

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

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

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Christi A. Grimm  
Principal Deputy Inspector General

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# *Office of Inspector General*

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## 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.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

In calendar year (CY) 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 reviews nationwide to assess compliance with these new life safety and emergency preparedness requirements. This review focuses on selected nursing homes in Iowa.

### OBJECTIVE

Our objective was to determine whether the Iowa Department of Human Services, Iowa Medicaid Enterprise (State agency) ensured that selected nursing homes in Iowa 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 that nursing homes comply with standards set forth in the National Fire Protection Association (NFPA) *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99).<sup>1</sup> CMS lists applicable requirements on Form CMS-2786R,

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

Fire Safety Survey Report.<sup>2</sup> 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.<sup>3</sup> CMS lists applicable requirements on its *Emergency Preparedness Surveyor Checklist*.<sup>4</sup>

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 Iowa, 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 no less than once every 15 months at nursing homes that participate in the Medicare or Medicaid programs.<sup>5</sup> However, nursing homes with repeat deficiencies can be surveyed more frequently.<sup>6</sup>

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.

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

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

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

<sup>5</sup> 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.

<sup>6</sup> 42 CFR § 488.308(c). The State agency generally conducts comprehensive surveys every 12 to 15 months and will follow up on deficiencies through either 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 12 to 15 months.

## HOW WE CONDUCTED THIS AUDIT

As of May 2019, a total of 437 nursing homes in Iowa 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 CYs 2016, 2017, and 2018.<sup>7</sup> These deficiencies included multiple high-risk deficiencies reported to CMS's ASPEN system by the State agency.<sup>8</sup>

We conducted unannounced site visits at the 20 nursing homes between July and November 2019. 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 Iowa 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 122 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 133 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.

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<sup>7</sup> We used 44 life safety and 4 emergency preparedness deficiency codes to select the 20 nursing homes with the most combined deficiencies.

<sup>8</sup> 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 have a standardized 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 that its surveys had previously cited. In addition, the State agency did not require nursing homes or inspection contractors: (1) to tag systems that have significant problems and are critical to the health and safety of nursing home residents and (2) to notify the State agency of these problems.<sup>9</sup>

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 with which nursing homes must comply and references each with an identification number referred to as a "K-Tag" (K-Tags 100 through 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, and 372).

Of the 20 nursing homes we visited, 18 had 1 or more deficiencies related to building exits, smoke and fire barriers, and smoke partitions.<sup>10</sup> Specifically, we noted the following deficiencies:

- discharge areas leading out from exit doors to safe areas were impeded (four facilities),
- self-closing doors did not close completely or were missing self-closing devices altogether (three facilities),
- pathways inside buildings that led to exit doors were blocked or impeded (two facilities),
- emergency exit doors were difficult to open (one facility),
- a gate on the egress path had a combination lock but did not have the combination posted (one facility), and
- a resident sleeping-room door was difficult to open (one facility).

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<sup>9</sup> Nursing homes may contract with companies to perform inspections of systems (such as fire alarm and sprinkler systems) in facilities. For this report, we refer to the companies that work under these arrangements as "inspection contractors."

<sup>10</sup> Among the 18 nursing homes, a total of 42 deficiencies were related to building exits, smoke and fire barriers, and smoke partitions.

In addition, at five of the facilities the illuminations of exit discharges were inadequate because of missing or burned-out lights or the lack of any lighting at all. Also, nine facilities had not properly inspected both emergency lighting and exit signs, or these did not illuminate when tested as determined from either: (1) the inspection records, which would show that the emergency lighting and exit signs had been properly inspected but which were incomplete or missing; or (2) the lights and signs themselves, which did not illuminate when tested.

Furthermore, 14 facilities had missing or damaged smoke and fire barriers, including broken ceiling tiles, gaps in resident sleeping-room doors, and other openings that could contribute to the spread of smoke and fire.

Photographs 1, 2, and 3 depict some of the deficiencies we identified during our site visits.



**Photograph 1 (left): Unable to open exit door off kitchen-dining area due to warped deck, which made this egress path unusable.**



**Photograph 2 (right): Emergency lighting not working when tested.**



**Photograph 3: Combination lock on gate along egress path did not have combination posted.**

## Fire Detection and Suppression Systems

Every nursing home is 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 fire suppression systems, must be maintained and repairs performed on all components at intervals necessary to maintain good working conditions. When a nursing home's fire alarm or sprinkler system is out of service, the nursing home must either put fire watch procedures<sup>11</sup> into effect or evacuate its residents. In addition, portable fire extinguishers must be inspected monthly. Smoke detectors are required in spaces open to corridors (K-Tags 324, 342, 344–347, 351–355, and 421).

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to their fire detection and suppression systems.<sup>12</sup> Specifically, one facility did not have a complete list of all devices connected to the fire alarm system that had been tested during its inspections. In addition, two facilities had sprinkler system heads that were blocked or obstructed, and one facility did not have its sprinkler system routinely tested and maintained. As a direct result of our review of sprinkler system testing and maintenance records, interviews with facility personnel, and consultation with a CMS surveyor, an Immediate Jeopardy was declared at Facility 16 due to a faulty fire pump.<sup>13</sup> Consequently, the facility initiated a fire watch.

At three facilities, hood suppression systems on cooking equipment were missing nozzle caps and two facilities did not have the proper documentation to show that their fire suppression systems had been inspected.

Also, four facilities had fire watch policies that did not include all the required contact information. In addition, four facilities did not inspect all of their portable fire extinguishers on an annual or monthly basis, one facility had fire extinguishers to which access was blocked, and one facility lacked an extinguisher in a courtyard gazebo that had an operating gas grill. Photographs 4 and 5 on the following page depict some of the deficiencies we identified during our site visits.

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<sup>11</sup> Fire watches require the continuous patrol of all areas of the building affected by the impairment to look for evidence of smoke, fire, or any abnormal conditions.

<sup>12</sup> Among the 10 nursing homes, a total of 17 deficiencies were related to fire detection and suppression systems.

<sup>13</sup> A fire pump is a device that provides the required water flow and pressure for a fire protection system.



**Photograph 4 (left): Sprinkler head obstructed by bird's nest.**  
**Photograph 5 (right): Access to fire extinguisher blocked by supply boxes.**

### **Hazardous Storage Areas**

In hazardous storage areas, nursing homes must install self-closing doors. In addition, rooms with oxygen cylinders must be properly placarded and have separately labeled storage spaces for full and empty cylinders. Oxygen cylinders must also be stored in a safe manner and used in the order received (K-Tags 321, 322, 500, 541, 754, 905, 908, and 923).

Of the 20 nursing homes we visited, 13 had 1 or more deficiencies related to hazardous storage areas.<sup>14</sup> Specifically, we found five facilities with gasoline cans or other hazardous chemicals that were not stored in approved flammable storage cabinets, four facilities with doors to hazardous storage areas that did not close properly, three facilities with doors to hazardous storage areas that were broken or that lacked installed self-closing devices, and two facilities with doors that had been propped open.

Also, we found four facilities with oxygen cylinders that had not been properly labeled as empty or full or that had empty and full containers stored together in oxygen storage rooms, and four facilities where multiple oxygen cylinders were stored in hallways and resident rooms or not secured in the oxygen storage rooms. Photographs 6 and 7 on the following page depict some of the deficiencies we identified during our site visits.

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<sup>14</sup> Among the 13 nursing homes, a total of 19 deficiencies were related to hazardous storage areas.



**Photograph 6 (left): Unsecured gasoline cans not stored in flammables storage cabinet.**  
**Photograph 7 (right): Empty oxygen cylinders stored in hallway.**

### **Smoking Policies and Fire Drills**

Nursing homes are required to establish smoking policies for residents and staff. Smoking may be permitted only in authorized areas where ash receptacles are provided. Furthermore, 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 and 741).

Of the 20 nursing homes we visited, 10 had 1 or more deficiencies related to smoking policies or fire drills.<sup>15</sup> Specifically, two facilities had ash cans containing trash and another facility had smoking policies that were inadequate because they applied only to staff and did not address smoking by residents. In addition, we found 10 facilities that did not ensure that fire drills were conducted each quarter covering all work shifts, did not vary the fire drill times from quarter to quarter for each shift, or did not document fire drills. Photograph 8 on the following page depicts one of the deficiencies we identified during our site visits.

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<sup>15</sup> Among the 10 nursing homes, a total of 13 deficiencies were related to smoking policies and fire drills.



**Photograph 8: Cigarette butts in trash can along with combustible materials.**

### **Elevator and Electrical Equipment Testing and Maintenance**

If a nursing home has an elevator, that elevator 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 are used, they must meet Underwriters Laboratories (UL) requirements and be used in a safe manner, and they cannot be mounted to building surfaces or attached to other power strips (i.e., “daisy chaining”). Extension cords can be used temporarily but must be removed immediately after use. Portable space heaters are allowed only in nonsleeping staff and employee areas (K-Tags 531, 781, 920, 921).

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to electrical equipment testing and maintenance.<sup>16</sup> Specifically, at 17 facilities, we found no records of patient beds, lifts, or other patient care-related electrical equipment being tested, and no records of repairs made to these devices. Additionally, 14 facilities used power strips and extension cords that did not meet UL requirements or were unsafely connected to appliances or other power strips. Photographs 9, 10, and 11 on the following page depict some of the deficiencies we identified during our site visits.

