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

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AUDITOR’S REPORT

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We have audited the Department of Health and Senior Services' monitoring of nursing homes and handling of complaint investigations. The scope of this audit included, but was not necessarily limited to, the year ended June 30, 2002. The objectives of this audit were to:

1. Review and evaluate the department's compliance with certain statutory requirements regarding inspections of nursing homes and residential care facilities.

2. Review and evaluate the department's compliance with certain statutory requirements regarding investigation and processing of complaints.

3. Review certain management controls and practices to determine the propriety, efficiency and effectiveness of those controls and practices as they relate to the monitoring of nursing homes and complaint investigations.

4. Review follow-up action taken on findings presented in our prior report.

Our audit was conducted in accordance with applicable standards contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, and included such procedures as we considered necessary in the circumstances. In this regard, we reviewed applicable state and federal laws, interviewed personnel, and inspected relevant records and reports of the Department of Health and Senior Services and some nursing homes. We also received input from advocacy groups and concerned citizens who provided our office with additional information about various nursing homes and the Department of Health and Senior Services' practices.

As part of our audit, we assessed the Department of Health and Senior Services' management controls to the extent we determined necessary to evaluate the specific matters described above and not to provide assurance on those controls. With respect to management controls, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation and we assessed control risk.

Our audit was limited to the specific matters described above and was based on selective tests and procedures considered appropriate in the circumstances. Had we performed additional procedures, other information might have come to our attention that would have been included in this report.

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

To avoid any perceived conflict of interest relating to this report or its scope, the State Auditor contracted with our firm to oversee the audit work performed by the State Auditor's professional audit staff. The accompanying Management Advisory Report presents the findings arising from our audit of the Department of Health and Senior Services' monitoring of nursing homes and handling of complaint investigations.

McBride, Lock & Associates

McBride, Lock & Associates

September 12, 2002

EXECUTIVE SUMMARY

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

This audit serves as a follow-up to a prior report released by the Missouri State Auditor on March 1, 2000. Our audit indicates progress was made in several areas. However, this audit noted other areas where corrective action was not achieved, as well as additional areas of concern.

Our review noted completed inspection files were sometimes submitted late to the Central Office and no system was in place to track the timing of inspection packet submissions. In addition, multiple systems are currently used to track and record the inspection and licensure processes. This has increased the occurrence of data entry errors and results in a duplication of effort. Approximately 80 percent of interim inspections conducted during state fiscal year 2002 cited no deficiencies. As a result, the department should consider whether a better use of existing staff resources would be to perform additional detailed inspections at "poor performing" facilities and/or whether these resources could better be utilized to evaluate inspector performance in a more timely manner.

On-site complaint investigation visits were not always initiated in a timely manner. In addition, information in the complaint database used to review timeliness was not always complete and accurate. The report also recommends the department continue to study the possibility of establishing a cost effective process for dissatisfied complainants to appeal the result of complaint investigations.

The Quality Assurance Unit was established in 2001 to review a sampling of completed inspections and complaint investigations to ensure they were conducted efficiently, consistently, and in accordance with applicable standards and regulation. However, the unit has performed only two reviews of complaint investigations and no facility inspections.

As noted in the previous audit, noncompliant facilities are not adequately sanctioned to encourage subsequent compliance, as many deficiencies are cited repeatedly at the same facility. The department continues to need more effective sanctioning tools to help bring problem facilities into compliance with state and federal standards, and to help ensure quality care is provided to the elderly on a consistent basis. The department has supported proposed legislative changes to streamline the process to fine facilities and enhance its sanctioning alternatives in recent legislative sessions. However, this legislation has not passed.

The department has no minimum staffing standard in place and does not track actual staff hours at nursing home facilities. As a result, the department cannot compare actual staffing information to estimated staffing needs to prevent understaffing and negative resident outcomes. The report also recommends the department improve contract monitoring activities related to the Quality Improvement Care Program for Missouri's Long-Term Care Facilities.

The department does not always obtain documentation that appropriate corrective action occurs when it identifies individuals listed on its Employee Disqualification Listing (EDL) that are illegally employed in a nursing home or in-home provider. In addition, our review noted inordinate delays from the time a complaint was filed to the time the individual was finally placed on the EDL.

One of seven regions has not investigated complaints and inspected nursing homes in a timely manner. The untimely performance of this region is at least partially attributable to a significantly greater workload and unfilled vacancies. In addition, the salaries paid social workers in Missouri are lower than those paid for similar positions in bordering states as well as the private sector. Compliance with the department's conflict of interest policy is not adequately documented, and inspectors are permitted to inspect facilities where they were previously employed.

MANAGEMENT ADVISORY REPORT – AUDITOR'S FINDINGS

DEPARTMENT OF HEALTH AND SENIOR SERVICES'
MONITORING OF NURSING HOMES AND
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MANAGEMENT ADVISORY REPORT -
AUDITOR'S FINDINGS

1. Inspections

Under federal and state regulations, the Department of Health and Senior Services, Section for Long-Term Care Regulation (SLCR) is charged with the responsibility to conduct inspections on all licensed nursing homes and residential care facilities in the state. Currently there are 1,185 of these facilities operating in Missouri. Federal regulations require nursing homes that are certified to participate in the Medicare and Medicaid programs to be subjected to a federal inspection (also commonly referred to as a survey) at least once every fifteen months. State regulations require each licensed nursing home and residential care facility to be inspected at least twice annually. One of these required inspections is designated the "full" inspection and must determine whether the facility is in compliance with all state licensing and provision of care requirements except for those reviewed during an "interim" inspection. The "interim" inspection (also known as the second inspection) is the other state mandated inspection. This inspection is outcome oriented and focuses on the quality of care provided and compliance issues related to the following areas; surety bonds, nurse aides training, resident funds, operating policies, grievance system, licensed administration, and the Patient Self-Determination Act. Section 198.032, RSMo 2000, requires inspection reports to be centrally filed in a manner that facilitates rapid access and availability to the public for examination and copying.

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

A. Inspection packets were not always submitted to the Central Office within the specified time frame. Our review of 60 completed inspection files noted 11 (18 percent) had been submitted late to the Central Office. In addition, the SLCR does not have a system in place to track the timing of inspection packet submissions.

Section III, Policy No. 316.20 of the Administrative Policy and Procedure manual of the SLCR, requires each region to submit inspection packets to the Central Office within 30 days of completion. To comply with departmental policy and to better facilitate access and availability to the public, inspection reports should be centrally filed in a timely manner. In addition, the SLCR should have a system in place to review for compliance with this policy. Such as system would allow the SLCR to review each region's performance, identify and avoid potential backlogs, and ensure the timely submission of all inspections.

B. The SLCR uses multiple systems to track and record the inspection and licensure processes for licensed facilities. This has increased the occurrence of data entry errors and results in a duplication of effort.

These systems and databases are all used for different purposes by SLCR staff. The On-line Survey and Certification Reporting System tracks and records inspections conducted on federally funded facilities; the ASPEN system is used by inspectors to prepare statements of deficiencies related to noncompliance cited at each facility; a Scheduling and Tracking database is used by Regional Managers to plan upcoming inspections; and the Production System is used by the Licensure Unit to track facility license applications and fire safety, ownership, operator, and facility history information.

