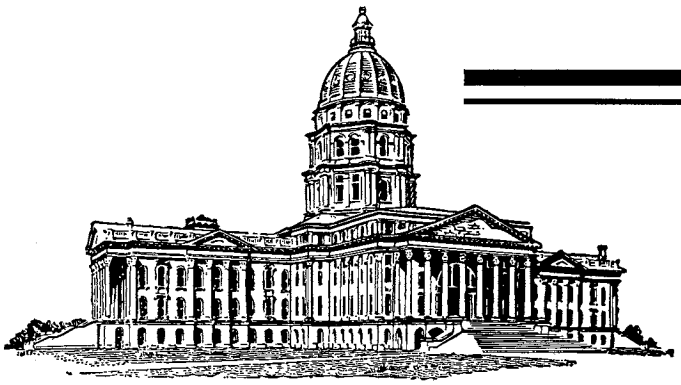

PERFORMANCE AUDIT REPORT

Reviewing the Department of Health and Environment's Regulation of Nursing Homes

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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To: Members, Legislative Post Audit Committee

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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. 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

Barbara J. Hinton
Legislative Post Auditor

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

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.* ..... page 22

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.* ..... page 23

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.* ..... page 27

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 reviewed, 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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This audit was conducted by Cindy Lash, Chris Clark, 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.ksleg.state.ks.us.**

Reviewing the Department of Health and Environment's Regulation of Nursing Homes

By law, the Department of Health and Environment is responsible for licensing nursing homes in Kansas and for investigating reports of abuse, neglect, or exploitation of nursing home residents. The Department has statutory authority to adopt rules and regulations to promote safe, proper, and adequate treatment and care of residents of nursing homes, and to fine nursing homes or suspend or revoke their licenses for failure to comply with Sate laws or regulations.

Through its Bureau of Adult and Child Care, the Department enforces regulations related to nursing homes and other health facilities such as hospitals and home health agencies. Department staff assess compliance with State regulations and federal certification standards through inspections of health facilities, and through investigations of allegations of abuse, neglect, or exploitation.

Recently legislators have been contacted by representatives from nursing home advocacy groups and members of the public who have expressed concerns the Department may not be doing enough to follow up on nursing home complaints it receives. They also are concerned the Department's inspection program may not be adequate to ensure that nursing homes are complying with State regulations. Concerns also have been voiced that the Department takes a lenient attitude toward nursing homes that are found to be in violation of its regulations.

This audit addresses the following questions:

1. **Does the Department ensure that complaints against nursing homes are properly prioritized and acted on?**

2. **Does the Department have a nursing home inspection program that is adequate to ensure that significant violations of State laws and regulations will be found?**

3. **Does the Department take sufficient action against nursing homes that repeatedly or seriously violate its regulations, as identified by complaints and inspections?**

To answer these questions, we interviewed Department officials and reviewed statutes and policy manuals. We reviewed a sample of complaints filed with the Department to see if they were prioritized and investigated properly and in a timely manner. We reviewed recent changes to the complaint program, and surveyed complainants to see if they were satisfied. We also surveyed Department inspection staff and nursing home administrators to get their opinions about the complaint program, the inspection program, and the Department's enforcement efforts.

We reviewed a sample of nursing home inspections, and observed several days of actual inspections. To assess the quality of the Department's inspections, we relied on annual reviews conducted by inspectors from the Health Care Financing Administration, because this type of assessment requires a medical background. We also selected a sample of 20 "problem" nursing homes, and reviewed the Depart-

ment's enforcement actions in response to deficiencies identified in the facilities. Specifically, we looked at whether correction orders were issued when they should have been, whether fines were appropriate, and whether the Department has the statutory authority it needs to deal with facilities that repeatedly or seriously violate State regulations. The Post Audit Committee directed us not to do a review of other states' procedures in order to complete the audit on a timely basis.

In conducting this audit work, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

We found that the Department has the basic elements of a well-designed system for handling complaints, but we identified problems in the way the system was applied. Most complaints appeared to be properly prioritized, but we thought about 10% were assigned at too low an investigative priority. Although most complaints were investigated in a timely manner, we think the Department's decision not to conduct independent investigations of certain complaints may not comply with State law. Finally, the Department isn't making full use of its automated complaint tracking system.

The Department's inspection program is designed so that it should uncover significant violations of State and federal laws and regulations. Inspectors appeared to be doing the types of work they are supposed to do. In a few cases, inspections weren't unannounced or weren't timely. The last published review of the Department's inspection practices by the Health Care Financing Administration, in 1995, commended the Department in some areas, but cited some problems in identifying deficiencies.

The Department's enforcement efforts aren't always effective at getting problem homes to correct deficiencies. We found that the Department didn't always issue correction orders to these problem homes when it should have, and that when fines were assessed, they were often too small to provide an incentive for improvement or to serve as an effective penalty or deterrent. State law caps fines at a low level compared to surrounding states and the federal government. In addition, the Department's decision to fine nursing homes only for the days an inspector was in the facility observing the violation, as opposed to fining the facility for the entire time it was out of compliance, further serves to keep fines low.

These and other findings will be discussed in more detail after a brief overview.

Overview of the Kansas Department of Health and Environment Nursing Home Regulatory Program

As of July 1, 1996, Kansas had 467 adult care facilities licensed to operate in the State. The term "adult care facilities" is broad, and includes nursing facilities (for the elderly, the disabled, and the mentally impaired), mental retardation facilities, residential health care facilities, assisted living facilities, and personal care facilities. See the accompanying box for a definition of these types of facilities. In total, those facilities had 30,634 beds as of July 1. In this audit, when we refer to nursing homes, we are only talking about the 365 nursing facilities for the elderly and the mentally impaired. These types of programs operate under similar regulations.

Types of Adult Care Facilities in Kansas

Many different types of facilities exist in Kansas to address the needs of elderly or impaired adults. These facilities are described below.

Nursing Homes - 350 facilities Facilities that provide 24-hour a day skilled nursing care.

Nursing Homes for Mental Health - 15 facilities
Facilities that provide 24-hour a day skilled nursing care and mental health services.

Mental Retardation Facilities - 44 facilities
Facilities that provide 24-hour a day skilled nursing care to individuals with functional impairments caused by mental retardation or related conditions.

Residential Health Care Facilities - 12 facilities
Facilities that provide 24-hour a day services to individuals who need personal care assistance and supervised nursing care. Living units are private with a lockable door, a bathroom, and sleeping, living, and storage areas.

Assisted Living Facilities - 38 facilities
Similar to residential health care except residents live in private apartments with kitchens.

Personal Care Facilities - 8 facilities
Facilities that provide services to individuals who can't properly care for themselves because of aging, illness, disease, or physical or mental infirmity, and who need simple nursing care for a few hours each week. (The Department is in the process of reclassifying these facilities as residential health care or assisted living.)

Nursing Homes in Kansas Are Subject to Both Federal and State Regulation

All nursing homes licensed to operate in Kansas must meet State licensing regulations. In addition, most Kansas nursing homes receive payments from the Medicare or Medicaid programs. Medicare pays the cost of caring for elderly and disabled people in Medicare-certified nursing homes, while Medicaid pays the cost of caring for needy individuals in Medicaid-certified nursing homes. To participate in these federal programs, nursing homes must meet certain federal operating standards.

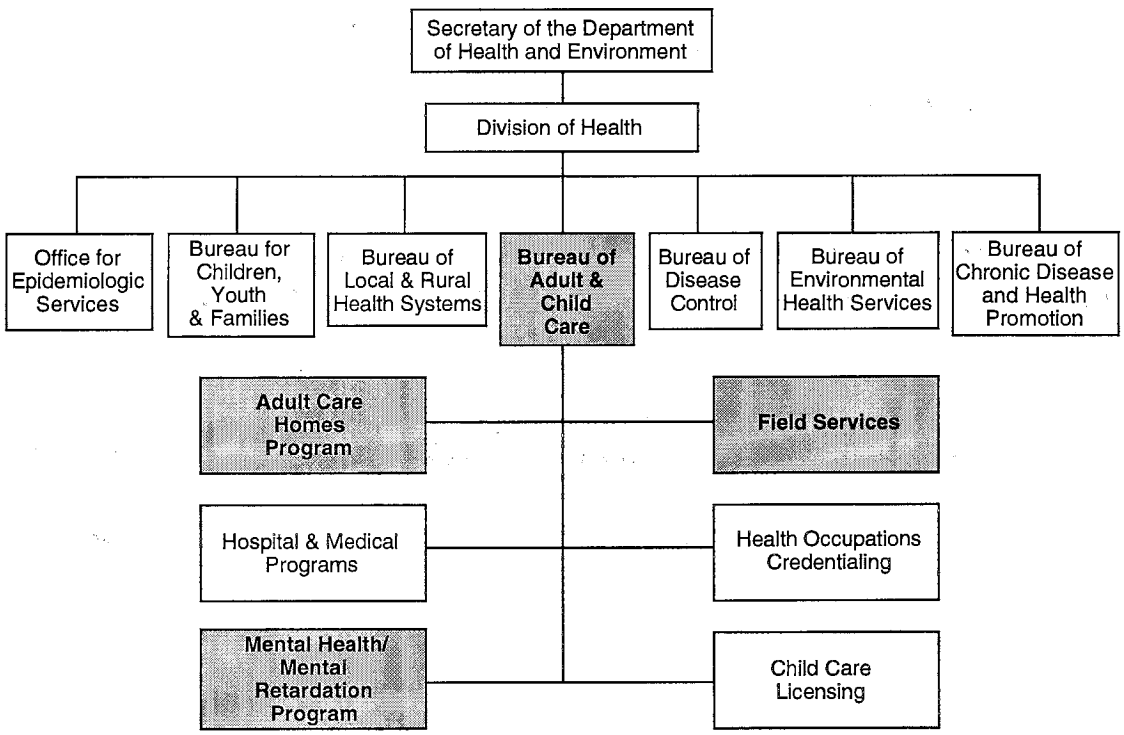
At the federal level, the Health Care Financing Administration establishes regulations for nursing homes. The Financing Administration has developed a set of very detailed regulations governing health, safety, and sanitation issues for

nursing homes. It also has developed a corresponding set of inspection guidelines, based on those regulations, that are used to inspect nursing homes nationwide.

To avoid duplicate inspections, the Financing Administration contracts with each state's nursing home regulatory agency to conduct nursing home inspections. Those agencies report the total amount of time their employees spend on these inspections, and Medicare and Medicaid reimburse them for a portion of their direct costs associated with these inspections. Kansas is reimbursed for 80% of its direct costs.

In Kansas, the Department of Health and Environment is primarily responsible for nursing home regulation, although four other State agencies also have some responsibilities in this area. The Department's Bureau of Adult and Child Care carries out these regulatory activities. The Bureau employed 146 staff during fiscal year 1996, and had a budget of approximately $6.8 million. The accompanying organization chart shows where the Bureau fits within the Department's overall organizational structure, and highlights the sections within the Bureau that work with nursing homes.

Organization of the Department of Health and Environment's Division of Health



This chart shows the programs we worked with during this audit, and their location within the Department's Division of Health.

Within the Bureau, staff in the following three program areas deal with nursing home issues:

- the Adult Care Home Program has three staff members who draft and interpret State regulations for nursing homes, assisted living facilities, and the like.
- the Mental Health/Retardation Facilities Program has 14 staff who inspect, license, and certify facilities serving the mentally ill and retarded. Three of the 14 staff members inspect nursing homes for the mentally ill, which are included in this audit.
- the Field Services Program has about 90 employees who inspect adult care homes, home health agencies, hospices, hospitals, and several other types of facilities. In addition, they handle and investigate complaints and manage the State licensure and federal certification recordkeeping for these facilities. This program area is responsible for most of the issues discussed in later sections of this report.

As the chart on page 6 shows, four other State agencies—the Department of Social and Rehabilitation Services, the Department on Aging, the Attorney General's Office, and the Fire Marshal—also have a role with nursing homes in Kansas.

Federal Regulations Require Nursing Homes To Be Inspected at Least Once Every 15 Months

To comply with State law and with federal regulations for the Medicare and Medicaid Programs, the Department must make sure that each nursing home is inspected at least once every 15 months. Typically, a team of 2-4 inspectors will spend about five days doing a complete nursing home inspection.

The inspectors follow guidelines that address areas covered by both State and federal nursing home regulations. When serious violations of regulations are uncovered during an inspection or complaint investigation, the Department will revisit the nursing home to see if those violations have been corrected. The number of regular nursing home inspections and revisits conducted, and the number of complaint investigations assigned during fiscal year 1996 is shown below.

	Number of Regular Inspections	Number of Revisits	Number of Complaint Investigations Assigned
Fiscal Year 1996	442	434	2,085

When nursing homes are out of compliance with regulations, the Department can apply a number of sanctions. If the Department's inspectors find deficiencies (violations of regulations) during an inspection or complaint investigation, the nursing home is required to submit a plan of correction showing how and when it will correct the violations. If the deficiencies are serious, the Department can do the following:

STATE AGENCIES WITH A RESPONSIBILITY TO SERVE THE NEEDS OF RESIDENTS IN KANSAS' LONG TERM CARE FACILITIES

Department on Aging, State Long-Term-Care Ombudsman

- Advocates for the well-being, safety, and rights of Kansas residents in long-term-care facilities.
- Identifies the needs of these individuals and makes recommendations to organizations with the authority to take action and meet those needs.
- Negotiates on behalf of Kansas residents in long-term-care facilities.
- Investigates complaints that don't involve abuse, neglect, or exploitation.

