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GAPS CONTINUE TO EXIST IN NURSING HOME EMERGENCY PREPAREDNESS AND RESPONSE DURING DISASTERS: 2007–2010

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EXECUTIVE SUMMARY: GAPS CONTINUE TO EXIST IN NURSING HOME EMERGENCY PREPAREDNESS AND RESPONSE DURING DISASTERS: 2007–2010, OEI-06-09-00270

WHY WE DID THIS STUDY

Federal regulations require that Medicare- and Medicaid-certified nursing homes have written emergency plans and provide employees with emergency preparedness training. In a 2006 report about nursing homes that experienced hurricanes, we found that emergency plans lacked many provisions recommended by experts. In response, the Centers for Medicare & Medicaid Services (CMS) issued guidance checklists for emergency planning of health care facilities, long-term care (LTC) ombudsman programs, and State survey agencies (SA). We conducted this study to assess emergency preparedness and response of nursing homes that experienced more recent disasters.

HOW WE DID THIS STUDY

For this study, we analyzed national survey data to determine compliance with Federal regulations. We also conducted site visits to 24 selected nursing homes that experienced floods, hurricanes, and wildfires in 2007–2010. We interviewed nursing home administrators and staff, local emergency managers, and representatives from State LTC ombudsman programs and SAs. We also compared the emergency plans of each selected nursing home to the CMS checklist for health care facilities.

WHAT WE FOUND

Most nursing homes nationwide met Federal requirements for written emergency plans and preparedness training. However, we identified many of the same gaps in nursing home preparedness and response that we found in our 2006 report. Emergency plans lacked relevant information—including only about half of the tasks on the CMS checklist. Nursing homes faced challenges with unreliable transportation contracts, lack of collaboration with local emergency management, and residents who developed health problems. LTC ombudsmen were often unable to support nursing home residents during disasters; most had no contact with residents until after the disasters. SAs reported making some efforts to assist nursing homes during disasters, mostly related to nursing home compliance issues and ad hoc needs.

WHAT WE RECOMMEND

We made three recommendations to CMS and one recommendation to the Administration on Aging (AoA). CMS agreed with our recommendations to revise Federal regulations to include specific requirements for emergency plans and training, update the *State Operations Manual* to provide detailed guidance for SAs on nursing home compliance with emergency plans and training, and promote use of the checklists. AoA agreed with our recommendation to develop model policies and procedures for LTC ombudsmen to protect residents during and after disasters. Finally, in a memorandum report, we outline guidance that CMS can consider when revising the checklist for health care facilities.

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OBJECTIVES

1. To determine the nationwide extent of nursing home compliance with Federal regulations for emergency preparedness.
2. To determine the extent to which selected nursing homes' emergency plans included tasks recommended by the Centers for Medicare & Medicaid Services (CMS) emergency preparedness checklist for health care facilities.
3. To describe the challenges experienced by selected nursing homes during disasters in 2007–2010.
4. To examine the role of selected long-term care (LTC) ombudsman programs and State survey agencies (SA) during disasters in 2007–2010 and their use of the CMS emergency preparedness checklists developed for each entity.

BACKGROUND

Nursing home residents and their families rely on facility administrators to plan and execute appropriate procedures during disasters. However, the numerous hurricanes during 2004 and 2005 prompted concern about nursing home emergency planning, disaster response, and coordination between nursing homes and State and local entities. In a 2006 Office of Inspector General (OIG) report, we found that, nationally, 94 percent of nursing homes met Federal regulations for emergency plans and 80 percent met Federal regulations for emergency training in 2004–2005.[1] However, in a sample of 20 nursing homes, we found that plans often lacked information suggested by experts; nursing home administrators and staff sometimes did not follow emergency plans during the hurricanes; and lack of collaboration between State and local emergency entities and nursing homes impeded emergency preparedness and management.

After OIG issued the 2006 report, CMS issued guidance regarding the emergency planning of health care facilities, including nursing homes. This study expands upon the 2006 report to examine the use of CMS's guidance by a sample of nursing homes that experienced floods, hurricanes, and wildfires during 2007–2010.

Federal regulations for nursing home emergency preparedness require that Medicare- and Medicaid-certified nursing homes have "detailed written plans and procedures to meet all potential emergencies and disasters such

[1] OIG, *Nursing Home Emergency Preparedness and Response During Recent Hurricanes*, OEI-06-06-00020, August 2006.

as fire, severe weather, and missing residents." Additionally, Federal regulations state that facilities must "train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures."[2] According to Federal regulations, certified nursing homes must comply with the Life Safety Code (LSC), which requires that nursing homes have "written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building;" and that fire drills be "conducted quarterly on each shift."[3] In December 2010, CMS issued an advanced notice of proposed rulemaking to establish national emergency preparedness requirements for Medicare and Medicaid providers and suppliers.[4] As of March 2012, CMS had not published the proposed rule for comment.

Verification of Nursing Home Compliance With Federal Regulations

The Omnibus Budget Reconciliation Act of 1987 established a survey and certification process for CMS and States to verify that Medicare- and Medicaid-certified nursing homes comply with Federal requirements.[5] CMS is responsible for enforcing these requirements. It enters into agreements with SAs to survey each nursing home at least once every 15 months to certify compliance with Federal requirements, including those for emergency preparedness.[6] CMS provides guidance to surveyors through the *State Operations Manual* (SOM), which specifies how surveyors determine compliance. When surveyors identify noncompliance with Federal requirements, CMS requires nursing homes to submit plans of correction and to correct the problems. If nursing homes do not correct the problems, CMS may take enforcement actions, including termination of the nursing homes' participation in Medicare and Medicaid.[7]

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[2] 42 CFR § 483.75(m).

[3] 42 CFR § 483.70(a)(i) states that the facility must meet the applicable provisions of the 2000 edition of the *Life Safety Code of the National Fire Protection Association* (NFPA), which is incorporated in the regulation by reference. See *NFPA 101 Life Safety Code*, 2000 edition, §§ 18.7.1.1–2 and 19.7.1.1–2. Accessed at http://www.nfpa.org on May 18, 2011.

[4] Department of Health and Human Services (HHS), Unified Regulatory Agenda (Dec. 20, 2010). *Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers* (CMS-3178-P). Accessed at http://www.regulations.gov on April 5, 2011.

[5] Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, §§ 4202 and 4212, Social Security Act, §§ 1819(g) and 1919(g), 42 U.S.C. §§ 1395i–3 and 1396r.

[6] 42 CFR §§ 488.308(a) and 488.330(a)(1)(i).

[7] 42 CFR §§ 488.402(d), 488.408, and 488.456.

Standard survey. The standard survey includes two assessments of emergency preparedness: emergency planning and emergency training.[8] To determine whether nursing homes meet Federal regulations for emergency planning, surveyors are instructed to review emergency plans.[9] Federal regulations state that nursing home emergency plans must include procedures to meet all potential emergencies, such as fires, severe weather, and missing residents.[10] The regulations do not specify required content for emergency plans; the SOM indicates only that emergency plans must include plans relevant to natural or manmade disasters and include procedures for finding a missing resident.[11] If surveyors find that emergency plans are deficient, they can cite nursing homes with a deficiency of Tag F517.[12] To determine whether a nursing home meets Federal regulations for training in emergency procedures, surveyors are instructed to question the nurse in charge and two nursing home staff members (e.g., nurse aide, housekeeper, maintenance person) about their facility's emergency plan.[13] If the nurse in charge or other staff members are unable to answer the questions correctly, the surveyors can cite the nursing home with a deficiency of Tag F518.[14]

LSC survey. SAs are also responsible for LSC surveys, which should be documented no later than 60 days after conclusion of the standard surveys.[15] Surveyors must complete additional specialized training to conduct the LSC survey, and special consultants, such as fire protection engineers or fire alarm technicians, may participate on the survey team.[16] In some cases, SAs may enter into subagreements or contracts with State fire authorities to assess LSC compliance.[17]

The LSC requires facilities to comply with a set of fire protection provisions designed to provide safety from fire, smoke, and panic.[18] The LSC survey includes two assessments for fire protection: whether the facility has a written plan for the protection and evacuation of all patients in an emergency and whether the facility conducts fire drills. If surveyors

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[8] CMS, SOM, Pub. No. 100-07, App. PP, Guidance to Surveyors for Long-Term Care Facilities, Tags F517 and F518.

[9] Ibid.

[10] 42 CFR § 483.75(m).

[11] CMS, SOM, App. PP, Tag F323.

[12] CMS, SOM, ch. 2, § 2728A.

[13] CMS, SOM, App. PP, Tags 517 and F518.

[14] CMS, SOM, ch. 2, § 2728A.

[15] CMS, SOM, ch. 2, § 2472C.

[16] CMS, SOM, App. I, Survey Procedures and Interpretive Guidelines for Life Safety Code Surveys, p. 1.

[17] CMS, SOM, ch. 2, § 2472B.

