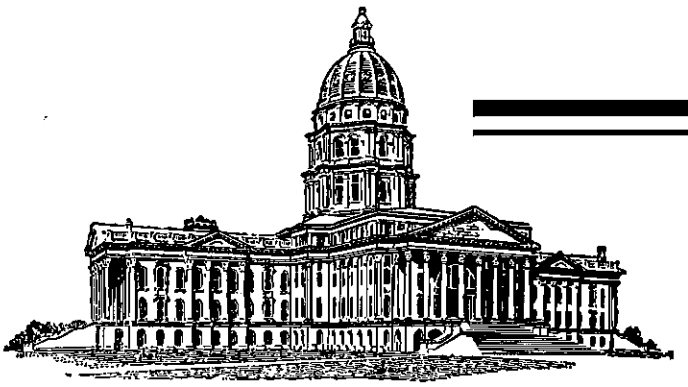

PERFORMANCE AUDIT REPORT

REVIEWING THE DEPARTMENT OF HEALTH AND ENVIRONMENT'S REGULATION OF NURSING HOMES

Executive Summary

with Conclusions and Recommendations

From a Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
August 1996

96-53

Legislative Post Audit Committee

Legislative Division of Post Audit

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LEGISLATIVE DIVISION OF POST AUDIT

800 SW Jackson
Suite 1200
Topeka, Kansas 66612-2212
Telephone (913) 296-3792
FAX (913) 296-4482

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MERCANTILE BANK TOWER
800 SOUTHWEST JACKSON STREET, SUITE 1200
TOPEKA, KANSAS 66612-2212
TELEPHONE (913) 296-3792
FAX (913) 296-4482

August 14, 1996

To: Members of the Kansas Legislature

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Reviewing the Department of Health and Environment's Regulation of Nursing Homes.*

The report also contains an appendix showing the results of surveys of people who filed nursing home complaints, nursing home administrators, and Department inspection staff.

The report includes a number of recommendations for improving the Department's complaint and inspection programs. We also recommended steps to strengthen the Department's enforcement procedures for nursing homes that repeatedly violate State laws and regulations. If you would like a copy of the full audit report, please call our office and we will send you one right away. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

REVIEWING THE DEPARTMENT OF HEALTH AND ENVIRONMENT'S REGULATION OF NURSING HOMES

EXECUTIVE SUMMARY

LEGISLATIVE DIVISION OF POST AUDIT

Question 1: Does the Department of Health and Environment Ensure That Complaints Against Nursing Homes Are Properly Prioritized and Acted On?

The Department's system for handling complaints generally is well-designed, and Department staff appear to handle complaints well most of the time. *The Department has a toll-free hotline staffed by a registered nurse who prioritizes complaints that are called in, enters information about complaints into a database, and forwards them to the appropriate officials for investigation. Complaints are investigated by registered nurses or social workers with formal training in complaint investigation, and both the regional and central offices oversee complaint investigations.*

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About 10% of the complaints we reviewed seemed to be assigned too low a priority. *About one in 10 of the 213 complaints we reviewed seemed to be classified too low to reflect their potential seriousness. For example, one complaint alleged that residents at a facility were left in soiled clothing, had skin tears, or weren't bathed for as long as two weeks. The Department classified this complaint as a Code 3 priority, which means it didn't have to be investigated until the next regular inspection of the nursing home, or within six months. We thought this complaint and others like it should have been classified as Code 2 priority, which means they would have to be investigated within two working days.*

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Given the priorities that were assigned, most complaint investigations were conducted within the timeframes required. *Of the 213 complaints we reviewed, 93% were investigated within the time required by State law and the Department's policies. Only 14, or about 7%, weren't completed on time. In addition, most complainants we surveyed thought the Department investigated their complaint on a timely basis.*

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The Department's decision not to have its own staff conduct independent investigations of certain complaints may not comply with State law. *Before January 1, 1996, the Department independently investigated all complaints reported to its hotline. But in 1996, as part of an effort to reduce costs, the Department gave itself the option of relying on the nursing homes' own investigations of complaints that didn't allege immediate jeopardy to the resident, and that were reported to the Department by the nursing home itself. If Department officials decide a nursing home's investigation isn't adequate or thorough, they can still follow up with a regular on-site investigation done by their staff.*

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Nursing home administrators and some Department inspectors we surveyed thought this policy was a better use of the Department's resources, however some of the inspectors didn't think the policy adequately protected nursing home residents from harm.