During our review of these systems, we noted examples of information that did not agree from one system to another (ie. facility names, inspection or revisit dates, federal tags cited). In addition, information maintained on one system was often duplicated on another system. One comprehensive system with report generating capability for all licensed facilities (state and federal) would promote consistency and efficiency. Such a system could be used to perform the functions the various systems currently are used for as well as tracking inspection packets as noted in A. above, and performing analytical analysis among the state's seven regions.

C. Sections 198.022.3 and 198.526, RSMo 2000, state that inspections must be conducted at least two times each year in all facilities licensed by the SLCR. One of these inspections must be a full inspection while the second is generally an interim inspection. However, the interim inspection often does not provide an accurate assessment of a facility's performance, and is not an effective use of a surveyor's review time. Approximately 80 percent of interim inspections conducted during state fiscal year (SFY) 2002 cited no deficiencies. In addition, the average number of deficiencies cited in an interim inspection (0.5) was significantly less than the average for full inspections (5.4) for that year.

The SLCR should consider alternatives to the interim inspection process. A better use of existing staff resources would be to perform additional detailed inspections at "poor performing" facilities while rewarding "good" facilities with less frequent reviews. This would require legislative action to change the existing state law.

D. In 1999, the General Assembly passed the legislation to establish the Missouri On-site Survey Evaluation Process (MOSEP). This legislation was designed to ensure uniformity of application of regulation standards in long-term care facilities throughout the state. Specifically, Section 198.527, RSMo 2000, requires the department to periodically evaluate its inspectors, and based on this evaluation, develop and implement additional training and knowledge standards.

The SLCR is not performing the required performance evaluations in a timely manner. Approximately 67 percent of SLCR employees had overdue performance evaluations. Region 3 had a delinquency rate of 100 percent, while region 6 a delinquency rate of 95 percent. All but two regions had delinquency rates above 50 percent.

Discussion with SLCR staff indicated that evaluations could not be completed more timely due to a lack of personnel and because the evaluation process had a lower priority than other responsibilities of the SLCR. Requests for funding to add four full time employees to perform the inspector evaluations have been denied by the Legislature for the state fiscal years ending June 30, 2003, 2002, and 2001. Since requests for additional staff resources have been denied, the department needs to consider other alternatives to comply with state law regarding staff evaluations. These alternatives include conducting an analysis to ensure current staff resources are being utilized as efficiently as possible and re-evaluating priorities.

E. As noted in the prior audit, state inspectors tend to cite fewer deficiencies when federal inspectors are not present. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), conducts two types of federal oversight and support surveys (FOSS) to determine if the SLCR is complying with the federal inspection process. The first of these two is the observational inspection process where CMS inspectors accompany the SLCR inspectors during the actual onsite inspection, providing guidance and advice to help them improve their inspection techniques. The second is the comparative or look behind inspection process where a separate inspection is conducted within two months of the state survey's completion date and results of the two inspections are compared to identify additional training needs for SLCR inspectors.

We reviewed 17 FOSS inspections conducted in SFY 2002 and noted that the average number of deficiencies cited by the state inspectors (7) was significantly less than when federal inspectors were present (18). The table below displays the results of our review of the FOSS process:

Inspection Comparison

	Comparative Inspection	**Observational Inspection**	**Prior State Inspection**
Number of inspections reviewed	3	14	17
Total deficiencies cited during inspections	50	266	117
Average number of deficiencies	17	19	7
Percentage of inspections with more deficiencies than the prior state survey	100 %	79 %	N/A

In addition to the averages noted above, two observational inspections resulted in significant variances in the number of deficiencies cited. In the first example, 36 deficiencies were cited during the observational survey while state inspectors only cited 9 deficiencies in the prior inspection on the same facility. In the second example, 31 deficiencies were cited during the observational survey while only 4 deficiencies were cited during the prior state survey.

Several factors contribute to the large variances in deficiencies cited. For instance, federal observational inspections were conducted on average approximately 337 days after the prior state inspection when federal inspectors were not present. Significant changes could have occurred at a facility during the course of this timeframe. In addition, during comparative inspections federal inspectors select a different sample of residents for their review. Also, according to department personnel, federal inspectors tend to be more critical and often cite problems which are not regulatory violations.

We commend the SLCR for reviewing federal survey results and formulating additional training programs to address needs identified by federal inspectors. However, the increased number of deficiencies cited when CMS inspectors are available for guidance and advice still indicates a need for future training of state inspectors.

WE RECOMMEND the Department of Health and Senior Services:

A. Ensure that completed inspections are submitted to the Central Office in a timely manner.

B. Develop a single comprehensive inspection system to adequately and accurately track and record all inspection information of licensed facilities.

C&D. Analyze the utilization of current staff resources and evaluate the benefits of interim inspections compared to additional inspections of poor performing facilities. Based on this analysis, the department should present options to the Legislature which include the additional amount, if any, of funding necessary to achieve all responsibilities, or reduce the responsibilities currently required by state law. Furthermore, the department should ensure staff evaluations are performed in accordance with state law.

E. Continue to evaluate the results of the observational and comparative federal inspections to identify potential training needs for state inspectors.

AUDITEE'S RESPONSE

A. The SLCR agrees that inspection packets are not always submitted to Central Office files within 30 days from completion of the inspection process. The SLCR disagrees that this has caused any untimely responses to public request for information. Whenever requests for information are made in which the inspection packets are in the region, the region

submits a copy of the packet to Central Office within seven working days. In November 2002, the SLCR began the process of entering inspections into the newly implemented Federal "Aspen Central Office" database. During SFY 2003, the SLCR will be developing management reports from the database that will be used to track the 30-day time requirement for inspection packets to be submitted to Central Office once the inspection process has been completed.

B. *As stated in A., in November 2002, the SLCR began the process of entering both federal surveys and state inspections into the federal "Aspen Central Office" database. In addition, by March 2003, all complaint investigations will also be entered into this system. The SLCR will be working with the Department of Health and Senior Services' (DHSS) Office of Information Systems (OIS) Unit to develop needed reports from the Aspen database, at which time other systems will be discontinued.*

C. *The Division of Health Standards and Licensure (DHSL) is currently in agreement that second inspections should only be required for "poor performing" facilities and will be seeking statutory changes to allow this to be implemented.*

D. *As previously notated by the auditors, additional funds and full time employees (FTEs) have been requested by the SLCR to ensure a continuous training process for field and central office survey staff. The request for additional funding and FTEs has been denied in the previous fiscal years (2001, 2002, and 2003). We agree that MOSEP could be a very useful education/training tool for our surveyors. However, the particular mandate associated with MOSEP (House Bill 316 and Senate Bill 326) was not funded. The SLCR does not currently have the FTEs that can be moved from regular licensure, survey and complaint functions to implement the MOSEP training program as an ongoing process. We will continue to request additional funding as well as FTEs from the legislature in order to incorporate MOSEP into our surveyors education/training program. Supervisory staff in each region conduct regular reviews of surveyors' performance and complete annual employee performance appraisals.*

E. *SLCR management staff are aware of the variance in the number of deficiencies cited by state inspectors whenever federal inspectors are present. As a result, the Field Operations Manager, Quality Assurance Manager and State Training Coordinator have been involved in reviewing these variances and have been working with each of the seven Regional Managers to develop training plans for each region. This process will continue, as well as increasing the reviews conducted by the Quality Assurance Unit to identify areas where training is needed.*

2. Complaint Investigations

The SLCR and Home and Community Services (HCS) are responsible for recording, investigating, and reporting the results of complaints made to the elderly abuse hotline maintained by the Department of Health and Senior Service's, Central Registry Unit (CRU). For state fiscal year 2002, approximately 8,000 SLCR and 15,300 HCS complaints were received.