[18] CMS, SOM, ch. 2, § 2470A.

find that emergency fire plans are deficient, they can cite the nursing homes with a deficiency of Tag K48. Surveyors should also evaluate whether nursing homes hold fire drills at unexpected times under varying conditions and whether nursing home staff members are familiar with emergency procedures. If fire drill records or staff responses during interviews are insufficient, surveyors can cite the nursing homes with a deficiency of Tag K50.[19]

State LTC Ombudsman Programs

Federal law requires that each State establish a State LTC ombudsman program, funded through the Administration on Aging (AoA), to advocate for residents in long-term care facilities, such as nursing homes.[20] The State LTC ombudsman is responsible for identifying, investigating, and resolving complaints made by or on behalf of nursing home residents relating to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of LTC residents.[21] The State LTC ombudsman also monitors the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions that pertain to the health safety, welfare, and rights of LTC residents.[22]

Federal law does not explicitly state how LTC ombudsman programs should participate in nursing home emergency planning, nor does it require that ombudsman programs take specific action during disasters. To provide a resource for LTC ombudsmen, AoA partially funded a report published in 2000 that describes possible LTC ombudsmen actions during nursing home closings and natural disasters. The report is a collection of experiences and perspectives of LTC ombudsmen during disasters, describing tasks such as helping to arrange transportation and to find facilities with available beds.[23]

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[19] CMS, SOM, App. I, Survey Procedures and Interpretive Guidelines for Life Safety Code Surveys, Task 5. NFPA, *NFPA 101 Life Safety Code*, 2000 edition, §§ 18.7.1.1–2 and 19.7.1.1–2. Accessed at http://www.nfpa.org on May 18, 2011. Form CMS-2786R (06/2007), "Fire Safety Survey Report 2000 Code–Health Care."

[20] 42 U.S.C. § 3058g(a)(1). AoA, *Investments in Change: Enhancing the Health and Independence of Older Adults, 2008 Annual Report*, p. 19.

[21] 42 U.S.C. § 3058g(a)(3)(A).

[22] 42 U.S.C. § 3058g(a)(3)(G).

[23] S. Murtiashaw, *The Role of Long-Term Care Ombudsman in Nursing Home Closures and Natural Disaster*, 2000, National Long-Term Care Ombudsman Resource Center, pp. 42–43. Accessed at http://www.ltcombudsman.org on April 23, 2010.

CMS Emergency Preparedness Checklists

In 2007, CMS published three emergency preparedness checklists as "recommended tools" for health care facilities, SAs, and State LTC ombudsman programs:

- *Health care facilities checklist*. This checklist includes 70 tasks, which CMS grouped into 23 task categories. Health care facilities, including nursing homes, could implement these tasks to ensure that they have a comprehensive emergency plan to respond to any disaster.[24] The checklist provides guidance for developing emergency plans; ensuring adequate supplies of food and water; identifying evacuation routes; and transporting patients, critical supplies, and equipment. It also recommends that facilities collaborate with local emergency management agencies, suppliers, and providers identified as part of a community emergency plan to care for evacuees.
- *State LTC ombudsman program checklist*. This checklist is a resource for State LTC ombudsmen and includes such tasks as ensuring that all regional and local ombudsmen are familiar with emergency planning pertinent to LTC facilities.[25]
- *State SA checklist*. This checklist encourages collaboration between SAs and emergency management agencies and provides guidance on the essential functions of SAs during disasters.[26]

Disasters in 2007–2010

From 2007 to 2010, several disasters substantially affected at least 210 nursing homes in 7 States, forcing residents to evacuate or shelter in place in response to floods, hurricanes, and wildfires.[27]

Floods. In March 2009, flooding of the Red River forced the evacuation of six nursing homes in North Dakota. Across the river in Minnesota, one nursing home was evacuated and the residents of another sheltered in place.[28] In May 2010, widespread flooding along the Mississippi and Cumberland Rivers in Tennessee forced the evacuation of at least two nursing homes. Another nursing home evacuated some of its residents, and the residents of four others sheltered in place.

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[24] CMS, *Survey & Certification: Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning*. Accessed at http://www.cms.gov on February 5, 2010.

[25] CMS, *Survey & Certification: Emergency Planning Checklist Recommended Tool For Persons in Long-Term Care Facilities & Their Family Members, Friends, Personal Caregivers, Guardians & Long-Term Care Ombudsman* (see Part II). Accessed at http://www.com.gov on February 5, 2010.

[26] CMS, *Survey & Certification: Emergency Preparedness Checklist Recommended Tool for Effective State Agency Planning*. Accessed at http://www.cms.gov on February 5, 2010.

[27] This number is limited to nursing homes affected by the disasters in our study.

[28] This area experienced flooding again in March 2010, although no nursing homes were evacuated.

Hurricanes. Within a span of 12 days in September 2008, Category 2 Hurricanes Gustav and Ike made landfall in Cocodrie, Louisiana, and Galveston Island, Texas. Hurricane Gustav forced the evacuation of 92 nursing homes in the coastal parishes of Louisiana.[29] Hurricane Ike, the third-costliest hurricane ever to hit the United States, devastated Galveston Island and led to a mass evacuation of the Texas gulf coast, including 84 nursing homes.[30] In September 2010, Category 2 Hurricane Earl threatened the Outer Banks of North Carolina, forcing the evacuation of three nursing homes; the residents of three others sheltered in place.

Wildfires. In October 2007, wildfires threatened heavily populated areas near San Diego, California, forcing the evacuation of five nursing homes; the residents of three others sheltered in place. In May 2009, wildfires near Santa Barbara, California, forced the evacuation of one nursing home, and the residents of four others sheltered in place.

METHODOLOGY

Scope

For this evaluation, we analyzed national CMS survey data to determine nursing home compliance with Federal regulations for emergency preparedness planning and training in 2009–2010. We compared emergency plans for 24 selected nursing homes to the CMS emergency preparedness checklists and to Federal regulations for emergency preparedness planning. We also interviewed nursing home staff; community authorities; State, regional, and local LTC ombudsmen; and SA staff to collect information about their experiences during disasters that occurred during 2007–2010.

Sample

We purposively selected 24 Medicare- and Medicaid-certified nursing homes whose residents sheltered in place or were evacuated in response to floods, hurricanes, or wildfires during 2007–2010. (See Appendix A for details about sample selection, including communities and selected nursing home characteristics.) The 24 nursing homes are within 16 communities in 13 counties across 7 States. They received services from 11 local and regional LTC ombudsman programs (see Table 1).

[29] According to the Saffir-Simpson Hurricane Wind Scale, a Category 2 hurricane has sustained winds of 96–110 miles per hour. Winds of this intensity are extremely dangerous and cause extensive damage. Accessed at http://www.nhc.noaa.gov on August 30, 2011.

[30] Federal Emergency Management Agency, *Hurricane Ike Impact Report*, December 8, 2008.

Table 1: Entities Represented in Selected Sample

Entity	Number
Local and Regional Entities	
Nursing homes	24
Communities	16
Counties	13
Local and regional LTC ombudsman program offices	11
State Entities	
State LTC ombudsman programs	7
SAs	7

Source: OIG analysis of 24 selected nursing homes affected by disasters during 2007–2010.

Data Sources and Data Collection

CMS survey data. We used CMS Online Survey, Certification, and Reporting (OSCAR) data to determine national nursing home compliance rates with Federal regulations regarding emergency planning and training in 2009 and 2010.[31] We obtained the data in March 2011.

Documentation. We obtained current (2010) emergency plans and supporting documents from each of the 24 selected nursing homes.[32] We also collected community emergency plans to determine the extent to which nursing homes coordinated their plans with the community plans. Additionally, we collected materials that regional and local LTC ombudsmen used to guide their response to nursing home emergencies. We also collected emergency plans and supporting documents from State LTC ombudsman programs.

Onsite interviews. We conducted structured onsite interviews with nursing home administrators, directors of nursing, and other staff involved in the disaster response for the 24 selected nursing homes. We asked respondents about their emergency plans and staff training. We also asked about their decisions to evacuate or shelter in place and their experiences before, during, and after the disaster.

We also conducted structured onsite interviews with local emergency management officials and LTC ombudsman program staff and volunteers in each of the 16 communities where the selected nursing homes are located. (See Table A-3 in Appendix A for the number of interview

[31] National statistics include nursing homes from all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

[32] Supporting documents included, but were not limited to, transportation agreements, training for transportation vendors and volunteers, records of staff training, exercises and drills, after-action reports, and the most recent internal review of the emergency plan.

respondents affiliated with each type of entity.) We asked respondents about their community emergency planning and response, evacuation orders, local requirements for nursing homes, assistance provided to nursing homes, implementation of plans during the specified disaster, and reflections about selected nursing homes' disaster responses. We conducted all onsite interviews between July and October 2010.

Telephone interviews. We conducted structured telephone interviews with officials from SAs and State LTC ombudsman programs for each of the seven States where the selected nursing homes are located. We asked respondents about their roles and responsibilities for emergency planning, actions taken during the specified disaster, the nature of evacuation orders, State nursing home requirements, and assistance provided to nursing homes for development and execution of plans. We also asked SAs about training provided to surveyors to prepare them for reviews of nursing home emergency plans and training documents. Additionally, we asked whether they used the CMS checklists as tools for emergency planning. We conducted all telephone interviews between July and November 2010.

Data Analysis

Quantitative analysis. To determine emergency preparedness compliance rates in 2009–2010, we used standard and LSC survey data to calculate the number of deficiencies issued for Tags F517, F518, K48, and K50. We then compared the 2009–2010 compliance rates with rates found in 2004–2005. Whenever possible, we also quantified interview and documentation data.

Qualitative analysis. To determine the extent to which selected nursing homes' emergency plans contained tasks recommended by the CMS emergency preparedness checklists, we compared the plans with the 70 tasks listed in the CMS checklist for health care facilities. For each CMS checklist task, we determined whether the nursing home emergency plan contained provisions that matched, partially matched, or did not match that CMS task. Finally, we reviewed the emergency plans to determine whether they included procedures for fire, severe storms, and missing residents, as stated in Federal regulations.[33] For example, if a plan did not include procedures for responding to fires, we categorized it as a nonmatch for emergency planning for fires.

