarm fire watch policy in NFPA 101 and no time is specified for a fire watch round in the code.

Conclusion

More Frequent Surveys

Surveys that are more frequent do not always result in a nursing home having fewer deficiencies. For example:

██████████ - This nursing home was designated a special focus facility at the time, therefore they received a full survey every 6 months. DHSS identified non-compliance in the area of emergency preparedness and life safety code requirements on 03/14/2018, when DHSS conducted a full certification survey at this nursing home. A revisit on 5/4/2018 showed the nursing home was in substantial compliance. The OIG auditors conducted onsite visits in July, 2018. Their documentation verifies the nursing home corrected the emergency preparedness deficiency previously cited by the state agency in March, however, they did not comply with E-0006. On 10/18/18, DHSS completed another full certification survey at the nursing home, identifying deficient practice in emergency preparedness and life safety code. Corrective action was made, which was verified by a revisit on 12/20/2018. There is no evidence in the report that surveys that are more frequent reduce the risk of resident injury or death.

██████████- DHSS conducted a survey on 12/07/2017. The facility was found in compliance with the emergency preparedness requirements. CMS conducted a comparative survey on 02/01/18, and verified the nursing home was in compliance with emergency preparedness requirements. The OIG conducted their audit on 10/25/2018 and noted several areas where the nursing home was non-compliant, however, the areas are not required by federal regulations, including the use of a generator, use of handheld radio for communications, etc. Although surveys were conducted on 12/07/17 and 2/1/2018, showing the facility egress doors were operational during testing, the OIG identified on 10/25/2018 that the egress doors were not functioning properly.

██████████- DHSS conducted a survey on 07/27/2018. In addition to the two DHSS LSC surveyors, a CMS Life Safety Code inspector was onsite at the same time conducting a training exercise for SLCR staff. As a result of the inspection, the facility was found in compliance with the emergency preparedness rules. Deficiencies were identified in life safety code that were corrected on 9/21/18. The OIG audit was conducted on 11/27/2018 that identified areas of non-compliance that were not present during the DHSS-CMS combined survey.

Standardized Training for Nursing Home Staff

Training does not always result in fewer deficiencies. Extensive training was provided prior to the implementation of the emergency preparedness rule by the state agency and CMS, however, each of the sampled nursing homes were deficient in this area when surveyed. Training continues to be available for nursing homes in the area of emergency preparedness and life safety code requirements. Additionally, federal regulations do not require nursing home staff to attend standardized training. Some of the training opportunities available for nursing home staff include:

CMS provides online training for surveyors and nursing home staff on their website related to emergency preparedness at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>

The National Fire Protection Agency (NFPA) has training developed that nursing homes may access in order to educate themselves on the fire safety requirements.

Prior to the implementation of the emergency preparedness regulations, DHSS provided multiple educational opportunities to nursing home providers related to emergency preparedness. Training for state surveyors/providers was released by CMS on Friday, September 1, 2017. This training course was provided online so that CMS, state agencies, and nursing home providers had ongoing access to the course, and could review it at any time. DHSS provided this information to providers and provider associations via the Department's listserv communication tool. Prior to this, CMS hosted a learning opportunity for providers on the Medicare Learning Network (MLN) site on April 27, 2017 regarding emergency preparedness requirements. Information regarding this training was communicated to providers in March, 2017. In-person training specific to emergency preparedness was developed and presented by DHSS in seven different locations throughout the state (Springfield, Jefferson City, Macon, Cape Girardeau, Independence, Bridgeton, and St. Joseph) during the months of September and October 2017 for all nursing home providers to attend. According to attendance records, approximately 1,362 providers attended these statewide joint training sessions with DHSS staff. Additionally, the Quality Improvement Program for Missouri (QIPMO), an organization that provides free training and

consultation to nursing homes in Missouri and funded largely through federal civil monetary penalty funds, conducted training in St. Louis on emergency preparedness on October 17, 2017.

Conclusion: Recommendations

Follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report.

DHSS will continue to evaluate compliance with emergency preparedness and life safety code requirements at each survey and ensure the nursing home implements corrective action for deficiencies cited.

Work with CMS to develop standardized life safety training for nursing home staff.

DHSS does not concur with this recommendation. DHSS feels standardized life safety training is available through CMS and NFPA. DHSS will continue to provide training in life safety as requested by nursing homes and provider associations.

Conduct more frequent surveys at nursing homes that have a history of multiple high-risk deficiencies, and follow up to ensure that corrective actions have been taken.

DHSS does not concur with this recommendation. The Mission and Priority Document (MPD) outlines the states responsibilities and priorities for the federal fiscal year, including prescribed survey timeframes. In FFY'19, DHSS used nearly all of the funds provided by CMS in order to conduct the required nursing home surveys and complaint investigations. Current funding by CMS does not support the hiring of additional surveyors in order to increase the frequency of these surveys. For FFY'20, DHSS has asked for an additional \$523,715 to assist in the retention of current surveyors and hiring of additional surveyors in order to meet current obligations. Without proper funding and commitment of additional survey staff, more frequent surveys cannot be completed unless other workload priorities are compromised, including the investigation of complaints.

Expand training of nursing home staffs with specific attention to the updating of emergency preparedness plan templates to address facility-specific preparations.

DHSS does not concur with this recommendation. DHSS feels training is already available through CMS, QIPMO, and provider associations. DHSS will continue to provide training in emergency preparedness as requested by nursing homes and provider associations.

Other Matters

The OIG points out that state requirements do not require the installation of carbon monoxide detectors in nursing homes. DHSS believes this information is not relevant to this audit, has no relation to the objective or the findings and should be stricken from the report.

DHSS does not see the correlation between the OIG recommendations and the impact on inadequate management oversight and high staff turnover at nursing homes, nor does the OIG provide a standard of

practice for evaluating either area. DHSS will continue to ensure the health and safety of Missouri residents living in nursing homes.

Sincerely,

Dean A. Linneman

Dean A. Linneman, Director
Division of Regulation and Licensure
Department of Health and Senior Services