



Claire McCaskill

Missouri State Auditor

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Department of Health
and Senior Services'
Monitoring of Nursing
Homes and Handling of
Complaint Investigations



Office Of
Missouri State Auditor
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The following findings were included in our audit report on the Department of Health and Senior Services' Monitoring of Nursing Homes and Handling of Complaint Investigations.

The Department of Health and Senior Services (DHSS) has only implemented 9 of 32 recommendations made in the two previous audits. Some of the recommendations were included in both reports. Significant cuts in surveyor positions contributed to some of the deficiencies noted.

The Section for Long-Term Care Regulation (SLCR) is responsible for conducting federal and state surveys/inspections on the nearly 1,160 licensed nursing homes and residential care facilities in the state. During fiscal year 2005, the SLCR did not perform 72 (11 percent) and 400 (41 percent) of the full and interim state-mandated inspections, respectively, as required by state law. 58 of the facilities received neither a full nor an interim inspection in fiscal year 2005. This situation represented a significant decline in the SLCR's compliance with its statutory inspection responsibilities compared to the 2003 audit. In addition, some of these facilities have been cited repeatedly for the same deficiencies. A review of 5 commonly cited deficiencies in 8 historically poor performing facilities disclosed 17 deficiencies were repeated at least once between fiscal year 2003 and 2005. None of these facilities received an interim inspection in fiscal year 2005.

Certification and/or inspection packets were not always submitted to Central Office within the specified time frame. In 20 of 88 files reviewed, the packets were submitted untimely. This condition was also noted in the prior two audit reports.

A review of 60 federal survey and state inspection files disclosed a 3 percent error rate in the proper classification of state deficiencies cited in inspections. Also, during fiscal year 2005, the SLCR did not prepare performance evaluations of its survey employees as required by state law. This condition was also noted in the 2003 audit report.

State surveyors tend to cite fewer deficiencies when federal inspectors are not present to monitor the federal survey process. We determined that in those surveys in which federal inspectors accompanied the SLCR surveyors, 83 percent of the deficiencies cited by federal inspectors during the inspections were also cited by the state surveyors. However, in those surveys where the federal inspectors conducted a separate inspection within two months of the state survey, only 15 to 20 percent of the deficiencies cited by the federal inspectors were also cited by state surveyors.

The SLCR is also responsible for recording, investigating, and reporting the results of complaints made related to nursing facilities. We identified the following concerns regarding SLCR's handling of such complaints:

YELLOW SHEET

- On-site complaint investigation visits are not always initiated in a timely manner as required. Error rates ranging from 1 percent for Priority A calls (allegations of imminent danger) to 28 percent for Priority C calls (other allegations of resident harm that do not rise to the level of higher priority calls) were noted. This condition was also noted in the two previous audit reports.
- The SLCR runs periodic reports of pending complaint investigations that are overdue for an exit meeting. We compared the January and February 2006 overdue reports and noted that 107 complaint investigations were listed as overdue on both reports, of which 105 were in the St. Louis region. It was determined the exit meetings had been conducted for most of these complaint investigations; however, documentation related to these meetings had not been entered into the system.
- It was noted the reporter and applicable facility are not always officially notified of a complaint investigation's outcome within the required timeframe.

The SLCR has no minimum staffing standard in place for nursing home facilities and does not track actual staff hours at those facilities. We noted that of the eight states contiguous to Missouri, five of those states (Arkansas, Illinois, Kansas, Oklahoma, and Tennessee) have some sort of minimum nursing care staffing requirements in place. Because Missouri has no minimum staffing standards, the SLCR cannot compare actual direct care staffing information to the level of staffing needed to prevent understaffing and negative resident outcomes. This condition was also noted in the two previous audit reports.

As of October 2005, 224 of the state's licensed nursing facilities had an Alzheimer special care unit or program. State law requires that any such facility disclose to the DHSS the form of care or treatment provided that distinguishes that unit or program as being especially applicable, or suitable, for persons with Alzheimer's disease or dementia. This law also states that as part of the long-term care facility's regular license renewal procedure, the DHSS shall examine the disclosure form and verify the accuracy of the information disclosed. It is not apparent that adequate actions are taken by the department, either during the licensing process or the inspection process, to verify the information on the disclosure form is accurate or that the nursing facility has followed the practices outlined in the form.

The SLCR's Quality Assurance Unit (QAU) was established in 2001 to review a sample of completed inspections and complaint investigations to ensure those inspections/investigations were conducted efficiently, consistently, and in accordance with applicable standards and regulations. As noted in the 2003 audit report, the QAU has not spent a significant amount of time performing this quality control function because QAU staff have been assigned other duties within the SLCR. Since the last audit, the QAU has not performed any quality control reviews of any completed inspections and only a few reviews of complaint investigations.

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DEPARTMENT OF HEALTH AND SENIOR SERVICES'
 MONITORING OF NURSING HOMES AND
 HANDLING OF COMPLAINT INVESTIGATIONS

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STATE AUDITOR'S REPORT



CLAIRE C. McCASKILL
Missouri State Auditor

Honorable Matt Blunt, Governor
and
Julia M. Eckstein, Director
Department of Health and Senior Services
and
David Durbin, Division Director
Division of Regulation and Licensure
and
Brenda Campbell, Division Director
Division of Senior and Disability Services
Jefferson City, MO 65102

We have audited the Department of Health and Senior Services' monitoring of nursing homes and handling of complaint investigations. The scope of this audit included the department's oversight of nursing homes (skilled nursing and intermediate care facilities) and residential care facilities that are licensed by the department's Section for Long-Term Care Regulation, and included, but was not necessarily limited to, the year ended June 30, 2005. The objectives of this audit were to:

1. Review and evaluate the department's compliance with certain statutory requirements regarding inspections of nursing homes and residential care facilities.
2. Review and evaluate the department's compliance with certain statutory requirements regarding the investigation and processing of complaints, including home and community services complaints.
3. Review certain management controls and practices to determine the propriety, efficiency, and effectiveness of those controls and practices as they relate to the monitoring of nursing homes and complaint investigations.
4. Review follow-up action taken on findings presented in the two previous audit reports of this area.

Our methodology to accomplish these objectives included reviewing applicable state and federal laws, as well as written policies and other pertinent documents; inspecting relevant records and reports of the Department of Health and Senior Services; and interviewing various

personnel of that department. We also received input from concerned citizens who provided our office with additional information about various nursing homes.

In addition, we obtained an understanding of internal controls significant to the audit objectives and considered whether specific controls have been properly designed and placed in operation. We also performed tests of certain controls to obtain evidence regarding the effectiveness of their design and operation. However, providing an opinion on internal controls was not an objective of our audit and accordingly, we do not express such an opinion.

We also obtained an understanding of legal provisions significant to the audit objectives, and we assessed the risk that violations of contract or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting significant instances of noncompliance with the provisions. However, providing an opinion on compliance with those provisions was not an objective of our audit and accordingly, we do not express such an opinion.

Our audit was conducted in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such procedures as we considered necessary in the circumstances.

The accompanying History and Organization is presented for informational purposes. This information was obtained from the department's management and was not subjected to the procedures applied in the audit of the Department of Health and Senior Services' monitoring of nursing homes and handling of complaint investigations.

The accompanying Management Advisory Report presents our findings arising from our audit of the Department of Health and Senior Services' monitoring of nursing homes and handling of complaint investigations.



Claire McCaskill
State Auditor

May 26, 2006 (fieldwork completion date)

The following auditors participated in the preparation of this report:

Director of Audits:	Kenneth W. Kuster, CPA
Audit Manager:	Gregory A. Slinkard, CPA, CIA
In-Charge Auditor:	Susan Beeler
Audit Staff:	Robyn Lamb
	Terri Erwin
	Ali Arabian
	Audrey Archuleta

MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

DEPARTMENT OF HEALTH AND SENIOR SERVICES'
MONITORING OF NURSING HOMES AND
HANDLING OF COMPLAINT INVESTIGATIONS
MANAGEMENT ADVISORY REPORT –
STATE AUDITOR'S FINDINGS

1. Federal Surveys and State Inspections

The Section for Long-Term Care Regulation (SLCR) did not inspect some nursing homes as required. In addition, state facility surveyors did not always remit certification and inspection packets to the SLCR Central Office timely, and the SCLR does not have a system in place to track the remittance of these packets. The state facility surveyors did not always classify state deficiencies correctly and tend to cite fewer deficiencies when federal inspectors are not present. In addition, a statutorily-required performance evaluation process is not being performed.