To examine the challenges experienced by selected nursing homes during disasters in 2007–2010, we analyzed transcripts from our interviews with nursing home administrators, staff, local emergency entities, LTC ombudsmen, and SA officials. Finally, to examine the roles of selected

[33] 42 CFR § 483.75(m).

LTC ombudsman programs and SAs during disasters, we analyzed transcripts from our interviews with State, local, and regional ombudsmen and SA officials. In analyzing the interview data, we developed themes and selected examples to illustrate the respondents' experiences.

Limitations

This study has two limitations. First, the purposive sample of 24 selected nursing homes is not representative of all nursing homes, nursing home emergency plans, or nursing home experiences during disasters. Second, during interviews we relied on respondents' recollections of disasters. Although this limitation applies to all interviews conducted for the study, for 10 of the 24 selected nursing homes, interviews took place 2–3 years after the disasters.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

In 2009–2010, 92 percent of nursing homes met Federal regulations for emergency plans and 72 percent for emergency training, slightly less than the percentages 5 years earlier

Of the 16,001 nursing homes surveyed nationwide during 2009 and 2010, most met Federal regulations. This is a slight decrease from the compliance rates for 2004 and 2005 reported 5 years earlier, when we found that 94 percent of nursing homes met Federal regulations for planning and 80 percent met regulations for training.[34] Although most nursing homes met Federal regulations for planning, 28 percent were found deficient for inadequately training staff to respond to disasters (see Table 2). Additionally, LSC surveyors cited 20 percent more nursing homes for deficiencies in emergency training than surveyors conducting standard surveys. Insufficient planning may be more prevalent than these results indicate, however. According to SA officials we interviewed, surveyors primarily focus on resident care issues during standard surveys, and therefore may not review emergency plans and training records as closely as LSC surveyors might. Officials from five of the seven States in our review reported that they did not train surveyors specifically on assessment of nursing home emergency plans. (See Appendix B for a list of nursing home emergency preparedness planning and training deficiencies nationally and by State.)

Table 2: Nursing Homes Cited for Deficiencies in Emergency Planning and Training: National (2009–2010)

Deficiencies	Facilities (n=16,001)	Percentage
Planning Deficiencies		
Standard survey (F517)	403	3
Life Safety Code (K48)	861	5
Total*	**1,214**	**8**
Training Deficiencies		
Standard survey (F518)	860	5
Life Safety Code (K50)	3,936	25
Total*	**4,466**	**28**

Source: OIG analysis of OSCAR data for 2009–2010.
*The totals for planning and training deficiencies are not the sums of the standard survey and LSC deficiencies because some facilities had one of each type of deficiency, resulting in some overlap in the categories.

[34] OIG, *Nursing Home Emergency Preparedness and Response During Recent Hurricanes*, OEI-06-06-00020, August 2006.

Among the 24 selected nursing homes, surveyors cited only 3 for planning or training deficiencies during their most recent surveys. For example, surveyors cited one nursing home for a planning deficiency resulting from insufficient stockpiles of food and a training deficiency for failing to train staff to extinguish a kitchen fire. The remaining two homes were found deficient for insufficient documentation of emergency training. As noted, Federal regulations state that nursing home emergency plans must include procedures to meet all potential emergencies, such as fires, severe weather, and missing residents.[35] We found that emergency plans for 12 of the 24 selected nursing homes lacked procedures for finding missing residents and that 1 of these plans also lacked procedures for responding to fires. During their most recent standard and LSC surveys, none of these 12 nursing homes were found deficient for emergency planning.[36]

Training for surveyors in five of seven States did not include instructions for evaluating emergency plans

In these five States, SA officials reported that their training for surveyors who conduct standard surveys did not include instructions on how to evaluate an emergency plan, details for assessing compliance, or training specific to planning for disasters in their States. Officials from the remaining two States reported that their surveyor training included instructions for assessing nursing home emergency plan compliance with Federal regulations. These instructions included methods for checking generators and water supplies and for identifying items typically missing from a plan, such as procedures for sheltering in place and planning evacuation routes.

On average, selected nursing homes' emergency plans included about half of the CMS-recommended checklist tasks, and none included all of them

Most nursing home administrators did not use the recommended CMS emergency preparedness checklist for health care facilities in developing their emergency plans; and the plans lacked many checklist tasks. Administrators from only 13 of the 24 nursing homes were aware of the checklist and only 7 of the 13 reported using it in developing their plans. Administrators who did not use the checklist explained that they used guidance from other sources, such as their corporate offices or local emergency managers. The number of CMS checklist tasks included in the 24 selected nursing homes' plans ranged from 19 to 57 out of 70 tasks (see

[35] 42 CFR § 483.75(m)(1).

[36] Emergency plans submitted to OIG by nursing homes may not have been the same plans reviewed by surveyors during the most recent nursing home certification survey.

Table 3). See Appendix C for a full list of CMS checklist tasks included in selected nursing homes' emergency plans.

Table 3: CMS-Recommended Tasks in Selected Nursing Homes' Emergency Plans

Number of CMS-Recommended Tasks (n=70)	Nursing Home Plans With Tasks* (n=24)
60–70	0
50–59	3
40–49	5
30–39	9
20–29	6
10–19	1
0–9	0
Total	**24**

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*We credited nursing home emergency plans with containing recommended tasks when they matched or partially matched the tasks.

Emergency plans from selected nursing homes lacked checklist tasks within six areas of concern

In reviewing selected nursing homes' emergency plans, we identified six areas of particular concern. These areas represent tasks that nursing homes often did not include in their plans but could affect residents during disasters: staffing; resident care; resident identification, information, and tracking; sheltering in place; evacuation; and communication and collaboration.

Table 4: CMS-Recommended Staffing Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
Staffing backup plan	22
Evacuate staff's family with the facility	19
Staffing requirements	19
Shelter staff's family at the facility	14
Ensure that staff accompany residents during evacuation	12

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

Staffing tasks. Ten of the twenty-four selected nursing homes' plans did not include any recommended tasks for ensuring sufficient staffing levels to provide continuous care for residents during disasters, potentially leading to delays in meeting medical and other physical needs. Additionally, 22 of 24 plans did not include backup plans for staff unable to report to work during the disaster and 19 of 24 plans lacked information regarding staffing requirements (see Table 4).

Resident-care tasks. Eleven of the twenty-four selected nursing homes' plans did not include any recommended resident-care tasks. For example, 23 of 24 plans did not describe how to handle resident illness or death during an evacuation or how to provide disaster counseling to residents. As another example, 15 of 24 plans did not contain information regarding specific characteristics and needs of residents (see Table 5).

Table 5: CMS-Recommended Resident-Care Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
Procedures for resident illness or death en route to evacuation site	23
Mental health and grief counselors at evacuation site	23
Resident care during evacuation	17
Specific characteristics and needs of residents	15

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

The lack of detailed information about resident-specific needs (e.g., nasogastric or enteral feeding tubes, ventilator, and oxygen) and characteristics (e.g., Alzheimer's and dementia) could pose a threat to the well-being of residents by failing to signal the need for special transportation and necessary medical care and equipment.

Resident identification, information, and tracking tasks. Five of the twenty-four selected nursing homes' plans did not include any tasks related to identifying residents, transferring their information, or tracking them. For example, 7 of the 24 plans did not specify any methods for identifying residents (e.g., wristband or nametag), and 11 plans did not specify what personal information must accompany residents during an evacuation (see Table 6).

Table 6: CMS-Recommended Identification, Information, and Tracking Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
Method used to identify residents during evacuation	7
Transfer the following information with each resident:	
Name and contact information for next of kin/power of attorney	19
Date of birth, diagnosis	17
Current drug/prescription and diet regimens	15
Name	11
Method to account for individuals during and after evacuation	10

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

The lack of information about residents' prescriptions (e.g., for treatment of diabetes) could pose a threat to residents' health if essential medications are not administered on time to those with chronic conditions.

Sheltering-in-place tasks. Twelve of the twenty-four selected nursing homes' plans did not include any of the recommended tasks for sheltering in place. For example, none of the 24 plans specified the amount of water needed to ensure sufficient supply for a minimum of 7 days (see Table 7).

Table 7: CMS-Recommended Sheltering-in-Place Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
To care for residents for a minimum 7 days:	
Adequate supply of potable water	24
Extra medical supplies and equipment	22
Generator fuel supply	19
Extra pharmacy stocks of common medications	19
Amounts and types of food in supply	17

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

Evacuation tasks. Eleven of the twenty-four selected nursing homes' plans did not include any recommended tasks regarding evacuation procedures. For example, 22 of 24 plans did not describe how the nursing home would transport and protect medical records and medications during an evacuation (see Table 8).

Table 8: CMS-Recommended Evacuation Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
Transportation and logistical support of:	
Adequate food supply	24
Water (including amount)	24
Critical supplies and equipment	19
Transportation and protection of medications under registered nurse	22
Transportation and protection of:	
Medical records	22
Wheelchairs and assistive devices	19
Evacuation routes:	
Evacuation routes only	15
Evacuation routes and alternative routes	23

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

Communication and collaboration tasks. Twenty-two of the twenty-four selected nursing homes' plans lacked tasks for communicating with local LTC ombudsmen, residents, and proper authorities during and after a disaster (see Table 9).

Table 9: CMS-Recommended Communication and Collaboration Tasks in Selected Nursing Homes' Emergency Plans

Task	Nursing Home Plans Without Task (n=24)*
Communication	
Communicate with and/or notify:	
Local LTC ombudsman program	22
Residents	15
Staff	8
Proper authorities	4
Resident families	4
Facility communication infrastructure in the event of telephone failure	7
Collaboration	
Collaborate with emergency managers to develop plan	16
Collaborate with emergency managers to determine whether to evacuate or shelter in place	17

Source: OIG analysis of 24 selected nursing homes' emergency plans in 2010.
*Numbers may not sum to totals shown in Appendix C because of combined task categories.