Department of Health and Environment, Bureau of Adult and Child Care

- Regulates nursing home facilities by inspecting facilities regularly to ensure they are complying with State and federal regulations. Takes enforcement action--which may include levying monetary penalties--against facilities that aren't complying with requirements.
- Investigates allegations of abuse, neglect, exploitation, inadequate care, and involuntary discharge. Maintains a complaint hotline for residents, staff, family members, and other concerned citizens.

Department of Social and Rehabilitation Services, Adult Protective Services

- Intervenes on behalf of nursing home residents who are unable to protect themselves or who need assistance in dealing with abusive, neglectful, or exploitative situations. The person causing problems for the residents and creating these situations must be someone with no connection to the long-term-care facility.

Department of Social and Rehabilitation Services, Medicaid Operations

- Determines if facilities are eligible for Medicaid reimbursement., based on KDHE recommendations. If so, reimburses such facilities for certain costs incurred in caring for Medicaid-eligible residents.
- Imposes civil monetary penalties and denies payment for new admissions in Medicaid-only facilities that aren't in compliance with federal Medicaid participation requirements, based on recommendations from the Department of Health and Environment.

State Fire Marshal

- Inspects long-term-care facilities to ensure they are complying with State and federal fire safety requirements. This inspection is done shortly after the Department of Health and Environment completes its inspection.

Office of the Attorney General, Medicaid Fraud and Abuse Division

- Investigates complaints of abuse or neglect that may involve criminal behavior against residents in long-term-care facilities.
- Investigates misappropriations of patients' personal funds by long-term-care facilities that receive Medicaid payments.
- Investigates and prosecutes violations of State laws pertaining to fraud in administering the Medicaid program.

- Issue a correction order
- Assess a fine up to $2,500 (or $5,000 in special circumstances)
- Require the facility to stop admitting new residents

When overall conditions in a nursing home are unacceptable, or residents are in immediate jeopardy, the Department can:

- Require the facility to stop admitting new residents
- Assess an immediate fine up to $10,000
- Revoke the facility's license to operate
- Take over operation of the facility

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

The Department has the basic elements of a well-designed system for handling complaints, but we identified some problems in the way the system was applied. Most complaints we reviewed seemed to be properly prioritized, but about 1 in 10 seemed to be assigned too low a priority level.

The Department's complaint investigations appeared to be thorough and, for the most part, timely, but its recent decision to delegate investigation of certain complaints to nursing homes may not comply with State law. Finally, the Department's automated complaint tracking system hasn't been fully implemented, and doesn't provide the type of reports Department officials need to better manage the complaint program. These and other findings will be discussed in the following sections.

The Department Classifies Complaints by Type and Priority To Determine How Quickly They Should Be Investigated

The Department of Health and Environment is responsible for investigating complaints alleging that nursing home residents have been abused, neglected, exploited, inadequately cared for, or inappropriately discharged from a nursing home. These investigations are done to ensure compliance with federal and State regulations regarding the health, safety, and welfare of any resident.

As soon as the Department receives a complaint, it classifies that complaint by the type of concern expressed— for example, abuse, neglect, or general care— and by the priority with which it needs to be investigated—Code 1, 2, or 3, as follows:

- Investigations for priority Code 1 complaints must start the day the complaint is received
- Investigations for Code 2 complaints must start within 24 hours, except investigations of inappropriate discharge, which must start within 48 hours
- Code 3 complaints are investigated during the next regular inspection of the facility, but no longer than six months after the complaint was received

Code 2 and Code 3 complaints may be investigated earlier than the timeframes listed here, at the discretion of the Department's regional managers. The graphic on page 10 defines the types and priorities, and gives examples of complaint allegations we reviewed for each classification.

In fiscal year 1996, the Department received more than 2,000 complaints about nursing homes, which were classified by type and priority as shown on the facing page.

Type of Complaint	Number Received	Percent
General Care	1,197	52.8 %
Abuse	413	18.2
FYI	252	11.1
Neglect	229	10.1
Exploitation	84	3.7
Referral	69	3.0
Discharge	16	0.7
Combination	9	0.4
Total	**2,269**	**100.0 %**

Investigation Priority	Number Received	Percent
Code 1	14	0.6
Code 2	730	32.2
Code 3	1,264	55.7
FYI	252	11.1
Combination	9	0.4
Total	**2,269**	**100.0 %**

The Department's System for Handling Complaints Generally Is Well-Designed, and Department Staff Appear to Handle Complaints Well Most of the Time

A good complaint-handling system should include a number of procedures and practices that ultimately are designed to help protect the health and safety of nursing home residents. Those procedures and practices should include the following:

- developing a complaint-handling system that's well-publicized and easy to access
- having standardized procedures for receiving complaints
- assigning complaints an investigation priority that's consistent with the seriousness of the complaint
- responding to complaints on a timely basis, in light of each complaint's assigned priority
- training staff to investigate complaints
- conducting complaint investigations in a thorough and consistent way, and in accordance with all applicable laws and regulations
- maintaining and using a system for tracking complaints to ensure they are appropriately investigated and resolved
- communicating the results of complaint investigations to complainants
- providing adequate oversight of the system to ensure it's being carried out as intended

Classification of Nursing Home Complaints

These examples came from actual complaint files we reviewed, and were classified as shown by the Department

Priority Code → / Type of Complaint ↓	Code 1	Code 2	Code 3
	Allegations of abuse, neglect, and exploitation that place a resident in immediate jeopardy, are investigated on-site by KDHE investigators. Investigation Timeframe Same day the complaint is received	Allegations of abuse, neglect, or exploitation that don't place a resident in immediate jeopardy and will be investigated by KDHE or will be investigated by the facility. Investigation Timeframe KDHE - initiated within 2 working days, but may be done sooner. Facility - completed within 7 days.	General care concerns, or vague, non-specific allegations referring to abuse, neglect, or exploitation. Investigation Timeframe Incorporated into the next inspection, but no later than 6 months. May be done sooner.
Abuse Neglect, inflicting physical or mental injury, or depriving a resident of services which are necessary to maintain physical and mental health.	• Staff are locking Alzheimers residents into their rooms at night.	• A resident has a black eye, the cause of which is unknown. • Staff are verbally abusive toward a resident.	Abuse is never classified as severity Code 3.
Neglect Failing to maintain reasonable care and treatment to such an extent that the resident's health or emotional well-being is injured.	• The air conditioner is broken, and the facility is very hot. • A resident wandered away and is still missing.	• A resident wandered out of facility, fell, and suffered a broken hip. • Three residents have had broken ribs in the last three weeks.	Neglect is never classified as severity Code 3.
Exploitation Intentionally taking unfair advantage of an adult's physical or financial resources by using undue influence, coercion, harassment, duress, deception, false representation, or false pretense.	We found no examples of severity Code 1.	• A resident's jewelry box is missing. • A staff member made sexual remarks to a resident, and touched her breasts.	Exploitation is never classified as severity Code 3.
Involuntary Discharge Discharging a resident from a facility without following State and federal regulatory guidelines.	Involuntary discharge is never classified as severity Code 1.	• The facility won't put the discharge notice in writing, and the family was given only 72 hours notice.	We found no examples of severity Code 3.
General Care Concerns Allegations that don't constitute abuse, neglect, or exploitation.	General-care concerns are always coded as severity Code 3.	General-care concerns are always coded as severity Code 3.	•Facility is dirty and baseboard smells like urine. • Staff are slow in responding to call lights.

Referrals: some complaints are referred to other agencies or entities for investigation, such as the Fire Marshal's Office (facility generator is out), or Department of Social and Rehabilitation Services (person with power of attorney is not acting in the resident's best interests), for example.
FYI: some complaints don't allege a threat to the health or safety of residents and don't provide enough detail to warrant an investigation. Some examples of complaints coded as FYI are that the facility is not serving food at the correct temperature, or that Saturday baths are often not done. This information should be considered during the next regular inspection.

Our review of the Department's written policies and procedures in these areas, as well as interviews with staff, showed the Department has developed a good system for receiving, documenting, and investigating complaints.

For example, the Department has established 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 the same inspectors who regularly inspect nursing homes, all of whom are registered nurses or social workers who receive formal training in complaint investigation. In addition, oversight of the complaint-handling system appeared to be built in at both the regional and central-office levels.

Based on our reviews of complaint files, our surveys of complainants, and our interviews with Department staff, nursing home staff, and advocate groups, we found the Department responds well to complaints in the majority of cases. In those parts of the system where we did find problems, the problems generally had to do with assigning priorities and the timing of investigations, and keeping complainants informed about the outcome of their complaints. Those problems are described in the sections that follow.

About 10% of the Complaints We Reviewed Seemed to be Assigned Too Low A Priority

When complaints about nursing homes are received, the person staffing the Department's complaint hotline (usually a nurse), makes an immediate assessment of the information, and classifies the complaint by type and severity. As noted earlier, the type of classification dictates how quickly each complaint will be investigated.

To determine whether complaints were being given a priority classification that was consistent with the severity of the allegation, we reviewed a sample of 213 of the 1,843 complaints received between July 1995 and April 1996.

About 1 in 10 of the complaints we reviewed seemed to be classified too low to reflect the potential seriousness of the complaint. We questioned the Department's severity coding and classification on 22 of the 213 complaints we reviewed, or about 10%.

For each complaint we questioned, the Department had classified the complaint either as "general care," which is always priority Code 3, or as "FYI"—information which should be considered during the next regular inspection, but which is not formally investigated. Code 3 complaints are supposed to be allegations that don't constitute abuse, neglect, or exploitation. When assigning a Code 3, the Department is saying the potential for substantial harm or loss of information doesn't exist.

Examples of the types of complaints we thought should have been classified as abuse, neglect, or exploitation (Code 2 priority), rather than as general care or informational, are as follows:

- a resident's family noticed the resident had skin tears, purple lesions, feces and food on the resident's clothing, broken glasses, and wasn't being fed regularly

- several residents were left in soiled clothing, one fell from a wheelchair while unattended, another had skin tears, and some weren't bathed for as long as two weeks

- several residents were reportedly abused by a particular nurse's aide (a pillow was placed over one resident's mouth), nursing home staff were verbally abusive to residents, and the staff didn't answer call lights

- scabies was present at the facility, and was spreading to staff and residents

- a resident's family members thought the resident had been hit, and the doctor at the hospital thought this may be true as well

Classifying a complaint as a Code 3, rather than as Code 2, extends the time the Department has to investigate the complaint. Under the policy in effect at the time most of these complaints were made, Department employees were assigned 21 days to complete the investigation. We looked at the general-care complaints we disagreed with. The 13 classified under the old policy were investigated within 10 days, on average.

The Department has since extended the policy up to six months. Of the five we reviewed under the new policy, one hadn't been investigated after three months, but four were investigated in an average of 11 days.

The potential time delay in investigating such complaints—if they are investigated at all—means residents remain at risk for further neglect or mistreatment for an extended time period. In addition, the delay significantly reduces the likelihood that the allegations ever can be substantiated, because the evidence and the people involved may no longer be available.

The Department's rationale for giving these types of complaints a low priority didn't appear to take the potential seriousness of those complaints into account. For 19 of the 22 complaints we thought the Department had assigned too low a priority to, we asked Department officials why each was coded as general care or FYI. These officials repeatedly identified these two factors:

- The complainant wasn't an eyewitness to the event or didn't provide specific details. If a caller can't give an eyewitness account or provide all the details, Department officials question the reliability of the information. Also, officials said investigators would just spin their wheels if they tried to investigate incidents based on sketchy details. The Department's complaint policy manual states that allegations should be treated as Code 3 if abuse, neglect, or exploitation is alleged but facts are vague, and specifics such as the name of the resident, name of the perpetrator, and date of event aren't provided. In addition, State law appears to require a specific resident to be named in order for a complaint to be classified as abuse, neglect, or exploitation.

- The complainant reported that the resident had been injured, but didn't specifically allege that the injuries resulted from abuse, neglect, or exploitation. For example, in cases where the complainant alleged such things as a resident falling to the floor during a transfer, a resident suffering a fractured foot when it was run over by a wheelchair, or a resident having broken glasses and purple

lesions, Department officials classified the complaints as general-care concerns because the caller didn't specifically state that he or she believed the incident was the result of abuse or neglect.

Any complaint intake system will have some method for screening complaints that seem frivolous or clearly unfounded, but the two criteria listed above may screen out real problems that need to be investigated quickly.

Within the Department, opinions were mixed about whether response times for general-care complaints were too long. As part of this audit, we surveyed the Department's inspectors and their supervisors on a number of issues. We received responses from 41 of the 83 staff members surveyed, for a response rate of 49%. (Complete survey results are listed in Appendix A.) About half the respondents said general-care complaints are investigated quickly enough to protect residents, but nearly one-third disagreed. Some of the concerns these respondents expressed are shown in the profile on the following page.

A nursing home advocacy group—Kansas Advocates for Better Care—also has expressed similar concerns that the Department is moving in the wrong direction on general-care complaints. Representatives of this group said that even before the policy change they had received complaints that the investigations were delayed too long.

Given the Priorities That Were Assigned, Most Complaint Investigations Were Conducted Within the Timeframes Required

We reviewed the 213 complaints in our sample to determine whether complaint investigations were initiated within the time established by the Department. In all, 93% of these complaints were investigated within the established timeframes. This is a high compliance rate, and shows that Department staff generally were able to investigate complaints as often as they were required.