Under federal and state regulations, the SLCR is charged with the responsibility to conduct federal and state surveys/inspections on all licensed nursing homes and residential care facilities in the state. As of October 2005, there were 1,159 of these facilities operating in Missouri. The SLCR has seven regional offices that employ state facility surveyors who are responsible for performing the surveys/inspections.

Federal regulations require nursing homes that are certified to participate in the Medicare and Medicaid programs to be subjected to a federally-mandated inspection (also know as a survey) at least once every 15 months. This survey is performed simultaneously with a scheduled state-required inspection. Section 198.526, RSMo, requires each licensed nursing home and residential care facility to be inspected at least twice annually. One of these required inspections is designated the annual or “full” inspection, which determines whether the facility is in compliance with all state licensing and provision of care requirements, except for those reviewed during an "interim" inspection. The "interim" inspection (also known as the second inspection), focuses on quality of care issues.

According to SLCR policy, when a regional office completes various phases of a survey or inspection, the certification or inspection packet information is entered into a computerized tracking system thereby making it available for review if the public requests information about a surveyed/inspected facility. The packet of information is then forwarded to the Central Office based on timeframes specified in SLCR policy.

Our review of the survey and inspection process noted the following areas of concern:

- A. During fiscal year 2005, the SLCR did not perform all nursing home inspections as required by law, and a number of nursing facilities were not inspected at all during that year. While all federally-mandated inspections of certified facilities were performed, 11 percent and 41 percent of the full and interim state-mandated inspections, respectively, were not conducted as presented in the following table:

Table 1.1: Fiscal Year 2005 State Inspections

Type of Inspection	Total Inspections Required	Total Inspections Completed	Total Inspections Required But Not Completed
State Annual Inspection	666	594	72
State Interim Inspection	972	572	400

Fifty-eight of the affected facilities received neither a full nor an interim inspection in fiscal year 2005, and this situation represented a significant decline in the SLCR's compliance with its statutory inspection responsibilities. In comparison, during the previous (2003) audit, it was reported that during fiscal year 2002 all full inspections and all but 40 interim inspections were conducted as required. The results of that audit had reflected improvement in the performance of inspections compared to the 2000 audit. The current situation resulted in several facilities not being inspected in fiscal year 2005 where care and treatment deficiencies and other problems had been found in prior fiscal years.

In addition, some of these facilities have been cited repeatedly for the same deficiencies. Based on our review of 5 commonly cited deficiencies in 8 historically poor performing facilities, we noted 17 deficiencies were repeated at least once between fiscal year 2003 and 2005. None of these facilities received an interim inspection in fiscal year 2005. Of 414 facilities that missed at least one inspection in fiscal year 2005, 40, 32, and 48 were issued state sanctions in fiscal years 2005, 2004, and 2003, respectively. In addition, a comparable number of these facilities also received federal sanctions during those years.

Most of the inspections that were not conducted related to facilities in Region 3 (Kansas City), Region 4 (Cameron), and Region 7 (St. Louis). According to DHSS officials, many of the historically poor performing facilities in the state are located in the Kansas City and St. Louis regions. Therefore, it is critical that the DHSS ensure inspections in these areas, as well as statewide, are performed as required by state law.

Discussions with SLCR staff indicated the required inspections were not completed during fiscal year 2005 due to lack of personnel. It should be noted the SLCR performs various complaint investigations each year and may have been in some of these facilities for a complaint investigation. However, these investigations usually focus only on the complaint and do not constitute an inspection.

The SLCR should make every effort to comply with state requirements by performing at least two inspections per year at each facility, unless a facility is determined to be in substantial compliance with regulations and one inspection is determined to be appropriate pursuant to Section 198.526.3, RSMo. In addition, the SCLR should consider performing additional inspections at facilities that are poor performing and/or where deficiencies are cited repeatedly to ensure compliance with applicable regulations.

- B. Certification and/or inspection packets were not always submitted to Central Office within the specified time frame. In addition, the SLCR does not have a system in place to track the timing of the packet submissions.

Our review of files documenting 33 completed federal surveys and 55 completed state inspections noted that certification and inspection information packets were not always submitted to the Central Office in a timely manner. We found that 14 certification and 6 inspection packets (23 percent) had been submitted after timeframes established by the SLCR. Of the 20 packets submitted untimely, 13 were submitted over 10 days late. Region 1 (Springfield), Region 3 (Kansas City), and Region 4 (Cameron) were responsible for 73 percent of all late packets noted during our review.

Section IV, Policy No. 402.00 of the Administrative Policy and Procedure manual of the SLCR, requires each region to submit federal survey information to the Central Office within 10, 30, or 40 calendar days depending on the type of packet information submitted and deficiencies cited. In addition, Section III, Policy No. 316.20 of the Administrative Policy and Procedure manual of the SLCR, requires each region to submit inspection packets to the Central Office within 30 days of the inspection's final action.

Discussions with SLCR officials indicated that packets were not always being submitted to the Central Office as required due to a lack of personnel and because the process had a lower priority than other responsibilities of the SLCR. However, failure to submit the certification/inspection packets to the Central Office as required results in non-compliance with departmental policy. In addition, federally-certified

facilities' certification information is not uploaded to the federal database until the certification packet is received by the Central Office. Therefore, the survey information available on the federal website related to these facilities would not be up-to-date.

To ensure compliance with policy, certification/inspection packets should be filed with the Central Office within the specified timeframes. In addition, the SLCR should have a system in place to review for compliance with these policies. Such a system would allow the SLCR to review each region's performance, identify and avoid potential backlogs, and ensure the timely submission of all inspections.

This condition was also noted in the prior two audit reports.

- C. When performing federal surveys and full state inspections, state surveyors did not always classify or document the classification of violations of state standards in a manner that was consistent with state laws, regulations, or SLCR policy. The occurrence and timing of a re-inspection of a cited facility is based on the violation classification.

Our review of 60 federal survey and state inspection files disclosed that 9 of 324 state deficiencies cited in those surveys/inspections (a 3 percent error rate) were either not classified in the correct category or the classification was not properly documented. The exceptions, noted at 8 facilities, related to surveyors not providing explanations justifying the classification of violations, the classification of violations not being specifically documented in the files, and classifications being cited that did not agree with the recommended classification according to state regulations. Of the eight facilities where improper or unsupported classifications were noted, four (50 percent) were located in Region 3 (Kansas City).

Section 198.085, RSMo, requires the classification of state violations into three categories. Class I violations present either an imminent danger to the health, safety, or welfare of any resident or a substantial probability that death or serious physical harm would result. Class II violations have a direct or immediate relationship to the health, safety, or welfare of any resident, but do not create imminent danger. Class III violations have an indirect or a potential impact on the health, safety or welfare of any resident. 19 CSR 30-82.020(3), (4), and (5) document each state facility rule and provide the recommended violation classifications for use by surveyors. Section III Policy No. 312.00 of the Administrative Policy and Procedure manual of the SLCR, recommends a surveyor use the lower classification when citing a violation of a rule with multiple classifications. The policy further states the surveyor may use the higher

classification; however, the surveyor is required to justify the higher usage.

The failure to document and classify facility violations correctly, besides not complying with state regulations and SLCR policy, could result in the lack or improper timing of a facility's re-inspection. To ensure compliance with state regulations and SLCR policy and the occurrence of appropriate re-inspections, all violations of standards should be correctly classified and be supported by adequate documentation and explanations, as necessary.

- D. During fiscal year 2005, the SLCR did not prepare performance evaluations of its survey employees pursuant to the Missouri On-site Survey Evaluation Process (MOSEP), as required by state law.

Legislation passed in 1999 established the MOSEP to identify education and training needs for state surveyors and to ensure the uniform application of regulation standards in long-term care facilities throughout the state. Section 198.527, RSMo, requires the department to periodically evaluate its surveyors, and based on this evaluation, develop and implement additional training and knowledge standards.