Administrators from 17 of the 24 selected nursing homes reported substantial challenges in responding to disasters

Administrators and staff from 17 of the 24 selected nursing homes reported facing substantial challenges in responding to disasters, whether they evacuated or sheltered residents in place. Of these 17 nursing homes, 11 were evacuated and 6 sheltered residents in place. Challenges included difficulty following emergency plans as written, logistical problems related to transportation and communication, and negative effects of evacuation on resident health (see Table 10). Further, most nursing homes that experienced challenges reported that they had not collaborated with local emergency management agencies to prepare for disasters.

Table 10: Nursing Home Challenges in Responding to Disasters

Challenge	Nursing Homes Reporting Challenge (n=17)*
Emergency Plan	
Emergency plan as written:	
Lacked detailed procedural information	9
Was not specific to disaster experienced	5
Was missing information or contained inaccurate information	3
Staff did not consult plan	2
Total	**12**
Logistics	
Unreliable transportation contracts and agreements	5
Hospital not available to shelter high-acuity residents	5
Nursing home resident dispersion	5
Nursing home residents moved more than once	4
Inadequate tracking systems for residents and supplies	4
Closed roads limited access to nursing home	4
Technological problems with communication devices	3
Total	**13**
Physical and Emotional Effects on Residents	
Some residents experienced:	
Negative effects of evacuation on physical health	9
Stress, anxiety, fear, or emotional trauma	9
Total	**12**

Source: OIG analysis of interviews with 24 selected nursing homes' administrators and staff in 2010.
*Nursing homes reporting challenges do not sum to the totals because some reported more than one challenge.

Of the 17 nursing homes that reported challenges, 7 met with local emergency managers before the disaster to review the situation, establish benchmarks for evacuation, and formulate a response plan. However, most of the 17 nursing homes did not have local emergency managers review their emergency plans, and none participated in communitywide emergency preparedness exercises and drills before the disaster.

Nursing home staff struggled to execute emergency plans

According to administrators from 12 of the 17 nursing homes that reported challenges, their emergency plans did not contain accurate or detailed information on how to execute their plans and respond to disasters. For example, one administrator of a nursing home that was flooded reported that its emergency plan did not include procedures for responding to floods, although the nursing home was in a flood plain. Another administrator of a nursing home that was evacuated acknowledged that most planning focused on sheltering in place rather than evacuating. This administrator did not have prior agreements with host facilities and found that identifying them at the last minute was a formidable task. Administrators of two nursing homes reported that they did not consult their written emergency plans to prepare for evacuation. They reported piecing together transport by calling upon other nursing homes and local emergency entities to evacuate their residents.

Nursing homes reported logistical problems related to transportation and communication

Administrators from 13 of the 17 nursing homes reported a range of logistical problems related to evacuation and sheltering in place. The most common problems, each reported by five nursing homes, were that transportation contracts were not honored, hospitals declined to shelter high-acuity residents unless their medical conditions warranted admission under normal circumstances, and difficulty was experienced in tracking residents dispersed to host facilities. Regarding widespread dispersion, residents of 1 home were sent to 20 host facilities, making it difficult for staff familiar with the residents to monitor their status and provide care. Four nursing homes that were evacuated reported difficulty tracking residents and supplies, in some cases temporarily “losing” residents and having difficulty matching displaced residents to personal equipment, such as wheelchairs. Some logistical difficulties were the result of community disaster conditions; for example, administrators from four nursing homes (as well as LTC ombudsmen) reported that closed roads limited staff access and equipment delivery, and administrators from three nursing homes reported technical problems using cell phones and walkie-talkies.

Nursing homes reported that some residents developed health problems, creating challenges in providing care

Administrators from 12 of the 17 nursing homes reported that some residents experienced deteriorating health conditions, skin issues, falls that resulted in injury, or death. Administrators from seven of these nursing homes reported that some residents' medical conditions deteriorated during evacuation, necessitating hospitalization either en route to or immediately after their arrival at host facilities. Administrators from four of these nursing homes also reported that an unspecified number of residents experienced skin issues, such as bedsores or tears, and administrators from two homes reported having a resident who fell, resulting in injury at a host facility. Finally, administrators from 9 of the 17 nursing homes indicated that some residents experienced emotional trauma, such as confusion and anxiety, resulting in at least 1 instance of required sedation.

Most nursing homes that reported challenges did not have local emergency managers review their plans, and none participated in communitywide emergency exercises and drills

Of the 17 nursing homes that reported challenges in following their emergency plans, 12 were in communities in which local emergency management entities did not review and approve their plans. During interviews, emergency managers in these communities expressed willingness to review plans but noted that they did not have the authority to monitor or verify compliance with the plans. Moreover, the emergency entity reviewing the plan may not be the agency that responds to the nursing home during a disaster. For example, in one county that required emergency management review of nursing home plans, the county emergency manager reviewed and approved a plan, but the emergency manager of the fire department that responded to the nursing home's request for assistance did not know of the home's plan.

Few nursing homes that reported challenges collaborated with local emergency managers before the disaster; only 4 of the 17 nursing homes reported meeting with them to prepare for specific disasters, 2 participated in regular communitywide preparedness meetings, and none participated in communitywide exercises and drills.[37]

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[37] Since the 2007 wildfires, nursing homes in San Diego County have participated in bed census drills as members of their county's nursing home disaster preparedness and response task force. Skilled Nursing Facility Disaster Preparedness Task Force, *The San Diego Model–A Skilled Nursing Disaster Preparedness and Response Plan*, 2009. Accessed at http://www.cahfdownload.com/cahf/dpp/SDModel-Final-08-27-09.pdf on June 4, 2010.

Six of the 17 nursing homes that experienced challenges were in communities in which local emergency managers stated that they perceive nursing homes as businesses and therefore responsible for management of their own disaster response. Emergency managers in these communities indicated they would assist nursing homes as a last resort, but that they had competing priorities for scarce resources. According to one emergency manager, a bus used to evacuate residents from a nursing home was originally to be used for indigent and homebound populations.

LTC ombudsmen were often unable to support nursing home residents during disasters

Local LTC ombudsmen reported that although they have no additional emergency-related tasks required by Federal regulation, they continue during emergencies to work to ensure resident welfare. State LTC ombudsman programs in four of the seven States had emergency plans to ensure continuity of service. Still, local LTC ombudsmen in all seven states were often unable to contact or visit residents of nursing homes affected by disasters, potentially affecting resident safety and welfare.

Although some LTC ombudsmen visited residents of the 24 selected nursing homes during the disasters, most had no contact with them until the disasters ended or residents returned to nursing homes

Administrators from only 3 of the 24 selected nursing homes reported that their local LTC ombudsmen visited residents, either while residents were in host facilities or immediately upon their return to their nursing homes. Ombudsmen from 7 of the 11 local LTC programs reported that areawide evacuations, closed roads, and evacuations to distant host facilities affected access to residents. Ombudsmen from 10 of the 11 local LTC programs indicated that the disasters likely increased resident vulnerabilities. Ombudsmen said that after reentering facilities, residents often talked about difficulties such as emotional trauma and loss of privacy.

Four of the seven State LTC ombudsman programs had emergency plans to ensure continuity of service to nursing home residents, but none reported using the CMS emergency preparedness checklist

Four of the seven State LTC ombudsman programs had written emergency plans to ensure program continuity during disasters. Officials from three of these programs reported they were aware of the CMS emergency preparedness checklist for State LTC ombudsman programs, but none reported using it to develop plans. Five of the seven State LTC ombudsmen reported that they provided disaster-related information to

regional and local LTC ombudsman programs, including one State LTC ombudsman who worked at the State operations command center during the disaster. Three State LTC ombudsmen indicated that they would like further clarification of their responsibilities before, during, and after disasters.

State survey agencies completed tasks related to nursing home compliance and addressed ad hoc facility needs

SA officials stated that the primary role of the SA was to enforce compliance with Federal and State regulations. However, agency officials often accepted additional responsibilities as needs arose, including tracking nursing home residents, helping to find placement for evacuated residents, and facilitating communication between nursing homes and community emergency entities.

SAs focused primarily on issues related to facility compliance with State and Federal regulations

Officials from the seven SAs indicated that their most important obligation related to emergency planning and disaster response was to continue their primary task of surveying nursing homes for compliance. They also expressed a responsibility to serve as a conduit between CMS and nursing homes, providing information to CMS officials and assisting facilities in understanding CMS payment and compliance provisions. Four of the seven SAs completed additional tasks as a result of the disasters that were related to facility compliance. For example, CMS allowed one SA to approve temporary waivers for host facilities to exceed their bed capacity to accept evacuated residents.

SAs accepted additional responsibilities as facility needs arose, including tracking and assisting with placement of residents

All seven SAs made efforts to assist nursing homes during disasters. For example, officials from four SAs tracked evacuated residents. In most cases, this tracking consisted of manually creating and updating spreadsheets. Officials in one of these States found that before the disaster, county emergency managers did not know of all nursing facilities in their area. As a solution, the SA created a facility report listing numbers of residents and beds as well as evacuation status. The SA routinely updated and distributed the report to emergency entities. SAs in three of

these four States also helped find suitable host facilities.[38] Further, officials from all SAs reported that they received and answered questions from nursing homes. Common questions included how to discharge residents to host facilities and how to obtain State and Federal reimbursement for evacuation costs.