A few investigations weren't conducted on a timely basis. Only 14 of the 213 complaints in our sample (about 7%) weren't completed on time. State law requires an investigation of allegations of abuse, neglect, or exploitation to be initiated within 24 hours. Four of these late complaints were allegations of abuse, neglect, or exploitation, so an investigation should have been initiated within 24 hours. Three of the four were investigated one work day late, and one was six days late.

Another complaint was to be completed within 21 days, but was misplaced for about 10 weeks before it was investigated by the Department. This complaint was reported by the facility administrator and the allegation was a possible rape of a resident. At the time the facility reported this to the Department, a police investigation had already begun and the resident had been examined at the hospital. (Neither the police nor the hospital found any evidence of rape.) The Department has a system to periodically check for overdue complaints, but this complaint was overlooked.

Nine general-care complaints in our sample weren't completed within the 21-day timeframe each was assigned. At that time, Department policy allowed a maximum of 90 days for this type of complaint. All nine were investigated within 90 days, but because they weren't completed in the time assigned, we counted them as untimely.

Department Staff Have Expressed Some Concerns About Complaint Investigations

We surveyed all 83 of the Department's field services staff, and received responses from 41 of them. About one-third of the respondents expressed concerns that general-care complaints weren't investigated quickly enough to protect residents. The following are staff members' comments:

- "Frequently Code 3's (general-care complaints) aren't investigated until two to three months after they're reported. It is difficult to go in two to three months later and substantiate a complaint. Staff and residents involved in the complaints are frequently gone."
- "On Code 3's, sometimes there is a significant time lapse between the time of the complaint and investigation. The case can deteriorate rapidly when systems fail and can result in harm to residents."
- "Some complaints cannot be checked six months later as too many persons involved may have died or employees moved on."
- "Code 1, 2, **and** 3 issues should be investigated timely and not six months from time of reported complaint."

Most complainants thought the Department's response to their complaint was timely. We surveyed individuals who filed 175 of the 213 complaints we reviewed during this audit to determine whether they were satisfied with the Department's handling of their complaints. (We weren't able to contact individuals who filed anonymous complaints or provided incomplete addresses.) We received responses from 83 complainants, for a response rate of 47%. Complete survey results are contained in Appendix A. Of the complainants who responded, 61% thought their complaint was investigated in a timely manner.

Most Complaint Investigations Performed By Department Staff Appeared To Be Thorough

We reviewed the Department's investigation reports for each of the 213 complaints in our sample, and made a judgment about whether the investigation appeared to be thorough. Federal and State guidelines direct inspectors to review records and observe those parts of the physical environment at the facility that may be relevant to the complaint, and to interview the complainant, the person the complaint was about, other witnesses and staff involved, and other residents with similar care needs.

For 98% of the complaints we reviewed, investigators followed the procedures required. In almost all cases, records indicated that inspectors had reviewed relevant records, and had interviewed appropriate witnesses. In two cases, we thought the inspectors should have interviewed additional witnesses, and in two other cases, we couldn't find sufficient documentation to tell what the inspectors did.

Most of the complainants we surveyed thought the Department's investigations were thorough. Of the complainants who responded to our survey, 53% felt their complaint was adequately investigated. About 15% thought they weren't adequately investigated, and nearly one-third said they didn't know.

However, only about 45% thought of the respondents thought their complaints were resolved appropriately; and 25% thought they weren't. Not surprisingly, respondents whose complaints weren't substantiated by the Department were less

satisfied with the resolution of their complaints than were those whose complaints were substantiated.

In all, a vast majority of the respondents thought hotline staff were courteous and felt their complaints were treated seriously.

The Department's Decision Not To Have Its Own Staff Conduct Independent Investigations of Certain Complaints May Not Comply With State Law

Sometimes, nursing homes officials observe instances of abuse, neglect, or exploitation in their facilities, or directly receive complaints about this type of behavior. When they become aware of such concerns, nursing home officials are required by federal law to report the incident immediately. They also are required to investigate these allegations, and report the results of their investigation to the Department within 5 working days of the incident.

In the past, when a nursing home representative reported a complaint to the Department's complaint hotline, the Department treated this information like any other complaint and performed its own independent investigation. However, as part of its effort to reduce the resources associated with handling complaints, Department officials now may rely on the results of the nursing home investigation, without conducting a separate independent investigation. This new policy applies only for complaints:

- that don't allege immediate jeopardy to the resident
- that were reported to the Department by the nursing home itself or by an anonymous source, or that were reported by both the nursing home and another complainant

If Department officials decide the nursing home's report isn't adequate or thorough, they still can direct staff to conduct a regular on-site investigation. Also, when a nursing home's documentation reflects violations of federal or State regulations, Department policies require Department staff to conduct their own inspection.

Department officials told us the rationale for this policy change was that the Department's inspectors were duplicating the efforts of nursing homes when they investigated complaints facilities already had investigated. They said Department inspectors rarely came up with different findings than the facility, and they could save the work associated with an estimated two full-time equivalent positions by making this change.

State law doesn't appear to allow the Department to "delegate" the responsibility for investigating complaints. State law requires the Department to initiate an investigation of any allegation of abuse, neglect, or exploitation within 24 hours, to conduct a personal visit with the resident involved, and to consult with other people having knowledge of the case.

The Director of the Bureau of Adult and Child Care told us that the new policy allows the Bureau to use its staff resources where they can be most productive, and that Department officials thought they had implied administrative authority to make

Comments About the Complaint Program

In the course of this audit, we sent a survey to nursing home administrators, Department field staff, and people who had complained about nursing homes. A number of the respondents wrote additional comments on their surveys, expressing their opinions about the complaint program.

Some comments were positive, such as:

- We feel the new investigation process which was started in January 1996 is very adequate and efficient.
- I feel for the most part, the inspectors are very open-minded and fair.
- KDHE staff were prompt, attentive, and professional.
- The lady handling my complaint did an excellent job.

However, we received far more negative comments, such as:

- Our allegations were quite serious. It was hard for us to believe that if they were really adequately investigated there would be no action taken against the nursing home.
- It should not take eight months to hear the result of the investigation.
- The investigators do a very poor investigation of nursing home facilities. They concentrate on paper work and charts and slide over the actual care of the resident.
- I feel the hotline is a complete joke. No matter what concern needs to be addressed, I felt like no one was listening.
- I feel sorry for nursing home patients; they have no one to help them, including KDHE.
- Facilities have not been properly trained for the internal investigations. Papers are usually not complete, causing an investigator to be assigned to make a visit and complete the investigation.

this change in response to a funding shortfall, even though there was no statutory language that clearly gave them that authority.

In addition, Department officials said that when a complaint comes in over the hotline, the questions that are asked by the Department's staff (such as, "is the resident in danger") constitute the beginning of an investigation by the Department.

Federal policies don't prevent the Department from taking this type of action. Federal regulations require the Department to investigate abuse, neglect, or exploitation complaints alleging immediate jeopardy to residents within two working days. (The Department's own policy on immediate jeopardy is more stringent, requiring such complaints to be investigated the same day they are received.)

If the complaint doesn't involve immediate jeopardy, federal policies simply direct the Department to use its professional judgment to determine the timing, scope, and duration of the investigation. Officials with the Health Care Financing Administration told us they didn't think the Department's policy violated any federal laws or regulations. Nonetheless, the Department still is required to comply with State law.

Nursing home administrators and many of the Department's inspectors support this change, but nursing home advocates and some inspectors don't. As part of this audit, we also surveyed a sample of nursing home administrators. We got responses back from 92 of 159 randomly selected administrators, for a response rate of 58%. (Complete survey results are contained in Appendix A.)

The administrators who responded overwhelmingly agreed that allowing the Department to rely on a facility's internal investigation of certain complaints was a better use of the Department's resources, and that this policy adequately protected residents from harm.

Department inspectors were less enthusiastic than nursing home administrators, but generally were supportive of the policy—about 60% of respondents said they thought it was a better use of resources, and about half agreed it adequately protected residents from harm. However, about one in five of the inspectors who responded disagreed with these statements.

In early 1996, Kansas Advocates for Better Care wrote to the Department asking it to rescind this policy. In his written response, the Secretary stated the change wouldn't compromise the safety of nursing home residents, and represented a responsive and appropriate way for the Department to fulfill its responsibilities.

Comparable information isn't available to tell whether nursing homes are less likely to substantiate complaints filed against them. Probably the biggest risk with relying on nursing homes' investigations, rather than conducting an independent investigation, is that nursing homes may not truthfully report their culpability in an incident.

As one indication of whether nursing homes would have a bias in substantiating complaints against themselves, we looked at all complaints of abuse, neglect, or exploitation that didn't involve immediate jeopardy to residents (Code 2 priority), that were filed from January through April 1996. We calculated the substantiation rate for complaints the Department investigated, and for those the nursing homes investigated.

Based on the information available, it appeared nursing homes were much more likely to substantiate the complaints they investigated (107 out of 175, or 61%), than were Department investigators (30 out of 86, or 35%). We discussed this outcome with Department officials, who offered the following explanations:

- nursing homes use a much less strict definition of substantiation than the Department uses. Nursing homes consider a complaint to be substantiated if they determine the event occurred; the Department, following federal guidelines, treats a complaint as substantiated <u>only</u> if investigators determine the event occurred as a result of abuse, neglect, or exploitation. For example, a nursing home would call a complaint substantiated if they observed a resident with unexplained bruises. The Department would not call the same complaint substantiated unless it found evidence that the bruises occurred as a result of abuse or neglect.

- most of the Code 2 complaints nursing homes report to the Department, and subsequently investigate, are based on events nursing home officials have observed in their facilities, so there is a high rate of substantiation.

Based on a brief review of several complaints investigated by nursing homes, we concurred that the facilities did indeed seem to be substantiating <u>events</u>, as the De-

partment suggested, rather than substantiating that abuse, neglect, or exploitation had in fact occurred.

Because the facilities and the Department use different definitions of the term "substantiated," there is no way to make a meaningful comparison between the outcomes of the two types of investigations. After receiving the facilities' reports, the Department's regional managers determine whether they need to take any further action based on their interpretation of the information in the report.

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

Federal regulations require the Department to provide a close-out notice to complainants informing them of the findings and disposition of complaints of abuse, neglect, and exploitation. (These would be all complaints categorized as Code 1 or 2.) Before January 1996, Department officials sent close-out notices to all complainants, including those whose complaints were classified as general care.

As part of its cost-cutting measures, the Department revised its policies effective January 1996 to send close-out notices for general-care complaints only if the complainant specifically asked to be notified. This action complies with federal requirements, and may be cost-effective. However, Department staff don't ask complainants if they want to be notified of the outcome. So unless a person whose complaint is categorized as general care (which the complainant doesn't know) specifically asks to be notified, they won't receive any information from the Department.

When we surveyed people who filed complaints, we asked them whether their complaints were acted on in a timely manner, adequately investigated, and appropriately resolved. In response, 20% to 30% of the respondents to each question indicated they didn't know. We also found that complainants who didn't receive a close-out notice from the Department were less satisfied with the Department's handling of their complaints than were those who received close-out notices.

Some complainants were dissatisfied with the information they received on close-out notices, but the Department may not be able to provide more. Some survey respondents, as well as other people who filed complaints with the Department, told us they were dissatisfied with the close-out notices they received because the notices gave them so little information.

The close-out notice is a checklist that simply indicates whether or not the complaint was substantiated, and whether deficiencies were written against the nursing home. It provides no information about what was done to investigate the complaint, and no details about what was found. However, the Department's ability to provide this information is limited because State law requires investigations to be confidential.

The box on the facing page describes one complainant's frustration in trying to obtain additional information about the complaint he filed, as well as the Department's responsibility to protect confidential 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. As of July 1995, the Department was entering every complaint it received into the system.

The complaint tracking system was purchased from the software company that developed the computer program the Department and many other states use for writing up regular inspection reports. The complaint system is designed to allow the following:

- initial information about the complaint can be entered by hotline staff, including the description and classification of the complaint, who it was reported by, which region the complaint was assigned to, when the investigation was to begin, and when the report was due back to Topeka

- investigative information can be entered by the investigator, including the date the investigation actually was begun, the outcome of the allegations, and any deficiencies cited

Such a database should provide the Department with useful management information, such as whether its investigations are timely, the percent of complaints substantiated, the types of deficiencies being cited, and the like. However, at this

Some Complainants Are Frustrated With the Follow-Up Notice of Investigation Results

As part of this audit, we surveyed a sample of individuals who had recently called in nursing home complaints to the hot line. A number of people who responded to our survey wrote negative comments about the form letter they received from the Department describing the disposition of their complaints. For example, one person was dissatisfied because he or she finally received the form letter months after calling in the complaint. Another survey respondent complained that the form letter didn't contain enough essential information, such as when the investigation was conducted, and what corrective actions (if any) were taken.

During this audit, we also came across documentation relating to a complainant's attempts to get additional information from the Department about a complaint he had reported in June 1995. This complainant wasn't satisfied with the form letter he received 10 weeks later, so he requested a copy of the investigation report. However, the Department is bound by confidentiality laws and wouldn't release the investigation report. According to State law, all information received by the Department and the written findings and actions recommended are confidential.

This complainant wrote that he was very frustrated with the complaint process and the associated confidentiality requirements. He has no record of whether his allegations were investigated, and has no specific information regarding the complaint issues. The Department has given him all the information it can about the complaint - a form letter stating whether the issues were substantiated or not.