SLCR surveyors prioritize their complaints into one of four categories based on the severity of the complaint. Per SLCR policy, all complaint investigations are to be initiated by contacting the reporter, if known, within 24 hours. After discussion with the reporter and review of all applicable information, the surveyor will prioritize the complaint. Complaint descriptions as well as timeframes for conducting the initial on-site visit are as follows:

- **Priority A:** Actual harm - Conduct the on-site visit within 24 hours.
- **Priority B:** Potential for serious harm exists - Conduct the on-site visit within 10 working days.
- **Priority C:** Actual minimal harm occurred or the potential exists - Conduct the on-site visit within 30 calendar days.
- **Priority D:** No harm is reported or potentially exists but there is a potential for a regulatory violation - Conduct the on-site visit within 60 calendar days.

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

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

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

SLCR management reports summarize the timeliness of complaint investigation activity as follows:

SLCR Complaint Investigations

Complaint Type	Investigations	Untimely Investigations	Error Rate
A	414	None	n/a
B	4,238	398	9%
C	2,692	390	14%
D	583	11	2%

In addition, approximately 269, 380, and 99 (6, 14 and 17 percent respectively) of all priority B, C, and D complaints did not have the relevant date information entered into the database. There were also several examples of negative timeframes noted, making it appear that the investigation had been completed before a complaint was even received. These instances were caused by data entry errors.

Delayed initiation can make it more difficult to determine whether an incident or violation actually occurred. As a result, the SLCR should ensure complaint investigations are initiated timely. In addition, the SLCR should ensure that all relevant date information is complete and accurate.

B. Our prior audit report noted complainants did not have a forum to appeal the result of a complaint investigation. In 1999, the General Assembly passed legislation requiring the SLCR to implement the Consumer Informal Dispute Resolution (CIDR) Pilot Project. The pilot project provided for face-to-face conferences between SLCR staff and complainants, residents, or their family members. The purpose of these meetings was to share information to satisfactorily resolve any concerns. This legislation also required the SLCR to report to the General Assembly on the effectiveness of the pilot project.

In its report to the General Assembly, the SLRC concluded the CIDR process showed merit and improved resident care. However, projected costs to implement this program statewide were estimated at over $1 million annually. Due to the state's budget situation, the SLCR recommended any further action on this project be discontinued until such funding is readily available. The report discussed the possibility of requiring CIDRs on only significant or frequent violations. This alternative would reduce the estimated cost of the CIDR program.

WE AGAIN RECOMMEND the Department of Health and Senior Services:

A. Section for Long-Term Care Regulation conduct on-site complaint investigations timely and maintain complete and accurate information regarding the dates of on-site complaint investigations.

B. Study the possibility of establishing a more cost effective process for dissatisfied complainants to appeal the result of complaint investigations.

AUDITEE'S RESPONSE

A. The SLCR is aware that not all complaints are responded to within the timeframes specified in the SLCR policy. In October 2000, a Field Operations Manager position was created in order to directly monitor, supervise and direct the work performance in the regions. Since that time, steady improvement has been made as noted in your review. The SLCR would like to note that 100% of priority A complaints were initiated and completed timely.

Due to the continued increase in the number of complaints received and the current difficulty in filling vacant positions due to poor salary benefits for surveyors, the SLCR anticipates continued problems in the timeliness of the completion of complaints in which little or no harm is alleged. Priority will be given to complaints alleging imminent danger or significant harm.

B. The SLCR currently notifies reporters of complaints made to the Elder Abuse and Neglect Hotline of the investigation findings. The SLCR also provides responses on both a regional and central office basis whenever a complainant is dissatisfied with the results of an investigation. Development of an adapted Consumer Informal Dispute Resolution (CIDR) process in the future will be dependent on receiving funding for the additional staff that would be required to implement such a program.

3. Quality Assurance Unit

The SLCR, Quality Assurance Unit (QAU) was established in 2001. The unit manager supervises approximately four support staff. The main function of the unit is to review a sampling of completed inspections and complaint investigations to ensure they were conducted efficiently, consistently, and in accordance with applicable standards and regulation.

Since the unit's inception, the unit performed only two reviews of complaint investigations and no facility inspections. According to unit personnel, more reviews could not be performed because staff were assigned to complete other duties within the SLCR. During our review of selected inspections and complaint investigations, we noted instances where inspectors deviated from the SLCR's established policies. These deviations included not meeting established investigation and reporting timeframes as well as instances where adequate documentation was not provided to support all aspects of the inspection or complaint investigation. A fully operational and effective quality assurance function would likely have discovered and corrected these deviations.

To help ensure inspections and complaint investigations are properly and consistently completed, the QAU should perform reviews on inspections and complaint investigations.

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

AUDITEE'S RESPONSE

During SFY 2002, the Quality Assurance Unit also conducted approximately 50 cursory reviews of complaint investigations and surveys and reported problems noted directly to Regional Managers. In September 2002, the SLCR set the following goal for the Quality Assurance Unit to meet - reviews of 10% of surveys, 10% of full state inspections, 5% of second inspections, and 5% of complaint investigations statewide and by regions.