Surveyors in three States identified a need for better planning and coordination for returning residents to facilities after disasters. In two of these States, the SAs monitored returns by communicating individually with facility administrators and relaying the aggregate information to community emergency entities. In the third State, local emergency managers notified the SA that they did not have time to check the suitability of nursing homes for reentry. Instead, SA surveyors visited the facilities to determine whether they met standards for returning residents. In other cases, SAs positioned themselves as a last resort should nursing homes require assistance because of unexpected circumstances, such as transportation contracts that were not honored. State surveyors also staffed community shelters as part of their duties as State employees.

All seven SAs had emergency plans, but none reported using the CMS emergency preparedness checklist for SAs

Officials from the seven SAs explained that as State agencies, their emergency plans were integrated into emergency preparedness plans for State health departments or for State emergency management agencies. Although officials from five of the seven States reported that they were aware of the CMS emergency preparedness checklist for SAs, none used it as a planning tool. One SA official indicated that his agency did not use the checklist because other State entities are responsible for emergency planning and preparedness. An SA official from another State said that CMS guidance regarding disaster management should focus on clarifying and communicating CMS policies, rather than on emergency planning issues. This official indicated that payment issues (e.g., the implications to the home facility of evacuating residents to a host facility) and instructions about what kind of information is required by CMS during disasters may not be clear and that it is "too difficult in the middle of a crisis to figure out the rules."

[38] After the disasters, two SAs indicated that they were in the process of purchasing tracking software, and one SA now has a system that requires nursing homes to update their resident status twice a day during State-declared disasters.

RECOMMENDATIONS

Five years after the release of the 2006 OIG report highlighting problems with nursing home emergency planning and procedures, we identified many of the same gaps in nursing home preparedness and response, specifically with emergency plans lacking relevant information, unreliable transportation contracts, negative effects on residents, and lack of collaboration with local emergency management entities.[39] Including tasks from the CMS emergency preparedness checklist for health care facilities is not required, and we found that most plans from selected nursing homes lacked many of the tasks recommended in the checklist. Though the tasks in the checklist exceed Federal regulatory requirements for nursing home emergency plans, their omission could compromise resident health and safety and jeopardize effective nursing home response to disasters. To improve nursing home emergency preparedness and response to disasters, we recommend that:

CMS revise Federal regulations by identifying and including in its regulations requirements for specific elements of emergency plans and training

Federal regulations require that Medicare- and Medicaid-certified nursing homes have detailed written emergency plans and procedures.[40] CMS should take into account the six areas of concern identified in this report to specify elements that should be required for inclusion in nursing home plans. These required elements should apply to all Medicare- and Medicaid-certified nursing homes. Additionally, to enhance the safety and welfare of nursing home residents during disasters, CMS should specify minimum Federal standards for the frequency and extent of disaster response training, exercises, and drills for nursing home staff.

CMS update the SOM to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training

The SOM, which provides CMS's guidance to SAs that assess nursing home compliance with Federal regulations, requires that surveyors conducting standard surveys "review" nursing home emergency plans, but provides no procedural guidance for how surveyors are to assess plans.[41] CMS should develop detailed and clear guidance for use during surveys to ensure more effective assessment of nursing home emergency plans. CMS

[39] OIG, *Nursing Home Emergency Preparedness and Response During Recent Hurricanes*, OEI-06-06-00020, August 2006.

[40] 42 CFR § 483.75(m).

[41] CMS, SOM, App. PP, Tag 517.

should also provide additional training for surveyors on emergency preparedness and plan assessment and standardize when surveyors should issue deficiency citations related to emergency planning.

CMS promote use of the emergency preparedness checklists for nursing homes, State LTC ombudsman programs, and SAs

CMS designed the emergency preparedness checklists as tools for effective emergency planning, yet nursing homes, State LTC ombudsman programs, and SAs rarely reported using the checklists as guidance. In some cases, officials from these entities were not even aware of the CMS checklists. CMS does not require nursing homes to use the checklists and the tasks in the checklist exceed Federal regulatory requirements for emergency plans. Additionally, nursing home administrators indicated that they receive emergency planning guidance from other sources. Still, we found that nursing home emergency plans were largely lacking tasks recommended in the CMS checklist for health care facilities, which provides a comprehensive index of emergency planning tasks.

Greater use of the checklists could assist nursing homes, State LTC ombudsmen programs, and SAs in improving emergency planning and disaster management. CMS should further promote use of the emergency preparedness checklists, such as by making additional outreach efforts and partnering with AoA, the Office of the Assistant Secretary for Preparedness and Response (ASPR), and other emergency preparedness entities. Finally, in a supplemental memorandum report, we outline guidance that CMS can consider when revising the checklist for health care facilities.[42]

AoA develop model policies and procedures to protect resident health, safety, welfare, and rights during and after disasters

AoA should collaborate with CMS, ASPR, SAs, and State LTC ombudsman programs to identify effective models for State and local LTC ombudsman programs during disasters and assist States in their development of policies and procedures to protect residents' health, safety, welfare, and rights during and after disasters. For example, guidance could include potential actions by State and local LTC ombudsmen during and after a disaster and identify common problems experienced by residents to assist ombudsmen with recognizing and addressing these problems. Additionally, AoA should provide a framework for LTC ombudsmen's contact with residents after a disaster. The framework could include developing protocols for ombudsmen assigned to a host facility to

[42] OIG, *Supplemental Information Regarding the Centers for Medicare & Medicaid Services' Emergency Preparedness Checklist for Health Care Facilities*, OEI-06-09-00271, April 2012.

visit displaced residents there. AoA could also encourage State, local, and regional LTC ombudsman programs to develop plans that, to the extent possible, ensure that ombudsmen are available to residents whether the nursing facility shelters residents in place or is evacuated.

AGENCY COMMENTS AND OFFICE INSPECTOR GENERAL RESPONSE

We received comments on the draft report from CMS and AoA.

CMS concurred with each recommendation.

In response to our recommendation that CMS revise Federal regulations by identifying and requiring specific elements of emergency plans and training, CMS stated that that it will include specific guidance concerning emergency plans and training when it proposes long-term care regulation revisions.

In response to our recommendation that CMS provide detailed guidance for surveyors assessing compliance with Federal regulations for emergency planning and training, CMS stated that it will update the SOM and provide additional training to States and surveyors. CMS also stated that it will issue a policy memorandum for SAs to alert health care providers of problems.

In response to our recommendation that CMS promote use of the emergency preparedness checklists, CMS stated that it will work with nursing homes, State LTC ombudsman programs, and SAs to reiterate the availability of the emergency preparedness materials and encourage their use. CMS also stated that it would review and update the checklists, as appropriate.

AoA concurred with our recommendation to develop model policies and procedures to protect residents during disasters. AoA stated that it is collaborating with CMS to update the LTC ombudsmen emergency planning checklist and will develop and implement dissemination and training strategies. Additionally, AoA stated that it is collaborating with ASPR to promote State LTC ombudsman program awareness and use of model policies.

For the full text of CMS and AoA comments, see Appendix D. We made minor changes to the draft report based on technical comments.

APPENDIX A

Sample Selection

Communities. We identified disaster-affected communities nationwide by reviewing information from the Federal Emergency Management Agency and State survey agencies (SA). We focused on disasters that affected multiple nursing homes during 2007–2010, selecting three types of disasters for this study: floods, hurricanes, and wildfires.

We selected at least two counties in five of the seven States. For the remaining two States (Minnesota and North Dakota), we selected one county in each State. We selected communities for site visits based on whether the disaster affected nursing homes within the counties. Table A-1 lists information about the communities and disasters associated with the selected nursing homes.

Table A-1: Community and Disaster Information for Selected Nursing Homes

State	County	Population*	Disaster	Year	Selected Nursing Homes (n=24)	
					Shelter in Place	Evacuation
CA	County 1	3,053,793	Wildfire	2007	1	2
	County 2	407,057	Wildfire	2009	2	1
LA	County 1	109,291	Hurricane	2008	0	1
	County 2	52,217	Hurricane	2008	1	1
MN	County 1	56,763	Flood	2009	1	1
NC	County 1	64,423	Hurricane	2010	2	1
	County 2	34,296	Hurricane	2010	0	1
ND	County 1	143,339	Flood	2009	0	2
TN	County 1	920,232	Flood	2010	0	1
	County 2	26,471	Flood	2010	1	0
	County 3	22,057	Flood	2010	0	1
TX	County 1	4,070,989	Hurricane	2008	1	1
	County 1	286,814	Hurricane	2008	1	1
Total					**10**	**14**

Source: Office of Inspector General (OIG) analysis of nursing homes in selected counties, 2010.
* Source: 2009 Population Estimates from the U.S. Census Bureau. Accessed at http://www.census.org on December 20, 2010.

Nursing Homes. We purposively selected 24 Medicare- and Medicaid-certified nursing homes based on their diversity in several factors: disaster response (shelter in place or evacuation), size (number of beds), ownership (for-profit or nonprofit), and the Centers for Medicare & Medicaid Services (CMS) 5-Star Quality of Care rating. To ensure that we interviewed key personnel present during the disaster, we included only nursing homes that still employed the administrator and director of nursing on duty at the time of the disaster. Table A-2 lists characteristics of all selected nursing homes.