The confidentiality requirements are designed to prevent the identification of the complainant and any person mentioned in the investigation report. But some complainants want to know more, and the law doesn't allow this.

time, the modems and other connective equipment required to link regional investigators with Topeka are available in only two of the Department's six regions. No investigative information from the other four regions is entered in the database.

Staff are unable to get much useful information out of the complaint database. The computer system produces several standardized reports that the Department uses, such as the complaint description that is sent to the regional office for investigation, and a monthly statistical summary that shows who the complaints were filed by, priority codes, which regional offices they were sent to, whether the Department or the facility was to investigate, and so on.

However, staff have not been able to get reports with other types of information that should be readily available from such a system. For example, we asked for a listing of Code 2 complaints reported from January to April 1996, sorted by who was to conduct the investigation (the Department or the nursing home), and alphabetized by facility location.

Department employees were unable to generate even a list of Code 2 complaints. Instead, they had to print a list of all complaints received, manually highlight the Code 2 complaints, and handwrite in who was supposed to investigate the complaint.

We don't know whether the customized database software was unable to generate the type of information we asked for, or whether staff were unfamiliar with the system's capabilities. Either way, a system full of complaint information that can't be used to produce different analyses of that information is not very functional.

Conclusion

The Department's complaint program functions well in many respects, but areas where we identified concerns 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 decisions 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 these decisions, 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.

Recommendations

1. To ensure it is complying with State law, and adequately protecting the health and safety of nursing home residents, the Department of Health and Environment should do the following:

   a. request an Attorney General's opinion on whether the Department can legally delegate its statutory investigation responsibilities to the nursing homes it regulates

   b. initiate an investigation of every complaint of abuse, neglect, or exploitation within 24 hours.

2. To more fully ensure that nursing home residents are protected from abuse, neglect, and exploitation, the Department should do one of the following:

   a. assign a Code 2 classification to vague allegations of abuse, neglect, and exploitation which would address the current problem of treating complaints that don't name a specific resident as Code 3, or

   b. create a new classification for vague allegations of abuse, neglect, or exploitation, with an appropriate timeframe for investigation

3. To increase the satisfaction of individuals who perform a public service by reporting incidents of potential abuse, neglect, exploitation, or inadequate care at nursing homes, the Department should do the following:

   a. ask all complainants if they would like to be notified of the outcome of the investigation, and send such notices if requested

   b. review the current close-out notice and work with legal staff to determine whether any additional information legally can be provided beyond what is on the current form

4. To improve its management of the complaint program, the Department should devote sufficient resources to resolve the problems that prevent it from fully using its automated complaint tracking system.

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

The Department's inspection program is designed to uncover significant violations of State and federal laws and regulations. A sample of recent nursing home inspections we examined indicated inspectors were doing the type of work they are supposed to in a facility, although we couldn't evaluate the quality of their work. With a few exceptions, the Department appeared to be meeting mandates to inspect every nursing home at least once every 15 months, although two of 30 inspections we reviewed weren't unannounced. Both nursing home administrators and Department inspectors said they thought the inspections were thorough, although a significant number of inspectors said they didn't think enough time was allowed to complete an inspection. A 1995 review of the Department's inspection process by the Health Care Financing Administration commended the Department in most areas, but cited some problems in identifying deficiencies. These and related findings are discussed in more detail in the sections that follow.

The Department's Inspection Program Is Designed So That It Should Uncover Significant Violations Of State and Federal Laws and Regulations

Although no inspection program is foolproof, a good inspection program should have a number of procedures and practices to help ensure that any existing violations of laws and regulations will be found and dealt with appropriately. Some of those major procedures and practices are as follows:

- hiring a sufficient number of qualified staff to carry out the inspection function
- adopting procedures and guidelines for conducting inspections to help ensure they are uniform and thorough
- training staff in how inspections should be conducted, and how regulations and guidelines should be interpreted
- inspecting all nursing homes on a regular basis, and at least as often as required by law
- documenting problems found in nursing home inspections, and following up on those problems to make sure they are corrected (followup is discussed in Question 3 of the audit)
- overseeing the inspection program to help ensure that inspections are being carried out as they should be

Our review of the Department's policies and procedures showed the Department generally has developed a good system for conducting inspections. For example, the Department follows guidelines published by the Health Care Financing Administration when it inspects nursing homes. These guidelines cover hundreds of regulatory areas related to the health, safety, and wellbeing of nursing home residents. We reviewed several major areas of State regulations, and didn't find any that weren't addressed in the Department's inspection program.

We also found the Department has a well-thought-out set of procedures for nursing home inspectors to follow when conducting nursing home inspections. Those procedures are summarized in the box on the next page. In addition, the Department makes sure its inspection staff are qualified to conduct inspections. It currently hires only nurses, and provides them with extensive training. When we surveyed nursing home administrators, the majority of those responding said that they thought the Department's staff were knowledgeable and well-trained.

Finally, we found that the Department had a formal system for documenting violations found during nursing home visits, and for scheduling revisits to those homes to check to see if the violations were corrected.

Because having a well-designed system isn't enough, we also conducted testwork to assess whether the Department's inspection process was, in fact, being carried out as intended. Our ability to independently assess the "quality" of inspections was limited, because much of the work done during an inspection requires medical evaluations of conditions and circumstances, and we don't have that expertise. As a result, our testwork for a sample of nursing homes focused on whether inspectors completed and documented all required tasks during inspections. To address the quality-of-inspections issue, we relied on the findings of quality assurance checks done by the Health Care Financing Administration.

To determine whether each home had been inspected at least once in the last 15 months, as required by State law and federal regulations, we reviewed records of nursing home inspections. We also tried to analyze the number and type of deficiencies recorded for nursing homes in each of six regions within the State to see if there appeared to be any regional differences, as some have alleged. Finally, we surveyed Department inspectors and a sample of nursing home administrators to get their opinions of the process. The findings from this testwork are discussed in the sections that follow.

Our Review of 30 Recent Inspections Showed That Records Were Complete, and that the Department's Inspectors Appeared to Be Covering All Required Areas

We reviewed the most recent inspection file for a random sample of 30 nursing homes. We checked each to see whether 17 major forms that are supposed to be completed as part of the inspection were in the file and had been filled out. These included such things as resident and family interviews, resident assessments, dietary worksheets, environmental quality worksheets, staff census, and inspector notes. The documentation for a single inspection is voluminous, and, as noted above, we didn't attempt to determine the quality of the inspectors' work. Rather, we looked to see if they appeared to be doing the types of work they are supposed to do in each facility, and concluded that they were.

In two of the 30 cases we reviewed, the inspections weren't "unannounced," as required by State law and federal regulation. In both cases, the Fire Marshal's inspection took place before the Department's inspection. In one case, the fire inspection occurred two weeks before the inspection; in the other, it was one month before. State law and federal regulations require inspections to be

The Department Is Required to Assess Nursing Homes' Performance Through an Inspection Process

The Department must ensure that long-term-care facilities comply with federal and State regulations to provide quality care for residents in an environment that provides the highest quality of life possible. To determine if facilities are in compliance, the Department regularly inspects facilities through an inspection using federal and State guidelines.

Before an inspection begins, the team, typically made up of two-to-four inspectors:

- reviews the last inspection report on the nursing home
- reviews complaints logged against the nursing home since the last inspection to identify potential problem areas
- contacts the State's Long Term Care Ombudsman to identify concerns that office may have about the home
- reviews the home's history to help determine what areas need the most attention

During an inspection, which usually takes one week to complete, the team must assess the following areas:

- the home's compliance with residents' rights and quality-of-life requirements
- the accuracy of residents' comprehensive assessments, and the adequacy of the resulting individual care plan
- the quality of the services provided, which addresses such areas as medical and nursing care, rehabilitative care, drug therapy, dietary and nutrition services, activities and social participation, and sanitation and infection control
- the effectiveness of the physical enforcement to empower residents, accommodate their needs, and maintain their safety

To make these types of assessments, the inspectors tour the facility and select a sample of residents for detailed review. They then do such things as review residents' medical records to ensure they are receiving appropriate care, and interview those residents and some of their family members to learn what they think about the facility's staff, environment, care, and other operations.

They also inspect the kitchen facilities and watch staff serve at least one meal. Sometime during the survey, inspectors interview various personnel to gather information about specific residents, and to learn more about the facility's operations. They also interview maintenance staff and inspect areas such as linen closets, storage areas, and heating and cooling plants to ensure these areas are clean and free of hazards.

If a complaint has been filed against the facility but hasn't been investigated, the team is required to incorporate an investigation into their activities. At the completion of the survey, the team members:

- analyze their findings
- decide whether to cite the nursing home for any deficiencies in meeting federal or State regulatory standards
- if the analysis indicates the home is providing substandard quality of care, inspectors begin an extended survey, which gives a more in-depth look at the care provided by the facility
- conduct an exit conference with the administrator to discuss team observations and preliminary findings.

After the survey, the team compiles a formal report which is reviewed by the regional manager before it is sent to the Department's central office in Topeka. The inspection process and the team's report help Department officials decide which facilities are providing good quality care, and which ones need more attention. The Department uses this information to decide how often a facility needs to be inspected.

unannounced, which they aren't if the Fire Marshal shows up in advance. In 1993, the Financing Administration cited the Department for this same problem.

When we discussed this issue with a Department official, he indicated that the Department doesn't care if the Fire Marshal arrives first, that it isn't always possible to keep the two agencies schedules in sync, and that if the problems in a facility are serious, the Fire Marshal's advance arrival doesn't give the homes enough time to fix those problems. In addition, federal policy changed in June 1996 and no longer requires fire inspections to be done at the same time as health inspections.

Nursing home administrators think Department inspectors are enforcing laws and regulations inconsistently; we generally weren't able to assess whether that was true. About 74% of the nursing home administrators who responded to our survey thought the Department's inspectors conducted thorough inspections, but representatives of the nursing home associations told us their members thought consistency was a problem. They said inspectors in different regions tended to emphasize different problems, and certain types of deficiencies were cited more in some regions than in others. Nearly 70% of the people responding to our survey of nursing home administrators said the Department didn't enforce laws and regulations consistently from region to region.

The Department has 65 inspectors assigned to its six regional offices. These people live all over the State and go from one inspection to the next. Such independence in working conditions does have the potential to lead to unidentified differences in inspection practices, which could result in facilities not all being treated the same. However, the Department has a quality improvement program designed to address this issue. Teams of quality improvement coordinators typically complete two inspections per month, checking to see if inspectors are following the same procedures. When differences are found, the Department's Quality Improvement Committee determines the way the tasks should be done. If necessary, additional training is provided to increase consistency.

During this audit, we'd hoped to be able to identify and compare the types of deficiencies being recorded for nursing homes in each region. Given the way the Department's records are kept and the volume of those records, however, it wasn't possible to perform that review and analysis within the timeframe for this audit. We were able to determine that the total number of deficiencies cited per inspection was fairly consistent. The average Statewide was 8.6 deficiencies per inspection. By region, average reported deficiencies per inspection ranged from a low of 7.1 in the southwest region to 9.5 in the northeast region.

The Department generally has made sure that nursing homes have been inspected at least as often as required by State and federal mandates. Under both federal and State requirements, all nursing homes must be inspected at least once every 15 months, with a Statewide average interval of 12 months. Although the average is one inspection a year, the Department officials told us they use different intervals between inspections to help maintain the element of surprise, and because problem homes may need to be inspected more frequently than other facilities.

Our analysis of the most recent round of inspections for each home showed that the average interval Statewide between inspections was 11.3 months. For five

Department Staff and Nursing Home Administrators Comments About the Inspection Process

During this audit, we surveyed all the Department's field services staff and a random sample of nursing home administrators. Overall, those who responded spoke favorably of the Department. However, respondents to both surveys expressed concerns about inconsistencies in the inspection or "survey" process, and some Department staff expressed concerns about the time they have to do inspections.

The following concerns were expressed by individuals who work for the Department:

- "There is a push by the Bureau to cut survey time by 25% in order to meet budget restrictions...In addition, fewer surveyors can be sent to facilities. Sometimes that... makes it difficult to do a thorough job."
- "...the time frame allowed for surveys with problem facilities is too short...There are times when I walk out of the facility feeling all bases haven't been covered."
- "We are expected to survey consistently throughout the State with a jumble of instructions."

Other Department staff said things were working well. For example, one individual said:

- "I like the new process and think focusing on specific areas of concern identified from past surveys, OSCAR reports, and complaints gives a good, thorough survey."

Some nursing home administrators expressed some concerns. For example:

- "We...attend meetings and hear opinions from the staff in H&E...Later, when surveyors are in our facility, we understand that they have been told something entirely different. We are getting too many mixed messages."
- "Many surveyors are not consistent. On one survey one surveyor thinks an issue is of great importance. A few months later, a different surveyor may think we're doing the same thing just fine."
- "Surveyors put their own interpretation in the regulations. For instance I have gotten a deficiency and the next surveyor comes in and corrects it and there were no real changes. The regulations are good. Surveyors and regional managers need to stop putting their own interpretation of what the regulation means into the process."

But other nursing home administrators expressed favorable opinions. For example:

- "Having been in the industry many years, I have seen tremendous growth and maturity both from the surveyors and consumers. I view it as a very positive force in helping provide top quality care for an aging population."
- "In general, our surveyors have been helpful and professional."

of 357 homes, the inspection wasn't completed in 15 months, but all five were completed in less than 16 months.

Under federal standards, an interval up to 15.99 months is considered timely. However, there is nothing in State law that would allow the Department to interpret 15 months as "anything less than 16 months." It appears that the Department hasn't complied with State law in these five cases, even though Department officials contend they have.