4. Repeat Deficiencies, Sanctions, and Corrective Action

The SLCR prepares a statement of deficiencies when a facility is found to be in violation of federal or state regulations during either the regular inspection process or a complaint investigation. Under federal requirements, each cited deficiency is designated a tag number from one of 190 categories or tags. A grid consisting of four levels and an alphabetic rating system is used to assign a score to each deficiency cited. One of four levels is assigned to reflect the severity of the problem and an alphabetic score ranging from A through L is assigned to reflect how many residents are affected. The scope and severity grid also acts as a guideline to the SLCR in determining how to penalize a noncompliant facility. There are three categories of remedies that may be imposed depending on the scope and severity score assigned to the deficiency and whether or not corrections are made at the time of a revisit. See the following chart for scope and severity placements and the allowable remedies:

SCOPE & SEVERITY GRID

Severity		Scope: Isolated	Scope: Pattern	Scope: Widespread
IMMEDIATE JEOPARDY		**POC** **Required: Cat. 3** ***Optional: Cat. 1*** ***Optional: Cat. 2***	**POC** **Required: Cat. 3** ***Optional: Cat. 1*** ***Optional: Cat. 3***	**POC** **Required: Cat. 3** ***Optional: Cat. 1*** ***Optional: Cat. 4***
	Level 4	**J**	**K**	**L**
ACTUAL HARM		POC Required: Cat. 2 *Optional: Cat. 1*	**POC** **Required: Cat. 2** ***Optional: Cat. 1***	**POC** **Required: Cat. 2** ***Optional: Cat. 1*** ***Optional: Temp. Mgt.***
	Level 3	G	**H**	**I**
NO ACTUAL HARM, POTENTIAL FOR MORE THAN MINIMAL HARM THAT IS NOT IMMEDIATE JEOPARDY		POC Required: Cat. 1 *Optional: Cat. 2*	POC Required: Cat. 1 *Optional: Cat. 2*	**POC** **Required: Cat. 2** ***Optional: Cat. 1***
	Level 2	D	E	**F**
NO ACTUAL HARM, POTENTIAL FOR MINIMAL HARM		No POC No Remedies Commitment to Correct Not on HCFA - 2567	POC	POC
	Level 1	A	B	C

Bold indicates: Substandard quality of care

Remedy Category 1	Remedy Category 2	Remedy Category 3
Directed Plan of Correction: **State Monitor; and/or *Directed In-Service	**Denial of Payment for New Admissions *Denial of Payment for All Individuals Imposed by HCFA and/or $50-3,000/day	*Temporary Management: Termination Optional: Civil Money Penalties $3,050-10,000/day

Source: Federal Register 11/10/94, p. 56183

The SLCR may recommend remedies be imposed by the U. S. Department of Health and Human Services, Centers of Medicare and Medicaid Services (CMS) when a facility is cited for a Level 2 deficiency or higher. However, repeat offenders cited at Level 2 are given an opportunity to correct the deficiency within three months of the last day of the on-site inspection. If substantial compliance is reached within the three months, the sanction is rescinded. If only part of the deficiency is corrected at the end of the three months, a denial of payment (DOP) for new admissions is imposed and an additional three months is granted to the facility to complete the correction process. If the facility has still not reached substantial compliance at the end of the six months, it is terminated from the Medicare and Medicaid programs. If deficiencies are corrected before the termination date and the facility is found to be in substantial compliance, it is allowed to continue participation in the Medicare/Medicaid programs. A facility cited for a Level 3 or higher deficiency during two consecutive inspections is labeled a "poor performing" facility and is not granted the opportunity to correct their deficiencies before a sanction is imposed.

The SLCR requested 44 DOPs and 43 civil monetary penalties (CMP) in state fiscal year (SFY) 2002, 73 DOPs and 18 CMPs in SFY 2001, and 66 DOPs and 39 CMPs in SFY 2000.

State regulations are also in place and corresponding deficiencies may be cited and remedies imposed. State tags are superceded by one of three scores to demonstrate its level of seriousness; Class I, Class II, or Class III. Class I deficiencies are the most severe while Class III's are the least serious. Some state regulations have multiple scores leaving it up to the surveyor's discretion to decide how to classify the cited deficiency.

State sanctions include issuance of a notice of noncompliance, consent agreements (including forced monitoring and loss of the ability to provide in-house nursing assistant training), voluntary closure, license denial, revocation or surrender, receiverships, and state CMPs. The remedy imposed is based on the severity of the deficiency. However, as under federal regulations, facilities are allowed an opportunity to correct lower level state deficiencies prior to the revisit and avoid the imposition of a potential remedy. State remedies imposed in SFYs 2002, 2001, and 2000, are as follows:

State Sanctions Imposed

	SFY 2002	SFY 2001	SFY 2000
Notice of Noncompliance	115	110	147
Consent Agreement	5	6	15
Voluntary Closure	0	0	0
License:			
Denial	7	3	7
Revocation	1	3	10
Surrender	3	1	1
Receiverships	1	0	2
Civil Monetary Penalty	0	0	1

Based on our review of repeat deficiencies, sanctions, and corrective actions we noted the following concerns:

A. As noted in the previous audit, the SLCR has not been able to sanction some noncompliant facilities aggressively enough to encourage subsequent compliance, as many deficiencies are cited repeatedly at the same facility. In addition, the SLCR currently has neither a procedure in place nor the manpower to ensure continued compliance at historically "poor performing" facilities.

Per federal and state regulations, the SLCR is not required to monitor a facility's continued compliance with their Plan of Correction (POC) past a scheduled revisit inspection. This results in some facilities only making temporary fixes and then being cited for the same deficiencies in the next annual inspection. During our review, we selected 10 historically "poor performing" facilities to determine

whether repeat deficiencies occurred for seven commonly cited federal tags. Our analysis showed 20 deficiencies were repeated in the 2001-2002 inspections, including deficiencies relating to the proper treatment of pressure sores and the failure to provide sufficient nursing staff on a 24-hour basis. Therefore, the POC had failed to prevent the deficiency from recurring. In addition, only one of these facilities was sanctioned as a result of a repeat deficiency. The remaining facilities were not sanctioned because the scope and severity of the deficiency did not require a sanction.

B. Section 198.067.3, RSMo 2000, allows the SLCR to seek CMP of up to $10,000 per day if there was a violation of a Class I standard and the resident suffered serious physical injury or abuse of a sexual nature. However, in State of Missouri, Department of Social Services, Division of Aging v. Carroll Care Centers, Inc., 11 S.W. 3d 844 (MO. App. 2000) the Missouri Court of Appeals upheld a lower court decision effectively limiting the SLCR's ability to seek a CMP to only when the nursing home had failed to correct the cited deficiency by the time of re-inspection. Thus, regardless of the severity of the deficiency, the SLCR's claim for sanctions could not be authorized by the court. For example, the SLCR sought a state CMP totaling $133,000 against a facility where four elderly women died of overheating in April 2001. However, this case was dismissed by the St. Louis County Circuit Court because the facility had fixed its cooling system by the time of re-inspection.

   In addition, according to SLCR personnel, filing CMP cases in the circuit courts is an onerous process that requires significant commitment of staff resources. As a result of this and because facilities are given the opportunity to correct most deficiencies without being subjected to the state CMP sanction, the SLCR has utilized this remedy only once in the past three fiscal years.

The SLCR needs effective sanctioning tools to help bring problem facilities into compliance with state and federal standards, and to help ensure quality care is provided to the elderly. The SLCR has supported proposed legislative changes to streamline the CMP process and enhance its sanctioning alternatives in recent legislative sessions. However, this legislation has not passed.

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

AUDITEE'S RESPONSE

The DHSS will continue to propose revisions to state statutes that provide for more effective sanctions in bringing "poor performing" facilities into compliance, including changes to the CMP process.

