Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

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

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 residents of 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 Florida ensured that selected nursing homes that participate in the Medicare or Medicaid programs complied with CMS and State requirements for life safety and emergency preparedness.

How OIG Did This Audit

Of the approximately 700 nursing homes in Florida that were enrolled in Medicare or Medicaid, we selected a nonstatistical sample of 20 nursing homes based on risk factors, including multiple high-risk deficiencies reported to CMS by Florida.

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.

What OIG Found

Florida did not ensure that selected nursing homes that participated in the Medicare or Medicaid programs complied with CMS and State requirements for life safety and emergency preparedness. All 20 nursing homes that we visited had deficiencies in areas related to life safety or emergency preparedness. Specifically, 19 nursing homes had 100 areas of noncompliance with life safety requirements related to building exits and smoke barriers, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment. Furthermore, 16 nursing homes had 87 areas of noncompliance with emergency preparedness requirements related to written emergency plans, emergency supplies and power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training.

The instances of noncompliance occurred because of several contributing factors, specifically inadequate management oversight and staff turnover at the nursing homes. In addition, Florida did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 12 to 15 months, even at these higher risk nursing homes.

What OIG Recommends and Florida Comments

We recommend that Florida (1) follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the deficiencies we identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies and follow up to ensure that corrective actions have been taken. We also made other administrative recommendations.

In written comments on our draft report, Florida agreed with our first and fifth recommendations and partially agreed with our seventh recommendation. Florida did not agree with our remaining recommendations. In addition, Florida provided general comments and concerns on our three findings and provided additional steps they have taken to address those findings. After reviewing Florida's comments, we modified our first finding to remove errors related to resident call systems and to more clearly summarize the number of deficiencies at each nursing home. We maintain that our findings and recommendations, as revised, are correct.