SLCR officials indicated the required performance evaluations were not conducted during fiscal year 2005 due to lack of personnel and funding. By not performing the required MOSEPs, the department cannot be assured all education and training needs have been identified for state surveyors.

This condition was also noted in the prior (2003) audit report.

- E. State surveyors tend to cite fewer deficiencies when federal inspectors are not present to monitor the federal survey process.

The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), conducts two types of federal monitoring surveys to determine if the SLCR is complying with the federal inspection process. The first type is known as the Federal Oversight and Support Survey (FOSS), in which federal inspectors will accompany the SLCR surveyors to monitor and rate their facility inspection procedures. The second type is a comparative survey, where CMS inspectors conduct a separate inspection within two months of the state survey's completion date, and the results of the federal and state inspections are compared to identify additional training needs for SLCR surveyors. A comparative survey can be either a health or a life safety code survey. A health survey reviews a facility for its compliance with

routine resident/patient care, whereas a life safety code survey reviews the facility for its adequacy regarding fire safety issues.

We reviewed all 30 federal monitoring surveys conducted during fiscal year 2005, 12 of which were FOSS inspections. The remaining 18 surveys were comparative surveys, consisting of 3 health surveys and 15 life safety code surveys. As presented in the following table, our review determined that 83 percent of the deficiencies cited by federal inspectors during the FOSS inspections were also cited by the state surveyors. However, only 20 percent and 15 percent of the deficiencies cited by federal inspectors during the health and life safety code comparative surveys, respectively, were also cited by state surveyors.

Table 1.2: Survey Comparison

	FOSS	Life Safety Code Comparative	Health Survey Comparative
Number of surveys reviewed	12	15	3
Total federal deficiencies cited	272	142	35
Total state deficiencies cited	227	46	13
Total deficiencies cited by both federal and state surveys	227	22	7
Percentage of deficiencies cited by both federal and state surveys	83%	15%	20%

In addition to the data presented above, our review found only one facility survey (a life safety code comparative survey) where state surveyors cited more deficiencies than the federal inspectors. Also, for two life safety code comparative surveys reviewed, there were significant variances between the number of federally cited deficiencies and state cited deficiencies. In one instance, the federal inspectors identified 20 deficiencies during the facility inspection, compared to only 3 deficiencies being cited by state surveyors in the prior inspection of that facility. Of the three deficiencies identified by the state surveyors, only one of the deficiencies was the same citation identified by the federal inspectors. In the other instance, the federal inspectors identified 13 deficiencies during the facility inspection, while no deficiencies were cited by state surveyors during the prior state survey.

Several factors can contribute to the large variances in deficiencies cited. For example, federal inspectors will visit a facility for a comparative inspection up to two months after the completion of the state survey. Significant changes could have occurred at a facility during the interim period. In addition, during comparative inspections, federal inspectors select a different sample of residents for their review than the sample chosen by state surveyors.

The increased number of deficiencies cited when CMS inspectors are present (during the FOSS inspections) compared to the number of deficiencies identified during the comparative surveys still indicates a need for future training of state inspectors.

This condition was also noted in the two previous audit reports.

As noted previously, SLCR officials indicated that several of the conditions discussed above were due to staff shortages and lack of adequate funding during fiscal year 2005. The DHSS placed a hiring freeze on surveyor staff as of January 1, 2005, and 18 surveyor positions were eliminated in March and April 2005 due to the state's financial difficulties. However, eight of these positions were reinstated in June and July 2005. In addition, the DHSS has been authorized 48 new surveyor positions in the fiscal year 2007 budget. Considering the significant number of additional surveyor positions that have been authorized by the legislature in the upcoming year, the department should consider how it can best use these additional resources to meet department priorities and comply with its statutory requirements.

WE RECOMMEND the Department of Health and Senior Services:

- A. Fill all available surveyor positions and perform all nursing home inspections as required by state law. The SLCR should perform at least two inspections per year at each facility as required, unless a facility is determined to be in substantial compliance with regulations and one inspection is determined to be appropriate pursuant to Section 198.526.3, RSMo. In addition, the DHSS should consider performing additional inspections of poor performing facilities or those which have been sanctioned in the past to ensure compliance with applicable regulations.
- B. Submit completed inspections to the Central Office in a timely manner.
- C. Ensure facility violations are properly classified in accordance with state regulations. In addition, if multiple classifications are available for a facility citation and the higher violation classification is used, an explanation justifying that citation should be adequately documented according to policy requirements.
- D. Complete the staff performance evaluations pursuant to the MOSEP program as required by law.
- E. Continue to evaluate the results of the FOSS and comparative surveys performed by CMS to identify potential training needs for state surveyors.

AUDITEE'S RESPONSE

- A. *SLCR is aware not all inspections are completed as required by state law. The authorization for additional survey staff in Fiscal Year 2007 promises to increase the ability of SLCR to complete all required inspections. However, the timely completion of required inspections may not be entirely accomplished in Fiscal Year 2007 as new staff must be hired and trained before they are allowed to independently perform inspections. Also, the department's ability to hire additional staff is contingent upon the availability of federal funds.*
- B. *SLCR agrees inspection packets are not always submitted to Central Office within specified time frames. SLCR will develop a system to track timeliness of inspection packet submission to improve the timeliness of inspection packets sent to Central Office.*
- C. *SLCR will strive to ensure all state citations are correctly classified as set forth in regulation and if multiple classifications are available and the higher violation classification is chosen, an explanation justifying the upgrade is documented. SLCR will reinforce this issue with each of the managers and supervisors responsible for reviewing citations to ensure citations are classified correctly and an explanation is included for any higher classification used. SLCR will also explore the possibility of incorporating a change to the ASPEN system to require a classification to be selected before proceeding to the citation text.*
- D. *SLCR agrees the Missouri On-site Survey Evaluation Process (MOSEP) could be a very useful education/training tool for our surveyors. However, SLCR does not agree that the MOSEP process can independently identify all surveyor education and training needs. The MOSEP process is to be completed once a year. While SLCR staff have not been performing the MOSEP process, supervisory staff in each region currently monitor staff continually throughout the year and conduct regular reviews of each surveyor's performance. Annual employee performance appraisals are completed based on the monitoring of staff performance throughout the year.*
- The particular mandate associated with MOSEP was not funded when the requirement was enacted in 1999. SLCR does not currently have sufficient staff to move from regular licensure, survey and complaint functions to implement the MOSEP training program as an ongoing process. SLCR will continue to discuss with department management funding options, including the possibility of requesting additional funding and FTEs through the Fiscal Year 2008 budgetary process, in order to incorporate the MOSEP into our surveyors' education/training program.*
- E. *SLCR is aware of the variance in the number of deficiencies cited by state inspectors when federal inspectors are present. SLCR does not agree that the mere occurrence of variances equates to training needs of state inspectors. SLCR*

does not agree that the FOSS findings are necessarily correct. The FOSS findings represent the judgment of the federal surveyor just as the state survey represents the judgment of the state surveyor. However, SLCR will continue to review results of FOSS and comparative surveys to identify potential training needs. Training needs specific to a region will be shared with the regional manager to develop a training plan. Training needs affecting more than a specific region will be incorporated into scheduled training throughout the year.

2.

Complaint Investigations

On-site complaint investigation visits are not always initiated in a timely manner as required by the SLCR policy. In addition, some information related to complaint investigations in one region was not always entered into the ASPEN Complaint Tracking System (ACTS) timely. Further, the reporter and/or facility are not always notified of a complaint investigation's outcome within the required timeframe.

The SLCR and Home and Community Services Section (HCS) are responsible for recording, investigating, and reporting the results of complaints made to the Elder Abuse and Neglect Hotline (800-392-0210) maintained by the department's Central Registry Unit (CRU). During fiscal year 2005, approximately 6,300 SLCR and 15,800 HCS complaints were received.