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<sup>16</sup> Among the 19 nursing homes, a total of 31 deficiencies were related to electrical equipment testing and maintenance.



**Photograph 9 (left): Unsafe use of power strip.**

**Photograph 10 (center): Unallowable use of triple plug.**

**Photograph 11 (right): Unallowable daisy chaining of power strips (one power strip plugged into another power strip).**

### **Life Safety Training**

While conducting our onsite inspections, we noted that—although not required by CMS—there was no existing State agency training program that, as a best practice, 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 State agency 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.

### **Inadequate Notification Requirements**

During our review of the Immediate Jeopardy deficiency at Facility 16, we found no requirement for nursing homes or inspection contractors to “tag” systems such as fire alarm or sprinkler systems or to notify the State agency when a significant problem is found with any of them. Only when these systems have been declared nonfunctional and the facility is required to institute a fire watch is a nursing home required to notify the State agency of problems with these systems. In this instance, the fire suppression system could not even be inspected due to the excessive leaking from the fire pump whenever it was tested. This raises a question: If the system could not be inspected, would it work in an emergency?

If a requirement were in place to notify the State agency when significant problems with these systems have been identified—rather than only after they have been declared nonfunctional—this situation, which developed into an Immediate Jeopardy with an initiated fire watch, could

have been avoided altogether. It is conceivable that in a similar situation in the future, one of these vitally important life safety systems might not function as required when needed most.

## **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 with which nursing homes must comply, and references each with an identification number referred to as an "E-Tag" (E-Tags 0001–0042).

### **Emergency Plan**

Every nursing home is required to have an emergency plan in place and to update the plan at least annually. The emergency plan must include a facility and community all-hazards risk assessment; address emergency events and resident population needs; include types of services available during an emergency and a continuity of operations plan; and address coordination with Federal, State, and local government emergency management officials (E-Tags 0001, 0004, 0006, 0007, 0009, and 0013).

Of the 20 nursing homes we visited, 17 had 1 or more deficiencies related to their emergency plans.<sup>17</sup> Specifically, we found that three facilities did not ensure that their emergency plans were updated annually. Also, at two other facilities, the supervisor on duty could not locate the emergency plan and had to wait for the facility administrator to arrive and point it out. In one of the two facilities, that did not occur until the following day. In addition: 13 facilities did not complete a risk assessment or their plan did not address all risk assessment elements, 8 facilities did not provide for coordination with all government emergency management officials, and 4 facilities did not consider resident population needs or continuity of operations.

### **Emergency Supplies and Power**

Nursing homes must have an emergency plan that addresses emergency power. Nursing homes are also required to provide an alternate source of energy (usually a generator) for maintaining temperatures to protect patient health, food storage, emergency lighting, fire protection, and sewage disposal (if applicable). Nursing homes with generators are required to perform weekly maintenance checks, monthly load tests, and annual fuel quality tests (if the generator operates on diesel fuel). Nursing homes should have a plan in place to keep generators fueled "as necessary" unless there is an evacuation (E-Tags 0015 and 0041).

Of the 20 nursing homes we visited, 9 had 1 or more deficiencies related to emergency supplies and power.<sup>18</sup> Specifically, one of the facilities did not adequately address the availability of

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<sup>17</sup> Among the 17 nursing homes, a total of 33 deficiencies were related to emergency plan requirements.

<sup>18</sup> Among the 9 nursing homes, a total of 11 deficiencies were related to emergency supplies and power.

emergency power in its emergency plan, and one facility did not have a working generator on the site. In addition, nine facilities did not have sufficient water on hand. (The Federal Emergency Management Agency recommends having in storage at least 1 gallon of water per person per day for 3 days).<sup>19</sup>

### **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 maintaining availability of medical records, using volunteers, and transferring residents, and have procedures for the nursing homes' role under a waiver to provide resident care at alternate sites during emergencies (E-Tags 0018, 0020, 0022–0026, and 0033).

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to their emergency plans for evacuations, sheltering in place, and tracking residents and staff during and after emergencies.<sup>20</sup> Specifically, we found that emergency plans did not address tracking residents and staff (three facilities), did not address sheltering in place (three facilities), and did not include, in their evacuation plan policies and procedures, all the required elements for safe evacuation from the facility (two facilities).

In addition, seven facilities' plans did not address their roles under a waiver to provide residents with care at an alternate site in an emergency, six facilities made no mention in their plans of the transfer of residents in an emergency or did not have signed transfer agreements with other facilities to demonstrate compliance, and three facilities did not address the use of volunteers in their plans.

### **Emergency Communications Plans**

Every nursing home is required to have a communications plan that includes names and contact information for staff, entities providing services, residents' physicians, 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 a plan for primary and alternate means of communication, such as cell phones or radios, and a plan for communicating the facility's occupancy, needs, and ability to provide assistance. In addition, nursing homes must have a plan for transferring medical records and a means to communicate information about the residents' conditions and location(s) in the event of an evacuation, and methods to

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<sup>19</sup> 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 with this standard. Rather, our findings regarding a sufficient amount of water or other emergency supplies are based on a totality of the applicable criteria.

<sup>20</sup> Among the 11 nursing homes, a total of 24 deficiencies were related to plans for evacuations, sheltering in place, and tracking residents and staff.

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

Of the 20 nursing homes we visited, 19 had 1 or more deficiencies related to the adequacy of their emergency communications plans.<sup>21</sup> Specifically, we found that 18 facilities did not have required name and contact information, 9 did not update their emergency communications plans annually, and 1 did not document procedures for communicating information about residents' condition and location in the event of an evacuation. We also found that two facilities did not have an official emergency communications plan (but had some contact information in other parts of their emergency plans).

### **Emergency Plan Training**

Every nursing home is required to have a training and testing program related to its emergency plan and to update that program 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<sup>22</sup> as well as a second full-scale testing exercise that can be community- or facility-based, or a “tabletop” exercise. An analysis of all training and testing exercises (and actual events) must be completed and documented and the emergency plan revised, if necessary (E-Tags 0036, 0037, and 0039).

Of the 20 nursing homes we visited, 11 had 1 or more deficiencies related to emergency plan training and testing.<sup>23</sup> Specifically, six facilities did not have an emergency preparedness training and testing program or did not update it annually, three facilities did not provide documentation of initial training on emergency procedures, and three facilities provided annual refresher training that was inadequate because not all emergency plan elements were included or documented in the training.

Furthermore, one facility did not conduct annual full-scale testing exercises and two facilities did not properly document their facility-based drills or their efforts to participate in a full-scale community exercise. Moreover, one facility did not conduct a second (full-scale community-based, individual facility-based, or tabletop) testing exercise, and four facilities did not conduct analyses of their full-scale or tabletop testing exercises. Four other facilities did not conduct any testing exercises.

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<sup>21</sup> Among the 19 nursing homes, a total of 30 deficiencies were related to emergency communications plans.

<sup>22</sup> The exercise can be facility-based if a community-based exercise is not possible. Furthermore, a nursing home is exempt from this requirement if it activated its emergency plan during the year.

<sup>23</sup> Among the 11 nursing homes, a total of 35 deficiencies were related to emergency plan training and testing.

## **Infectious Disease Planning**

While conducting our onsite inspections, we noted that four facilities had not performed all-hazard risk assessments, and an additional three facilities did not include infectious diseases in their all-hazard risk assessment planning. In Memo #QSO19-06-ALL dated February 1, 2019, to State Agency Survey Directors, CMS updated Appendix Z of the *State Operations Manual*, stating: “After review, CMS determined it was critical for facilities to include planning for infectious diseases within their emergency preparedness program.” This update added guidance to Appendix Z that “[p]lanning for using an all-hazards approach should also include emerging infectious disease (EID) threats.” Although we conducted our onsite inspections at each of these facilities after February 1, 2019, none of these seven facilities had included infectious diseases in their all-hazard risk assessment planning. In addition, of the 13 nursing homes that did include infectious diseases in their all-hazard risk assessments, 7 categorized this as one of the top 5 risks but did not address it in their emergency plans.

## **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.

Although nursing home management and staff are ultimately responsible for ensuring resident safety, 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, conducting more frequent comprehensive life safety and emergency preparedness surveys at facilities with a history of multiple high-risk deficiencies,<sup>24</sup> and requiring nursing homes and inspection contractors to tag fire alarm and sprinkler systems that may not work when required.

## **RECOMMENDATIONS**

We recommend that the Iowa Department of Human Services, Iowa Medicaid Enterprise:

- 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;

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<sup>24</sup> Although 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.

- 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
- require nursing homes and inspection contractors to: (1) tag systems that are critical to the health and safety of nursing home residents when they have found that these systems may not work as required when needed and (2) notify the State agency.

### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency concurred “with limitations” with our first three recommendations and the associated findings and described corrective actions it had taken or planned to take. The State agency did not concur with our fourth recommendation, which, it said, “goes beyond . . . regulatory requirements and would require a change in those governing regulations, which is not within the authority of the State [agency].” With respect to our findings, the State agency agreed that it did not ensure nursing home compliance with all CMS requirements for life safety and emergency preparedness, but it added that we had noted various deficiencies that were not present during prior or subsequent State agency inspections. In this regard, the State agency said that our audit findings did not reflect the State agency’s history of ensuring nursing home compliance. The State agency also disagreed with some of our findings; for instance, it did not concur that an Immediate Jeopardy existed at Facility 16 (as discussed in “Fire Detection and Suppression Systems” earlier in this report).