5. Facility Staffing

A. The SLCR has no minimum staffing standard in place and does not track actual staff hours at nursing home facilities. As a result, the SLCR cannot compare actual direct care staffing information to an estimated level of staffing needed to prevent understaffing and negative resident outcomes. Section 198.079, RSMo 2000, requires the SLCR to promulgate reasonable standards and regulations related to the number and qualifications of employed and contract personnel having responsibility for any service provided for residents. However, the current Code of State Regulations (CSR), 19 CSR 30-85.042 (37), only requires nursing homes to provide "sufficient staff" to meet the residents needs.

Currently, the SLCR reviews actual staffing levels if a complaint was received related to a staffing concern or the survey team knows from their "off-site" review that a facility has had certain negative resident outcomes that might be related to understaffing. The survey team will also review various quality indicators and the facility's prior history of non-compliance. These measures resulted in approximately 30 facilities being cited for understaffing during the first nine months of state fiscal year 2002. However, as noted in our prior audit and according to department personnel, some facilities have brought in staff from other business-related facilities during an inspection. This practice could temporarily hide or mask an understaffing problem, and may result in no staffing deficiency being cited and potential future negative resident outcomes.

As noted in our prior report, studies have shown a relationship between the number of staff hours and the quality of care at a nursing facility. The SLCR should compare actual direct care staffing information to a minimum nursing staffing requirement to help ensure quality care is provided to nursing home residents. In addition, the SLCR should also make actual direct care staffing information available to the public so better informed placement decisions can be made. The SLCR has the authority and responsibility to set reasonable staffing levels.

B. Under the Quality Improvement Care Program for Missouri's Long-Term Care Facilities (QIPMo), the University of Missouri's Sinclair School of Nursing (UMSSN) performs various duties, including analyzing information related to facility staffing and maintaining a secured data set of Minimum Data Set (MDS) data. The MDS is analyzed to interpret quality of care and resident outcomes, among other things. The UMSSN also conducts facility visits providing training in these areas. The DHSS has contracted with the UMSSN for these services since 1999 with annual costs exceeding $600,000; however, the activities and expenditures related to the QIPMo contract are not adequately documented.

Our review of contracts, progress reports, and invoices related to the contract concluded that the DHSS has not determined or evaluated whether the benefits

derived from the program exceeds the related costs. Progress reports often did not contain sufficient information for the DHSS to determine whether or when specific contract requirements were started or completed, and the costs associated with each requirement or individual facility visits. In addition, invoices requesting reimbursement were often sporadic and lacked sufficient detail. Only two invoices were received in SFY 2002, and the invoices received did not itemize expenses by activity and purpose.

In preparation to extend the SFY 2003 QIPMo contract, the DHSS noted similar concerns related to the program. As a result, changes were made to the current contract requiring quarterly and semi-annual performance reports as well as quarterly invoices. While these changes have been implemented to address the concerns noted above, the DHSS should continue to evaluate the QIPMo program to ensure effective use of state resources and contract compliance.

WE RECOMMEND the Department of Health and Senior Services:

A. Establish reasonable minimum staffing standards for nursing facilities as required by state law and maintain a system which accumulates these facilities' actual direct care staffing hours. The actual staffing information should be made available to the public, and should be compared to the minimum requirements to predict and prevent negative resident outcomes.

B. Improve monitoring activities related to the QIPMo project. These activities should include a thorough review of the cost effectiveness of the program, and ensuring progress reports and related invoices are adequately documented and reviewed.

AUDITEE'S RESPONSE

A. The DHSL and SLCR are currently reviewing studies completed on the effectiveness of the use of staffing ratios. Minimum staffing ratios, in order to be effective, must consider factors such as the acuity of the level of care of residents in a facility. As the acuity level of residents change, so may the need in the frequency and type of nursing services required. Currently, the SLCR evaluates adequacy of nursing staff based on care needs of residents in the facility and any negative outcomes. SLCR staff determines if the facility has sufficient numbers of staff with sufficient qualifications.

B. The Division of Health Standards and Licensure agrees that in prior years monitoring activities of the QIPMo contract were inadequate. Consequently in FY 2003, the Division of Health Standards and Licensure has required progress reports be submitted quarterly that describe specific services, per contract, that were provided during that quarter. Invoices are submitted quarterly subsequent to the progress reports. The Division of Health Standards and Licensure will also be evaluating the cost effectiveness of the QIPMo Program.

6. Employee Disqualifications

Various sections of state law require the Department of Health and Senior Services (DHSS) to maintain an Employee Disqualification Listing (EDL) which includes the names of persons who have been finally determined by the department, pursuant to Section 660.315, RSMo 2000, to have recklessly, knowingly, or purposely abused or neglected or to have misappropriated any property or funds of a nursing home resident or in-home services client. In most instances a complaint is made to the Central Registry Unit's hotline and then turned over to the SLCR or Home and Community Services (HCS) staff for investigation, depending on whether the complaint relates to a nursing home or in-home service provider, respectively.

Assuming the complaint was substantiated, the case is labeled for EDL referral and sent to the Central Office (CO) for processing. After the complaint file is reviewed and processed by CO staff, it is forwarded for legal review to determine whether individuals should be placed on the EDL and for what length of time. If the person to be added to the EDL challenges the allegation, he may file for a hearing with the DHSS. In addition, persons placed on the EDL following the hearing shall have the right to seek judicial review as provided under Chapter 536, RSMo.

DHSS is also responsible for ensuring that nursing homes and in-home providers do not employ individuals currently listed on the EDL. On a monthly basis, the SLCR conducts a match of persons listed on the EDL against quarterly Employment Security wage records. If individuals are found to be employed inappropriately, the DHSS requires the nursing home or in-home provider to immediately terminate their employment.

We noted the following concerns during the course of our audit:

A. The SLCR's employment security match conducted in May 2002 identified 17 individuals listed on the EDL that were employed in a nursing home or in-home provider. The SLCR notified the applicable facilities of these instances. However, in eight instances the SLCR did not obtain documentation regarding corrective action taken by the facilities.

   To ensure the safety of nursing home residents is not compromised, the SLCR should obtain documentation that appropriate corrective action has occurred.

B. Our review of the 17 cases identified in the May 2002 EDL match also noted inordinate delays from the time a complaint was filed to the time the individual was placed on the EDL. These cases took an average of 155 days to be investigated and filed with the CO, another 195 days to be forwarded for legal review, and another 122 days before the individual was finally placed on the DHSS EDL. Nine of the 17 individuals identified in the match were placed on the EDL during fiscal year 2002. Eight of the nine remained employed in a nursing home or in-home capacity until the end of the EDL referral process. Included in

these eight cases was one case that took approximately 1,500 days and another that took 1,100 days from the receipt of the complaint to when the individual was finally placed on the EDL. These delays occurred due to the untimely processing of EDL referrals at several points in the process as detailed below:

- During the first four months of calendar year 2002 there was a sudden increase of EDL cases, including some dating as far back as 1998, forwarded from the SLCR's Compliance Unit for legal review. We reviewed the oldest 37 complaints that were initially received in calendar years 1998 and 1999. On average, these investigations were completed and sent to the CO within 164 days. In addition, it took CO staff an average of two years and six months to forward the complaints for legal review. SLCR personnel indicated that the backlog was caused by overburdened staff and an inadequate EDL case tracking system.