For the SLCR, the CRU forwards complaint calls to the applicable regional office. Surveyors prioritize the complaints into one of seven categories based on the severity of the complaint. These complaint descriptions, as well as timeframes for conducting the initial on-site visits, are as follows:

- **Priority A:** Allegations of imminent danger - Conduct the on-site visit within 24 hours.
- **Priority B:** Allegations of actual harm that do not indicate ongoing immediate jeopardy - Conduct the on-site visit within 10 working days.
- **Priority C:** Other allegations of resident harm that do not rise to the level of A or B - Conduct the on-site visit within 30 calendar days.
- **Priority D:** Allegations of regulatory violations with low impact to the resident(s) - Conduct the on-site visit in conjunction with the next scheduled inspection.
- **Priority E:** No immediate jeopardy - administrative review/offsite investigation.

- **Priority F/G:** Referred to another entity, such as the Long-Term Care Ombudsman Program or local law enforcement/emergency responders.
- **Priority H:** No action necessary.

HCS complaints are categorized based on the severity of the complaint into one of three classifications by a CRU social worker. However, the HCS investigator can obtain supervisor approval to change this original classification.

While our review noted no concerns with the handling of HCS complaints, we did identify the following concerns regarding SLCR complaints:

- A. On-site complaint investigation visits are not always initiated in a timely manner as required by SLCR policy. The SLCR provided us with reports summarizing the timeliness of on-site complaint investigations for priority A, B, and C calls (those calls determined to be more serious) for fiscal year 2005 as follows:

Table 2.1: SLCR Complaint Investigations

Complaint Type	Investigations	Untimely Investigations	Error Rate
A	296	4	1%
B	3,021	167	6%
C	1,978	562	28%

Each of the untimely priority A calls was initiated within three days; however, any delay in an investigation of alleged imminent danger is not acceptable. In addition, delays in investigating priority B and C calls can make it more difficult to determine whether an incident or violation has actually occurred.

Discussion with SLCR staff indicated that the untimely investigation of these complaint calls was the result of lack of sufficient personnel.

This condition was also noted in the two previous audit reports.

- B. Some information related to complaint investigations in Region 7 (St. Louis) was not being entered into the ACTS system timely.

The SLCR runs periodic reports of pending complaint investigations that are overdue for an exit meeting, the meeting the SLCR surveyors hold with facility representatives to discuss the outcome of an investigation. We compared the January 7, 2006 overdue report to the February 15, 2006 overdue report and noted that 107 complaint investigations listed as overdue on the January report were still listed as overdue on the February

report. Of these, 105 were in Region 7. Upon further review, it was determined the exit meetings had been conducted for most of these complaint investigations; however, documentation related to these exit meetings had not been entered timely into the ACTS system. According to SLCR officials, this delay in data entry was due to lack of adequate staffing in the Region 7.

For DHSS management and other supervisory officials to have up-to-date information related to the status of complaint investigations, all actions and supporting information related to investigations needs to be input into the ACTS system on a timely basis. In addition, this situation results in a delay in the eventual uploading of the entire investigation packet into the federal database where it can be accessed by the public.

- C. The reporter and applicable facility are not always officially notified of a complaint investigation's outcome within the required timeframe.

Section VII, Policy No. 706.00 of the SLCR's Administrative Policy and Procedure manual, requires a letter of determination be sent to the reporter of the complaint with the results of the investigation within fourteen calendar days of the exit meeting date. That same policy also requires the facility be notified in writing of the results of the investigation within fourteen calendar days of the exit meeting date, if the complaint was considered unsubstantiated.

During a test of SLCR complaint investigations, we noted that in 9 of 51 (18 percent) unsubstantiated complaints, the facility was not notified by letter of the outcome of the investigation within the 14-day requirement. While some of these exceptions were only a few days late, we noted two that were sent 88 and 192 days after the exit meeting date, respectively. In addition, during this same test we noted that in 9 of 25 (36 percent) complaints in which the reporter was not anonymous, the reporter was not notified of the outcome of the investigation within the 14-day requirement. Again, while some of these exceptions were only a few days late, we noted one determination letter which was not sent to the reporter until 108 days after the exit meeting date.

The SLCR should make every effort to notify the reporter and applicable facility of the outcome of an investigation on a timely basis. By not sending out the required notification timely, the reporter and facility remain unaware of the official outcome of the investigation.

WE RECOMMEND the Department of Health and Senior Services:

- A. Ensure the SLCR conducts on-site complaint investigations on a timely basis in accordance with established policy.

- B. Enter all complaint investigation information into the ACTS system timely.
- C. Send the required letters reporting the outcome of investigations to the reporter and facility on a timely basis in accordance with established policy.

AUDITEE'S RESPONSE

- A. *SLCR is aware that some on-site complaint investigations were not conducted within specified time frames. SLCR would like to note, however, that the vast majority of time frames not met involved complaints classified as lower priority complaints. SLCR gives priority to complaints alleging immediate jeopardy or significant harm. We hope that additional staff – when hired and trained – will help to increase timeliness.*
- B. *SLCR recently instituted a policy that requires certain information to be entered into ACTS within 15 days of the exit conference. This required information allows DHSS management and other supervisory officials to have up-to-date information related to the status of complaint investigations. SLCR monitors this information on a monthly basis to ensure compliance and notifies the regional manager of any problems noted.*
- C. *SLCR is aware that required letters are not always sent on a timely basis as required by SLCR policy. Some of the exceptions noted involve SLCR's failure to notify the facility of the outcome of the investigation. SLCR would like to point out that facilities are notified verbally of the outcome of the investigation at the time of the exit conference. SLCR does, however, recognize the importance of providing outcome information in writing, and will reinforce with section management staff the need to ensure all letters are sent consistently and on a timely basis.*

3.	Facility Staffing
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The SLCR has no minimum staffing standard in place for nursing home facilities and does not track actual staff hours at those facilities. As a result, the SLCR cannot compare actual direct care staffing information to an estimated level of staffing needed to prevent understaffing and negative resident outcomes. This condition was also noted in the two previous audit reports.

Section 198.079, RSMo, requires the SLCR to promulgate reasonable standards and regulations related to the number and qualifications of employed and contract personnel having responsibility for any service provided for residents in intermediate care and skilled nursing facilities. However, the current Code of State Regulations (CSR), 19 CSR 30-85.042 (37), only requires nursing homes to

employ nursing staff "in sufficient numbers and with sufficient qualifications" to meet the residents' needs. This is subjective and is open to interpretation of the state surveyor staff.

Currently, the SLCR reviews actual staffing levels if a complaint is received related to staffing levels or the survey team knows from a preliminary off-site review that a facility has had certain negative resident outcomes that might be related to understaffing. The survey team will also review various quality indicators and the facility's prior history of non-compliance. These measures resulted in approximately 20 facilities being cited for staffing deficiencies during fiscal year 2005. However, as noted in the previous two audit reports and according to department personnel, some facilities have brought in additional staff during inspections. This practice could temporarily hide or mask an understaffing problem, and may result in no staffing deficiency being cited and potential future negative resident outcomes.

During the current audit, we determined that of the eight states contiguous to Missouri, five of those states (Arkansas, Illinois, Kansas, Oklahoma, and Tennessee) have some sort of minimum nursing care staffing requirements in place. These minimum staffing requirements varied between these states, with three of the states' minimum standards relating to ratios of staff to residents and the other two states' standards relating to a minimum number of direct care hours per day.

Prior to September 30, 1998, Missouri had minimum nursing staff requirements in place for a number of years. However, on that date, the minimum standards were rescinded from state regulations. DHSS officials have stated that re-establishing minimum staffing standards could be counterproductive. They indicated that in the past when there were minimum standards in place, facilities would only staff the minimum number required. Without these requirements, nursing facilities have been forced to review their resident/patient load and acuity levels to determine how many staff are needed to provide adequate care.

However, as noted in the two previous audit reports, studies have shown a relationship between the number of staff hours and the quality of care at a nursing facility. The SLCR should consider comparing actual direct care staffing information to a minimum nursing staff requirement to help ensure quality care is provided to nursing home residents. In addition, the SLCR should make actual direct care staffing information available to the public so better informed placement decisions can be made. The SLCR has the authority and responsibility to set reasonable staffing level requirements.

WE RECOMMEND the Department of Health and Senior Services reconsider the decision not to re-establish minimum staffing standards for nursing facilities.