After reviewing the State agency’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.<sup>25</sup> We maintain that our findings, as revised, and all of our 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 standards, and in Iowa 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. Requiring nursing homes to tag critical systems and notify the State agency when those systems are not working as required would improve the State’s ability to ensure the safety of nursing home residents.

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<sup>25</sup> Our draft report specified 125 instances of noncompliance with life safety requirements; our final report specifies 122 such instances. Our draft report specified 139 instances of noncompliance with emergency preparedness requirements; our final report specifies 133 such instances. The State agency provided evidence that it had cited these nursing homes for five of these instances of noncompliance and that the nursing homes were in compliance with another two of these at the time of their most recent State agency surveys. We chose not to dispute the State agency’s disagreement with the remaining two instances.

A summary of the State agency's comments and our responses appears below. The State agency's comments, from which we have redacted references to a third-party entity, appear as Appendix D.

## **OFFICE OF INSPECTOR GENERAL RECOMMENDATION ON FOLLOWUP WITH SELECTED NURSING HOMES**

### **State Agency Comments**

The State agency concurred with our first recommendation but disagreed with some of the specific deficiencies noted in our findings. In addition, citing delays brought on by the COVID-19 pandemic, the State agency said that it did not receive our inspection reports until several months after we completed our inspections and that its followup with the nursing homes was also not as timely as would normally occur. The State agency also stated that at our exit conference, we told State agency officials that: (1) no deficiencies were issued to the nursing homes at the time of our inspections and (2) the nursing homes were responsible for following up with the State Fire Marshal (SFM) if they disagreed with any deficiencies.<sup>26</sup> The State agency added that, other than the one nursing home with the issue related to the faulty fire pump, none of the nursing homes contacted it regarding the deficiencies.

The State agency also stated that it would ensure that other State agencies follow up with each of the 20 nursing homes to ensure that corrective actions have been taken with respect to each of the life safety and emergency preparedness deficiencies identified in our report. In addition, the State agency described procedures that it planned to use to conduct followup visits at nursing homes to which access is restricted because of the pandemic.

### **Office of Inspector General Response**

We did not issue formal deficiencies to any of the nursing homes themselves because although the State agency has the authority to cite nursing homes directly, we do not. However, at the conclusion of each of our onsite nursing home inspections, we did provide a list of deficiencies we identified to nursing home management and staff so that immediate corrective actions could be taken. In addition, we informed the nursing homes that we would forward our findings to the State agency for review and encouraged the facilities to correct the deficiencies before any subsequent surveys by the State agency. At the conclusion of each site visit, we reviewed the checklists with nursing home staff, offering them the opportunity to challenge any of the deficiencies with which they disagreed. We also encouraged the nursing homes to follow up with the State agency if there was any confusion about our role or if they disagreed with any of the deficiencies we had identified.

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<sup>26</sup> As the State agency mentioned earlier in its written comments, it has entered into an agreement with the Iowa Department of Public Safety, SFM, which is charged with enforcing State building code and fire requirements. Because for this audit the State agency was our auditee, we maintain our focus on the State agency in this report.

## OFFICE OF INSPECTOR GENERAL RECOMMENDATION ON TRAINING

### State Agency Comments

The State agency concurred “with limitations” with our second recommendation. The State agency said that it had conducted 37 training sessions over the past 5 years and added that it provides classes to nursing home administrators and maintenance directors through several outside organizations. In addition, the State agency said that CMS “provides a wealth of resources for providers to understand their life safety obligations” and that NFPA “offers products, training, and resources for health care provider compliance with CMS Life Safety and Emergency Preparedness requirements.”

The State agency also stated that, at CMS’s request, it would work with CMS to develop a standardized program of instruction for nursing home staff. In addition, the State agency said that by December 31, 2020, it would review its current training program and ensure that it addresses the deficiencies conveyed in this report. The State agency also said that it would review its current emergency preparedness checklist and ensure that it comports with the Federal regulatory requirements and the checklist that we used for this audit.

### Office of Inspector General Response

We acknowledge the State agency’s Life Safety and Emergency Preparedness training programs but note that there is still room for improvement in them. During our audit, when we asked about the content of the Life Safety program training courses, the State agency responded that they “focus on current topics of interests.” We believe that more standardized and 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 health care and (2) includes periodic educational programs (footnote 24).

The State agency’s comments referring to the availability of training offered by CMS, the NFPA, and other outside organizations place the responsibility for taking advantage of outside training opportunities on nursing home management and staff. 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 is not taking 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 RECOMMENDATION ON FREQUENCY OF SURVEYS**

### **State Agency Comments**

The State agency concurred “with limitations” with our third recommendation. The State agency said that it conducts nursing home survey and certification oversight consistent with CMS protocols as set forth in chapter 8 of the *State Operations Manual* and follows up on cited deficiencies to ensure compliance with corrective action plans. The State agency noted that after receiving a complaint, it must conduct an onsite inspection within: (1) 2 working days for an immediate high-jeopardy situation, (2) 10 working days for a nonimmediate high-jeopardy situation, and (3) 45 days for all other situations.

The State agency also stated that it follows the requirements of the CMS Mission and Priority document and devotes resources to fulfilling those priorities identified by CMS. The State agency added that additional Federal and State funding would be needed to expand survey activities beyond those already conducted. The State agency said that the existing process for ensuring compliance “sufficiently provides additional oversight over those nursing facilities that have a history of multiple high-risk deficiencies” and that it would “continue to diligently comply with CMS protocols and priorities.”

### **Office of Inspector General Response**

We recognize the effect of the funding constraints that the State agency described. 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.

## **OFFICE OF INSPECTOR GENERAL RECOMMENDATION ON REQUIRING INSPECTION CONTRACTORS TO TAG SYSTEMS CRITICAL TO NURSING HOME RESIDENTS’ HEALTH AND SAFETY**

### **State Agency Comments**

The State did not concur with our fourth recommendation. The State agency said that this recommendation “goes beyond the current Life Safety Code and other regulatory requirements and would require a change in those governing regulations, which is not within the authority of the State [agency].” The State agency referred to Life Safety Code and NFPA requirements regarding fire alarm systems that are out of service for more than 4 hours in a 24-hour period and sprinkler systems that are out of service for more than 10 hours in a 24-hour period. The State agency added that although there is no requirement to tag systems that are critical to life and safety, these requirements ensure “the operability of the fire alarm and sprinkler systems and the safety of the residents.” The State agency added that it is in full compliance with the Life Safety Code and other regulatory requirements.

In addition, the State agency said that the current complaint investigation process (mentioned in the State agency’s comments on our third recommendation) “is sufficient to ensure the safety of nursing facility residents” and added that it would continue to comply with the existing Federal and Life Safety Code requirements for nursing home oversight.

### **Office of Inspector General Response**

Our recommendation does not imply that the State agency was out of compliance with the existing Life Safety Code and NFPA requirements regarding fire alarm and sprinkler systems that were out of service for the stated periods of time. For instance, we determined that the fire pump at Facility 16 began leaking in May 2019—after the State agency had conducted its survey. Rather, our fourth recommendation focuses on what we see as a significant gap in the current process to safeguard the health and safety of nursing home residents. Under the current process, nursing homes are not required to notify the State agency until critical life safety systems are no longer functional. Because of this, the State agency is unaware of potentially dangerous situations at these nursing homes. Under 42 CFR § 483.70(b), nursing homes “must operate and provide services in compliance with all applicable Federal, State and local laws, regulations, and codes.” This recommendation would not require a change to existing regulatory requirements but rather, would enhance those requirements at the State level.

In addition, we disagree that the current complaint investigation process mentioned in the State agency’s comments on our third recommendation is sufficient to ensure the safety of nursing home residents. From the time the fire pump had been found to be leaking (after the May 2019 required monthly testing was conducted) until our site visit in September 2019, no other monthly tests were performed on the fire pump. Furthermore, neither the second quarter sprinkler system inspection nor the annual fire pump inspection was conducted. Because the nursing home did not test the fire pump as required, it was not until we conducted our site visit, identified this deficiency, and contacted CMS that the State agency was notified. If we had not been onsite conducting our audit, and if these required tests and inspections had remained unperformed, it is possible that the fire pump would eventually have become nonfunctional but not detected as such.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING OUR OVERALL FINDING**

### **State Agency Comments**

The State agency concurred “with limitations” with our finding that it did not ensure that the selected nursing homes had complied with CMS requirements for life safety and emergency preparedness “on the dates of the audit.” The State agency gave several reasons or considerations that limited its concurrence with this finding.

The State agency agreed that it did not ensure nursing home compliance with all CMS requirements for life safety and emergency preparedness at all points in time. The State agency added, though, that it met the State Survey Performance requirements identified in the *CMS State Operations Manual* (chapter 8, “Standards and Certifications”). In addition, the State agency said that, rather than reviewing specific nursing homes’ compliance on a given date, an audit that focused on “the history of surveys, audits, findings, corrections, and fines would better reflect the State’s performance.”