Because of Federal Funding Uncertainties, The Department Recently Cut Some Activities From Its Inspections

Most of the money for the nursing home inspection program comes from the federal government, through Medicare or Medicaid. Although the State must pay 20% of the total direct costs of the inspection program, the money it uses to make that contribution actually comes from additional federal funds the State receives for "indirect overhead" associated with the program. This means the inspection program is affected significantly by changes in the federal budget.

In fiscal year 1996, the Department experienced tremendous financial uncertainties with the program, as the federal budget suffered through repeated temporary extensions before final approval. Department officials were notified early in the process that they likely would receive about the same amount of federal funds this year as in 1995. However, this amount was insufficient to meet the Department's needs, so, in response, they requested and received federal approval to reduce the inspection effort in the following manner:

- The group interview was eliminated. Additional questions were added to the individual interviews to capture the information previously gathered at the group interview.
- Closed record reviews (this refers to resident who have died or moved to another facility) were eliminated.
- The surveyors were no longer required to observe medication passes unless a resident specifically expressed a concern in this area.

In addition, the routine investigation of general care complaints was delayed until the next survey or for six months, unless assigned by the regional manager for an earlier investigation. Federal law doesn't address investigation of these types of complaints, so this change was approved by the Department's Secretary.

We found that, on average, Department inspectors were in a facility five or six times each year, between 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

Each year, the Financing Administration independently evaluates the Department's adult care inspection process to determine if there are any problems. As part of this review, federal officials send out a team of inspection specialists, typically nurses, to conduct inspections and compare their results with results of the Department's inspections. In past years, federal staff conducted their reviews within 60 days after the Department had been at a nursing home. Recently, federal staff have begun accompanying the Department's inspectors when they inspect a nursing home. The reviews cover all types of adult care facilities that receive Medicare or Medicaid funding, not just nursing homes.

The most recent report available, for federal fiscal year 1995, found that the Department:

- used qualified staff for inspections
- investigated complaints in a timely manner
- investigated "dumping" complaints against hospitals

- conducted inspections of home health agencies, nursing homes, and nursing homes for the mentally retarded in a timely manner
- fully explained and properly documented deficiencies identified during surveys
- agreed with federal findings for the most serious deficiencies in long-term-care facilities when federal inspections were done within 60 days after State inspections

However, the report also noted that the Department's findings didn't agree with the findings of federal inspectors on 9 of 52 violations when federal inspectors accompanied the Department's inspectors to the facilities.

Overall, it appears that the Department is performing well in the areas reviewed by the Health Care Financing Administration, although they didn't concur with federal official on 17% of deficiencies identified. In 1994, federal inspectors also cited this as an area where the Department needed improvement. That year the nonconcurrence rate was 8%.

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 assessment 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 program, but said it needed to improve its ability to identify deficiencies.

Recommendations

1. To comply with State law, and adequately protect the health and safety of residents, the Department should inspect every nursing home within 15 months, as required.

2. To address a problem identified in the 1994 and 1995 Health Care Financing Reports, the Department should conduct additional training for its inspectors on how to recognize and when to cite deficiencies.

3. To address concerns about consistency of inspection Statewide, the Department should review appropriate information about the consistency of nursing home inspections.

   If it finds they aren't consistent, it should provide training for its staff to ensure that all inspections are conducted as consistently and thoroughly as possible.

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

The Department's efforts weren't always effective at getting the 20 problem homes we reviewed to correct deficiencies. For these homes, the Department didn't always issue correction orders when it should have, nor did it always include serious problems identified by its inspectors when it did issue such orders. Fines appeared to be too low to serve as an effective penalty or deterrent. Finally, although State law provides a range of penalties for violations that significantly and adversely affect nursing home residents, there is little the Department can do about nursing homes that violate less-serious regulations, even on a repeated basis. These and other findings will be discussed in the sections that follow.

The Department Can Use a Number of Enforcement Options In Responding to Nursing Homes That Don't Comply With State Laws and Regulations

The State has a graduated series of penalties it can impose on nursing homes that aren't in compliance with State regulations. Some penalties come into play when nursing homes have serious deficiencies or fail to correct these deficiencies, while others may be assessed only when residents are in immediate jeopardy of serious harm, or when the home has a history of serious problems.

Certain penalties typically are invoked when inspectors find serious deficiencies or nursing homes fail to correct those deficiencies. If the Department's inspectors find deficiencies during an inspection, nursing homes are given a copy of the deficiency report and required to submit a plan of correction within 10 days. The plan has to specify how and when the facility will correct the violations, and it must be approved by the Department. If the deficiencies are serious, the Department can do one or more of the following:

- Issue a correction order. This action is taken when deficiencies exist that significantly and adversely affect the health, safety, nutrition, or cleanliness of one or more residents. The Department must revisit the facility within 14 days from the date the correction order is served to determine whether corrections have been made.

- Assess a fine. If deficiencies cited in the correction order haven't been corrected, the Department can assess a civil penalty of up to $500 per day per deficiency for each day after the date specified in the correction order for fixing the deficiency. The maximum fine allowed is $2,500.

  If any of the deficiencies cited in the correction order also were cited against the facility during an inspection or investigation in the past 18 months, the civil penalty can be doubled, not to exceed $5,000.

- Institute a ban on admissions. Following emergency proceedings under the Kansas Administrative Procedures Act, the Department can prohibit new admissions to a nursing home until

the Secretary agrees to remove the ban. This action, which can have a significant effect on the finances of the facility, can be taken when:

—the facility has deficiencies that significantly and adversely affect the health, safety, nutrition, or cleanliness of one or more residents
—conditions in a facility are life-threatening
—the facility doesn't substantially comply with regulations
—the facility is insolvent

A ban on admissions can be invoked at the same time as a correction order is issued.

Other penalties address the most severe problems in facilities. These penalties are used more sparingly. However, when conditions in a facility are unacceptable, the Department can do the following:

- Assess an immediate fine. If conditions in a nursing home have caused, or are likely to cause, serious injury, harm, impairment, or death to one or more residents, the Department can assess an immediate fine of $1,000 per day per deficiency. The maximum fine allowed is $10,000.

- Revoke the facility's license to operate. The Department can suspend or revoke a facility's license for several reasons, including willful or repeated violation of nursing home laws and regulations, and failure to assure that treatment of residents is in accordance with acceptable medical practices.

- Take over operation of the facility. The Department can operate the home in receivership when life-threatening conditions exist in the facility, the facility is insolvent, or the Department has revoked the facility's license.

The accompanying table shows the number of actions the Department has taken from 1990 through 1995 against nursing homes in Kansas. As the table shows, the most common enforcement actions are issuing correction orders and levying fines. Bans on new admissions of patients and license revocations are fairly infrequent.

Number and Type of Enforcement Actions
1990 - 1995

	Correction Orders Issued	Fines Assessed	Bans on Admissions	Revocations of Licenses
1990	206	35	20	23
1991	246	52	18	24
1992	183	36	10	10
1993	140	46	14	3
1994	128	34	20	12
1995	166	43	14	3

The focus of this question was on nursing homes that repeatedly violate State and federal laws and regulations. To assess whether the Department was taking sufficient actions against these nursing homes, we reviewed recent histories for a sample of 20 "problem" homes. We selected some homes based on discussions with the Department's regional managers about which homes in their areas were "problem" homes. We selected other homes based on the number of violations reported for them during recent inspections and the number of complaints filed.

During our reviews, observations, and testwork, we determined whether the Department or its inspectors had done the following:

- issued correction orders when nursing homes had serious deficiencies
- assessed penalties if deficiencies identified in correction orders still weren't corrected
- conducted revisits and reinspections as needed to determine whether deficiencies had been corrected
- took other enforcement actions, as seemed appropriate, if deficiencies persisted despite repeated correction orders and fines

The Department's Enforcement Efforts Aren't Always Effective At Getting Problem Homes To Correct Deficiencies

To determine whether the Department took sufficient action against the 20 "problem" homes in our sample, we reviewed the last four regular inspections and subsequent revisits on these facilities, as well as all enforcement actions taken during this time. For two of the facilities we reviewed only the last three inspections. Although the time period covered by the inspections varied from facility to facility, we reviewed the Department's involvement with these nursing homes for at least 1.5 years, and for slightly more than three years in some cases.

We found that the Department appeared to be reviewing correction plans submitted by nursing homes to ensure they addressed the deficiencies noted, and that Department inspectors generally were reinspecting homes with deficiencies within a reasonable time. The time between return visits ranged from 2.6 months to 6 months, and in all but five cases, those return visits were conducted within the time period set.

As we reviewed the Department's files for each home, we noted that a number of deficiencies were cited over and over again on the inspection reports. For example, one home was cited in three consecutive inspections for inappropriate treatment of incontinent residents, another home was cited in three consecutive inspections for placing residents in physical restraints strictly for staff convenience, and another was cited in four consecutive inspections for failing to provide proper treatment for pressure sores, including two times when feces contaminated the sores. We also noted that violations would appear to be temporarily corrected, and then show up again during a later inspection.

The accompanying table summarizes information about total and repeat violations for the 20 problem nursing homes we reviewed.

Summary of Violations
For 20 Problem Nursing Homes

Inspections reviewed	1st	2nd	3rd	4th
Avg. time between inspections (in mos.)		8.9	10.7	9.7
General information about violations				
Total violations reported	278	281	326	369
Violations repeated from at least one previous inspection (fine may be imposed)		77	83	93
Specific information about repeated violations				
# of deficiencies repeated....		once	twice	three times
		77	34	15
# of homes with repeat violations		18	11	7
Avg. # of violations per home		4.3	3.1	2.1

As the table shows, the total number of violations cited at these problem homes increased by about one-third during the period we looked at, from 278 to 369. The table also shows that violations repeated from at least one previous inspection increased as well, from 77 to 93. On the third inspection, we found that 34 deficiencies had been cited in at least two previous inspections. And on the fourth inspection, 15 of the same deficiencies had been cited in at least three previous inspections. The profile on the next two pages shows the Department's actions with one of these problem facilities.

We examined the enforcement actions the Department took with regard to these homes in such areas as issuing correction orders, assessing fines when appropriate, fining homes enough to provide an incentive to improve, and taking other actions when fines alone weren't effective at getting homes to fix persistent violations. Our findings are discussed in the sections that follow.

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

Correction orders should be issued when inspectors find deficiencies that significantly and adversely affect the health, safety, nutrition, or cleanliness of one or more residents. After an inspection is finished and a deficiency report prepared, the regional manager, the region's quality assurance coordinator, and Bureau officials in Topeka all review the report. A recommendation for a correction order can be initiated at any level, from the inspectors who conducted the survey to the Program Di-

rector of Field Services. Correction orders are typically signed by the Department of the Bureau of Adult and Child Care, on behalf of the Department Secretary. The Department issued a total of 67 correction orders to the 20 facilities in our sample during the timeframe we reviewed.

Based on our review of deficiencies cited in inspections, we thought the Department should have issued additional correction orders, or included additional deficiencies in the correction order, for 8 of the 20 facilities in our sample. It appeared to us the Department should have issued additional correction orders for four facilities, and should have included additional deficiencies in orders it did issue for five facilities.

Examples of deficiencies that weren't part of a correction order, but that we thought should have been, and the regulations they violated, are shown below:

Deficiencies Observed	Regulatory Requirement
Hot water temperatures in resident bathrooms, in the whirlroom room, and in a shower room were 122 to 130 degrees, creating the risk of accidental scalding.	The facility must ensure that the resident's environment remains as free of accident hazards as is possible
Two residents were not being bathed when needed, a resident who asked for toileting assistance was told to use the diaper he/she was wearing, staff failed to knock before entering residents' rooms, and a resident receiving catheter care was left exposed from the waist down beside a window that people were observed walking by.	The facility must promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
11 of 18 residents reviewed were incontinent but were not on appropriate treatment programs. Related urinary tract infections were noted, and the inspector observed improper techniques with a catheter.	A resident who is unable to control his or her bladder must receive appropriate treatment and services to prevent urinary tract infections, and to restore as much normal bladder function as possible
2 of 13 dependent residents reviewed weren't assessed for bowel and bladder training program. One resident had greenish-brown crust on lips and tongue. Both eyes were crusted shut with dried yellow matter, and lips were cracked at the corner of the mouth.	A resident who is unable to carry out activities of daily living must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
Facility doesn't always have a licensed nurse on duty. During a two-week time period, 18 of 42 shifts lacked licensed coverage.	The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

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

The primary goal of enforcement action is to bring nursing homes back into compliance with laws and regulations, thereby ensuring that residents' health and welfare is adequately protected. A secondary goal is to penalize them for noncompliance. Fines must be set high enough that it's more cost-effective for a home to fix the problem than to let it go and continue to pay "nuisance fines." For example, it could be more cost-effective for nursing home owners to repeatedly pay small fines

for uncorrected deficiencies in patient care, than for them to hire the necessary staff to prevent the problems.

During the time period we reviewed, the Department assessed 32 fines against 14 of the 20 problem homes in our sample. Most of these fines (24 of 32) were assessed because nursing homes failed to correct problems identified in correction orders. However, eight fines were assessed immediately after the inspection because of the severity of the problem. For fines issued after a correction order, the daily amount ranged from $200 to $500, while the total amount fined ranged from $200 to $2,500. For the eight immediate fines, amounts ranged from $300 to $5,000.