State law requires the Department to investigate all allegations of abuse, neglect, and exploitation, and doesn't appear to allow the Department to "delegate" the responsibility for investigating such complaints.

The Department no longer informs all complainants of the disposition of their complaints, and some who do receive such notices are dissatisfied with the information they receive. *As a cost-cutting measure, the Department no longer sends close-out notices to individuals who file a complaint the Department classifies as Code 3 (the Department's category for less-serious complaints), unless the complainant specifically asks to be notified of the outcome.*

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Some complainants who did receive follow-up information were dissatisfied because the notices didn't provide information about what was done to investigate the complaint or details about the investigation findings. However, State law requires investigations to be kept confidential, so the Department may not be able to provide that information.

The Department isn't making full use of its automated complaint tracking system. *In Spring 1995, the Department began using an automated complaint tracking system, which should enable it to monitor such things as whether investigations are timely and the percent of complaints substantiated. However, four of the Department's six regions don't have the capability to electronically transmit information about the complaint investigations to the computer system in Topeka, so no "tracking" data are available on complaints investigated in those regions. In addition, staff were unable to generate reports of basic information we requested from the computer.*

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Question 1 Conclusion: *The Department's complaint program functions well in many respects, but weaknesses we identified are particularly serious because of the vulnerability of the people most directly affected by the Department's policies--nursing home residents. In particular, we think residents may be adversely affected by the Department's decision to classify vague allegations of abuse, neglect, or exploitation as Code 3 (the lowest investigation priority). Although the Department should be applauded for looking for ways to make better use of its resources and reduce costs, we think that this decision, as well as it's decision to delegate certain complaint investigations to nursing homes, may not be in the best interest of nursing home residents.*

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Question 1 Recommendations. *A brief summary of the report's recommendations, with a summary of applicable comments from the Department, is presented below.*

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We recommend that the Department

- *request an Attorney General's opinion on whether it can legally delegate its statutory investigation responsibilities to the nursing homes it regulates*
- *initiate an investigation of every complaint of abuse, neglect, or exploitation within 24 hours*

- *assign a Code 2 classification, instead of a Code 3, to allegations that seem to suggest abuse, neglect, and exploitation, but that don't name a specific resident, OR create a new classification for vague allegations of abuse, neglect, and exploitation with an appropriate timeframe for investigation*
- *ask all complainants if they would like to be notified of the outcome of the investigation, and send such notices if requested*
- *determine if additional information can legally be provided to complainants beyond what currently is provided*
- *devote resources to resolve the problems that prevent it from fully using its automated complaint tracking system*

The Department disagreed with several of our recommendations. Department officials said it wasn't necessary or appropriate to request an Attorney General's opinion on whether they can legally delegate the Department's statutory investigation responsibilities to the nursing homes its regulates. They further indicated that having a trained nurse take complaints over the hotline constitutes the beginning of an investigation, that they didn't see the value to upgrading the priority code of vague allegations of abuse, neglect, and exploitation, and that offering to send general-care complainants a follow-up letter can't be justified by the potential benefit.

Department officials agreed to review their follow-up letter to see if complainants legally can be provided any additional information, and to redirect resources to resolve problems with the automated complaint tracking system.

Question 2: Is the Department's Nursing Home Inspection Program Adequate to Ensure that Significant Violations of State Laws and Regulations Will Be Found?