AUDITEE'S RESPONSE

SLCR does not agree with this finding. SLCR believes minimum staffing ratios, in order to be effective, must consider factors such as acuity level of the residents and the training and competency of staff. As the acuity level of residents changes and/or staff turnover occurs, the need in the frequency and type of nursing services and other staffing required may also change. Currently, SLCR evaluates the adequacy of nursing staff based on the care needs of the residents and any negative outcomes based on the staffing in the facility. SLCR believes establishing minimum staffing standards would not improve the quality of care for residents, but would make citations more difficult when facilities meet the minimum staffing standards but are providing poor quality of care. Also, please reference the Federal HHS Study: "State Experiences with Minimum Nursing Staff Ratios for Nursing Facilities: Findings from Case Studies of Eight States", which was presented at the exit conference. We believe the study strongly supports our position regarding minimum staffing standards.

AUDITOR'S COMMENT

We disagree that the federal study referred to in the auditee's response strongly supports the department's position regarding minimum staffing requirements. This study, issued in November 2003, was not conclusive regarding the need for minimum standards and there appear to be differing opinions regarding their merit. It should be noted that at the time of the study, 36 states had some type of minimum staffing requirements. In addition, the study reviewed 8 states in-depth, including Missouri, and the other 7 states subjected to the in-depth review had some type of minimum staffing requirements. We believe the DHSS should continue to study this matter and consider the recommendation presented in this finding.

4.

Alzheimer Special Care Units

The SLCR is not adequately verifying the accuracy of disclosure forms related to Alzheimer special care units/programs as required by law.

Some long-term care facilities have established special units or programs to care for individuals who have been diagnosed with Alzheimer's disease or a related disorder. As of October 2005, 224 of the 1,159 licensed facilities (19 percent) had an Alzheimer special care unit or program.

Section 198.510, RSMo, requires that any such facility disclose the form of care or treatment provided that distinguishes that unit or program as being especially applicable, or suitable, for persons with Alzheimer's disease or dementia. This disclosure is to be made to the department (the DHSS) which licenses the facility. According to that statute, this disclosure should be made on a form developed by the department and include an explanation as to how the care is different from the rest of the facility in various areas including, but not limited to, the unit/program's

overall philosophy and mission, assessment and establishment of a patient care plan, staff training and continuing education practices, the costs of care and any additional fees, and safety and security measures. A copy of this disclosure form is to be given to the patient and the patient's family at the time of admission.

This statute also states that as part of the long-term care facility's regular license renewal procedure, the licensing department (the DHSS) shall examine the disclosure form and verify the accuracy of the information disclosed. Based on our discussions with SLCR officials, it is not apparent that adequate actions are taken by the department, either during the licensing process or the inspection process, to verify the information on the disclosure form is accurate or that the nursing facility has followed the practices outlined in the form.

During the license renewal process, we were told the Licensure Unit receives these forms with the license renewal requests and turns the forms over to the Policy Unit for review. The Policy Unit reviews the forms for missing information or obvious errors, but no other procedures are performed to verify the accuracy of the disclosure form as part of the licensing process.

Department policies also provide that the accuracy of the disclosure form is to be verified during the inspection process; however, if this is done it appears it is generally not documented. Section III, Policy No. 305.00 of the SLCR's Administrative Policy and Procedure manual states that during an annual inspection, the surveyor is to utilize the Alzheimer's unit disclosure form by comparing the inspection's findings regarding the care provided to sampled Alzheimer patients against the information presented in the disclosure form. In addition, that policy states the surveyor will review the availability and distribution of the disclosure form.

While state surveyors may be verifying the accuracy of the information on the disclosure forms during the inspection process, it does not appear this is documented in the completed inspection documents or surveyor notes. A SLCR official indicated that surveyors are most concerned about overall patient care and as long as sampled patients are properly cared for, the surveyors are probably not concerned about verifying and documenting the accuracy of the disclosure form information.

As a result of this situation, there is not adequate assurance the Alzheimer Special Care disclosure forms submitted by the applicable facilities to the department and distributed to the applicable patients/families accurately reflect the special care and operating practices at those facilities.

WE RECOMMEND the DHSS review its current practices related to the verification and review of Alzheimer special care units/programs and the disclosure forms which are submitted by the applicable facilities. Steps should be

taken to ensure the disclosure forms accurately reflect the care and practices at those facilities.

AUDITEE'S RESPONSE

SLCR acknowledges that every aspect of the Alzheimer's disclosure form is not verified for accuracy. The disclosure form is submitted to SLCR with the licensure application (every two years). SLCR does examine the form for content, but does not verify all information contained on the form. During onsite inspections, SLCR determines if residents on special care units are receiving the appropriate care in accordance with each resident's care plan. SLCR staff will cite a facility for failure to provide the appropriate care. At any one time, residents on a special care unit may require various levels of the services the facility discloses. It would be difficult for SLCR to mandate a facility provide certain services in the absence of any negative outcome to residents. However, SLCR will consider options that better provide for review of the disclosure form.

5.

Quality Assurance Unit

The SLCR's Quality Assurance Unit (QAU) has not performed many quality assurance reviews as was intended when the unit was created, but instead its personnel have been assigned primarily to other duties.

The QAU, which is made up of a unit manager and four support staff, was established in 2001. This unit was created with the intent that its main function would be to review a sample of completed inspections and complaint investigations to ensure those inspections/investigations were conducted efficiently, consistently, and in accordance with applicable standards and regulations. As noted in the previous (2003) audit report, the QAU has not spent a significant amount of time performing this quality control function because QAU staff have been assigned other duties within the SLCR. Since the last audit, the QAU has not performed any quality control reviews of any completed inspections and only a few reviews of complaint investigations.

According to SLCR officials, among the other duties performed by QAU staff since the last audit was to help with the implementation of the ASPEN Complaint Tracking System (ACTS). It appears work related to this system's implementation was the unit's primary responsibility in 2003 and part of 2004, and included the creation of an ACTS training manual and developing and conducting staff training for the new system. The QAU staff have also helped conduct long-term care facility surveys and inspections due to the lack of trained surveyors in the state.

The ACTS system implementation was completed in 2004. With the completion of this project and the new surveyor positions which have been approved for

fiscal year 2007, it appears the QAU staff should be able to concentrate on performing the quality assurance reviews of inspections and complaint investigations as was intended when the unit was established.

WE AGAIN RECOMMEND the Department of Health and Senior Services assign QAU personnel to perform regular reviews of facility inspections and complaint investigations.

AUDITEE'S RESPONSE

SLCR acknowledges the QA unit has not been performing the amount of reviews as intended when the unit was created. In the past several fiscal years, SLCR has experienced difficulty in hiring and retaining qualified staff. Also in Fiscal Year 2005, SLCR experienced layoffs of several surveyor positions. As a result, the QA unit, which is primarily comprised of surveyors, has been conducting surveys and inspections in order to comply with federal and state statutory requirements. With the addition of staff in Fiscal Year 2007, SLCR should be staffed at a level to enable the QA unit to focus on quality reviews of inspection and complaint packets.

FOLLOW-UP ON PRIOR AUDIT FINDINGS

DEPARTMENT OF HEALTH AND SENIOR SERVICES'
MONITORING OF NURSING HOMES AND
HANDLING OF COMPLAINT INVESTIGATIONS
FOLLOW-UP ON PRIOR AUDIT FINDINGS

In accordance with *Government Auditing Standards*, this section reports the auditor's follow-up on action taken by the Department of Health and Senior Services (DHSS) on findings in the Management Advisory Report in the prior (2003) audit report issued by McBride, Lock & Associates, CPAs, and the auditor's follow-up on action taken by the DHSS on findings from the Management Advisory Report from the next previous (2000) audit report issued by the Missouri State Auditor's Office, except those findings that were listed as implemented, no long valid, or not warranting further action. The prior recommendations which have not been implemented, but are considered significant, are repeated in the current MAR. Although the remaining unimplemented recommendations are not repeated, the DHSS should consider implementing those recommendations.