The State agency added that we noted deficiencies that either were not present during the SFM’s inspections or were identified and remedied. The State agency noted that we cited Facilities 2 and 20 for not having their emergency plans updated annually and said that State agency inspections both before and after our site visits had found both nursing homes in compliance with this requirement. In addition, 2 days before our site visit the SFM had also surveyed Facility 12 and had noted the same deficiencies that we had noted (several emergency preparedness deficiencies as well as the need for testing and maintenance of the fire alarm system).

The State agency also said that “the State cannot ensure the absence of deficiencies at every given moment in time and a deficiency noted on a particular date does not reflect the State’s history of ensuring nursing facility compliance.”

### **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. With respect to the State agency’s comment about what we should have reviewed to better reflect its performance, we did review, as part of our audit, the State agency’s history of surveys, findings, and corrections and compared them across multiple surveys to assist us in arriving at our conclusions. Although we determined that the State agency complied with the survey frequency requirement at 42 CFR § 488.308(a), we also found a total of 47 instances in which the same deficiency occurred in either 3 consecutive surveys, 3 out of 4 surveys, or 4 consecutive surveys; these instances involved 17 of the 20 nursing homes in our audit.<sup>27</sup> Repeated issues we identified dealt with fire alarm system installation, fire alarm testing and maintenance, sprinkler system testing and maintenance, and essential electrical systems maintenance and testing. We are confident in the objectivity, thoroughness, and accuracy of the audit process we used to arrive at our conclusions.

After reviewing the State agency’s comments, we revised our findings to remove, from this final report, the deficiencies related to the emergency plans at Facilities 2 and 20 as well as fire alarm system testing and maintenance at Facility 12. However, the State agency’s statement

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<sup>27</sup> As stated in 42 CFR § 488.308(a): “Basic period. The survey agency must conduct a standard survey of each SNF [skilled nursing facility] and NF [nursing facility] not later than 15 months after the last day of the previous standard survey.”

that the SFM had noted “the same deficiencies” that we had noted for Facility 12 is not entirely accurate. Because the SFM noted four deficiencies in Facility 12’s emergency plan, we have removed those deficiencies from our final report. However, this report continues to reflect an additional 12 deficiencies that we found in our site visit but that the SFM had not identified in its survey 2 days earlier.

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 was not the case for many of the emergency preparedness deficiencies (such as evacuation plans and shelter-in-place plans) that we identified.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING OUR LIFE SAFETY FINDINGS**

### **State Agency Comments**

The State agency concurred “with limitations” with our life safety findings. These limitations referred to the State agency’s comments discussed above in “Office of Inspector General Recommendation on Training.” The State agency also referred to the deficiency at Facility 12 regarding fire alarm testing and maintenance that we discussed above in “State Agency Comments and Office of Inspector General Response Regarding Our Overall Finding.”

Further, the State agency did not concur that an Immediate Jeopardy existed at Facility 16 at the time of our inspection. The State agency discussed the timeline of events from the SFM’s inspection of the facility in May 2019 to two inspections of the fire pump in September 2019. The first inspection concluded that the sprinkler system worked and that the pump was operational and stated that “just because a pump is leaking does not mean that it doesn’t work.” The second inspection noted that the fire pump passed the flow test but also recommended replacing it “because several parts needed to be replaced or would need to be replaced in the near future, and parts for this pump would not be available.” The State agency added that at no time before our site visit had any of the contractors with which the facility worked indicated that the fire pump was not operational. The State agency also stated: “During the OIG inspection on September 19, 2019, the facility administrator issued a fire watch at the OIG’s direction.”

In addition, the State agency did not concur with our draft report’s finding that Facility 11 did not have proper documentation to show that the fire suppression systems for its kitchen cooking equipment had been inspected. The State agency pointed out that our site visit checklist had marked the incorrect date for one of the semiannual inspections. The State agency also disagreed with a finding in our draft report that stovetop cooking equipment at Facilities 11 and 12 was being used improperly without an installed Class K fire extinguisher. The State agency said that this type of fire extinguisher is not required when stovetops are being used only for food warming or limited cooking.

The State agency also concurred “with limitations” with our statement (in “Inadequate Notification Requirements” earlier in this report) that there is no requirement to tag fire alarm and sprinkler systems when significant problems are found with them and to notify the State agency of these issues. The State agency referred to the requirements for these systems (discussed above in “Office of Inspector General Recommendation on Requiring Inspection Contractors To Tag Systems Critical to Nursing Home Residents’ Health and Safety”) and said that “while there is not a specific tag-out system for ‘significant problems,’ a standard that creates a fair amount of ambiguity, there is a tag-out system for inoperable sprinkler systems, which provides a clear standard that ensures the safety of residents.” The State agency added that it believed that this finding was related to the leaking fire pump at Facility 16 and repeated that neither the fire pump nor the sprinkler system was inoperable: “the sprinkler system was functioning and would not have appropriately been removed from service.”

### **Office of Inspector General Response**

After reviewing the State agency’s comments, we revised our findings to remove, from this final report, three deficiencies related to instances of noncompliance with life safety requirements. We maintain that our other findings in this area remain valid. Regarding the Immediate Jeopardy and the fire watch declared at Facility 16, the State agency’s comments are not accurate. As we state in our finding (“Fire Detection and Suppression Systems”), the State agency issued the Immediate Jeopardy deficiency after conducting its own survey and consulting with a CMS surveyor. We also note that the State agency issued the Immediate Jeopardy deficiency to Facility 16 on the same day—September 25, 2019—as the day that, according to the State agency’s comments, the SFM spoke to the technician who performed the first inspection of this nursing home’s fire pump. With respect to the initiation of the fire watch, during our site visit we met with Facility 16’s administrator and maintenance director and, together, we spoke with a CMS surveyor on the speaker phone. During this call, neither we nor the CMS surveyor suggested to or directed Facility 16’s administrator to issue a fire watch. That decision was made solely by Facility 16’s administrator.

We acknowledge that the Facility 11 site visit checklist that we gave to the State agency recorded the incorrect date for one of the semiannual inspections of that nursing home’s fire suppression systems. However, we were aware that Facility 11 had correctly performed the inspections of these systems in its kitchen area. The deficiency noted in our site visit checklist, which we also mentioned in our draft report, involved—at Facility 11 as well as Facility 12—stovetop cooking equipment that lacked installed Class K fire extinguishers. After reviewing our checklists and the State agency’s comments, we revised our findings to remove, from this final report, these two deficiencies related to instances of noncompliance with life safety requirements.

In addition, the State agency was correct that our statement, about the lack of a requirement to tag fire alarm and sprinkler systems when significant problems are found and to notify the State agency, was related to the leaking fire pump at Facility 16. However, our statement about tagging and notification was a statement of fact as to the current requirements in these

situations; it was not, in and of itself, a finding. This statement of fact, however, bears directly on one of the comments, cited above, that the State agency made about that leaking fire pump: that at no time before our site visit had any of the contractors with which the facility worked indicated that the fire pump was not operational. As we explain in our finding on “Fire Detection and Suppression Systems,” the Immediate Jeopardy and the fire watch were issued “[a]s a direct result of our review of sprinkler system testing and maintenance records.” We could find no evidence that the State agency was aware of the problems with Facility 16’s fire pump before the two September 2019 inspections—which might not have taken place, at least in that timeframe, if we had not raised the issue during our site visit. This fact bears upon the point we made about the lack of a notification requirement: namely, that Facility 16 was not required to notify the State agency unless the pump could be proven to be inoperable. The resultant risk to the health and safety of nursing home residents forms the basis for our fourth recommendation to the State agency.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE REGARDING OUR EMERGENCY PREPAREDNESS FINDINGS**

### **State Agency Comments**

The State agency concurred “with limitations” with our emergency preparedness findings. These limitations referred to the comments we discussed above (in “State Agency Comments and Office of Inspector General Response Regarding Our Overall Finding”) regarding the deficiencies that our draft report noted at Facilities 2 and 20 (for not having their emergency plans updated annually) and the several emergency preparedness deficiencies at Facility 12 that our draft report noted. The State agency also noted that the requirement that nursing homes include emerging infectious disease threats in their all-hazard risk assessment planning became effective February 1, 2019, which was after the SFM inspected 14 of the nursing homes. The State agency added that it “will and has taken steps to ensure compliance with this requirement going forward.”

### **Office of Inspector General Response**

After reviewing the State agency’s comments, we revised our findings to remove, from this final report, six deficiencies related to instances of noncompliance with emergency preparedness requirements (footnote 25). We acknowledge the point that the State agency raised regarding the effective date of the infectious disease requirement (from Appendix Z of the CMS *State Operations Manual*). Neither our draft report nor this final report identified deficiencies at any of those nursing homes that did not include emerging infectious diseases in their all-hazard risk assessments.

## **OTHER MATTERS**

The Iowa Administrative Code (IAC) for Public Safety [661] does not require the installation of carbon monoxide detectors in nursing homes. However, the fire safety requirements for new

and existing single-family residences, single-family rental units, and multiple-unit residential buildings at IAC 661-211.11 state:

**Carbon monoxide alarms—required.** Carbon monoxide alarms are required in the following buildings if the building is served by a fuel-burning heater, fuel-burning furnace, fuel-burning appliance, fuel-burning fireplace, or has an attached garage.