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The Department's inspection program is designed so that it should uncover significant violations of State and federal laws and regulations. *The Department follows State and federal regulations and guidelines in its inspections, uses qualified staff to conduct inspections, has a formal system for documenting violations staff identify, and schedules revisits when necessary to see if the violations were corrected.*

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Our review of 30 recent inspections showed that records were complete, and that the Department's inspectors appeared to be covering all required areas. *Inspectors appeared to be doing the types of work they were supposed to be doing during an inspection. In two of the 30 cases we reviewed, the inspections weren't "unannounced," as required by State law and federal regulation. In these cases, the Fire Marshal conducted his inspection from 2 weeks to one month before the Department's inspectors, which effectively told the facilities that a Department inspection soon would follow. The federal government recently dropped its requirement that fire inspections be done at the same time as, or within 30 days after, health inspections, so this should not be a problem in the future.*

About 70% of the nursing home administrators who responded to our survey said the Department didn't enforce laws and regulations consistently from region to region in the State. We couldn't tell whether inspectors tended to cite certain types of deficiencies more often in some regions than in others, but found there was little difference in the average number of deficiencies cited per inspection from region to region.

The Department generally has made sure that nursing homes have been inspected at least every 15 months, as required by State and federal mandates. On average, records showed that inspectors were in a nursing home five to six times each year for inspections, revisits, and complaint investigations.

The last published review by the Health Care Financing Administration commended the Department in most areas, but also cited some problems with identifying regulatory violations. *The Financing Administration reviews the Department's inspection program annually. The 1995 review noted many areas of strength in the program, but indicated the Department needed improvement in identifying deficiencies. This same problem had been cited in the Administration's 1994 review.*

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Question 2 Conclusion: *Nursing homes get a lot of attention from the Department. Between regular inspections, follow-up visits, and complaint investigations, the Department's inspectors are in each home an average of five to six times yearly. The Department has a comprehensive program of nursing home inspections that is staffed by well-qualified and well-trained inspectors. Although a handful of homes weren't inspected as frequently as required by law, all were less than a month late. There was no way for us to know whether the inspectors recorded all the violations that may have existed at the time the nursing homes were inspected, and we didn't have the expertise to make some of the assessments the inspectors would make. However, when we reviewed inspection files, inspectors appeared to be doing a comprehensive job of covering and documenting their work in all the areas outlined in the Department's inspection protocols. The Health Care Financing Administration's last published review noted many strengths in the Department's inspection, but said it needed to improve its ability to identify deficiencies.*

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Question 2 Recommendations. *A brief summary of the report's recommendations, with a summary of applicable comments from the Department, is presented below.*

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We recommend that the Department:

- *inspect every nursing home within 15 months, as required by law*
- *conduct additional training for its inspectors on how to recognize and when to cite deficiencies*
- *review its inspections for consistency, and if they aren't consistent, provide training for its staff to ensure that all inspections are conducted as consistently and thoroughly as possible*

The Department generally didn't concur with our recommendations. Departrment officials said they think they fully meet the State requirement to conduct one unannounced inspection each 15 months,

and that federal directives to the Department to improve its ability to identify regulatory violations may have resulted from federal inspectors not being as well trained or experienced as the Department's inspectors. Finally, Department officials said that inspector inconsistency may simply be a "perception problem," but that the Department's internal quality improvement process will continue to focus on consistency.

Question 3: Does the Department Take Sufficient Action Against Nursing Homes That Repeatedly or Seriously Violate Its Regulations, As Identified by Complaints and Inspections?

The Department can use a number of enforcement options in responding to nursing homes that don't comply with State laws and regulations. *When inspectors find serious deficiencies at a nursing home or if a home fails to correct its deficiencies, the Department can do a number of things, including issue a correction order, assess a fine, require a facility to stop admitting new residents, revoke a facility's license, or take over operation of the facility.*

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The Department's enforcement efforts aren't always effective at getting problem homes to correct deficiencies. *Although the Department reviewed facilities' plans for correcting deficiencies, and revisited the facilities to see whether problems had been corrected, we found that a number of deficiencies were cited over and over again on inspection reports for the 20 problem facilities we reviewed. Problems would be temporarily corrected, but would reappear in a subsequent inspection.*