DEPARTMENT OF HEALTH AND SENIOR SERVICES'
MONITORING OF NURSING HOMES AND
HANDLING OF COMPLAINT INVESTIGATIONS
(Report No. 2003-08, dated January 22, 2003)

2003-1. Inspections

- A. Inspection packets were not always submitted to the Central Office within the specified time frame. In addition, the SLCR did not have a system tracking the timing of inspection packet submissions.
- B. The SLCR used multiple systems to track and record the inspection and licensure processes for licensed facilities. This increased the occurrence of data entry errors and resulted in a duplication of effort.
- C. State regulations required inspections to be conducted at least two times each year in all licensed facilities, one being a full inspection and the second being an interim inspection. A better use of existing staff resources would have been to perform additional detailed inspections at "poor performing" facilities while rewarding "good" facilities with less frequent reviews. This would have required legislative action to change the existing state law.
- D. The SLCR was not performing the Missouri On-site Survey Evaluation Process (MOSEP) performance evaluations as required by Section 198.527, RSMo, in a timely manner.
- E. SLCR inspectors tended to cite fewer deficiencies when federal inspectors were not present during inspections.

Recommendation:

- A. Ensure that completed inspections are submitted to the Central Office in a timely manner.
- B. Develop a single comprehensive inspection system to adequately and accurately track and record all inspection information of licensed facilities.
- C&D. Analyze the utilization of current staff resources and evaluate the benefits of interim inspections compared to additional inspections of poor performing facilities. Based on this analysis, the department should present options to the legislature which include the additional amount, if any, of funding necessary to achieve all responsibilities, or reduce the responsibilities currently required by state law. Furthermore, the department should ensure staff evaluations are performed in accordance with state law.
- E. Continue to evaluate the results of the observational and comparative federal inspections to identify potential training needs for state inspectors.

Status:

A, D

&E. Not implemented. See MAR finding number 1.

B. Partially implemented. The SLCR has still not implemented a comprehensive inspection system; however, there does not appear to be as much duplication of data between the current systems as was noted previously. In addition, we did not note inaccurate or inconsistent data being presented in the various systems. Although not repeated in the current MAR, our recommendation remains as stated above.

C. Partially implemented. Legislation was passed in 2003 which allows the DHSS to waive a second or interim inspection if a facility is in compliance with regulations. As a result, during fiscal year 2005 the SLCR waived the interim inspection for 185 nursing facilities. DHSS personnel indicated that due to staffing shortages, additional inspections of "poor performing" facilities have not been conducted. See MAR finding number 1.

2003-2.

Complaint Investigations

A. On-site complaint investigation visits were not always initiated in a timely manner as required by SLCR policy. In addition, information in the complaint database used to review this requirement was not always complete and accurate.

- B. The General Assembly passed legislation in 1999 requiring the SLCR to implement the Consumer Informal Dispute Resolution (CIDR) Pilot Project. This pilot project provided for face-to-face conferences between SLCR staff and complainants, residents, or their family members. This legislation also required the SLCR to report to the General Assembly on the effectiveness of the pilot project. The SLRC subsequently concluded the CIDR process had shown merit and improved resident care; however, projected costs to implement this program statewide were estimated at over \$1 million annually. Due to the state's budget situation, the SLCR recommended any further action on this project be discontinued until such funding was available.

Recommendation:

The Department of Health and Senior Services:

- A. Section for Long-Term Care Regulation conduct on-site complaint investigations timely and maintain complete and accurate information regarding the dates of on-site complaint investigations.
- B. Study the possibility of establishing a more cost effective process for dissatisfied complainants to appeal the result of complaint investigations.

Status:

- A. Partially implemented. We again noted that on-site complaint investigation visits are not always initiated within the required timeframes. See MAR finding number 2. However, we did not note problems with the completeness or accuracy of the information in the complaint database.
- B. Not implemented. DHSS personnel indicated that budgetary constraints continued to plague the department during the current audit period and, as a result, no further progress was made in this area. Although not repeated in the current MAR, our recommendation remains as stated above.

2003-3. Quality Assurance Unit

Since the inception of SLCR's Quality Assurance Unit (QAU) in 2001, the unit had performed only two reviews of complaint investigations and no reviews of facility inspections. The main function of the unit was to review a sampling of completed inspections and complaint investigations.

Recommendation:

The Department of Health and Senior Services assign QAU personnel to perform regular reviews of facility inspections and complaint investigations.

Status:

Not implemented. See MAR finding number 5.

2003-4. Repeat Deficiencies, Sanctions, and Corrective Action

- A. The SLCR had not been able to sanction some noncompliant facilities aggressively enough to encourage subsequent compliance. In addition, the SLCR had neither a procedure in place nor the manpower to ensure continued compliance at "poor performing" facilities.
- B. State law had allowed the SLCR to seek civil monetary penalties (CMP) in the event of serious violations of standards; however, filing CMP cases in the courts had been an onerous process. As a result, the SLCR had utilized this remedy only once in the previous three years.

Recommendation:

The Department of Health and Senior Services continue to identify methods, including proposing revisions to the state CMP process, to more effectively bring repeat and severe offenders and "poor performing" facilities into compliance.

Status:

- A. Not implemented. We again noted instances of repeat deficiencies being noted in inspections. In addition, the DHSS has not performed additional inspections of "poor performing" facilities. See MAR finding number 1.
- B. Implemented. Legislation was passed in 2003 which has allowed the SCLR to more effectively use CMPs as a sanctioning tool against noncompliant facilities. As a result, 17 CMPs were recommended as sanctions against noncompliant facilities since the previous audit, compared to only 1 CMP being recommended during the prior audit period. The SLCR should continue to use CMPs as a sanction when it is effective to do so.

2003-5. Facility Staffing

- A. The SLCR had no minimum staffing standard in place and did not track actual staff hours at nursing home facilities. As a result, the SLCR could not compare actual direct care staffing information to an estimated level of staffing needed.
- B. Under the Quality Improvement Care Program for Missouri's Long-Term Care Facilities (QIPMo), the DHSS had contracted for services with the University of Missouri's Sinclair School of Nursing to perform various

duties, including analyzing information related to facility staffing. Annual costs of these services exceeded \$600,000. The DHSS had not determined or evaluated whether the benefits derived from the program exceeded the related costs.

Recommendation:

- A. Establish reasonable minimum staffing standards for nursing facilities as required by state law and maintain a system which accumulates these facilities' actual direct care staffing hours. The actual staffing information should be made available to the public, and should be compared to the minimum requirements to predict and prevent negative resident outcomes.
- B. Improve monitoring activities related to the QIPMo project. These activities should include a thorough review of the cost effectiveness of the program, and ensuring progress reports and related invoices are adequately documented and reviewed.

Status:

- A. Not implemented. See MAR finding number 3.
- B. Implemented. During the fall of 2005, the DHSS began conducting a quarterly monitoring review of the contract services and the related invoices. In addition, it should be noted that the annual costs of this contract were reduced from \$625,000 in fiscal year 2002 to \$520,000 in fiscal year 2003 and 2004, and then reduced further to \$230,000 in fiscal year 2005.

2003-6. Employee Disqualifications

- A. The SLCR was conducting monthly matches of employment security wage data to persons listed on the Employee Disqualification Listing (EDL). However, when a match identified individuals listed on the EDL that were employed in nursing facilities, the SLCR did not always obtain documentation that corrective action had been taken by the facilities.
- B. Inordinate delays were noted from the time a complaint was filed to the time the individual was placed on the EDL.

Recommendation:

- A. Ensure documentation is maintained to support corrective action was taken by facilities notified of disqualified employees.

- B. Ensure reasonable timeframes are set for all aspects of the EDL referral process and track referrals to ensure compliance with these timeliness standards.

Status:

- A. Implemented.
- B. Partially implemented. The SCLR has still not set specific timeframes for each stage of the EDL process. Currently, the only established timeframe is that a case is to be forwarded from Central Office to Legal Services within 10 days. However during the current audit, we noted improvement in the amount of time it took to get individuals placed on the EDL. Although not repeated in the current MAR, our recommendation remains as stated above.

2003-7.

Staffing, Salaries, and Conflict of Interest Disclosures

- A. SLCR's Region 7 (St. Louis) had not investigated complaints and inspected nursing homes in a timely manner due, at least in part, to a greater workload in that region and unfilled staff positions.
- B. The salaries paid to DHSS' social workers, facility surveyors, and nurses were lower than those paid for similar position in bordering states as well as the private sector. As a result, it was difficult to attract and retain employees.
- C. Compliance with the DHSS' department-wide conflict of interest policy was not adequately documented and inspectors were permitted to inspect facilities where they had been previously employed.