- **211.11(1)** *New construction.* Multiple-unit residential buildings and single-family residences for which construction is begun on or after July 1, 2018.
- **211.11(2)** *Existing buildings.* Single-family rental units, single-family residences, and multiple-unit residential buildings.

The IAC specifically excludes nursing homes at 661-211 by stating: “The provisions of this chapter do not apply to nonresidential occupancies including but not limited to Group I and Group E occupancies.” The International Building Code, chapter 3, “Occupancy Classification and Use,” classifies nursing homes as Group I occupancies.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

As of May 2019, a total of 437 nursing homes in Iowa participated in the Medicare or Medicaid programs. Of these 437 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 2016, 2017, and 2018.

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 conducted unannounced site visits and performed our fieldwork at the 20 selected nursing homes throughout Iowa from July through November 2019.

### 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 Quality and Certification Oversight Reports (QCOR) online reporting system a list of all 437 active nursing homes in Iowa that were participating in the Medicare or Medicaid programs as of May 2019;
- compared the list obtained from CMS's QCOR online reporting system with the State agency Directory of Nursing Homes to verify completeness and accuracy;
- obtained from the nursing homes identified in CMS's QCOR online reporting system a list 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;<sup>28</sup>

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<sup>28</sup> Deficiencies that the State agency enters into the ASPEN system are uploaded to CMS's Certification and Survey Provider Enhanced Reports system and are available to the public through the QCOR online reporting system (<https://qcor.cms.gov/>).

- selected for onsite inspections the 20 nursing homes in Iowa with the most combined life safety and emergency preparedness deficiencies for CYs 2016, 2017, and 2018, and for each:<sup>29</sup>
  - reviewed the available deficiency reports prepared by the State agency for the nursing home; 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 homes, CMS, and State agency officials on July 23, 2020.

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.

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<sup>29</sup> On one of our site visits, one of the nursing homes selected was found to be in the process of closing. We terminated our visit and selected another facility from our list of homes obtained from CMS's QCOR online reporting system.

**APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

| <b>Report Title</b>   | <b>Report Number</b>                 | <b>Date Issued</b> |
|---|--------------------------------------|--------------------|
| <i>North Carolina Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i> | <a href="#"><u>A-04-19-08070</u></a> | 9/18/2020          |
| <i>Illinois Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>       | <a href="#"><u>A-05-18-00037</u></a> | 9/17/2020          |
| <i>Missouri Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>       | <a href="#"><u>A-07-18-03230</u></a> | 3/13/2020          |
| <i>Florida Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>        | <a href="#"><u>A-04-18-08065</u></a> | 3/6/2020           |
| <i>Life Safety and Emergency Preparedness Deficiencies Found at 18 of 20 Texas Nursing Homes</i>  | <a href="#"><u>A-06-19-08001</u></a> | 2/6/2020           |
| <i>California Should Improve Its Oversight of Selected Nursing Homes' Compliance With Federal Requirements for Life Safety and Emergency Preparedness</i>     | <a href="#"><u>A-09-18-02009</u></a> | 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>       | <a href="#"><u>A-02-17-01027</u></a> | 8/20/2019          |

**APPENDIX C: AREAS OF NONCOMPLIANCE AT EACH NURSING HOME**

**Life Safety Deficiencies**

| <b>Nursing Home</b> | <b>Building Exits and Fire Barriers</b> | <b>Fire Detection and Suppression Systems</b> | <b>Hazardous Storage</b> | <b>Smoking Policies and Fire Drills</b> | <b>Elevator and Electrical Equipment Testing and Maintenance</b> | <b>Total</b> |
|---------------------|---|---|--------------------------|---|--|--------------|
| 1                   | 3                                       | 3   | 2                        | 1                                       | 2  | <b>11</b>    |
| 2                   | 1                                       | 0   | 0                        | 0                                       | 2  | <b>3</b>     |
| 3                   | 2                                       | 0   | 0                        | 1                                       | 1  | <b>4</b>     |
| 4                   | 6                                       | 1   | 2                        | 0                                       | 1  | <b>10</b>    |
| 5                   | 2                                       | 0   | 0                        | 0                                       | 2  | <b>4</b>     |
| 6                   | 2                                       | 3   | 1                        | 1                                       | 2  | <b>9</b>     |
| 7                   | 2                                       | 0   | 1                        | 2                                       | 0  | <b>5</b>     |
| 8                   | 1                                       | 0   | 0                        | 0                                       | 2  | <b>3</b>     |
| 9                   | 3                                       | 2   | 0                        | 1                                       | 2  | <b>8</b>     |
| 10                  | 1                                       | 2   | 2                        | 1                                       | 2  | <b>8</b>     |
| 11                  | 2                                       | 1   | 0                        | 0                                       | 1  | <b>4</b>     |
| 12                  | 4                                       | 0   | 2                        | 2                                       | 2  | <b>10</b>    |
| 13                  | 0                                       | 1   | 1                        | 0                                       | 2  | <b>4</b>     |
| 14                  | 0                                       | 0   | 1                        | 0                                       | 1  | <b>2</b>     |
| 15                  | 2                                       | 1   | 1                        | 0                                       | 2  | <b>6</b>     |
| 16                  | 3                                       | 2   | 2                        | 2                                       | 2  | <b>11</b>    |
| 17                  | 2                                       | 0   | 2                        | 0                                       | 2  | <b>6</b>     |
| 18                  | 1                                       | 0   | 0                        | 1                                       | 1  | <b>3</b>     |
| 19                  | 2                                       | 0   | 1                        | 1                                       | 1  | <b>5</b>     |
| 20                  | 3                                       | 1   | 1                        | 0                                       | 1  | <b>6</b>     |
| <b>Total</b>        | <b>42</b>                               | <b>17</b>                                     | <b>19</b>                | <b>13</b>                               | <b>31</b>  | <b>122</b>   |

### 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            | 6              | 1                            | 5  | 3                        | 5                       | 20         |
| 2            | 2              | 1                            | 2  | 2                        | 4                       | 11         |
| 3            | 0              | 0                            | 2  | 4                        | 0                       | 6          |
| 4            | 4              | 2                            | 2  | 2                        | 2                       | 12         |
| 5            | 1              | 0                            | 0  | 1                        | 0                       | 2          |
| 6            | 1              | 1                            | 0  | 1                        | 0                       | 3          |
| 7            | 2              | 1                            | 0  | 1                        | 2                       | 6          |
| 8            | 0              | 0                            | 0  | 1                        | 0                       | 1          |
| 9            | 2              | 2                            | 1  | 1                        | 1                       | 7          |
| 10           | 2              | 1                            | 2  | 2                        | 0                       | 7          |
| 11           | 1              | 0                            | 0  | 1                        | 0                       | 2          |
| 12           | 1              | 1                            | 3  | 2                        | 5                       | 12         |
| 13           | 2              | 1                            | 2  | 1                        | 3                       | 9          |
| 14           | 0              | 0                            | 0  | 2                        | 0                       | 2          |
| 15           | 1              | 0                            | 1  | 0                        | 1                       | 3          |
| 16           | 1              | 0                            | 0  | 1                        | 1                       | 3          |
| 17           | 1              | 0                            | 0  | 1                        | 0                       | 2          |
| 18           | 3              | 0                            | 3  | 1                        | 7                       | 14         |
| 19           | 1              | 0                            | 1  | 1                        | 0                       | 3          |
| 20           | 2              | 0                            | 0  | 2                        | 4                       | 8          |
| <b>Total</b> | <b>33</b>      | <b>11</b>                    | <b>24</b>  | <b>30</b>                | <b>35</b>               | <b>133</b> |

**Note:** Under a 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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Kim Reynolds, Governor

Adam Gregg, Lt. Governor

Kelly Garcia, Director

Patrick J. Cogley  
Regional Inspector General for Audit Services  
HHS-OIG-Office of Audit Services  
Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

RE: *Iowa Should Improve Its Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness, Draft Report, A-07-19-03238*

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS), the Iowa Department of Inspections and Appeals, and the State Fire Marshal's Office on the September 16, 2020 draft report concerning the Office of Inspector General's (OIG) review of compliance with life safety and emergency preparedness requirements for long-term care facilities.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the Final Report. DHS strives to administer its programs in compliance with applicable Federal and State law, regulations, and other policies. DHS is committed to working with CMS to resolve the issues identified in this audit review and are appreciative of the hard work your staff has undertaken relative to this audit.

Questions about the attached response can be addressed to:

Jody Lane-Molnari, Executive Officer II  
Division of Fiscal Management  
Iowa Department of Human Services  
Hoover State Office Building, 1<sup>st</sup> Floor SW  
1305 E Walnut Street  
Des Moines, IA 50319-0114

**Email:** [jlanelmo@dhs.state.ia.us](mailto:jlanelmo@dhs.state.ia.us)

**Phone:** 515-281-6027

Sincerely,  
/s/

Julie Lovelady  
Interim Medicaid Director

Enclosure

cc: Greg Tambke, Assistant Regional Inspector General for Audit Services

**IOWA DEPARTMENT OF HUMAN SERVICES  
RESPONSE TO OIG DRAFT REPORT:**

***Iowa Should Improve Its Oversight of Selected Nursing Homes' Compliance  
with Federal Requirements for Life Safety and Emergency Preparedness  
Draft Report, A-07-19-03238***

**Background**

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.