Table A-2: Selected Nursing Home Characteristics

Facility ID	Disaster Response	Size	Ownership	Chain	CMS Rating
California 1	Shelter in place	63	Nonprofit	Yes	4
California 2	Shelter in place	80	Nonprofit	Yes	5
California 3	Evacuate	156	Nonprofit	Yes	2
California 4	Evacuate	149	For-profit	No	2
California 5	Evacuate	90	Nonprofit	Yes	4
California 6	Shelter in place	59	Nonprofit	Yes	4
Louisiana 1	Shelter in place	128	For-profit	No	4
Louisiana 2	Evacuate	124	Nonprofit	Yes	2
Louisiana 3	Evacuate	198	For-profit	No	1
Minnesota 1	Evacuate	195	Nonprofit	No	3
Minnesota 2	Shelter in place	87	For-profit	Yes	3
North Carolina 1	Shelter in place	92	For-profit	Yes	1
North Carolina 2	Shelter in place	122	For-profit	No	1
North Carolina 3	Evacuate	104	For-profit	No	3
North Carolina 4	Evacuate	126	For-profit	Yes	2
North Dakota 1	Evacuate	192	Nonprofit	No	3
North Dakota 2	Evacuate	109	For-profit	Yes	1
Tennessee 1	Shelter in place	144	For-profit	No	*
Tennessee 2	Evacuate	119	For-profit	Yes	3
Tennessee 3	Evacuate	155	For-profit	No	2
Texas 1	Shelter in place	100	For-profit	No	1
Texas 2	Evacuate	109	For-profit	Yes	1
Texas 3	Shelter in place	62	For-profit	Yes	4
Texas 4	Evacuate	105	Nonprofit	No	5

Source: We obtained information about facility size, ownership, chain status, and location from the CMS Nursing Home Compare Web site. Accessed at http://Medicare.gov, March–June 2010.
*CMS rating for this new facility was not available at the time that we selected the nursing homes.

Interview Respondents. As part of data collection, we interviewed nursing home staff from all 24 selected nursing homes; their associated local emergency entities; local, regional, and State long-term care (LTC) ombudsmen; and SAs. Table A-3 lists the number of interview respondents affiliated with each type of entity.

Table A-3: Number of Interview Respondents Affiliated With Each Type of Entity

Respondent Affiliation	State							
	CA	LA	MN	NC	ND	TN	TX	Total
Local or Regional Entity								
Nursing home	23	10	6	27	7	28	11	112
Area agency on aging	0	1	0	1	0	0	0	2
City emergency management	0	0	0	0	1	0	5	6
County emergency management	2	2	1	1	1	2	4	13
County public health department	3	0	3	5	4	1	0	16
Fire department	0	9	2	3	0	13	0	27
Local/regional LTC ombudsman program	6	4	3	6	1	3	3	26
Police department	0	1	0	1	0	0	0	2
Other*	1	0	1	3	1	4	0	10
State Entity								
State LTC ombudsman program	1	1	1	3	1	1	1	9
State department of health	4	2	2	1	1	1	0	11
State survey agency	2	2	3	1	3	2	5	18
State emergency management agency	0	0	0	1	0	0	0	1
Other*	0	1	0	0	0	0	0	1
Total	**42**	**33**	**22**	**53**	**20**	**55**	**29**	**254**

Source: OIG analysis of interviews with respondents in the communities and States where selected nursing homes are located, 2010.
* Other includes contractors, county commissioners, attorneys, and hospital representatives.

APPENDIX B

Nursing Home Deficiencies in Emergency Planning and Training

Table B-1: Nursing Homes Cited by State Survey Agencies for Deficiencies in Emergency Planning and Training by Type of Deficiency: National and State, 2009–2010

National or State	Total Number of Nursing Homes Surveyed	Total Emergency Planning Deficiencies (Tags F517 and K48)		Total Emergency Training Deficiencies (Tags F518 and K50)	
		n	Percentage	n	Percentage
National	**16,001**	**1,214**	**7.6**	**4,466**	**27.9**
State					
Alabama	231	23	10.0	57	24.7
Alaska	15	2	13.3	4	26.7
Arizona	139	7	5.0	39	28.1
Arkansas	248	2	0.8	25	10.1
California	1,251	293	23.4	586	46.8
Colorado	215	39	18.1	87	40.5
Connecticut	239	6	2.5	45	18.8
Delaware	48	0	0.0	16	33.3
District of Columbia	19	5	26.3	3	15.8
Florida	681	34	5.0	81	11.9
Georgia	360	7	1.9	27	7.5
Guam	1	1	100.0	0	0.0
Hawaii	48	1	2.1	8	16.7
Idaho	80	1	1.3	24	30.0
Illinois	800	125	15.6	385	48.1
Indiana	516	38	7.4	193	37.4
Iowa	456	12	2.6	224	49.1
Kansas	348	2	0.6	163	46.8
Kentucky	287	12	4.2	28	9.8
Louisiana	287	12	4.2	23	8.0
Maine	109	3	2.8	17	15.6
Maryland	232	11	4.7	19	8.2
Massachusetts	433	11	2.5	102	23.6
Michigan	431	86	20.0	164	38.1
Minnesota	387	2	0.5	136	35.1
Mississippi	206	1	0.5	22	10.7
Missouri	525	29	5.5	241	45.9
Montana	87	3	3.4	30	34.5

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Table B-1: Nursing Homes Cited by State Survey Agencies for Deficiencies in Emergency Planning and Training by Type of Deficiency: National and State, 2009–2010 (Continued)

National or State	Total Number of Nursing Homes Surveyed	Total Emergency Planning Deficiencies (Tags F517 and K48)		Total Emergency Training Deficiencies (Tags F518 and K50)	
		n	Percentage	n	Percentage
National	**16,001**	**1,214**	**7.6**	**4,466**	**27.9**
State					
Nebraska	232	8	3.4	79	34.1
Nevada	51	2	3.9	19	37.3
New Hampshire	80	3	3.8	28	35.0
New Jersey	362	8	2.2	48	13.3
New Mexico	74	1	1.4	26	35.1
New York	640	20	3.1	125	19.5
North Carolina	429	2	0.5	54	12.6
North Dakota	87	0	0.0	5	5.7
Ohio	972	122	12.6	411	42.3
Oklahoma	336	2	0.6	67	19.9
Oregon	138	82	59.4	60	43.5
Pennsylvania	718	19	2.6	110	15.3
Puerto Rico	7	0	0.0	6	85.7
Rhode Island	86	0	0.0	6	7.0
South Carolina	186	3	1.6	9	4.8
South Dakota	110	0	0.0	32	29.1
Tennessee	330	7	2.1	79	23.9
Texas	1,252	73	5.8	282	22.5
Utah	101	0	0.0	30	29.7
Vermont	40	0	0.0	3	7.5
Virgin Islands	1	0	0.0	1	100.0
Virginia	291	9	3.1	24	8.2
Washington	235	20	8.5	74	31.5
West Virginia	127	0	0.0	10	7.9
Wisconsin	398	63	15.8	107	26.9
Wyoming	39	2	5.1	22	56.4

Source: Office of Inspector General analysis of the Centers for Medicare & Medicaid Services Online Survey, Certification, and Reporting data for 2009–2010.

APPENDIX C

Centers for Medicare & Medicaid Services-Recommended Checklist Tasks

Table C-1: Centers for Medicare & Medicaid Services-Recommended Checklist Tasks Included in 24 Selected Nursing Homes' Emergency Plans

Tasks (n=70)		Nursing Home Plans With Tasks (n=24)*		
		M	**PM**	**NM**
1.	**Develop Emergency Plan:** Gather all available information when developing the emergency plan. This information includes, but is not limited to:			
	1a. Copies of any state and local emergency planning regulations or requirements.	4	1	**19**
	1b. Facility personnel names and contact information.	11	**12**	1
	1c. Contact information of local and state emergency managers.	1	**17**	6
	1d. A facility organization chart.	**15**	0	9
	1e. Building construction and Life Safety systems information.	6	**16**	2
	1f. Specific information about the characteristics and needs of individuals for whom care is provided.	9	0	**15**
2.	**All-Hazards Continuity of Operations (COOP) Plan:** Develop a continuity of operations business plan using an all-hazards approach (e.g., hurricanes, floods, tornadoes, fire, bioterrorism, pandemic, etc.) that could potentially affect the facility directly and indirectly within the particular area of location. Indirect hazards could affect the community but the not the facility and as a result interrupt necessary utilities, supplies or staffing. Determine all essential functions and critical personnel.	1	**23**	0
3.	**Collaborate with Local Emergency Management Agency:** Collaborate with local emergency management agencies to ensure the development of an effective emergency plan.	8	0	**16**
4.	**Analyze Each Hazard:** Analyze the specific vulnerabilities of the facility and determine the following actions for each identified hazard.			
	4a. Specific actions to be taken for the hazard.	**22**	0	2
	4b. Identified key staff responsible for executing plan.	**24**	0	0
	4c. Staffing requirements and defined staff responsibilities.	4	**20**	0
	4d. Identification and maintenance of sufficient supplies and equipment to sustain operations and deliver care and services for 3-10 days, based on each facility's assessment of its hazard vulnerabilities.	2	**17**	5
	4e. Communication procedures to receive emergency warning/alerts, and for communication with staff, families, individuals receiving care, before, during and after the emergency.	4	**19**	1
	4f. Designate critical staff, providing for other staff and volunteer coverage and meeting staff needs, including transportation and sheltering critical staff members' family.	1	**13**	10
5.	**Collaborate with Suppliers/Providers:** Collaborate with suppliers and/or providers who have been identified as part of a community emergency plan or agreement with the health care facility to receive and care for individuals. A surge capability assessment should be included in the development of the emergency plan. Similarly, evidence of a surge capacity assessment should be included if the supplier or provider, as part of its emergency planning, anticipates the need to make housing and sustenance provisions for the staff or the family of staff.	0	**15**	9
6.	**Decision Criteria for Executing Plan:** Include factors to consider when deciding to evacuate or shelter in place. Determine who at the facility level will be in authority to make the decision to execute the plan to evacuate or shelter in place (even if no outside evacuation order is given) and what will be the chain of command.	3	**20**	1
7.	**Communication Infrastructure Contingency:** Establish contingencies for the facility communication infrastructure in the event of telephone failures (e.g., walkie-talkies, ham radios, text messaging systems, etc.)	**17**	0	7

*We coded plans as a match (M) if they included all parts of a task, a partial match (PM) if they included at least one part of a task (e.g., listing the person responsible for carrying out a task, but not describing how the task would be performed), and a nonmatch (NM) if they lacked all parts of a task. The highest number in each category is in bold font.