  As of July 2002, one of these cases was recommended for EDL referral, one was recommended for referral to the State Board of Nursing, six were pending review, and 29 were not recommended for referral. Legal counsel stated the untimely processing of referrals hampers the integrity of the process and makes it more difficult to tie up any loose ends and locate witnesses again if needed. Finally, of the six cases still pending review, one of these individuals has remained working for an in-home services provider and another was employed at a nursing home until the fourth quarter of 2001.

- DHSS notifies individuals of its decision to place them on the EDL. These individuals have 30 days to appeal this decision, and Section 660.315, RSMo 2000, requires DHSS to set a hearing within 30 days. However, no timeframes have been established concerning when the hearing takes place or for when a final determination is made after the hearing. During our review of the 48 appeals received by the EDL hearings officer through September 10, 2002, we noted that the average number of days before an actual hearing was held was approximately 100 days. Approximately 40 more days, on average, were then incurred before a final determination was made and the case was closed.

The DHSS has recently implemented changes to improve the EDL referral process. These changes are as follows:

- Three additional staff were assigned the responsibility of processing EDL referrals.

- A database that tracks the date the EDL case was received by the CO, the date the case was referred for legal review, the current location of each case file, and the final determination of each EDL referral was established and implemented.

- A policy was drafted establishing required timeframes for certain phases of the EDL referral process, including a 10 day turn around from the end of investigation to receipt by the CO, and a 10 day limit for cases to be referred for legal review.

- Data entry responsibilities for the review process were improved.

The purpose of the EDL procedure is to protect residents in nursing facilities and those individuals requiring in-home services from disqualified caregivers. An untimely EDL referral process allows potentially inappropriate individuals to continue to have patient contact in nursing homes and when providing in-home services.

WE RECOMMEND the Department of Health and Senior Services:

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

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

AUDITEE'S RESPONSE

The SLCR does require facilities to provide documentation of the termination of an employee found to be on the Employee Disqualification List (EDL). If the documentation is not provided, the EDL Unit contacts the administrator of the facility and requests such documentation. In all instances, the SLCR verifies that the facility has terminated the employee, although the written documentation from the facility may have been misfiled. Appropriate filing of the documentation has been an issue in the past for the EDL Unit; however, corrective measures were implemented in January 2002 and since improvement has been noted. Prior to January 2002, the EDL Unit also was not processing all referrals in a timely manner. Corrective action was implemented and referrals are now being processed by the SLCR EDL Unit within 10 working days.

7. Staffing, Salaries, and Conflict of Interest Disclosures

A. SLCR Region 7 (St. Louis, St. Charles, and Jefferson counties) has not investigated complaints and inspected nursing homes in a timely manner. The SLCR recently performed an analysis of state fiscal year 2002 staffing levels and workloads at each of its seven regions. This analysis indicated the following:

Workload/Staff Ratio Comparison
Year Ended June 30, 2002

	Region 7	Statewide
Beds per Full Time Employee (FTE)	649	481
Complaints per FTE	82	50
Number of Complaints Not Investigated Timely	426	799
Number of Complaints Not Submitted Timely	176	176
Number of Overdue Inspections	40	40
Number of Unfilled FTEs (ie. vacancies)	9	16
Number of FTEs authorized	34	162

As noted by the above analysis, the untimely performance of Region 7 is at least partially attributable to a significantly greater workload than other regions in the state, as well as unfilled vacancies. In attempts to decrease Region 7's workload, the SLCR moved one county in SFY 2001 and two more counties in SFY 2002 out of Region 7, to other regions in the state. However, due to an increase in the number of complaints statewide this did little to lessen Region 7's workload.

Adequate staffing levels must be available at all regions to ensure nursing home inspections and complaint investigations are efficiently and effectively handled through-out the state.

B. As noted in the State Auditor's report *Audit of Child Abuse and Neglect Reporting and Response System,* released in December 2000, the salaries paid social workers in Missouri are lower than those paid for similar positions in bordering states as well as the private sector. The DHSS employs social workers in the Home & Community Services (HCS) and the Central Registry Unit (CRU). Similarly, salaries are also not competitive for the SLCR surveyors (inspectors) and nurses.

We contacted four states contiguous to Missouri and obtained salary information on positions similar to the Facility Surveyor (FS) I, II, and III (note that Facility Advisory Nurse salaries are very similar to those of the FSs). Our findings were compared to Missouri rates as of June 30, 2002, and are scheduled on the table below:

State	Base Salary FS I	Base Salary FS II	Base Salary FS III
Missouri	$28,488	$31,992	$34,644
Arkansas	$28,390	$33,466	$35,638
Oklahoma	$29,474	$32,403	$35,419
Illinois	$30,000	$34,764	$36,708
Kansas	$35,048	$40,560	$44,761

In addition, our findings concerning social worker (SW) salaries as of June 30, 2002, are as follows:

State	Base Salary SW I	Base Salary SW II	Base Salary SW III
Missouri	$22,248	$24,456	$25,440
Arkansas	$23,433	$24,931	$28,289
Illinois	$25,836	$28,128	$32,280
Kansas	$26,000	$28,704	$33,197
Oklahoma	$26,083	$28,675	$34,478

Lower salary levels contribute to problems the DHSS has experienced with filling vacancies, especially in its St. Louis region. Vacancies in the SLCR's Region 7 directly attributed to their inability to timely complete all required interim inspections and complaint investigations. A more competitive salary structure would help the DHSS to attract and retain employees.

C. The DHSS has a department-wide conflict of interest policy. This policy promotes objectivity relating to the inspection and complaint investigation process. However, compliance with this policy is not adequately documented, and inspectors are permitted to inspect facilities where they were previously employed. According to department personnel, former facility employees are allowed to participate in inspections and complaint investigations at facilities where they were previously employed once two years have lapsed from their previous employment. Currently, the department relies on an employee's application form and verbal communications to determine their previous work history.

The DHSS should require employees to periodically prepare formal written conflict of interest statements to better ensure and document compliance with conflict of interest policy. In addition, the DHSS should re-examine its current practice of allowing former facility employees to participate in inspections of and complaint investigations at those facilities.

WE RECOMMEND the Department of Health and Senior Services:

A. Consider various alternatives including shifting some of the workload, reallocating staff, and/or requesting additional surveyor positions to help ensure complaints are investigated and nursing homes are inspected in a timely manner.

B. Seek increased funding for salaries for facility surveyors, facility advisory nurses, social workers, and supervisor positions.

C. Require employees to periodically prepare written conflict of interest statements, and discontinue the practice of allowing employees to inspect or investigate complaints at facilities where they were formerly employed.

