Report in Brief
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U.S. DEPARTMENT OF HEALTH & 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

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.

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.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71803230.asp.