The following table summarizes the number and type of violations for which nursing homes were fined:

Violation	Number of Correction Order Fines	Average Fine Amount	Number of Immediate Fines	Average Fine Amount
Inadequate prevention or treatment of pressure sores	9	$544	3	$3,033
Improper or inadequate care of residents	9	$444	0	n/a
Inadequate supervision, protection from hazards, and protection from abuse	3	$333	3	$1,367
Other	3	$1,033	2	$1,100
Total	**24**	**$542**	**8**	**$1,925**

As the table shows, the average fine imposed for failure to correct deficiencies identified in a correction order was $542, and the average immediate fine was $1,925 (the average for all fines was $888 per fine). In total, the Department fined these 14 homes $28,400, or about $2,000 per home, during the timeframe we reviewed. Of course, homes don't always pay the full amount assessed. If they appeal the fine, a hearing office may reduce the amount.

In contrast, federal fines for facilities in our sample were much higher than State fines. Only six facilities in our sample had paid federal fines during the period we reviewed, because the Health Care Financing Administration wasn't authorized to impose fines on homes under its jurisdiction until July 1, 1995. The fines paid ranged from a high of nearly $21,000 to a low of about $2,000. The average fine, and the average each facility paid in federally imposed fines, was $7,700. Federal law allows fines to be reduced by 35% if a facility waives its right to a hearing. The federal fines listed above are the amounts actually paid by the facilities.

CHRONOLOGY OF REGULATORY ACTIVITIES FOR ONE PROBLEM HOME

This profile shows the extent of the Department's involvement with one of the problem homes in our sample. As the information on these pages shows, problem facilities have many deficiencies, are frequently complained about, and are visited regularly by the Department.

Date	Activity	Outcome
2/93 to 7/93	10 Complaints	All were general-care concerns classified as C3.
12/93	Department Survey	The Department found 13 deficiencies in the following categories: • Resident behavior & facility's response - 2 • Resident assessments - 4 • Quality of care - 3 • Staff sufficiency - 1 • Infection control - 2 • Facility administration - 1
1/6/94	Correction Order	No fine. Deficiencies in the following categories led to the correction order: • Freedom from abuse and neglect • Treatment of pressure sores • Proper nutrition
1/10/94	Revisit	The deficiencies were corrected.
4/19/94	Revisit	One deficiency was cited for the following: • Facility must have a registered nurse
5/94 to 8/94	Five Complaints	All were general-care concerns classified as C3.
9/15/94	Correction Order	Deficiencies in the treatment of pressure sores led to the correction order.
9/19/94	Revisit	The deficiencies were corrected.
1/95	Department Survey	The Department found eight deficiencies in the following categories: • Resident rights - 1 • Quality of life - 1 • Resident assessments - 1 • Quality of care - 2 • Staff sufficiency - 1 • Facility administration - 1 • Fire hazards - 1
2/95	Two complaints	Both were general-care concerns classified as C3.
3/3/95	HCFA Survey	HCFA threatened to terminate its Medicare agreement with the facility. The following seven Level A deficiencies were identified: • Quality of life • Resident assessments • Quality of care • Nursing services • Dietary services • Infection control • Facility administration
3/95	Four complaints	All were general-care concerns classified as C3.
3/23/95	Correction Order	The facility was fined $500 fine for deficiencies in treating pressure sores.
3/28/95	Revisit	The deficienty concerning pressure sores was corrected.
4/95	Four complaints	Three were general-care concerns classified as C3. One was an abuse allegation classified as A2.

Date	Activity	Outcome
5/5/95	Revisit	Level A deficiencies found during 1/95 survey were corrected. HCFA rescinded action to terminate facility from the Medicare program.
5/22/95	Correction Order	The facility was fined $150 for the following deficiencies: • Treatment/prevention of stasis ulcers • Services to residents with feeding tubes • Infection control
5/31/95	Revisit	All deficiencies cited in the correction order, except one related to feeding tubes, were corrected
6/95 to 7/95	Five complaints	All were general-care concerns classified as C3.
8/2/95	Revisit	Deficiency regarding feeding tubes was still uncorrected.
8/15/95	Correction Order	Deficiency in services to residents with feeding tubes led to this order.
8/21/95	Revisit	Deficiency regarding feeding tubes was corrected.
9/95 to 10/95	Three complaints	Two were abuse allegations classified as A2. One was a general-care concern classified as C3.
11/95	Department Survey	The Department found 14 deficiencies in the following categories: • Quality of life - 2 • Resident assessments - 4 • Quality of care - 2 • Food - 1 • Infection control - 1 • Physical environment - 1 • Fire hazards - 3 This survey led to the facility's designation as a poor performing facility. The Department recommended $50/day civil money penalty, denial of payments for new admissions, and provider agreement termination if deficiencies weren't corrected by specified dates.
11/95	Two complaints	One was classified FYI; one was a general-care concern classified as C3.
12/4/95	Correction order	One deficiency related to increasing residents' range of motion.
12/8/95	Revisit	No fine levied on the correction order because deficiency was corrected.
1/96 to 5/96	Seven complaints	One was classified as FYI. Three were general-care concerns classified as C3. Three were abuse allegations classified as A2.
5/8/96	Correction Order	The facility was fined $300 for five deficiencies in the following areas: • Resident rights when treatment needs changing • Right to be seen by a doctor when needs change • Quality of care • Accident hazard free environment • Sufficient nursing staff
5/24/96	Revisit	Two deficiencies cited in correction order remained: • Resident rights when treatment needs changing • Right to be seen by a doctor when needs change
5/96 to 6/96	Five complaints	Three were general-care concerns classified as C3. Two were abuse allegations classified as A2.

We reviewed enforcement records and inspection results to determine whether the Department had imposed fines when it was allowed to; that is, when deficiencies cited in a correction order were not corrected by the time of the inspectors' revisit. We found that Department assessed a fine each time it could have. However, we found a number of reasons why fines being assessed against problem homes with repeat violations were too low, as described in the sections that follow.

The Department doesn't fine nursing homes for every day a deficiency exists. A nursing home can be fined up to $500 a day for each violation of a State regulation, up to a maximum per facility of $2,500 (or $5,000 in cases where violations are repeated over an 18-month period). For deficiencies posing serious harm to residents, a fine of $1,000 per day, or no more than $10,000, may be imposed.

We found that daily fines were being assessed for a very small number of days—usually only one or two—even though violations appeared to exist over a several-week period. Department officials told us their practice has been to assess a fine only for the number of days a Department inspector actually observes the uncorrected deficiency. (In a few cases, such as when a resident walks away from a facility but returns before the inspector arrives, direct observation is not required). According to Department staff, actual observation is required as evidence in cases when the facility appeals the fine to a hearing officer. Being fined only for the days an inspector observes a violation results in relatively small fines, and gives a facility little incentive to correct deficiencies quickly.

In one case we reviewed, residents had been kept in physical restraints without a doctor's order for at least 37 days. However, the nursing home was fined for only two days—for a total of $1,000--because the inspector actually observed the restrained residents only on the two days she was in the facility. In another case, a home was cited for deficiencies because one bathroom shower stall was water-damaged and moldy, and contained cracked tile. This deficiency existed for 74 days before the facility was fined $300 for one day's deficiency—the one day the inspector was in the facility.

We reviewed eight cases where a total of 13 State regulations were violated. The longest period of time for which a fine was imposed was five days. For 9 of these 13 violations, fines were imposed for only one day.

The Department's practice in this area wasn't common, compared with other officials we talked with. For example, we reviewed relevant laws for three nearby states—Iowa, Colorado, and Oklahoma. Officials we contacted in Iowa and Oklahoma told us they assess fines for the period of time the facility is out of compliance with State law, not the time the violation is actually observed by an inspector. Colorado follows federal regulations, as described below.

Health Care Financing Administration officials told us penalties for federally imposed fines accrue as early as the date the facility was first out of compliance, as determined by the Department or by the Financing Administration.

The Department didn't double fines, as allowed by law, when it could have done so. State law allows the Department to double a fine if a violation for

which a fine is imposed has been cited within the past 18 months during an inspection or investigation of the facility. We reviewed 21 of the 24 violations for which fines were imposed on the 20 nursing homes in our sample. Fines for 13 violations could have been doubled, but weren't.

The actual fines imposed for these facilities ranged from $150 to $2,500. In the case of one facility, the Department imposed a fine of $1,200 for failure to keep pressure sores from developing. The nursing home appealed the judgment, and a hearing officer reduced the fine to $500, noting that this was the first time the facility had been fined for this particular violation. However, the $1,200 fine could have been doubled, because the facility had been cited during an inspection during the past 18 months for the same violation.

Two months later, the same facility was assessed $300 for improper procedures with gastronomy tubes. This fine also could have been doubled, but wasn't. Once again, the facility appealed, and a hearing officer reduced the fine to $150.

Department officials told us they routinely consider the possibility of doubling fines when fines are calculated. They also said their policy is to double fines only when a violation has been cited in a correction order during the past 18 months. This policy is more lenient than if the Department would double fines when a violation was cited during an inspection in the past 18 months, as allowded by law. We found 13 violations that had been cited in previous inspections, but none had been cited in earlier correction orders.

Maximum fines in Kansas also are lower than in nearby states. We don't know whether other states actually assess the maximum fines allowed by law, but they have higher maximums than Kansas, as shown in the accompanying table.

Maximum Fines for Violations of State Laws and Regulations

State	Maximum Fine
Kansas	$500/day; $2,500 total fine; ($5,000 total if repeated within 18 months) $10,000 total if serious threat
Oklahoma	$10,000 per day
Missouri	$10,000 per day
Iowa	$10,000 per violation

As the table shows, two of the three other states whose laws we reviewed can charge up to $10,000 per day for violations of state laws and regulations. Even under the worst-case scenario, Kansas law allows the Department to charge a total of $10,000 per fine order.

The Department's maximum fine levels also prevent it from adequately fining a facility with numerous problems. For example, if the Department wanted to fine a facility the daily maximum— $500 per day—for three violations that inspectors observed for three days, it could not do so. The fine for that situation should be $4,500, but the Department would be limited to a $2,500 maximum fine.

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 they do so on a repeated basis. None of the current remedies can be applied unless, at a minimum, deficiencies exist that significantly and adversely affect the health, safety, nutrition, or cleanliness of one or more residents.

The Department writes many deficiencies for problems that don't directly harm residents, and requires nursing homes to submit a plan showing how they will correct these problems. But, if the facility doesn't follow through and fix the situation, there really isn't anything the Department can do.

Violations with no remedies often relate to housekeeping or maintenance. Violations that don't significantly and adversely affect residents may relate to the quality of care or services received, but often they address a resident's physical surroundings. Examples we saw of some of these deficiencies, and the regulations they violate, included the following:

Deficiencies Observed	Regulatory Requirement
Handrails not firmly attached to shower walls, and handrails missing on both sides of the corridor in one place.	Corridors should be equipped with firmly secured handrails on each side.
Peeling paint and plaster, missing floor tiles, mold and mildew in the shower, and rusty bed frames.	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.
Residents with long, ragged toenails and ragged fingernails, unshaven, some with food on faces and hands. Staff talk about residents in loud voices.	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
Urine on floor of bathroom, toilet seat with brown substance, stained, soiled floor tiles in bathroom, toilet seats stained, scratched, mildew in shower rooms, rotting sheetrock in utility room.	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.
Facility failed to provide appropriate treatment to increase range of motion or prevent further decrease of range of motion in 4 of 22 residents. Doctors' orders for frequency of range of motion exercises not always followed.	A resident with limited range of motion must receive appropriate treatment and services to increase, or prevent further decrease, in range of motion.

Although these types of violations may not be the most critical to residents' health and safety, they diminish the quality of life for nursing home residents who have little alternative but to remain in the facility. It makes little sense to have regulations to protect the quality of nursing home residents' lives if there is no effective way to enforce them.

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.

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.

Recommendations

1. To ensure that it has the enforcement tools it needs to get nursing homes to correct problems, the Department should propose legislation to the 1997 Legislature to do the following :

    a. remove or significantly raise the statutory maximums on fines

    b. 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

2. To provide an incentive for nursing homes to correct problems as soon as possible, the Department should do the following:

    a. revise its current policy that allows fines to be assessed only for days an inspector is on site, to be more in-line with policies followed by surrounding states and the federal government, which assess fines for the time the facility is out of compliance with laws or regulations

    b. revise its policy related to doubling fines to take into account violations cited in inspections and investigations as allowed by law, rather than just violations cited in correction orders

    c. 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

APPENDIX A

Surveys of Nursing Home Complainants, Nursing Home Administrators, and Department Field Services Staff

From the sample of 213 nursing home complaints we reviewed in this audit, we were able to get complete mailing addresses for 167 complainants. The remaining complainants were either anonymous, or did not have complete mailing addresses. These 167 complainants had reported 175 of the 213 complaints in our sample. We sent a survey to these complainants the first week of June, 1996. Generally, the survey asked the complainants how satisfied they were with the investigation of their complaint(s). We received responses for 83 of the 175 complaints, for a response rate of 47.4%.

We also sent a survey to a random sample of 159 nursing home administrators, on June 6, 1996. Generally the survey asked for the Administrator's opinions of the Department's inspection process, complaint process, and enforcement process. We received 92 responses, for a response rate of 57.9%.

Finally, we sent a survey to all of the Department's Field Services Staff who were classified as Health Facility Surveyors I, II, or III, but we excluded those who are responsible for overseeing mental retardation facilities. We sent our survey to 83 staff on June 10, 1996. Generally the survey asked the staff for their opinions on staff training, the Department's inspection process, complaint process, and enforcement process. We received 41 responses, for a response rate of 49.4%.