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Table C-1: Centers for Medicare & Medicaid Services-Recommended Checklist Tasks Included in 24 Selected Nursing Homes' Emergency Plans (Continued)

Tasks (n=70)	Nursing Home Plans With Tasks (n=24)		
	M	**PM**	**NM**
8. Develop Shelter in Place Plan: Due to the risks in transporting vulnerable patients and residents, evacuation should only be undertaken if sheltering-in-place results in greater risk. Develop an effective plan for sheltering-in-place, by ensuring provisions for the following are specified:			
8a. Procedures to assess whether the facility is strong enough to withstand strong winds, floods, etc.	0	4	**2**
8b. Measures to secure the building against damage (plywood for windows, sandbags and plastic for flooding), safest areas of the facility are identified.	**2**	0	4
8c. Procedures for collaborating with local emergency management agency, fire, police and EMS agencies regarding the decision to shelter-in-place.	7	0	**1**
8d. Sufficient resources are in supply for sheltering-in-place for at least 7 days, including:			
8d1. Ensuring emergency power, including back-up generators and accounts for maintaining a supply of fuel.	0	**15**	9
8d2. An adequate supply of potable water (recommended amounts vary by population and location).	0	11	**13**
8d3. A description of the amounts and types of food in supply.	7	7	**10**
8d4. Maintaining extra pharmacy stocks of common medications.	5	0	**19**
8d5. Maintaining extra medical supplies and equipment (e.g., oxygen, linens, vital equipment).	2	4	**18**
8e. Identifying and assigning staff who are responsible for each task.	**19**	4	1
8f. Description of hosting procedures, with details ensuring 24-hour operations for minimum of 7 days.	0	6	**18**
8g. Contract established with multiple vendors for supplies and transportation.	**13**	5	6
8h. Develop a plan for addressing emergency financial needs and providing security.	2	8	**14**
9. Develop Evacuation Plan: Develop an effective plan for evacuation, by ensuring provisions for the following are specified:			
9a. Identification of person responsible for implementing the facility evacuation plan (even if no outside evacuation order is given).	**22**	0	2
9b. Multiple pre-determined evacuation locations (contract or agreement) with a "like" facility have been established, with suitable space, utilities, security and sanitary facilities for individuals receiving care, staff and others using the location. A back-up may be necessary if the first one is unable to accept evacuees.	**15**	4	5
9c. At least one pre-determined evacuation location is 50 miles away.	**12**	0	**12**
9d. Evacuation routes and alternative routes have been identified, and the proper authorities have been notified. Maps are available and specified travel time has been established.	0	**21**	3
9e. Adequate food supply and logistical support for transporting food is described.	0	9	**15**
9f. The amount of water to be transported and logistical support is described.	0	6	**18**
9g. The logistics to transport medications is described, including ensuring their protection under the control of a registered nurse.	2	**17**	5
9h. Procedures for protecting and transporting resident/patient medical records.	2	**19**	3
9i. The list of items to accompany residents/patients is described.	8	0	**16**
9j. Identify how persons receiving care, their families, staff and others will be notified of the evacuation and communication methods that will be used during and after the evacuation.	4	**18**	2

continued on next page

Table C-1: Centers for Medicare & Medicaid Services-Recommended Checklist Tasks Included in 24 Selected Nursing Homes' Emergency Plans (Continued)

Tasks (n=70)	Nursing Home Plans With Tasks (n=24)		
	M	**PM**	**NM**
9. Develop Evacuation Plan (Continued): Develop an effective plan for evacuation, by ensuring provisions for the following are specified:			
9k. Identify staff responsibilities and how individuals will be cared for during evacuation, and the back-up plan if there isn't sufficient staff.	1	**17**	6
9l. Procedures are described to ensure residents/patients dependent on wheelchairs and/or assistive devices are transported so their equipment will be protected and their personal needs met during transit (e.g., incontinent supplies for long periods, transfer boards and other assistive devices).	3	5	**16**
9m. A description of how other critical supplies and equipment will be transported is included.	5	9	**10**
9n. Determine a method to account for all individuals during and after the evacuation.	**14**	3	7
9o. Procedures are described to ensure that staff accompany evacuating residents.	**12**	1	11
9p. Procedures are described if a patient/resident becomes ill or dies in route.	1	2	**21**
9q. Mental health and grief counselors are available at reception points to talk with and counsel evacuees.	1	2	**21**
9r. It is described whether staff family can shelter at the facility and evacuate.	5	5	**14**
10. Transportation & Other Vendors: Establish transportation arrangements that are adequate for the type of individuals being served. Obtain assurances from transportation vendors and other suppliers/contractors identified in the facility emergency plan that they have the ability to fulfill their commitments in case of disaster affecting an entire area (e.g., their staff, vehicles and other vital equipment are not "overbooked," and vehicles/equipment are kept in good operating condition and with ample fuel.). Ensure the right type of transportation has been obtained (e.g., ambulances, buses, helicopters, etc).	**17**	1	6
11. Train Transportation Vendors/Volunteers: Ensure that the vendors or volunteers who will help transport residents and those who receive them at shelters and other facilities are trained on the needs of the chronic, cognitively impaired and frail population and are knowledgeable on the methods to help minimize transfer trauma.	0	0	**24**
12. Facility Reentry Plan: Describe who will authorize reentry to the facility after an evacuation, the procedures for inspecting the facility, and how it will be determined when it is safe to return to the facility after an evacuation. The plan should also describe the appropriate considerations for return travel back to the facility.	8	2	**14**
13. Residents & Family Members: Determine how residents and their families/guardians will be informed of the evacuation, helped to pack, have their possessions protected and be kept informed during and following the emergency, including information on where they will be/go, for how long and how they can contact each other.	1	**18**	5
14. Resident Identification:			
14a. Determine how residents will be identified in an evacuation; and ensure the following identifying information will be transferred with each resident*			
14a1. Name.	**13**	4	7
14a2. Social Security Number.	4	4	**16**
14a3. Photograph.	6	3	**15**
14a4. Medicaid or other health insurer number.	5	4	**15**
14a5. Date of birth, diagnosis.	7	4	**13**
14a6. Current drug/prescription and diet regimens.	9	**14**	11
14a7. Name and contact information for next of kin/responsible person/Power of Attorney.	5	4	**15**

*OIG analysis found that 17 of the 24 selected nursing homes' emergency plans contained the first element of this task, "Determine how residents will be identified in an evacuation."

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Table C-1: Centers for Medicare & Medicaid Services-Recommended Checklist Tasks Included in 24 Selected Nursing Homes' Emergency Plans (Continued)

Tasks (n=70)	Nursing Home Plans With Tasks (n=24)		
	M	**PM**	**NM**
14. Resident Identification (Continued):			
14b. Determine how this information will be secured (e.g., laminated documents, water proof pouch around resident's neck, water proof wrist tag etc) and how medical records and medications will be transported so they can be matched with the resident to whom they belong.	2	3	**19**
15. Trained Facility Staff Members: Ensure that each facility staff member on each shift is trained to be knowledgeable and follow all details of the plan. Training also needs to address psychological and emotional aspects on caregivers, families, residents, and the community at large. Hold periodic reviews and appropriate drills and other demonstrations with sufficient frequency to ensure new members are fully trained.	0	**17**	7
16. Informed Residents & Patients: Ensure residents, patients and family members are aware of and knowledgeable about the facility plan, including:			
16a. Families know how and when they will be notified about evacuation plans, how they can be helpful in an emergency (example, should they come to the facility to assist?) and how/where they can plan to meet their loved ones.	2	1	**21**
16b. Out-of-town family members are given a number they can call for information. Residents who are able to participate in their own evacuation are aware of their roles and responsibilities in the event of a disaster.	1	0	**23**
17. Needed Provisions: [Processes for determining] if provisions need to be delivered to the facility residents – power, flashlights, food, water, ice, oxygen, medications – and if urgent action is needed to obtain the necessary resources and assistance.	1	5	**18**
18. Location of Evacuated Residents: [Processes for determining] the location of evacuated residents, document and report this information to the clearing house established by the state or partnering agency.	2	4	**18**
19. Helping Residents in the Relocation: [Training for staff] Suggested principles of care for the relocated residents include: Encourage the resident to talk about expectations, anger, and/or disappointment; Work to develop a level of trust; Present an optimistic, favorable attitude about the relocation; Anticipate that anxiety will occur; Do not argue with the resident; Do not give orders; Do not take resident's behavior personally; Use praise liberally; Include the resident in assessing problems; Encourage staff to introduce themselves to residents; Encourage family participation.	0	2	**22**
20. Review Emergency Plan: Complete an internal review of the emergency plan on an annual basis to ensure the plan reflects the most accurate and up-to-date information. Updates may be warranted under the following conditions: regulatory change; new hazards are identified or existing hazards change; after tests, drills, or exercises when problems have been identified; after actual disasters/emergency responses; infrastructure changes; funding or budget-level changes.	11	0	**13**
21. Communication with the Long-Term Care Ombudsman Program: Prior to any disaster, discuss the facility's emergency plan with a representative of the ombudsman program serving the area where the facility is located and provide a copy of the plan to the ombudsman program. When responding to an emergency, notify the local ombudsman program of how, when and where residents will be sheltered so the program can assign representatives to visit them and provide assistance to them and their families.	1	1	**22**
22. Conduct Exercises & Drills: Conduct exercises that are designed to test individual essential elements, interrelated elements, or the entire plan:			
22a. Exercises or drills must be conducted at least semi-annually.	7	0	**17**
22b. Corrective actions should be taken on any deficiency identified.	8	0	**16**
23. Loss of Resident's Personal Effects: Establish a process for the emergency management agency representative (FEMA or other agency) to visit the facility to which residents have been evacuated, so residents can report loss of personal effects.	0	0	**24**

Source: Office of Inspector General analysis of 24 selected nursing homes' emergency plans' inclusion of CMS-recommended emergency preparedness planning tasks in 2010, using CMS, "Survey & Certification: Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning." Accessed at http://www.cms.gov on February 5, 2010.