Nursing homes are required to comply with all Federal, State, and local laws, regulations, and codes, as well as accepted professional standards and principles.<sup>1</sup> Federal regulations on life safety require that nursing homes comply with standards set forth in the National Fire Protection Association (NFPA) *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99).<sup>2</sup> Federal regulations on emergency preparedness 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.<sup>3</sup>

The Iowa Medicaid Enterprise (IME), a division of the Iowa Department of Human Services (Iowa DHS), is the single state Medicaid agency and has responsibility under Title XIX for ensuring that Medicaid nursing facilities are compliant with standards set by federal statute and regulation.<sup>4</sup> This includes the responsibility for certification and survey of Medicaid nursing facilities in the State of Iowa.<sup>5</sup> IME's State Plan provides that it will fulfill this responsibility through survey and certification by Iowa's Department of Inspections and Appeals (DIA).<sup>6</sup> Under Iowa statute, DIA is responsible for the regulation of health care facilities, including licensing and inspection of nursing facilities.<sup>7</sup> With respect to the specific Medicaid nursing facility survey and certification requirements, Iowa DHS has contracted with DIA to undertake those obligations.<sup>8</sup>

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<sup>1</sup> 42 CFR § 483.70.

<sup>2</sup> 42 CFR § 483.90.

<sup>3</sup> 42 CFR § 483.73.

<sup>4</sup> 42 U.S.C. § 1396a(28)(A); 42 C.F.R. § 488.303.

<sup>5</sup> 42 U.S.C. § 1396a(28)(D)(ii); see also 42 U.S.C. § 1396r(e).

<sup>6</sup> Appendix A, State Plan Section 4.11.

<sup>7</sup> Iowa Code, ch. 135C; Iowa Code § 10A.702 (the Health Inspections Division of DIA is the sole licensing authority for health care facilities).

<sup>8</sup> Appendix B, Iowa DHS – Iowa DIA Memorandum of Understanding, see entire contract and specifically p. 15, stating “DIA shall conduct initial certification and re-certification on-site surveys, revisit surveys, and complaint investigations for Medicaid-

Additionally, the Secretary of Health and Human Services entered into an 1864 agreement with the State of Iowa, Department of Inspections and Appeals, under which the DIA agrees to fulfill the Secretary's nursing facility certification and survey responsibilities under Title XVIII.<sup>9</sup>

The federal nursing facility standards are grouped in three categories: standards related to the provision of services, standards related to resident's rights, and standards related to administration and other matters.<sup>10</sup> The subject of this OIG audit – Life Safety and Emergency Preparedness – fall within “administration and other matters.” To ensure federal compliance with Life Safety and Emergency Preparedness requirements, DIA has entered into an agreement with the Iowa Department of Public Safety, State Fire Marshal (SFM),<sup>11</sup> which is charged with enforcing State Fire and Building Code requirements.<sup>12</sup>

Thus, the Iowa DHS, through IME, has the primary responsibility for ensuring Medicaid nursing facility compliance. To carry out this responsibility, IME has partnered with DIA and the SFM. IME, DIA, and the SFM (collectively the “State”) have prepared this joint response to the OIG report.

## **I. Response to OIG Findings**

### **A. General Finding: The State agency did not ensure that selected nursing homes in Iowa that participated in the Medicare or Medicaid program complied with the CMS requirements for life safety and emergency preparedness.**

The State concurs with limitations on the General Finding stated above. The State agrees that it did not ensure nursing facility compliance with life safety and emergency preparedness on the dates of the audit, but notes the following limitations on its concurrence.

#### **1. The State Survey Agency Has Complied with the CMS State Survey Performance Requirements.**

The State agrees that it did not ensure nursing facility compliance with all CMS requirements for life safety and emergency preparedness at all points in time. However, the State did meet the State Survey Performance requirements identified in the CMS, State Operations Manual, Chapter 8 – Standards and Certification. That manual states:

#### **CMS considers survey performance to be inadequate if the State:**

##### **1. Demonstrates a pattern of failure to:**

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certified NFs to ensure that all entities are in compliance with the criteria set forth in Title XIX and state laws, rules/regulations, and manuals.”

<sup>9</sup> Appendix C, CMS-Iowa 1864 Agreement.

<sup>10</sup> 42 U.S.C. § 1396r(b)-(d).

<sup>11</sup> Appendix D, Iowa DIA – Iowa DPH Agreement.

<sup>12</sup> Iowa Code, chs. 100, 103, 103A, and 104A.

- **Identify deficiencies, and the failure cannot be explained by changed conditions in the facility or other specific factors;**
- **Cite only valid deficiencies (i.e., the State cites unfounded deficiencies);**
- **Conduct surveys in accordance with the requirements of this Chapter;**
- **Use Federal standards, protocols, and the forms, methods, procedures, policies and systems specified by CMS in instructions;**
- **Utilize enforcement actions to assure continued compliance;**
- **Input online data timely and accurately;**
- **Conduct surveys in accordance with the required time frames;**
- **Respond to complaints in accordance with requirements;**
- **Lead in the implementation by providers of Federally required patient assessment instruments or data sets; and/or**
- **Operate Federally required systems for the collection of patient assessment data.**

**2. Fails to identify an immediate jeopardy situation.<sup>13</sup>**

DIA surveys are planned, scheduled, conducted, and processed in a timely manner. During the survey, DIA and the SFM identify deficiencies. For identified deficiencies, DIA requires a plan of correction. DIA and the SFM follow up on those correction plans and deficiencies to ensure that the nursing facility has corrected the deficiency. DIA and the SFM conduct audits or site visits when they receive a complaint. DIA and SFM follow the same procedure for ensuring that the nursing facility corrects deficiencies identified as a result of a complaint investigation.

**2. The State's Oversight of the Selected Nursing Facilities Is Better Reflected in the History of Surveys, Audits, Findings, Corrections, and Fines.**

The OIG's Report indicates that it did not evaluate the State's "overall internal control structures," but "limited [its] review of internal controls to those applicable to [their] audit objective." To the extent that the OIG is evaluating the State's performance, rather than the specific nursing facilities' compliance on a given date, the history of surveys, audits, findings, corrections, and fines would better reflect the State's performance.

**3. Deficiencies Noted by OIG Auditors Were Not Present During the SFM Inspection or Were Identified and Remedied.**

Seventeen of the twenty facilities inspected by the OIG were inspected by the SFM four to fourteen months before the OIG inspection.<sup>14</sup> Fifteen of the twenty facilities were inspected by the

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<sup>13</sup> CMS State Operations Manual, Chapter 8, Section 8000C.

<sup>14</sup> Appendix E, State Fire Marshal Surveys, p. 2. The cited page provides a chart identifying the most recent SFM inspections both before and after the OIG inspections.

SFM after the date of the OIG inspection.<sup>15</sup> The OIG auditors noted deficiencies that were not present during SFM inspections.

For example, Facility 20 was inspected by the OIG on November 11, 2019, and the OIG cited the facility for not having its emergency preparedness plan updated annually.<sup>16</sup> The SFM inspected the facility prior and subsequent to the OIG inspection - on October 2, 2018 and December 18, 2019.<sup>17</sup> At the time of the SFM inspections, Facility 20 was in compliance.<sup>18</sup> Thus, while the OIG cited a deficiency, there was no deficiency at the time of the SFM inspections.

As another example, Facility 2 was inspected by the OIG on July 24, 2019, and the OIG cited the facility for not having its emergency preparedness plan updated annually.<sup>19</sup> The SFM inspected the facility prior and subsequent to the OIG inspection – on July 12, 2018 and October 4, 2019.<sup>20</sup> At the time of the SFM inspections, Facility 2 was in compliance.<sup>21</sup>

In addition to noting deficiencies that were not present during SFM inspections, the OIG auditors noted deficiencies that were identified by the SFM and remedied. For example, the OIG inspected Facility 12 on September 12-13, 2019.<sup>22</sup> The OIG identified a number of Emergency Preparedness deficiencies.<sup>23</sup> It also noted that Facility 12 did not have its fire alarm system routinely tested and maintained.<sup>24</sup> The SFM inspected Facility 12 on September 10, 2019, just two days before the OIG inspection.<sup>25</sup> Those same deficiencies were noted by the SFM on that survey and have since been remedied.<sup>26</sup>

The OIG audits were conducted from July 23, 2019 to November 17, 2019, and the inspection documents were not provided to the Iowa DHS until June 26, 2020. As noted, the SFM inspected all of the facilities at some time prior or subsequent to the OIG survey in compliance with applicable regulations and guidance. The SFM uses a Life Safety Code checklist similar to the OIG checklist.<sup>27</sup> The SFM also created a list to evaluate Emergency Preparedness,<sup>28</sup> which is based on materials provided by CMS for Emergency Preparedness surveyor training.<sup>29</sup>

The safety of residents in Iowa's nursing facilities is a top priority for the State, and it makes every effort to strictly follow State survey standards for evaluating the compliance of nursing facilities.

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<sup>15</sup> App. E, p. 2.

<sup>16</sup> OIG Facility 12 Preparedness Survey, p. 1.

<sup>17</sup> App. E, pp. 602-637 (Oct. 2, 2018); pp. 637-649 (December 18, 2019).