On all three surveys, we asked for scaled responses, as follows: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree, or don't know. Throughout this audit report, when referring to survey responses, we grouped strongly agree and agree, and we grouped strongly disagree and disagree.

Legislative Division of Post Audit

Survey of Nursing Home Complainants

The Legislative Division of Post Audit is currently conducting a performance audit of the Department of Health and Environment's nursing home regulatory program. To help us in our audit, we are asking a sample of people who recently made complaints about nursing homes to answer the following questionnaire. The information obtained from this questionnaire will not be reported in a manner that would identify you; however, the workpapers related to this audit, including this questionnaire, will become public documents once the audit is completed.

Please return the questionnaire in the enclosed, self-addressed, stamped envelope (or fax the completed survey to the attention of Cindy Lash at 913-296-4482) no later than Monday, June 17, 1996. If you have any question related to the questionnaire, please contact Cindy Lash or Chris Clarke at Legislative Post Audit, 8th and Jackson, Suite 1200, Topeka, KS 66612 (913)296-3792.

Please circle one response for each statement:

1. I received a letter informing me of the outcome of my complaint

YES	NO
66.3%	33.7%

	1	2	3	4	5	6
	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree	don't know
2. My complaint was acted on in a timely manner	28.8%	32.5%	1.2%	3.8%	10.0%	23.8%
3. The allegations in my complaint were adequately investigated	23.2%	29.3%	2.4%	3.7%	10.9%	30.5%
4. I felt the complaint issues were resolved appropriately	20.3%	25.3%	8.9%	8.9%	15.2%	21.5%
	1	2	3	4	5	6
	strongly agree	agree	neither agree nor disagree	disagree	strongly disagree	not applicable
5. The hot-line staff were courteous and treated my call seriously	67.1%	20.7%	1.2%	3.7%	3.7%	3.7%

The staff of Legislative Post Audit wishes to thank you in advance for your cooperation. If you wish to make any additional comments on the subject of the Department's handling of nursing home complaints, please use the space on the back of this page.

SURVEY OF NURSING HOME ADMINISTRATORS CONCERNING KDHE NURSING HOME INSPECTIONS

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of nursing home inspections in Kansas. One objective of the audit is to determine whether the Kansas Department of Health and Environment's nursing home inspection program is adequate to ensure that significant violations of State laws and regulations will be found. To help us meet this objective, we are conducting a survey of nursing home administrators in Kansas.

Please answer the following questions. The returned surveys will be part of the audit working papers which will become public when the audit is completed. Please return the completed survey in the enclosed, self-addressed, postage-paid envelope by **Monday, June 17, 1996**. If you have any questions, please contact Cindy Lash or Tracey Elmore at Legislative Post Audit, 800 SW Jackson, Suite 1200, Topeka, KS 66612, or call (913) 296-3792.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
POLICIES AND PROCEDURES:						
1. The Department keeps me informed when it makes changes in the way:						
a. complaint investigations or surveys will be conducted	16.5%	44.0%	13.1%	16.5%	8.8%	1.1%
b. laws and regulations will be interpreted	5.3%	28.7%	14.9%	35.1%	16.0%	0.0%
SURVEYORS:						
2. In general, surveyors who visit my facility:						
a. are well-trained	13.2%	56.0%	16.5%	12.1%	2.2%	0.0%
b. are knowledgeable about laws and regulations governing nursing homes	14.1%	62.0%	17.4%	4.3%	2.2%	0.0%
c. are fair	6.5%	38.0%	21.9%	29.3%	4.3%	0.0%
d. conduct thorough surveys	27.5%	46.2%	19.7%	5.5%	1.1%	0.0%
e. are consistent in how they assess facility conditions	2.2%	15.2%	16.3%	38.0%	27.2%	1.1%

SURVEYS:	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
3. The survey process is effective at identifying significant violations of State laws and regulations.	13.2%	51.6%	13.2%	16.5%	4.4%	1.1%
4. The survey process focuses on too many insignificant issues.	34.4%	36.7%	15.6%	12.2%	1.1%	0.0%
5. In general, survey results are communicated in a prompt, efficient manner.	18.9%	58.9%	10.0%	11.1%	1.1%	0.0%
6. In general, deficiencies are communicated in a prompt, efficient manner.	15.2%	56.5%	15.2%	10.9%	2.2%	0.0%
7. The Department is helpful when I ask for advice on:						
a. correcting deficiencies	11.0%	34.1%	8.7%	35.2%	7.7%	3.3%
b. interpreting regulations	10.9%	44.6%	17.3%	18.5%	5.4%	3.3%
c. developing a Plan of Corrective Action	8.8%	31.9%	14.2%	29.7%	11.0%	4.4%
d. investigating complaints	16.3%	45.7%	19.5%	12.0%	1.1%	5.4%
ENFORCEMENT:						
8. In my opinion, the Department enforces laws and regulations consistently from region to region.	0.0%	1.1%	15.3%	29.7%	39.6%	14.3%
9. The Department takes strong action against facilities that don't provide adequate care.	17.2%	44.1%	12.8%	10.8%	8.6%	6.5%
10. The State penalties imposed for noncompliance with laws and regulations are:						
a. too lenient	1.4%	5.6%	19.3%	51.4%	18.1%	4.2%
b. about right	6.3%	45.0%	22.4%	17.5%	5.0%	3.8%
c. too harsh	15.7%	27.7%	24.1%	21.7%	6.0%	4.8%
11. The federal penalties imposed for noncompliance with laws and regulations are:						
a. too lenient	2.7%	0.0%	13.5%	47.3%	28.4%	8.1%
b. about right	1.3%	18.4%	27.6%	31.6%	13.2%	7.9%
c. too harsh	36.0%	29.2%	15.8%	10.1%	2.2%	6.7%

COMPLAINTS:	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
12. The policy allowing the Department to rely on a facility's internal investigation of certain complaints:						
a. is a better use of the Department's resources	46.2%	46.2%	5.4%	1.1%	1.1%	0.0%
b. adequately protects residents from harm	25.6%	55.6%	12.2%	4.4%	1.1%	1.1%
c. creates extra work for us	2.2%	15.7%	19.2%	51.7%	11.2%	0.0%

SURVEY OF FIELD SERVICES STAFF CONCERNING KDHE NURSING HOME REGULATION

The Legislative Post Audit Committee has directed the Legislative Division of Post Audit to conduct a performance audit of nursing home inspections in Kansas. One objective of the audit is to determine whether the Kansas Department of Health and Environment's regulation of nursing homes is adequate to ensure that significant violations of State laws and regulations will be found and dealt with. To help us meet this objective, we are conducting a survey of the Department's field services staff.

Please take the time to answer the following questions. The returned surveys will be included in the audit working papers which will become public once the audit is completed. Please return the completed survey in the enclosed, self-addressed, postage-paid envelope by **Wednesday, June 19, 1996**. If you have any questions, please contact Cindy Lash or Tracey Elmore at Legislative Post Audit, 800 SW Jackson, Suite 1200, Topeka, KS 66612, or call (913) 296-3792.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
TRAINING:						
1. The training I receive for my job is generally:						
a. appropriate (covers the correct subject matter)	39.0%	41.5%	7.3%	12.2%	0.0%	0.0%
b. adequate (there is a sufficient amount of it)	40.0%	35.0%	10.0%	15.0%	0.0%	0.0%
2. The training I receive on changes in laws, regulations, or State policies is generally:						
a. timely	34.1%	34.1%	14.7%	17.1%	0.0%	0.0%
b. in depth	31.7%	31.7%	22.0%	14.6%	0.0%	0.0%
SURVEYS:						
3. Surveys are done frequently enough to ensure that most nursing home residents are receiving adequate care.	29.3%	68.3%	2.4%	0.0%	0.0%	0.0%
4. The survey process is thorough enough to identify any significant problems that a nursing home may have.	26.8%	46.3%	5.0%	19.5%	0.0%	2.4%
5. Overall, the amount of time allowed for carrying out surveys is:						
a. too short	8.8%	29.4%	14.7%	41.2%	5.9%	0.0%
b. about right	12.5%	47.5%	25.0%	15.0%	0.0%	0.0%
c. too long	0.0%	3.0%	12.1%	57.6%	27.3%	0.0%

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
6. The survey process focuses on too many unimportant details.	5.7%	8.6%	14.3%	57.1%	14.3%	0.0%

7. Please describe any significant problems you are aware of in the nursing home survey process.

14.8% of those commenting said the recent changes to the survey process have weakened the process.
44.4% of those commenting said the time allotted to complete surveys is insufficient for doing a thorough job.
40.8% of those commenting had varied comments that were grouped as "other."

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
ENFORCEMENT:						
8. Enforcement actions, such as correction orders, civil money penalties, etc., are:						
a. used frequently enough	26.8%	41.5%	7.4%	14.6%	2.4%	7.3%
b. applied consistently within my region	22.0%	46.3%	7.3%	17.1%	2.4%	4.9%
c. applied consistently from region to region within the State	4.9%	14.6%	19.5%	22.0%	0.0%	39.0%
d. effective at getting nursing homes to correct deficiencies	26.8%	39.0%	19.5%	9.8%	0.0%	4.9%
9. The State penalties imposed for noncompliance with laws and regulations are:						
a. too lenient	8.1%	10.8%	29.8%	40.5%	8.1%	2.7%
b. about right	18.9%	51.4%	16.2%	8.1%	2.7%	2.7%
c. too harsh	5.7%	2.9%	25.6%	42.9%	20.0%	2.9%
10. The federal penalties imposed for noncompliance with laws and regulations are:						
a. too lenient	0.0%	13.9%	30.5%	38.9%	13.9%	2.8%
b. about right	7.9%	52.6%	15.8%	21.1%	0.0%	2.6%
c. too harsh	5.7%	11.4%	25.8%	37.1%	17.1%	2.9%

11. Please describe any significant problems you are aware of in the nursing home enforcement process.

22.7% of those commenting said providers use the survey process and conflict resolution to their own advantage. Surveyors are put on the defensive.

77.3% of those commenting had varied comments that were grouped as "other."

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Don't Know
COMPLAINTS:						
12. Under the current complaint process for nursing homes:						
a. when complaints are received, they are accurately classified by type and severity	12.8%	51.3%	10.2%	23.1%	2.6%	0.0%
b. Code 1 complaints are investigated quickly enough to protect residents	43.6%	51.3%	2.5%	2.6%	0.0%	0.0%
c. Code 2 complaints are investigated quickly enough to protect residents	29.3%	56.1%	12.2%	2.4%	0.0%	0.0%
d. Code 3 complaints are investigated quickly enough to protect residents	14.6%	36.6%	17.1%	19.5%	12.2%	0.0%
e. classifying certain complaints as FYI (which requires no formal investigation) does not place residents at increased risk of harm	17.1%	58.5%	14.7%	7.3%	2.4%	0.0%
13. The policy allowing the Department to rely on a facility's internal investigation of certain complaints:						
a. is a better use of the Department's resources	21.4%	38.1%	19.1%	9.5%	11.9%	0.0%
b. adequately protects residents from harm	17.1%	31.7%	31.7%	4.9%	12.2%	2.4%

14. Please describe any significant problems you are aware of in the nursing home complaint process.

28.6% of those commenting said the investigation of Code 3 complaints is too long after the incident.

33.3% of those commenting said facility investigations of complaints aren't always adequate.

38.1% of those commenting had varied comments that were grouped as "other."

APPENDIX B

Agency Response

On August 30th we provided copies of the draft audit report to the Department of Health and Environment. Its response is included as this appendix.

The Department's response questioned the appropriateness or necessity of some of our recommendations. In response, Legislative Post Audit makes the following comments:

1. Question 1, Recommendation 1a. The Department doesn't think it's necessary or appropriate to request an Attorney General's opinion on whether it can legally accept a nursing home's own investigation of certain complaints rather than conduct its own independent investigation. We agree that State and federal regulations require a nursing home administrator to self-investigate complaints of abuse, neglect, and exploitation. However, this investigation is an internal management tool for the facility, and shouldn't be substituted for the external oversight that a regulatory agency can and should provide through an independent investigation of the facts.

2. Question 1, Recommendation 2a. We disagree with the Department's assertion that vague allegations of abuse, neglect, and exploitation aren't serious. Even if the complainant isn't sure whether an injury happened as a result of abuse or because of an accident, or doesn't know who perpetrated the abuse or neglect, or what day it happened, the situation is no less serious for the nursing home resident who may have been victimized.

3. Question 2, Recommendation 1b. After we received its response, the Department provided us with documentation that since May 30, 1996, the federal government has allowed the Fire Marshal's inspections to be done separately from the Department's inspections. Because of this, we added clarifying information to the report text and deleted recommendation 1b. However, the two cases we cite in the report occurred before May, while the two inspections still were linked. For these cases, the Fire Marshal's arrival effectively announced the Department's upcoming survey.

4. Question 3, Recommendation 1b. In its response, the Department cites its authority under K.S.A. 39-931a(b)(1) as one method of pursuing sanctions against homes with repeated violations of less-serious regulations. The statute the Department cites allows it to revoke the license of nursing home operators, a very severe penalty which, as the table on page 31 shows, the Department seldom uses. The recommendation deals with repeated violations that don't significantly and adversely affect nursing home residents. It is unlikely that revoking a home's license would be an appropriate response to this situation. In our opinion, the Department needs some sort of middle-ground sanctions that will serve as an incentive for the homes to correct these types of problems. The other statute the Department cited, K.S.A. 65-3508, allows the Board of Adult Care Home Administrators to revoke the license of a nursing home administrator or to reprimand, censure or otherwise discipline an administrator. The members of the Board are appointed by the Secretary, but the Department has no direct control over decisions of the Board.