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For the problem homes we reviewed, the Department didn't always issue correction orders to nursing homes to address serious deficiencies, and those that were issued weren't always comprehensive. *During the timeframe we reviewed, the Department issued 67 correction orders to the 20 facilities in our sample. We thought the Department should have issued additional correction orders, or included additional deficiencies in the correction orders, for 8 of the 20 facilities.*

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Fines assessed against nursing homes with repeat violations were too small to provide an incentive for improvement, or to serve as an effective penalty or deterrent. *During the period we revlewed, the Department assessed 32 fines against 14 of the 20 homes in our sample. The average fine paid for failure to correct deficiencies identified in a correction order was $542, and the average immediate fine (for more serious problems) was $1,925. By law, fines are capped at $2,500 for failure to correct deficiencies cited in a correction order, and at $10,000 for immediate fines. In comparison, the average federal fine paid by homes in our sample was $7,700.*

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The Department assessed a fine each time it could do so, but fines tended to be low because the Department's practice has been to assess a fine only for the number of days a Department inspector actually observes a deficiency, rather than for every day the deficiency exists. In addition, the Department, did not double fines when it had statutory authority to do so.

There is little the Department can do about nursing homes that violate less-serious regulations. *None of the enforcement actions provided in State law address the problem of nursing homes that violate less-serious State regulations, even when the homes do so on a repeated basis. Current remedies can be applied only when deficiencies exist that significantly and adversely affect the health, safety, nutrition, or cleanliness of one of more residents. Because of this, conditions that may diminish the quality of life for residents, but that aren't critical to their health, may go uncorrected .*

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Question 3 Conclusion: *The Department may be hampered by State laws that cap fines at relatively low levels, and that provide no enforcement tools to use with facilities that repeatedly violate regulations that don't significantly and adversely affect nursing home residents. Its efforts also may be hampered by hearing officers who reduce fines significantly.*

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However, the Department doesn't appear to be taking full advantage of the enforcement options it has. Department officials don't always issue correction orders when they should, they have adopted a policy that ensures a nursing home will only be fined for a few days of noncompliance, even if the problem continues for some time, and they don't double fine amounts when they could.

The limitations of the law and the Department's practices may help to explain why some violations continued to exist for as long as three years in the problem homes we reviewed.

Question 3 Recommendations. *A brief summary of the report's recommendations, and a summary of applicable comments from the Department, is presented below.*

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We recommend that the Department:

- *propose legislation to the 1997 Legislature to remove or significantly raise the statutory maximums on fines*
- *create effective enforcement tools to use with facilities that repeatedly violate State regulations that don't significantly and adversely affect nursing home residents, but that impair the quality of residents' lives if they aren't followed*
- *revise its current policy and assess fines for the time the facility is out of compliance with laws or regulations*
- *revise its policy related to doubling fines to take into account violations cited in inspections and investigations, as allowed by law*
- *ensure that correction orders are being issued for all deficiencies that significantly and adversely affect the health, safety, nutrition, or cleanliness of nursing home residents*

The Department didn't concur with several of our recommendations. Department officials think the agency's current fines are effective, that they don't need additional tools to deal with habitual violators of less-serious regulations, and that their current practices for doubling fines are appropriate.

Department officials said they would have legal staff review the current policy of assessing fines only for days the inspector is on site, and that they have revised their process for issuing correction orders to ensure that deficiencies that may meet the criteria for correction orders are more fully considered.

This audit was conducted by Cindy Lash, Chris Clarke, Tracey Elmore, Sharon Patnode, and Tim Patton. If you need any additional information about the audit's findings, please contact Ms. Lash at the Division's offices. Our address is: Legislative Division of Post Audit, 800 SW Jackson Street, Suite 1200, Topeka, Kansas 66612. You also may call (913) 296-3792, or contact us via the Internet at **LPA@PostAudit#1.ksleg.state.ks.us.**