APPENDIX D

Agency Comments: Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Strategic Operations
and Regulatory Affairs

200 Independence Avenue SW
Washington, DC 20201

DATE: JAN 0 5 2012

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Gaps Continue To Exist In Nursing Home Emergency Preparedness and Response During Disasters: 2007-2010 (OEI-06-09-00270)"

Thank you for the opportunity to review and comment on the subject OIG draft report. OIG's study focused on determining compliance with Federal regulations and compared emergency plans for selected nursing homes against the Centers for Medicare & Medicaid Services (CMS) checklist for health care facilities. Information was also collected about the roles of State long-term care (LTC) ombudsman programs and State Agencies (SAs) in assisting nursing homes during these disasters. During this study, OIG's findings were:

- In 2009-2010, 92 percent of nursing homes met Federal regulations for emergency plans and 72 percent for emergency training, slightly less than 5 years earlier.
- On average, selected nursing homes' emergency plans included about half of the CMS-recommended checklist tasks, and none included all.
- Administrators from 17 of the 24 selected nursing homes reported substantial challenges in responding to disasters.
- LTC ombudsmen were often unable to focus on nursing home residents during disasters.
- State Agencies completed tasks related to nursing home compliance and addressed ad hoc facility needs.

In its report, OIG made four recommendations to the Secretary of Health and Human Services and the Administrator of CMS. In making these recommendations, OIG took into consideration there are no requirements for use of CMS Emergency Preparedness checklists as well as the continued need to respond to disasters to protect resident health, safety, welfare, and rights during and after disasters. Our response to these recommendations is stated below.

OIG Recommendation

CMS revise Federal regulations by identifying and including in its regulations requirements for specific elements of emergency plans and training.

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CMS Response

CMS concurs with this recommendation. We will include specific guidance concerning emergency plans and training when appropriate long term care regulation revisions are proposed. We also agree that LTC facilities should develop and implement emergency preparedness policies and procedures to ensure the safety and welfare of residents and staff. The policies and procedures should, at a minimum, address the six areas identified in the OIG report: sufficient staffing; post disaster reporting on the status of residents; identifying and tracking of residents during a disaster; requirements to shelter in place; evacuation procedures and communication and collaboration.

OIG Recommendation

CMS update the State Operations Manual (SOM) to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training.

CMS Response

CMS concurs with this recommendation. We will update the SOM to provide guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training. We will provide training to States and surveyors on any changes to the SOM and survey process including materials already available on the CMS website. We will continue to address emergency preparedness in future trainings. In addition, we will use the OIG Report to develop a Survey and Certification policy memo for State Survey agencies to alert providers of the problems and advise that updates will be forthcoming.

OIG Recommendation

CMS promote use of the emergency preparedness checklists for nursing homes, State LTC ombudsman programs, and SAs.

CMS Response

CMS concurs with this recommendation. These checklists were developed in 2007 by a technical evaluation panel. The Emergency Preparedness Checklist Recommended Tool for Effective Health Care Facility Planning was revised in 2009. We will work with the nursing homes, State LTC ombudsman programs and SAs to reiterate the availability of emergency preparedness materials on the CMS website and encourage their utilization as well as recommendations for revision. We will review and update them as appropriate

OIG Recommendation

AoA develop model policies and procedures to protect resident health, safety, welfare and rights during and after disasters.

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CMS Response

CMS defers response to AoA for this recommendation.

CMS appreciates the opportunity to comment on this draft report, and we look forward to working with the OIG on this and other issues.

Agency Comments: Administration on Aging

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
Administration on Aging

Washington D.C. 20201

JAN 17 2012

TO: Daniel R. Levinson
Inspector General

FROM: Kathy Greenlee
Assistant Secretary for Aging

SUBJECT: OIG Draft Report: *Gaps Continue to Exist in Nursing Home Preparedness and Response During Disasters: 2007—2010*, OEI-06-09-00270

Thank you for the opportunity to comment on the subject OIG draft report.

The Administration on Aging (AoA) provides formula grants under the Older Americans Act (the Act, 42 U.S.C. 3001 et seq.) to States for, among other things, the establishment and operation of Long-Term Care Ombudsman programs. Therefore, this response relates to the OIG recommendations regarding AoA as well as Long-Term Care Ombudsman programs.

1. **OIG Recommendation: CMS promote use of the emergency preparedness checklists for nursing homes, State [Long-Term Care] ombudsman programs, and [State agencies]**

With respect to state Long-Term Care Ombudsman programs, AoA concurs with and has already initiated action with CMS to implement the recommendation above.

During a meeting with CMS officials in December, 2011, AoA and CMS identified the need to review the referenced CMS checklist related to the Long-Term Care Ombudsman program to update its content in order to improve its usefulness to states' Long-Term Care Ombudsman programs. After the checklist is updated by CMS and AoA, AoA plans to develop and implement dissemination and training strategies among states' Long-Term Care Ombudsman programs.

2. **OIG Recommendation: AoA develop model policies and procedures to protect resident health, safety, welfare, and rights during and after disasters**

AoA concurs with and has already initiated action to implement this recommendation to the extent that it relates to state Long-Term Care Ombudsman programs.

Administration on Aging (continued)

Long-Term Care Ombudsman Programs are designed to resolve complaints and advocate for the interests of residents of long-term care facilities at both the individual and systems level. However, they are not designed to be, nor do have the resources to serve as, first responders in emergencies or disasters. In fact, the Act contains no provision for, nor does AoA receive appropriations for, activities specifically related to Long-Term Care Ombudsman program emergency preparedness or response.

Nevertheless, AoA has provided and plans to continue provision of resources, technical assistance and training to states' Long-Term Care Ombudsman programs to support their work with nursing home residents (and residents of other long-term care facilities) who have faced disaster. These activities are designed to assist Ombudsman programs in fulfilling the broad function to "provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents" under section 712(a)(3)(B) of the Act. Resources include, but are not limited to, a dedicated webpage on the AoA-funded National Ombudsman Resource Center website: http://www.ltcombudsman.org/issues/emergency-preparedness. The webpage contains the CMS checklist mentioned above, model plans, and training resources designed for long-term care ombudsmen, among other things.

In addition, AoA is collaborating with the Assistant Secretary for Preparedness and Response (ASPR) to further promote awareness and use of model policies (for example, health care coalitions promoted by ASPR) by state Long-Term Care Ombudsman programs to support the health, safety, welfare and rights of nursing home residents during and after emergencies or disasters.

While states' Ombudsman programs support the health, safety, welfare and rights of nursing home residents who have been subject to disasters, their capacity to do so is limited in some geographic areas. For example, in one state included in this study, the Long-Term Care Ombudsman program has two staff members who are dedicated to the Ombudsman program on a full-time basis for the entire state. Further, in many states the program's direct work with residents is carried out largely by volunteers with varied ability, expertise and willingness to respond during and after disasters.

AoA will continue to provide models of effective practice and other resources to respond to the needs of nursing home residents. However, as a result of the variation among states, AoA acknowledges that states will need flexibility in order to realistically implement these models in the absence of designated resources to carry out emergency preparedness and response activities.

In addition to its provisions related to Long-Term Care Ombudsman programs, AoA has provided extensive resources, technical assistance and training to assist States in carrying out their emergency planning responsibilities for older Americans under the Act. Specifically, the Act provides for emergency planning within area plans on aging (in Section 306) and state plans on aging (in Section 307).

Administration on Aging (continued)

In its support of States' emergency preparedness activities, AoA provides, among other things:

- An emergency preparedness webpage on the AoA website: http://www.aoa.gov/AoARoot/Preparedness/index.aspx; and
- Emergency preparedness planning resources for state plan on aging development as part of the AoA-supported TASC Planning Zone of the National Association of States United for Aging and Disabilities (NASUAD): http://www.nasuad.org/tasc/emergency_preparedness_resources.html.

The Administration on Aging would again like to thank the OIG for their work in conducting this review. If we can be of further assistance, please let me know.

/S/

Kathy Greenlee

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; A. Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Deborah Cosimo served as the project leader, and Petra Johansson was the lead analyst. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Leah Bostick, Nathan Dong, Ben Gaddis, Anthony Guerrero-Soto, and Chet Yean; central office staff who contributed include Jennifer Jones, Kevin Farber, and Sandy Khoury.

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