State of Kansas

Bill Graves  Governor

Department of Health and Environment
James J. O'Connell, Secretary

August 8, 1996

Barbara J. Hinton, Legislative Post Auditor
Legislative Division of Post Audit
Mercantile Bank Tower, Suite 1200
800 Jackson
Topeka KS 66612-2212

Dear Ms. Hinton:

Thank you for the opportunity to provide a written response to the Legislative Post Audit entitled "Reviewing the Department of Health and Environment's Regulations of Nursing Homes." This audit, which evaluated questions of whether or not the department ensures complaints against nursing homes are properly prioritized and acted upon, whether or not our inspection program is adequate to ensure significant violations of laws are found, and whether or not we take sufficient action against nursing homes, will be a useful tool in helping to make our program even better than identified by the audit.

The department is extremely pleased that the audit conclusions included the following significant points.

- The department's system for handling complaints generally is well designed and department staff appear to handle complaints well most of the time.
- Most complaint investigations were conducted within timeframes required.
- Most complainants thought the department's response to their complaint was timely.
- Most complaint investigations performed by department staff appear to be thorough.
- For 98 percent of the complaints reviewed, investigators followed procedures required.
- The department's inspection program is designed so that it should uncover significant violations.

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- The audit review showed that records were complete and the department's inspectors appeared to be covering all required areas.

- The auditor's own independent retrospective evaluation of the coding of complaints agreed with the department's coding 90 percent of the time (see additional discussion below).

- The department has made sure that nursing homes have been inspected at least as often as required by state and federal mandate.

- The survey of complainants revealed a high degree of satisfaction for such a sensitive program.

- The survey of nursing home administrators showed a majority think that our field surveyors are well trained, knowledgeable, and fair.

- The survey of KDHE surveyor staff shows a degree of confidence in statewide policy.

This is a remarkable level of achievement for such a complex program. These findings by the audit team should provide a high degree of confidence to our state citizens that our nursing facility regulatory program is functioning quite well.

At the same time, we do take seriously other findings by the audit that question some of the policy or procedural decisions the department has made over the years to merge a number of complex state and federal laws into a cohesive program.

I remain concerned that some of the statements in the audit would lead a casual reader to a conclusion that is not consistent with the totality of the audit. The total picture presented by the audit is that our nursing home regulation program functions exceptionally well. For example, for the audit team to disagree with only 10 percent of the code determinations we make for complaints should result in a more positive conclusion than "About 1 in 10 of the complaints we reviewed seemed to be classified too low to reflect the potential seriousness of the complaint." What is remarkable is that even under the critical eye of an audit, we were found correct at least 90 percent of the time. It is also important to note that the majority of those found incorrect were found incorrect due to the auditors using a definition of abuse/neglect that included general facility complaints, which we never code one or two.

We are also concerned that rather than consistently presenting our complaint code system as a classification system the audit sometimes presents it as a priority system. Our classification system is designed to make a distinction between abuse, neglect or exploitation complaints and general care complaints. Although most abuse, neglect or exploitation complaints do get investigated more quickly than general care complaints, it is because of the seriousness of the complaint, not our coding system. In fact some general care complaints are investigated just as quickly based on the evaluation of our nurse managers or Topeka based staff.

Another concern is found on page 12 where the audit states that department employees were assigned 21 days to complete the investigation. This is not correct. During the time period in question, our policy provided for a maximum of 90 days. On page 13 of the audit it is concluded that nine complaints were not completed within the 21 day timeframe, implying they were not timely completed. All nine were investigated within 90 days, but the audit incorrectly concludes that they were not timely completed.

These points are raised not for the purpose of argument, but as just some examples of the fact that, given the way the conclusions or summations have been expressed in the Report, an inaccurate, negative impression of the program may be left. I will not attempt an exhaustive listing of all such examples here, but would ask that members of the Committee and all readers of the Report carefully consider the underlying factual materials presented in reaching their own conclusions. Accordingly, the balance of my response will be specific to the recommendations identified by the audit.

Page 21 Recommendation 1a. We do not agree that it is necessary or appropriate for the department to request an Attorney General's opinion. Facilities are responsible to self-investigate allegations of abuse, neglect or exploitation pursuant to CFR 483.13, including a requirement that the facility administrator report the results of all investigations to the state agency. In addition, KAR 28-39-150 (d) (3) and (4) include similar requirements, and finally KSA 39-1404 requires the department to initiate an investigation within 24 hours. It does not require that the department, in all cases, duplicate the investigation already required of the facility and its administrator. Of course, we always reserve the right to conduct our own on-site inspection. We believe that our policy of accepting the facility investigation of certain complaints a logical implementation of the statutory and regulatory requirements. Indeed, the audit found no evidence that resident safety was compromised by this approach and it suggests that facilities confirm abuse, neglect or exploitation more often than does the department. (This is likely due to their use of a broader definition of terms than the statutory definitions the department must use, but the conclusion remains valid that the facilities do not "cover up.") It should also be noted that failure to fulfill the required duties can lead to imposition of sanctions on the licensed administrators.

Recommendation 1b. Because our complaint telephone hotline is staffed by a trained nurse who begins the investigation process upon receipt of the call, we believe that we do initiate an investigation of every complaint within 24 hours. Upon receipt, the complaint is assigned for investigation or prescribed forms for the facility to document their internal investigation are provided the facility. We believe this meets the intent of the law.

Recommendation 2a. We are not clear what value there would be in assigning a code 2 classification to "vague allegations of abuse, neglect or exploitation" when these types of complaints are by definition vague. The abuse, neglect, exploitation laws found in KSA 39-1401 et seq. are geared toward specific protection of each specific resident and our policy of classifying "vague complaints" as something other than abuse or neglect is consistent with the law, and provides for the optimum allocation of resources. It does not compromise or delay investigation of serious complaints.

Recommendation 2b. We believe our current policy is consistent with the intent of this recommendation because code three investigations wait the maximum period of six months ***only*** if they are of the most general in nature or border on insignificant. Creating a new classification for vague allegations would not result in a different outcome than our existing system provides. Code three complaints may in fact be investigated immediately if they indicate serious threat to resident safety, well-being or comfort. Therefore, code three complaints are investigated any where from immediately to six months, so the creation of additional classifications would be pointless.

Recommendation 3a. KSA 39-1404 (e) requires the department to inform the complainant upon request of the complainant that an investigation has been made and if the allegation has been substantiated, that corrective measures will be taken. The department already exceeds this requirement because all complainants who report possible abuse or neglect are asked if they would like a written response and a response is provided even if the allegation was not substantiated. Complainants who file general care reports are not routinely asked if they would like a written report regarding the outcome of the investigation and soliciting such reports would require resources that are not justified by any potential benefit.

Recommendation 3b. The department will review with our legal office the current close out notice to determine if additional information legally can be provided to those complainants who receive a response. As noted above, KSA 39-1404 requires that we advise the complainant whether or not an investigation has been made and that if the allegation is substantiated, that corrective measures will be taken. KSA 39-1411 (d) provides that both the report received by the Kansas Department of Health and Environment (pursuant to KSA 39-1402 (b) "report" includes intake information) and our written findings, evaluations and actions are confidential and not subject to the Open Records Act. Accordingly, the information provided complainants is generic in nature. It is well recognized, and is reflected in the confidentiality provision of the statute, that effective complaint investigation

systems can be jeopardized by too much disclosure. Although we doubt that we can provide additional information, we will obtain a current review of our practice by our legal office with a view toward this recommendation.

Recommendation 4. We agree that our system of tracking complaints would be enhanced by being able to fully use an automated complaint tracking system and the department will redirect resources to resolve this issue as soon possible. It is important to note, however, that the audit did not reveal any negative outcome in terms of protecting nursing home residents because of the difficulties we have had in fully automating our complaint tracking system.

Page 28 Recommendation 1a. KSA 39-935 was amended by KDHE request in 1989 for the purpose of making it consistent with federal survey schedules. Federal survey protocol has allowed until very recently for the 15th calendar month to be fully consumed, in other words, any survey completed in less than 16 months was deemed to be in compliance. Because the federal certification surveys and state licensure surveys are merged, all re-surveys have been done in less than 16 months. In addition, state law only requires one unannounced inspection each 15 months, a standard we completely satisfy. As noted elsewhere in the audit, in fiscal year 1996, the department conducted 442 regular inspections, 434 revisits, and assigned 2,085 complaint investigations, resulting in a visit to each nursing home an average of five or six times each year. This, along with the audit's analysis that the average statewide interval between inspections was 11.3 months, confirms that no resident's safety was compromised by our applying the "less than 16 months" standard to just 5 surveys out of the total of 2961 inspections of nursing facilities.

Recommendation 1b. The department does make certain that every nursing home inspection is unannounced. This recommendation is based on the audit finding that on two occasions, the State Fire Marshal had visited the nursing home for compliance with life safety code requirements prior to our surveyors visiting for compliance with state licensure and federal certification standards. We do not agree that this is "announcing" the survey and point out specifically that the Health Care Financing Administration has now officially allowed for these two processes to be considered "de-linked" so that no warning of a subsequent visit by either the Fire Marshal or KDHE can be presumed by the facility.

Recommendation 2. This recommendation is in response to differences of opinion on regulation compliance that is common in HCFA and state agency relationships. As noted in the audit, our findings did agree with federal findings for the most serious deficiencies. We believe it is more important to be correct than to have absolute agreement with HCFA surveyors, who in some cases are not as well trained or experienced as our surveyors. Nevertheless, we filed an appropriate corrective plan, as required, with HCFA.

Recommendation 3. It is important to note the concerns about consistency were identified primarily by nursing home providers but no evidence citing inconsistency was identified by the audit process. Indeed, the audit found a high degree of consistency in terms of number of deficiencies when comparing geographic area to geographic area.

Although consistency is not an absolute, the department does have in place an internal quality improvement process which includes cross-training of surveyors, cross-assignment of surveyors, and on site monitoring surveys for the purposes of providing the highest degree of consistency practical. We will continue to implement this and similar programs to assure the consistency does not become any more than a perception problem on the part of the industry. However, we will not try to achieve a level of consistency that interferes with the professional judgements of nurse surveyors.

Page 41 Recommendation 1a. The department does not agree that the audit revealed any empirical evidence suggesting that an increase in the statutory civil money penalties would enhance the correction or prevention process. In fact, the Department of SRS and KDHE are on record, by submitting a request for deemed equivalency on enforcement sanctions to HCFA, as believing existing civil money penalties are appropriate. Federal authority to impose civil money penalties has resulted in fines being levied that are so unreasonable as to be not collectable, and in some cases, it may have precipitated closing of facilities and moving of residents. We believe that our current civil money authority is an effective tool in achieving and maintaining compliance with the statewide average being compliance within three days of receipt of civil money penalty. The proposition that increasing the civil money penalty maximums would improve upon this response cannot be supported by this history nor by the facts elicited in the audit.

Recommendation 1b. The department has a whole host of state enforcement tools which we believe are effective in remedying state violations, including correction orders, prohibiting new admissions, and civil money penalties. Addressing the habitual violator of regulations that do not significantly and adversely affect nursing home residents is difficult because these individual situations do not rise to a level of seriousness that will support a significant penalty, imposition of which must withstand appeal. The department does have authority as enforcement agency for the Board of Adult Care Home Administrators pursuant to KSA 65-3508 to pursue sanctions against administrators who repeatedly violate any provisions of the licensing law. A similar provision applicable to licensure of facilities exists in KSA 39-931a (b) (1). In specific circumstances these mechanisms may be employed more frequently in light of this recommendation.

Recommendation 2a. This recommendation relates to a difference of opinion on whether or not our current practice in issuing civil money penalties is effective. We acknowledge our policy is that the daily fines be assessed only for days the inspector is on site or can prove the deficiency existed. To assess penalties based upon the assumption the deficiency existed

when it cannot be proven, may unnecessarily bog down the enforcement process resulting in a less effective program. Nevertheless, the department will readdress this issue with our legal staff. As noted above, each enforcement action must be able to be upheld on appeal, administrative and judicial.

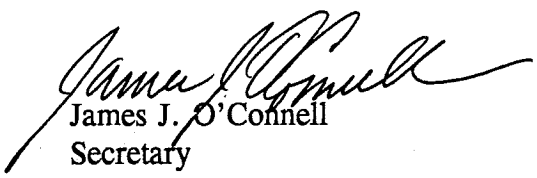
Recommendation 2b. Our interpretation of the statute (KSA 39-946 (b)) is that a doubling of the civil money penalty requires a linkage to a previous correction order because a particular deficiency may not rise to the level required to justify a correction order, and it would be inappropriate to double a penalty for a previous minor infraction. We believe our current practice of doubling the penalty only if the previous deficiency was included in a previous correction order is appropriate and meets the intent of the statute, which is discretionary to the Secretary.

Recommendation 2c. The department identified through its own QI process that some deficiencies that might support a correction order were previously not adequately evaluated for possible correction order. In April of 1996 we revised the process to assure that all deficiencies that may meet the correction order criteria are more fully considered.

I appreciate the opportunity to have this formal response included as an official appendix to the post audit report.

In conclusion, I thank you and your staff for the professionalism and courteousness extended my staff during this most complex of legislative post audits.

Sincerely,



James J. O'Connell
Secretary