
— NURSING HOME LITIGATION

When the Power Goes Out

Heat, Emergency Power, and Nursing Home Residents

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In September 2017, Hurricane Irma knocked out the air conditioning at a nursing home in Hollywood, Florida. Over several days the building grew dangerously hot, and a dozen residents eventually died. The facility sat across the street from a hospital. Florida responded with rules requiring nursing homes and assisted living facilities to have generators and enough fuel to keep indoor temperatures at or below 81 degrees for at least 96 hours after losing power.

Nationally, things look worse than most people assume. On April 28, 2026, the HHS Office of Inspector General released an audit of nursing home emergency power (A-02-23-01022), prompted by failures during Hurricane Ida and Winter Storm Uri in 2021. Of 100 sampled facilities, 72 had problems. Projected to the roughly 15,000 nursing homes in the country, OIG estimated that about 73 percent don't have adequate or reliable emergency power. About half had inadequate generator maintenance, nearly four in ten had generators that didn't cover all the circuits they should, and about one in ten were running generators 40 or more years old. OIG blamed limited resources and frequent management and staff turnover, and said plainly that residents at these facilities face increased risk of injury or death during a power failure. CMS agreed to share the findings with nursing homes.

Heat waves are getting longer and grids are strained. For nursing home residents, that combination is dangerous.

WHAT THE RULES REQUIRE

Medicare and Medicaid nursing homes must meet federal emergency preparedness requirements (42 C.F.R. § 483.73). They need an all-hazards plan built on a risk assessment that considers things like power loss and extreme temperatures. Their policies must address alternate energy sources to maintain temperatures that protect residents' health and safety, plus

emergency lighting, fire detection, and sewage. They must train staff, run exercises, and maintain a communication plan covering families and officials. If they rely on generators, the rules pull in national fire and electrical codes governing installation, testing, inspection, and maintenance.

Residents also have a right to a safe, comfortable environment, and facilities certified after October 1, 1990 must keep temperatures between 71 and 81 degrees (§ 483.10(i)(6)). Some states, like Florida, go further.

WHY HEAT HITS RESIDENTS SO HARD

The body's ability to regulate temperature declines with age. Heart disease, kidney disease, and diabetes make heat harder to tolerate. Common medications add risk: diuretics increase fluid loss, anticholinergic drugs reduce sweating, and certain antipsychotics, antidepressants, and blood pressure medications interfere too. Residents with dementia may not know they're hot or thirsty or be able to say so, and residents who can't move can't get themselves somewhere cooler. Early heat illness in older adults can look like confusion, weakness, a fall, or a change in behavior, and it's easy to miss until it becomes heat stroke.

A FICTIONAL CASE

During a heat wave, a storm knocks out power to a southern nursing home on a Friday afternoon. The generator starts but runs only emergency lights, some outlets, and refrigerators, not air conditioning. By Saturday afternoon, the second floor reaches 92 degrees. Staff open windows and bring in fans. On Sunday morning, a 79-year-old with dementia and heart failure who takes a diuretic is found unresponsive with a temperature of 106. She dies at the hospital.

PREPARATION

What did the emergency plan say about power loss and heat, and did the risk assessment consider an extended outage in extreme heat? What did the generator actually power? Many are built only for life-safety loads and can't run air conditioning. Did the facility know that, and what was its cooling plan? When was the generator last tested and serviced, and do the records meet code? Was there enough fuel, and a refueling contract? Had the facility ever exercised this scenario?

RESPONSE, HOUR BY HOUR

When did power fail? When did staff start logging indoor temperatures, and were they measured in resident rooms or only in hallways? When did the facility notify its corporate office, the state, local emergency management, and families? Were high-risk residents identified, moved somewhere cooler, or transferred? Were temperatures, fluid intake, and condition monitored more closely? Was the medical director involved?

And the hardest question: when should the facility have evacuated or transferred residents? Plans usually address it. Moving frail residents carries its own risks, but waiting too long can be fatal. The Hollywood deaths turned partly on exactly that decision.

BEYOND HEAT

Residents who depend on powered equipment, such as oxygen concentrators, ventilators, suction, feeding pumps, or pressure-relieving air mattresses, are at immediate risk if that equipment isn't on emergency power. Was there a list of those residents and a plan for each? How much backup oxygen was on hand? Cold is dangerous too; Winter Storm Uri was part of what prompted the OIG audit. The questions just run in reverse.

STAFFING AND COMMUNICATION

Storms keep staff from getting to work, and those who are there get exhausted. Who actually worked that weekend, and for how many hours? A good plan on paper and three staff for sixty residents in 92-degree heat is a different problem from a fully staffed building. And did families hear about conditions from the facility or from the news? Some might have taken their loved one home or pushed for transfer had they known.

THE RESIDENT'S OWN CARE

She had dementia and heart failure and took a diuretic, which put her at high risk. Was she flagged? Were her vital signs, including temperature, checked more often? Was she offered fluids, and was intake recorded? Did a physician review her medications given the heat? How long since her last check when she was found? A resident who was flushed, confused, and not drinking at midnight with no call to the physician is a very different case from one who seemed fine at 2 a.m.

CAUSATION

These deaths are sometimes clear-cut and sometimes involve residents who were already very frail. Connect the building conditions to her decline and to what adequate cooling, closer monitoring, or earlier transfer would probably have changed. Her temperature and labs on arrival at the hospital, the death certificate, and any autopsies are central.

RECORDS WORTH REQUESTING

- The emergency plan and risk assessment
- Generator specifications and the list of circuits it powered
- Generator testing, inspection, and maintenance records; fuel records and supply contracts
- Indoor temperature logs

- Communications with state and local agencies and with families
- The resident's clinical records, including vital signs and intake
- Staffing records and hours worked for the period
- Survey history for emergency preparedness deficiencies (E-tags)
- State emergency power rules, weather data, and utility outage records

SOURCES

- HHS-OIG, *Most Nursing Homes Throughout the United States Do Not Have Adequate or Reliable Emergency Power Systems*, A-02-23-01022 (Apr. 28, 2026)
- 42 C.F.R. §§ 483.10(i)(6), 483.73
- Florida emergency power rules for nursing homes and assisted living facilities (2018)

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case arising from a power failure or extreme temperatures in a long-term care facility and want the emergency plan, the generator, and the hour-by-hour response examined together, we'd welcome the conversation.

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