AUDITEE'S RESPONSE

Due to induction salaries for surveyors being non-competitive to equivalent private sector positions and similar positions in other states, the Missouri SLCR has experienced difficulty in recruiting and retaining qualified survey staff. This is most problematic in the St. Louis and Kansas City metropolitan areas. The SLCR has reassigned counties in those areas to other regions and also has sent survey teams on a routine basis from Central Office to assist with the survey and inspection workload. Due to the travel time and distance involved, it is not reasonable to send staff from other regions to assist with complaint investigations. The SLCR continues to review resources allocated, however, until the induction pay and salaries for surveyors are made competitive with the private sector and adjacent states, inadequate staffing will continue. The SLCR continues to enforce the DHSS conflict of interest policy and will discuss the auditor's recommended changes at the divisional level for recommending possible revisions.

FOLLOW-UP ON PRIOR AUDIT FINDINGS

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

In accordance with *Government Auditing Standards,* issued by the Comptroller General of the United States, this section reports the auditor's follow-up on action taken by the Department of Social Services, Division of Aging (DA) and the Department of Health and Senior Services (DHSS), on findings in the Management Advisory Report (MAR) of the audit report issued by the Missouri State Auditor's Office, report number 2000-13, dated March 1, 2000. The prior recommendations which have not been implemented, but are considered significant, are repeated in the current MAR. Although the remaining unimplemented recommendations are not repeated, the Department of Health and Senior Services should consider implementing those recommendations.

1. Inspections

   A. Inspection reports were not submitted to and/or were not entered into the centralized database maintained by the Central Office in a timely manner. As a result, the DA was unable to rely on the system to properly monitor and ensure facility inspections mandated by state law have been performed. In addition, reports that were not properly submitted to the Central Office were not readily accessible to the public as required by state law.

   B. The DA determined it had failed to conduct 53 full and 363 interim inspections that were required by state law during state fiscal year (SFY) 1999.

   C. The DA was unable to provide documentation that an inspection had been conducted at two facilities in SFY 1996 or at another facility in SFY 1997. In addition, the DA was unable to provide inspection reports to substantiate that 23 full and 68 interim inspections had been performed in SFYs 1996 through 1998.

   D. The DA rarely performed inspections other than those required by state law.

   E. Federal and state regulations required inspections to be unannounced and unpredictable; however, several examples were noted of the inspection order and/or inspection dates of facilities being very patterned.

   F. The DA had not studied readily available reports of deficiency patterns to identify areas where enforcement activities could be improved.

   G. DA inspectors cited more deficiencies when federal inspectors were present during inspections.

H. Extensive revisions were made to two statement of deficiencies (SODs) without full or complete documentation. In another inspection, a DA official's review indicated that 3 additional deficiencies should have been cited.

Recommendation:

The Division of Aging:

A-D. Develop and utilize a centralized inspection monitoring system to track inspections and then ensure completed inspections are submitted to the Central Office and entered into the system in a timely manner. We also recommend the DA perform all inspections as required by state law, and take the necessary steps which would allow the DA to perform additional inspections of poor performing facilities.

E. Continue to develop and implement policies to reduce the predictability of inspections.

F. Analyze the available reports of deficiency patterns to identify areas where enforcement may be weak or inconsistent and consider their impact upon the inspection process.

G&H. Ensure inspectors are adequately trained and supervised, require the informal dispute resolution process to be followed when facilities dispute statements of deficiencies, ensure all deficiencies are adequately documented, and are accurately and properly reported, and develop procedures to ensure the reasons for changing draft SOD's are adequately documented.

Status:

A. Partially implemented. The DHSS has developed and is utilizing a centralized inspection monitoring system to track inspections. Survey results are entered into this system by regional managers and then periodically reviewed by the Field Operations Manager at the Central Office. However, our current audit again noted instances where survey results were not submitted to Central Office in a timely manner. See MAR finding number 1.

B. Partially implemented. Only one of seven regions was found to not be in compliance during state fiscal year 2002 as all full inspections and all but 40 interim inspections were conducted. See MAR finding number 7.

C. Implemented.

D. Not implemented. Additional inspections are not performed on a regular basis. The DHSS supported legislation to reward "good" facilities by only performing one annual inspection while performing more visits of "poor performing"

facilities. However, this legislation has failed each of the last three years. See MAR finding number 1.

E. Partially implemented. Examples of patterned surveys were again noted during our current review. However, the department met federal requirements concerning unpredictable surveys (10 percent of surveys conducted on nights and weekends). Although not repeated in the current MAR, our recommendation remains as stated above.

F. Partially implemented. Currently, the DHSS, Section for Long-term Care Regulation (SLCR) analyzes as many as four different databases. See MAR finding number 1.

G. Partially implemented. The DHSS has developed training plans to increase the ability to properly identify deficiencies. However, recent results from federal inspections have identified additional potential training needs. See MAR finding number 1.

H. Implemented. With the implementation of the principles of documentation, it appears there has been a focus on training concerning the documentation required for SODs. In addition, we noted no instances where a SOD was extensively changed or an informal dispute resolution conference (IDR) was not properly conducted.

2. Complaint Investigation Processing and Procedures

A. The DA did not always initiate complaint investigations in a timely manner.

B. As of May 10, 1999, there were 1,657 overdue complaints for which a completed summary report had not been submitted to the Central Office. In addition, the DA did not always send a letter to the resident's family or the reporter as required by state law.

C. The "B" status was assigned when the allegation in the complaint was valid but corrective action had been taken by the time the DA could investigate, or a regulatory violation had occurred but the DA could not determine that the harm or serious violation was clearly the fault of the facility. B status complaints usually did not result in any punitive action against a facility. The DA assigned the "B" status for 23 percent of Abuse/Neglect complaints and for 17 percent of Class I complaints.

D. No process existed for dissatisfied complainants to appeal the result of a complaint investigation.

Recommendation:

The Division of Aging:

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

C. Reexamine the policies related to enforcement actions when corrective action had been taken before the investigation was completed. In addition, the DA should consider stronger enforcement actions which may lead facilities to develop additional preventive measures.

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

Status:

A. Partially implemented. Improvement has been made in this area for high priority complaints during SFY 2002. However, lower priority complaints were still not initiated timely. See MAR finding number 2.

B. Partially implemented. For SFY 2002, only one region was not in compliance with the SLCR's provisions concerning timeliness. See MAR finding number 7.

C. Implemented. The prior "B" status no longer exists but does have equivalent statuses under new procedures. However, in SFY 2002, less than 6 percent of institutional complaints fell into this status.

D. Implemented. See MAR finding number 2 for a related concern.

3. Repeat Deficiencies, Sanctions, and Corrective Action

A. The DA did not study sanctions to determine which were most effective in bringing facilities into compliance, did not verify that the state's Medicaid agency imposed the denial of payment sanction on facilities, and did not determine whether the denial of payment actually resulted in financial penalties on facilities. Also, the DA did not always consider a facility's history of past noncompliance when determining the sanction to be imposed.

B. DA officials stated that their ability to effectively seek state civil monetary penalties (CMP) is hampered by the onerous process of filing cases in the circuit courts, which required a very significant commitment of staff resources.

C. Many Plans of Correction (POCs) did not meet the DA's criteria for acceptance, several contained almost identical wording to the prior POC that had most recently failed, and it was questionable whether some of the POCs could reasonably be expected to prevent a repeat deficiency. In addition, the DA did not monitor facilities for compliance with POCs.