Recommendation:

- A. Consider various alternatives including shifting some of the workload, reallocating staff, and/or requesting additional surveyor positions to help ensure complaints are investigated and nursing homes are inspected in a timely manner.
- B. Seek increased funding for salaries for facility surveyors, facility advisory nurses, social workers, and supervisor positions.
- C. Require employees to periodically prepare written conflict of interest statements, and discontinue the practice of allowing employees to inspect or investigate complaints at facilities where they were formerly employed.

Status:

- A. Partially implemented. The SLCR has continued to have difficulty filling surveyor positions in Region 7. Since the previous audit, Central Office staff as well as staff from other regions have been used to help survey/inspect facilities in that region. However, the SLCR has still had problems performing the required inspections and complaint investigations in some regions, including Region 7. See MAR finding numbers 1 and 2.
- B. Partially implemented. Based on information obtained during the current audit, it appears the facility surveyor and social service worker salaries in Missouri are now more comparable to the amounts paid by contiguous states. Although not repeated in the current MAR, our recommendation remains as stated above.
- C. Not implemented. The DHSS still does not require written conflict of interest statements from its employees. In addition, survey employees are still allowed to participate in inspections of facilities where they were previously employed as long as two years have lapsed from that previous employment. We were informed the DHSS follows federal policy when surveying federally-certified facilities (as well as non-certified facilities) which requires a two-year waiting period for a surveyor to conduct a survey at a facility where he or she was formerly employed. Although not repeated in the current MAR, our recommendation remains as stated above.

**REVIEW OF THE DIVISION OF AGING'S
MONITORING OF NURSING HOMES AND
HANDLING OF COMPLAINT INVESTIGATIONS
(Report No. 2000-13, dated March 1, 2000)**

Note: Recommendations 1C, 1H, and 2C were implemented as of January 2003.

2000-1. Inspections

- A. Inspection reports were not submitted to and/or were not entered into the centralized database maintained by the Central Office in a timely manner. As a result, the system could not be relied upon to monitor and ensure required facility inspections had been performed. In addition, reports that were not properly submitted to the Central Office were not readily accessible to the public as required by state law.
- B. 53 full and 363 interim inspections required by state law during fiscal year 1999, were not conducted.

- D. Inspections were rarely performed other than those required by state law.
- E. Federal and state regulations required inspections to be unannounced and unpredictable; however, several examples were noted of the inspection order and/or inspection dates of facilities being very patterned.
- F. Readily available reports of deficiency patterns to identify areas where enforcement activities could be improved were not studied.
- G. State inspectors cited more deficiencies when federal inspectors were present during inspections.

Recommendation:

A, B

- &D. Develop and utilize a centralized inspection monitoring system to track inspections and then ensure completed inspections are submitted to the Central Office and entered into the system in a timely manner. We also recommend all inspections be performed as required by state law, and take the necessary steps which would allow additional inspections to be performed of poor performing facilities.
- E. Continue to develop and implement policies to reduce the predictability of inspections.
- F. Analyze the available reports of deficiency patterns to identify areas where enforcement may be weak or inconsistent and consider their impact upon the inspection process.
- G. Ensure inspectors are adequately trained and supervised.

Status:

- A. Not implemented. Survey results are no longer entered into the system by the Central Office; they are entered at the regional level. However, our current audit again noted instances where survey packets were not submitted to the Central Office in a timely manner. See MAR finding number 1.
- B. Not implemented. The 2003 audit noted significant improvement in the completion of required inspections, with only one of the seven regions not completing all required inspections. That audit reported that in fiscal year 2002, all full inspections and all but 40 interim inspections were conducted as required. However, during the current audit it was determined that 72 annual and 400 interim inspections (in 3 regions) were

not conducted as required in fiscal year 2005. See MAR finding number 1.

- D. Partially implemented. Legislation was passed in 2003 which allows the DHSS to waive a second or interim inspection if a facility is in compliance with regulations. As a result, during fiscal year 2005 the SLCR waived the interim inspection for 185 nursing facilities. However, due to staffing shortages, additional inspections of "poor performing" facilities have not been conducted. See MAR finding number 1.
- E. Partially implemented. Examples of patterned surveys were again noted in two regions during the current audit. However, the DHSS met federal requirements concerning unpredictable surveys (10 percent of surveys conducted on nights and weekends). Although not repeated in the current MAR, our recommendation remains as stated above.
- F. Implemented. State sanction patterns are quantified and discussed at provider (i.e. facility) meetings. In addition, because many of the state deficiencies are mirrored on the federal side, the DHSS will review the top 10 state deficiencies noted to identify any inconsistencies.
- G. Not implemented. See MAR finding number 1.

2000-2. Complaint Investigation Processing and Procedures

- A. Complaint investigations were not always initiated in a timely manner.
- B. As of May 1999, there were over 1,650 overdue complaints for which a completed summary report had not been submitted to Central Office. In addition, letters were not always sent to the resident's family or the reporter as required by state law.
- D. No process existed for dissatisfied complainants to appeal the result of a complaint investigation.

Recommendation:

- A&B. Ensure complaint investigations are initiated and completed timely, the results of those investigations are properly documented, and reports are submitted in a timely manner to help ensure appropriate enforcement actions are taken against facilities that are not in compliance with state and federal regulations. In addition, the agency should ensure required reports are available to the public, and the resident's next of kin or the reporter is notified of the results of all complaint investigations.

- D. Study the merits of establishing a process for dissatisfied complainants to appeal the result of complaint investigations.

Status:

- A. Not implemented. See MAR finding number 2.
- B. Partially implemented. Improvements have been made in this area since the 2000 audit; however, during the current audit we noted instances in one region in which data related to investigations was not always input in the system on a timely basis, delaying the completion/closure of some investigations. See MAR finding number 2.
- D. Partially implemented. Legislation was passed in 1999 to create the Consumer Informal Dispute Resolution Pilot Program. This was a one-year pilot program and due to budget constraints, the SLCR's recommendation to the legislature at that time was to discontinue any further action. DHSS personnel indicated that nothing has been done since that time due to budget constraints. Although not repeated in the current MAR, our recommendation remains as stated above.

2000-3. Repeat Deficiencies, Sanctions, and Corrective Action

- A. Sanctions were not studied to determine which were most effective in bringing facilities into compliance, it was not verified that the state's Medicaid agency imposed the denial of payment sanction on facilities, and it was not determined whether the denial of payment actually resulted in financial penalties on facilities. In addition, a facility's history of past noncompliance was not considered when determining the sanction to be imposed.
- B. State officials indicated their ability to seek state civil monetary penalties (CMP) was hampered by the onerous process of filing cases in the circuit courts, which required a significant commitment of staff resources.
- C. Many Plans of Correction (POCs) did not meet the criteria for acceptance, several contained almost identical wording to the prior POC that had most recently failed, and it was questionable whether some of the POCs could reasonably be expected to prevent a repeat deficiency. In addition, the facilities were not always monitored for compliance with POCs.

Recommendation:

- A. Consider the facility's history of past noncompliance when selecting sanctions and study sanctions to determine those which are most effective in reducing noncompliance.

- B. Work with the legislature to modify the state CMP process so that it can be a more effective tool in bringing facilities into compliance.
- C. Ensure Plans of Correction fully meet the established criteria including methodologies for facilities to monitor their continued compliance with the POCs, and ensure the POCs adequately address any systemic deficient conditions. We also recommend the agency ensure all POCs can reasonably be expected to correct the deficiency and not accept POCs which have failed in the past. Further, procedures should be developed to continually monitor compliance with POC provisions for facilities with a history of repeat deficiencies.

Status:

- A. Implemented. The DHSS does consider a facility's past performance when selecting sanctions for noncompliance if allowed to under federal and state law. In addition, the SCLR studied the effectiveness of sanctions and other remedies and determined that each type has its own merits in certain situations.
- B. Implemented. Legislation was passed in 2003 which has allowed the SCLR to more effectively use CMPs as a sanctioning tool against noncompliant facilities. As a result, 17 CMPs were recommended as sanctions against noncompliant facilities since the 2003 audit compared to only 1 CMP being recommended between the 2000 and 2003 audit periods. The SCLR should continue to use CMPs as a sanction when it is effective to do so.
- C. Not implemented. We again noted instances of repeat deficiencies being noted in inspections. In addition, the DHSS does not perform additional inspections of "poor performing" facilities. See MAR finding number 1.