<sup>18</sup> App. E, pp. 602-637 (not cited on deficiency summary, Oct. 2, 2018); p. 646 (identified as compliant on December 18, 2019).

<sup>19</sup> OIG Facility 2 Emergency Preparedness Survey, p. 1.

<sup>20</sup> App. E, pp. 30-43 (July 12, 2018); pp. 44-54 (October 4, 2019).

<sup>21</sup> App. E, pp. 30-43 (not cited on deficiency summary July 12, 2018); p. 53 (identified as compliant on October 4, 2019).

<sup>22</sup> OIG Facility 12 Life Safety Code and Emergency Preparedness Surveys.

<sup>23</sup> OIG Facility 12 Emergency Preparedness Survey.

<sup>24</sup> OIG Facility 12 Life Safety Code Survey, p. 6.

<sup>25</sup> App. E, pp. 338-349.

<sup>26</sup> See App. E, pp. 350-379 (deficiencies identified); pp. 380-389 (deficiencies remedied).

<sup>27</sup> See checklists used in App. E.

<sup>28</sup> See checklists used in App. E.

<sup>29</sup> See Appendix F, Excerpt of CMS Emergency Preparedness Surveyor Training.

As illustrated by the examples above, the State cannot ensure the absence of deficiencies at every given moment in time and a deficiency noted on any particular date does not reflect the State's history of ensuring nursing facility compliance.

**B. Life Safety Findings: We found 125 instances of noncompliance with life safety requirements related to building exits and fire barriers, fire detection and suppressions systems, hazardous storage, smoking policies and fire drills, and elevator and electrical equipment testing and maintenance.**

**1. General Response.** Except for the limitations noted in (A)(1)-(3) and any limitations or nonconcurrences in (B)(2) below, the State concurs with Life Safety Findings.

**2. State's response to the following specific Life Safety findings.**

**a. There was no existing State agency training program that, as a best practice, nursing home management could use to conduct to educate newly hired staff on how to comply with CMS requirements for life safety.**

The State concurs with limitations. While the State has not created a curriculum for nursing home management to use to train newly hired staff, the SFM has created life safety trainings to educate the health care industry on Life Safety Code requirements in health care facilities. The SFM has provided no less than 37 life safety training courses over the last five years.<sup>30</sup> Those trainings are open to nursing facility administrators and employees. In conjunction with those trainings, the SFM provides PowerPoint slides to attendees.<sup>31</sup>

In addition to the robust training provided by the SFM, at the request of CMS, Iowa DHS, DIA, and the SFM would willingly participate in developing CMS training. The State believes that all state agencies should be collaborative partners in such development to ensure consistency and nation-wide participation.

**b. One facility did not have its fire alarm system routinely tested and maintained.**

The State concurs in part with this finding. The SFM surveyed Facility 12 on September 10, 2019.<sup>32</sup> It found that Facility 12's most recent testing and maintenance of its fire alarm system was on March 25, 2019 and did not note another testing within the six-month period preceding March 25, 2019.<sup>33</sup> The SFM cited Facility 12 for failing to have semi-annual testing.<sup>34</sup>

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<sup>30</sup> Appendix G, State Fire Marshall Life Safety Training, p. 2-3.

<sup>31</sup> App. G, p. 4-63.

<sup>32</sup> App. E, pp.338-349.

<sup>33</sup> App. E, pp. 340, 345.

<sup>34</sup> App. E, pp. 345, 356.

The OIG inspected Facility 12 just two days after the SFM inspection and cited the same deficiency – Facility 12’s failure to comply with semi-annual testing.<sup>35</sup>

Facility 12 responded to the SFM’s citation in their plan of correction (POC) for 2019.<sup>36</sup> That plan indicates that the Maintenance Director corrected the error on September 25, 2019 by completing the semi-annual fire alarm testing on that date and recording it in the maintenance log book.<sup>37</sup> A follow-up email indicates that the fire alarm testing was completed by a licensed fire alarm inspector.<sup>38</sup> The SFM conducted an on-site revisit on October 14, 2019 and confirmed compliance.

Therefore, while the State agrees that Facility 12 had this deficiency on the date of the OIG audit, it disagrees that it reflects a failure by the State to conduct adequate oversight of the facility.

### **c. An immediate jeopardy was declared at Facility 16 due to faulty fire pump.**

The State does not concur that an immediate jeopardy existed at the time of the OIG inspection.

At the time of the SFM inspection on May 13, 2019, there was no evidence that the fire pump would not operate as needed upon activation of the sprinkler system.<sup>39</sup> The SFM Fire Inspector cited the facility for not completing monthly testing of the fire pump.<sup>40</sup>

After the SFM inspection, the facility’s Maintenance Supervisor observed that the fire pump was leaking during a monthly fire pump test.<sup>41</sup> At the SFM’s revisit on June 17, 2019, the SFM was advised of the leak and that the facility was working with a contractor to replace the pump.<sup>42</sup> The Maintenance Supervisor was advised by the contractor that the pump was still operational.<sup>43</sup>

At no time prior to the OIG inspection had any of the contractors with whom the facility worked indicated that the fire pump was not operational.<sup>44</sup> During the OIG inspection on September 19, 2019, the facility administrator issued a fire watch at the OIG’s direction.<sup>45</sup>

An inspection was performed by a licensed Iowa Fire technician on September 22, 2019.<sup>46</sup> In a September 25, 2019 telephone call with a SFM inspector, the technician indicated that the

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<sup>35</sup> OIG Facility 12 Life Safety Code Inspection Checklist, p. 6.

<sup>36</sup> App. E, p. 381.

<sup>37</sup> App. E, p. 381.

<sup>38</sup> App. E, p. 388.

<sup>39</sup> App. E, pp. 505, 511; Appendix H, State Fire Marshal Notes and Complaint Documents, pp. 4-5, 8, 10.

<sup>40</sup> App. E, p. 511.

<sup>41</sup> Appendix H, Facility 16, State Fire Marshal Notes and Complaint Documents, Complaint Visit – October 23, 2019, pp. 4-5, 8.

<sup>42</sup> App. H, pp. 4, 10.

<sup>43</sup> App. H, pp. 4-5, 8, 10.

<sup>44</sup> App. H, pp. 4-5, 8, 10.

<sup>45</sup> App. H, pp. 4, 8.

<sup>46</sup> App. H, pp. 4, 12-16.

sprinkler system worked.<sup>47</sup> He stated that the PSI indicated that the pump was operational.<sup>48</sup> He stated that just because a pump is leaking does not mean that it doesn't work.<sup>49</sup>

On September 27, 2019, [OIG REDACTED TEXT]<sup>31</sup> performed a flow test on the pump.<sup>50</sup> That test revealed that the flow and pressures met the pump's design.<sup>51</sup> The pump passed the flow test.<sup>52</sup> [OIG REDACTED TEXT] recommended replacing the pump because several parts needed to be replaced or would need to be replaced in the near future, and parts for this pump would not be available.<sup>53</sup>

Based on the foregoing, the State does not concur that the pump would not have operated according to the pump's design at the time of the OIG inspection. The State does not concur that there was immediate jeopardy to the facility residents.

**d. Two facilities did not have proper documentation to show that their fire suppression systems had been inspected.**

The State does not concur that one facility – Facility 11 – did not have proper documentation to show that their fire suppression systems had been inspected. The OIG report indicated that inspections were documented for 5/30/18 and 11/27/18.<sup>54</sup> The SFM's report from a survey dated August 8, 2019 indicates inspections were documented for 5/30/19 and 11/27/18.<sup>55</sup> After receiving the OIG report, the SFM requested and reviewed the facility's fire suppression inspection records and confirmed that the inspection dates in the SFM inspection were correct. Copies of those inspection records are attached showing inspections dates of 11/27/18 and 5/30/19.<sup>56</sup> The OIG auditors incorrectly noted the year of the May inspection.

**e. Two facilities had stovetops that were being used improperly without an installed Class K fire extinguisher.**

The State does not concur. The cooking equipment referred to in the reports was set up for limited cooking not producing grease laden vapors (Facility 12 and Facility 11) and, therefore, did not require a Class K Fire Extinguisher. Life Safety Code 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96. However, Life Safety Code 19.3.2.5 provides that "[w]here residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3." Further, NFPA 96, Section 1.1.4 states that NFPA 96 does not apply where all the following have been met:

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<sup>47</sup> App. H, p. 12.

<sup>48</sup> App. H, p. 12.

<sup>49</sup> App. H, p. 12.

<sup>50</sup> App. H, p. 18.

<sup>51</sup> App. H, p. 18.

<sup>52</sup> App. H, p. 18.

<sup>53</sup> App. H, p. 18.

<sup>54</sup> OIG Facility 11 Safety Code Inspection Checklist, p. 5.

<sup>55</sup> Appendix E, p. 324.

<sup>56</sup> Appendix E, pp. 334-335.

<sup>31</sup> **Office of Inspector General Note**—The deleted text has been redacted because it refers to a third-party entity.

- “(1) Only residential equipment is being used.
- (2) Fire extinguishers are located in all kitchen areas in accordance with NFPA 10, Standard for Portable Fire Extinguishers.
- (3) The facility is not an assembly occupancy.
- (4) The authority having jurisdiction has approved the installation.”