Recommendation:

The Division of Aging:

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

B. Work with the legislature to modify the state CMP process so that it can be a more effective tool in bringing facilities into compliance.

C. Ensure Plans of Correction fully meet the established criteria including methodologies for facilities to monitor their continued compliance with the POCs, and ensure the POCs adequately address any systemic deficient conditions. We also recommend the DA ensure all POCs can reasonably be expected to correct the deficiency and not accept POCs which have failed in the past. Further, the DA should develop procedures to continually monitor compliance with POC provisions for facilities with a history of repeat deficiencies.

Status:

A&B. Partially implemented. The DHSS does consider a facility's past performance when selecting sanctions for noncompliance if allowed to under federal and state law. In addition, the SLCR studied the effectiveness of sanctions and other remedies and determined that each type has its own merits in certain situations. The DHSS sought legislative changes to allow the Department to more aggressively cite deficient facilities and make the state CMP process less onerous. However, this legislation has failed in each of the last three legislative sessions. See MAR finding number 4.

C. Partially implemented. While the DHSS has made improvements in this area, we again noted examples of POCs that were insufficient in addressing repeat deficiencies. In addition, the DHSS does not monitor for continued compliance after the reinspection occurs. See MAR. finding number 4.

4. Staffing of Nursing Homes

A. The DA contradicted the intent of state law when they rescinded the minimum nursing staff requirements in September 30, 1998.

B.1. The Minimum Data Set (MDS) produced an estimate of the actual hours of nursing care that was necessary to provide adequate staffing to meet the needs of each nursing home's residents; however, the nursing homes were not able to access those estimates for use in scheduling the number and type of staff that should be sufficient to meet their needs.

2. The DA had not developed a system which accumulates the actual staff hours at each facility to identify homes that are operating significantly below appropriate staffing levels.

C. The DA inspectors did not review facility staffing levels and compare them to any minimum standard or industry benchmark.

D. The DA cited one facility for inadequate staffing but at a level too low to assess additional sanctions. In addition, the DA accepted a POC which did not adequately address the staffing shortage.

Recommendation:

The Division of Aging:

A&B. Establish reasonable minimum staffing ratios as required by state law. In addition, the DA should take steps to develop a system which accumulates the actual staff hours at facilities, and compare recommended staffing levels to actual staffing at facilities to identify potential staffing problems.

C&D. Inspectors utilize recommended and actual staffing data to help identify negative resident outcomes. We further recommend the DA aggressively cite staffing deficiencies and subject facilities that are found to be out of compliance with the staffing requirements to the maximum federal and state sanctions (including civil monetary penalties) warranted. In addition, the DA should ensure approved POCs are reasonably expected to address the staffing deficiencies noted.

Status:

A-C. Not implemented. See MAR finding number 5.

D. Partially implemented. We did not note any examples where the scope and severity of the staffing deficiency was cited at an inappropriate level. See MAR finding number 4 for related concerns.

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

A.1. The DA had not developed an automated process to identify persons listed on the DA Employee Disqualification Listing (EDL) who are working in nursing homes, in-home service providers, and other entities prohibited from hiring those persons.

2. The DA had not developed an automated process to identify employers who were employing individuals with certain criminal backgrounds prohibited by state law.

3. The DA did not always sanction facilities that had hired a person listed on the DA EDL.

4. Our audit identified nine instances where individuals on the DA EDL worked for an in-home vendor under contract with the Department of Social Services.

B. The DA had not developed an automated process to identify instances where persons listed on the Department of Mental Health (DMH) EDL were working for nursing home operators or in-home care providers.

C. The DA had not developed an automated process to identify instances where persons found to have abused children were working for nursing home operators and in-home care providers.

Recommendation:

The Division of Aging seek legislation which would prohibit the employment of individuals found to have abused and/or neglected children and DMH clients from working in nursing homes. The DA should then develop an automated process to identify instances in which persons listed on the DA EDL, the DMH EDL, or the Central Registry of Child Abuse and Neglect (CA/N), or individuals with criminal backgrounds are inappropriately working for nursing facilities, in-home service providers, or other entities prohibited from hiring those persons. In addition, the DA should more aggressively sanction and fine facilities and providers who hire persons listed on these EDLs and/or Central Registry. The DA should also consider raising the violation for hiring a person listed on the EDL to a Class I violation.

Status:

Partially implemented. The DHSS has developed an automated process to detect instances where individuals on the DHSS EDL are inappropriately working. However, EDL deficiencies are still not routinely cited as a Class I violation. Legislation that would have prevented individuals on the DMH EDL and the DFS CA/N from working in nursing homes has not been passed in recent legislative sessions. Also, the DHSS has not been granted access to the Missouri State Highway Patrol's criminal database. In addition, for new employee hires, facilities are required to make inquires through the recently created Family Care Safety Registry. Although not repeated in the current MAR, our recommendation remains as stated above.

HISTORY AND ORGANIZATION

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

Prior to August 2001, the the Division of Aging (DA) was located within the Department of Social Services. In August 2001, the Department of Health was renamed the Department of Health and Senior Services (DHSS) and the functions of the DA were moved to the DHSS by executive order. The State Board of Senior Services (BSS) was created to serve as an advisory body for activities of the department.

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

The Section for Long-Term Care Regulation (SLCR) has the legal authority to intervene in cases where abuse, neglector exploitation is apparent among institutionalized elderly or disabled persons. The SLCR performs inspections and investigates complaints of abuse or neglect at long-term facilities, works with the U. S. Department of Health and Human Services to determine Medicaid/Medicare certification of facilities, helps establish eligibility for Medicaid and cash grant assistance for residents in long-term care facilities, reviews and approves architectural plans for proposed long-term care facilities, and provides data for certificate of need determinations, and develops and implements appropriate rules and regulations in accordance with the Omnibus Nursing Home Act.

The Division of Senior Services serves to assure that all elderly and adult disabled citizens can remain independent and safe in their communities and homes by administering state and federal community-based programs. The division advises legislators, advocates, state agencies and other organizations and individuals regarding services and data available to support this function. When abuse complaints are reported, the division conducts investigations and provides any necessary protective services.

The Central Registry Unit (CRU) is the central intake unit for the state that takes and electronically records calls and keeps them on file for one year or longer. Reports are filled out when calls are received that include the name, address, telephone number, date of birth, etc. of the eligible adult. They also include the nature of the incident and reason for the call and the names of any available witnesses. The types of calls received are classified as abuse, neglect, misappropriation of funds, falsification of documents, and financial exploitation. The CRU begins an interview by determining whether the victim is over the age of 60 or between the ages of 18 and 59 with a substantial mental or physical impairment. All of this information is kept confidential and is used to conduct an investigation. During the year ended June 30, 2002, the

Department of Health and Senior Services received about 8,100 Section for Long-Term Care Regulation complaints and about 15,300 Home and Community Services complaints.

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

An organization chart follows:

Department of Health and Senior Services
Organization Chart (Senior Services and Regulation Only)
June 30, 2002