2000-4.

Staffing of Nursing Homes

- A. The intent of state law was contradicted when the minimum nursing staff requirements were rescinded in 1998.
- B.1. The Minimum Data Set produced an estimate of the actual hours of nursing care that were necessary to provide adequate staffing to meet the needs of each nursing home's residents; however, the nursing homes were not able to access those estimates for use in scheduling the number and type of staff that should be sufficient to meet their needs.
- 2. A system had not been developed which accumulated the actual staff hours at each facility to identify homes that are operating significantly below appropriate staffing levels.

- C. Inspectors did not review facility staffing levels and compare them to any minimum standard or industry benchmark.
- D. One facility was cited for inadequate staffing but at a level too low to assess additional sanctions. In addition, a POC was accepted which did not adequately address the staffing shortage.

Recommendation:

- A&B. Establish reasonable minimum staffing ratios as required by state law. In addition, steps should be taken to develop a system which accumulates the actual staff hours at facilities, and compare recommended staffing levels to actual staffing at facilities to identify potential staffing problems.
- C&D. Inspectors utilize recommended and actual staffing data to help identify negative resident outcomes. We further recommend staffing deficiencies should be cited aggressively and subject facilities that are found to be out of compliance with the staffing requirements to the maximum federal and state sanctions (including civil monetary penalties) warranted. In addition, the agency should ensure approved POCs are reasonably expected to address the staffing deficiencies noted.

Status:

- A-C. Not implemented. See MAR finding number 3.
- D. We did not note any examples where the scope and severity of the staffing deficiency was specifically cited at an inappropriate level by the survey team. Only about 20 federally-certified facilities (out of 491) were cited for staffing deficiencies during fiscal year 2005.

2000-5. Employee Disqualification Listings, Central Registry, and Criminal Backgrounds

- A.1. An automated process had not been developed to identify persons listed on the Employee Disqualification Listing (EDL) who were working in nursing homes, in-home service providers, and other entities prohibited from hiring those persons.
- 2. An automated process had not been developed to identify employers who were employing individuals with certain criminal backgrounds prohibited by state law.
- 3. Facilities were not always sanctioned that had hired a person listed on the EDL.

4. Nine instances were identified where individuals on the EDL worked for an in-home vendor under contract with the Department of Social Services.
- B. An automated process had not been developed to identify instances where persons listed on the Department of Mental Health (DMH) EDL were working for nursing home operators or in-home care providers.
- C. An automated process had not been developed to identify instances where persons found to have abused children were working for nursing home operators and in-home care providers.

Recommendation:

Seek legislation which would prohibit the employment of individuals found to have abused and/or neglected children and DMH clients from working in nursing homes. An automated process should be developed to identify instances in which persons listed on the agency's EDL, the DMH EDL, or the Central Registry of Child Abuse and Neglect, or individuals with criminal backgrounds are inappropriately working for nursing facilities, in-home service providers, or other entities prohibited from hiring those persons. In addition, facilities and providers who hire persons listed on these EDLs and/or Central Registry should be more aggressively sanctioned and fined. In addition, consideration should be given to raising the violation for hiring a person listed on the EDL to a Class I violation.

Status:

Partially implemented. The DHSS has developed an automated process to detect instances where individuals on the DHSS EDL are inappropriately working. However, EDL deficiencies are still not routinely cited as a Class I violation. Legislation that would have prevented individuals on the DMH EDL and the DFS CA/N from working in nursing homes has not been passed in recent legislative sessions. Also, the DHSS has not been granted access to the Missouri State Highway Patrol's criminal database; however, during the full state inspection process, sample employees are chosen and the facility's background check documentation is reviewed. In addition, for new employee hires, in-home service providers and home health agencies are required to make inquiries through the Family Care Safety Registry. Although not repeated in the current MAR, our recommendation remains as stated above.

HISTORY AND ORGANIZATION

DEPARTMENT OF HEALTH AND SENIOR SERVICES'
MONITORING OF NURSING HOMES AND
HANDLING OF COMPLAINT INVESTIGATIONS
HISTORY AND ORGANIZATION

The Department of Health and Senior Services (DHSS) serves as the central agency coordinating all programs relating to the lives of older Missourians. Its goals are to improve the quality of life, maintain personal dignity, and protect the basic rights of Missouri's senior citizens. Its services include institutional programs, which safeguard residents in nursing homes and long-term care facilities; home and community care programs, which provide support for older persons who live in the community; and programs for immediate assistance to older persons and disabled individuals who encounter abuse, neglect, or exploitation. The DHSS promotes public awareness of the needs and abilities of elderly persons while maximizing independence for these older Missourians.

Prior to August 2001, the Division of Aging, an operating division of the Department of Social Services, was responsible for most of these functions. In August 2001, the Department of Health was renamed and the functions of the Division of Aging were moved to the DHSS by executive order. In August 2005, the DHSS' Division of Senior Services and Regulation was split into the Division of Regulation and Licensure and the Division of Senior and Disability Services.

The Section for Long-Term Care Regulation (SLCR), located organizationally under the Division of Regulation and Licensure, has the legal authority to intervene in cases where abuse, neglect, or exploitation is apparent among institutionalized elderly or disabled persons. The SLCR has seven regions across the state that are headquartered in the following cities: Springfield, Poplar Bluff, Kansas City, Cameron, Macon, Jefferson City, and St. Louis. This section performs inspections and investigates complaints of abuse or neglect at long-term care facilities, works with the U.S. Department of Health and Human Services to determine Medicaid/Medicare certification of facilities, and helps establish eligibility for Medicaid and cash grant assistance for residents in long-term care facilities. In addition, the SLCR reviews and approves architectural plans for proposed long-term care facilities, provides data for certificate of need determinations, and develops and implements appropriate rules and regulations in accordance with the Omnibus Nursing Home Act.

The Division of Senior and Disability Services administers a coordinated, integrated home and community service delivery system to ensure the needs of Missouri's elderly and persons with disabilities are met. This division has five regions across the state that are headquartered in the following cities: Springfield, Cape Girardeau, St. Louis, Kansas City, and Columbia. Services such as personal care, homemaker, chore, nursing, respite, adult day health care, counseling, and consumer-directed services are made available to the elderly and persons with disabilities in their homes. When abuse complaints are reported, the division conducts investigations and provides necessary protective services. Through these programs, approximately 66,000 elderly and disabled individuals are served each year.

The Central Registry Unit (CRU), a unit within the Division of Senior and Disabilities Services, maintains the Elder Abuse and Neglect Hotline (800-392-0210) and is responsible for responding

to reports of alleged abuse, neglect, or financial exploitation of persons 60 years of age or older and other eligible adults between age 18 and 59 with substantial mental or physical impairment. The CRU was established pursuant to a state law which requires the department to maintain a central registry capable of receiving and maintaining reports received in a manner that facilitates rapid access and recall of the information reported, and of subsequent investigations and other relevant information. The Home and Community Services Section, within the Division of Senior and Disability Services, provides investigation, intervention, and follow-up services to victims who are still living in their home or a community setting and stresses the mentally competent adult's right to make his or her own decisions. Reports of abuse, neglect or other complaints regarding long-term care facilities are also handled by the Elder Abuse and Neglect Hotline. The investigation of these complaints is conducted by long-term care survey staff around the state. During the year ended June 30, 2005, the CRU received approximately 6,300 complaints related to licensed nursing homes and long-term care facilities and approximately 15,800 home and community services complaints.

Missouri's Long-Term Care Ombudsman Program helps to inform residents of their rights so that they may protect themselves as individuals and/or as a group. Ombudsman volunteers give their time and assistance to the program to ensure all complaints are investigated and followed through properly. They also coordinate activities for the residents with other support groups.

An organization chart follows:

DEPARTMENT OF HEALTH AND SENIOR SERVICES
 ORGANIZATION CHART (Applicable Sections of Senior Services and Regulation)
 JUNE 30, 2005