**f. There is no requirement for nursing homes or inspection contractors to “tag” systems such as fire alarm or sprinkler systems to notify the State agency when a significant problem is found with any of them. Only when these systems have been declared nonfunctional and the facility is required to institute a fire watch is a nursing home required to notify the State agency of problems with these systems.**

The State concurs with limitation. The State concurs that there is no Life Safety requirement to “tag” systems to notify the State agency when a “significant problem” is found. However, there are specific Life Safety and NFPA provisions that apply to fire alarm systems and sprinkler systems.

With respect to fire alarm systems, while there is nothing in the Life Safety Code that requires a fire alarm system to be “tagged” out of service, the Life Safety Code does provide for notice to the state authority and either evacuation or institution of a fire watch if the fire alarm system is out of service for a period of time. Specifically, Life Safety Code 9.6.1.6 provides:

“Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated, or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.”

With respect to sprinkler systems, NFPA 25, Section 15.3.1 (2011 Edition) states that “a tag shall be used to indicate that a system, or part thereof, has been removed from service.” In addition, under that same provision, sprinkler systems that are out of service for more than 10 hours in a 24-hour period must either be evacuated (or) a fire watch must be implemented. Thus, while there is not a specific tag-out systems for “significant problems,” a standard that creates a fair amount of ambiguity, there is a tag-out system for inoperable sprinkler systems, which provides a clear standard that ensures the safety of residents.

The State believes this finding is related to the leaking fire pump at Facility 16. As noted in Section I(B)(2)(c) above, neither the fire pump nor the sprinkler system were inoperable. Rather, the sprinkler system was functioning and would not have been appropriately removed from service.

Therefore, while there is no requirement to “tag” systems, such as fire alarm or sprinkler systems when a “significant problem” is found with any of them, there are specific Life

Safety Code and NFPA provisions that ensure operability of the two systems. . The requirements can only be changed by federal regulation or by changing the Life Safety Code (which can only be changed through a committee and a vote). The State is in full compliance with the Life Safety Code and other regulatory requirements.

**C. Emergency Preparedness Findings: We found 139 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.**

**Response:** The State concurs with the same limitations noted in (A)(1)-(3) above. In addition, the State notes that the requirement of Infectious Disease planning added February 1, 2019 was added after the SFM inspected fourteen of the twenty facilities.<sup>57</sup> The State will and has taken steps to ensure compliance with this requirement going forward.

**II. Response to OIG Recommendations.**

**A. Recommendation: We recommend that the Iowa Department of Human 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.**

**Response:** Except for those deficiencies with which the State agency disagrees in Part I, the State concurs with the recommendation.

The OIG inspections were undertaken in July through November of 2019. The Iowa DHS did not receive the OIG inspection reports until June 26, 2020. At the exit conference held on July 23, 2020, the OIG indicated that no deficiencies were issued to the facilities at the time of the OIG inspections. Rather, OIG recommended that the facilities call the SFM if they disagreed with the deficiencies and the OIG stated (at the exit conference) that it was up to the facilities to follow up. It is understandable with the outbreak of COVID-19 beginning in January of 2019 that the OIG did not get the reports to the Iowa DHS until June. Other than the issue related to the fire pump at the one facility, none of the facilities contacted the SFM regarding deficiencies. Consequently, the follow up of other deficiencies has not been as timely as would otherwise occur. Nevertheless, as noted above, all but five of the facilities that were the subject of the OIG review, have been surveyed since the OIG inspections.<sup>58</sup>

The Iowa DHS will ensure that DIA, through the SFM's office, follows up with each of the 20 nursing facilities to ensure that corrective actions have been taken with respect to each of the life safety and emergency preparedness deficiencies identified in the report. Due to the pandemic,

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<sup>57</sup> App. E, p. 2 (note dates of SFM surveys).

<sup>58</sup> App. E, p. 1.

DIA and the SFM cannot enter certain nursing facilities at this time. To address this recommendation, the SFM will take the following steps:

1. By 12/31/2020, the SFM will follow up with each nursing facility to determine what corrective action plans were taken in response to the OIG inspection.
2. If an on-site visit is needed and the SFM is able to enter the facility, it will follow up on those deficiencies on or before 12/31/2020.
3. If an on-site visit is needed and the SFM is not able to enter the facility, it will follow up on the deficiency within 45 days after the SFM is allowed to enter the nursing facility.

**B. Recommendation: We recommend that the Iowa Department of Human Services work with CMS to develop standardized life safety training for nursing home staff.**

**Response:** The State concurs with limitations. The Iowa SFM is a national leader in educating the health care industry on Life Safety Code requirements. Over the past five years it has conducted no less than 37 training sessions, including two annual conferences each year held in conjunction with the Iowa Health Care Association (IHCA).<sup>59</sup> The SFM provides classes to nursing facility administrators and maintenance directors through the IHCA, Leading Age Iowa, the Iowa Hospital Association and others.

The State further notes that CMS provides a wealth of resources for providers to understand their life safety obligations.<sup>60</sup> Additionally, the National Fire Protection Association offers products, training, and resources for health care provider compliance with CMS Life Safety and Emergency Preparedness requirements.<sup>61</sup>

To address this recommendation, the State will take the following steps:

1. At the request of CMS, the SFM will work with CMS to develop a standardized program of instruction for nursing home staff.
2. By 12/31/2020, the SFM will review its current training program and ensure that the training addresses the deficiencies noted in the OIG Report.
3. By 11/30/2020, the SFM will review its current emergency preparedness checklist and ensure that it comports with the federal regulatory requirements and the checklist used by OIG for this audit.

**C. Recommendation: We recommend that the Iowa DHS conduct more frequent surveys at nursing homes that have a history of multiple high-risk deficiencies.**

The State concurs with limitations. The State conducts nursing facility survey and certification oversight consistently with CMS protocols as set forth in the State Operations Manual, Chapter 8.

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<sup>59</sup> App. G, p. 2-3.

<sup>60</sup> <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/LSC>

<sup>61</sup> See <https://catalog.nfpa.org/CMS-Adopts-2012-NFPA-101-and-2012-NFPA-99-C3744.aspx?icid=D650>

DIA and the SFM follow up where deficiencies have been cited to ensure that facilities comply with corrective action plans.

When a complaint is received by the State, it is triaged for investigation based on the nature of the concerns alleged. If the complaint involves an immediate high jeopardy situation, an on-site inspection must occur within two working days.<sup>62</sup> If the complaint involves a high-level nonimmediate jeopardy situation, an on-site inspection must occur within ten working days.<sup>63</sup> For all other situations, an on-site inspection must occur within 45 days.<sup>64</sup> The SFM conducts complaint visits and follow-ups to those visits as required.

In addition, DIA follows the requirements of the CMS Mission and Priority document, which requires that survey activities be conducted in accordance with the priority Tier structure provided in that document.<sup>65</sup> Resources are devoted to fulfilling those priorities identified by CMS. Additional federal and state funding would be needed to expand survey activities beyond those already conducted. Nevertheless, Iowa DHS, DIA, and SFM believe that the existing process for ensuring compliance after a deficiency has been found during a scheduled survey or complaint survey sufficiently provides additional oversight over those nursing facilities that have a history of multiple high-risk deficiencies. The State will continue to diligently comply with CMS protocols and priorities.

**D. Recommendation: We recommend that the Iowa DHS require nursing home and inspection contractors to: (1) tag systems that are critical to the health and safety of nursing home residents when they have found that these systems may not work as required when needed; and (2) notify the State agency.**

The State does not concur with this recommendation. The recommendation goes beyond the current Life Safety Code and other regulatory requirements and would require a change in those governing regulations, which is not within the authority of the State.

As noted above, there are specific Life Safety and NFPA provisions that apply to fire alarm systems and sprinkler systems.

With respect to fire alarm systems, while there is nothing in the Life Safety Code that requires a fire alarm system to be “tagged” out of service, the Life Safety Code does provide for notice to the state authority and either evacuation or institution of a fire watch if the fire alarm system is out of service for a period of time. Specifically, The State notes that Life Safety Code 9.6.1.6 specifically provides:

“Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated, or an

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<sup>62</sup> Iowa Code § 135C.38.1.a(1)(a).

<sup>63</sup> Iowa Code § 135C.38.1.a(1)(b).

<sup>64</sup> Iowa Code § 135C.38.1.a(1)(c).

<sup>65</sup> Appendix I, CMS 2020 Mission and Priority Document.

approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.”

With respect to sprinkler systems, NFPA 25, Section 15.3.1 (2011 Edition) states that “a tag shall be used to indicate that a system, or part thereof, has been removed from service.” In addition, under that same provision, sprinkler systems that are out of service for more than 10 hours in a 24-hour period must either be evacuated (or) a fire watch must be implemented.

Therefore, while there is no requirement to “tag systems that are critical to life and safety,” when the systems “do not work as required,” the specific Life Safety Code and NFPA provisions noted above ensure the same goal – the operability of the fire alarm and sprinkler systems and the safety of the residents. The requirements can only be changed by federal regulation or by changing the Life Safety Code (which can only be changed through a committee and a vote). The State is in full compliance with the Life Safety Code and other regulatory requirements.

In addition, the current complaint investigation process noted in the State’s response to Recommendation C is sufficient to ensure the safety of nursing facility residents. The State will continue to comply with the existing federal and Life Safety Code requirements for nursing facility oversight.