



**Thomas A. Schweich**  
Missouri State Auditor

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# HEALTH AND SENIOR SERVICES

## Monitoring of Long-Term Care Facilities and Handling of Complaint Investigations

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December 2011  
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# CITIZENS SUMMARY

## Findings in the audit of The Department of Health and Senior Services, Monitoring of Long-Term Care Facilities and Handling of Complaint Investigations

Background	The Department of Health and Senior Services (DHSS) licenses and inspects long-term care facilities and investigates complaints affecting the elderly and disabled. The Section for Long-term Care Regulation (SLCR) surveys and inspects certain facilities and investigates related complaints. The Central Registry Unit maintains the Elder Abuse and Neglect Hotline and receives reports of alleged abuse, neglect, or financial exploitation of eligible persons. The Bureau of Home and Community Services (HCS) provides services to eligible persons, oversees in-home service providers and investigates abuse complaints.
Surveys and Inspections of Long-Term Care Facilities	Sections 198.022 and 198.526, RSMo require the SLCR to conduct at least two inspections each year of all licensed facilities. The SLCR staff did not conduct 471 of the 1,132 (42%) statutorily-required interim or "second" inspections. The SLCR surveyors and inspectors did not always perform survey and inspection tasks within required timeframes. Similar conditions were noted in prior reports.
Complaint Investigations of Long-Term Care Facilities	The SLCR staff did not always conduct on-site complaint investigations within the applicable timeframe, promptly notify the reporter and/or the facility of the results, or accurately and promptly enter the investigation dates into the automated system. In addition, Region 7, which encompasses the city of St. Louis and the counties of St. Charles, St. Louis and Jefferson, is responsible for 32 percent of facility complaints and has historically had difficulty hiring and retaining staff. Similar conditions were noted in prior reports. The SLCR recently reassigned 30 facilities from Region 7 to Region 5 to reduce the Region 7 workload.
Performance Reviews	When the SLCR surveyors and federal surveyors reviewed the same 56 facilities, federal surveyors noted 317 more deficiencies than the SLCR surveyors. More training may be needed to ensure the SLCR surveyors are properly identifying and citing deficiencies. We noted a similar condition in our three previous audit reports. The SLCR's complaint investigations need improvement, and the SLCR does not routinely conduct performance evaluations of its surveyors using the Missouri On-Site Survey Evaluation Process, as required by state law and noted in our prior audit report.
Staffing at Nursing Facilities	Section 198.079, RSMo, requires the SLCR to establish reasonable standards and regulations related to the number and qualifications of nursing facilities staff, but the current Code of State Regulations does not set any objective standard for minimum staffing requirements at nursing facilities.
Alzheimer's Special Care Units	As noted in our prior audit report, the SLCR does not adequately verify the information contained in disclosure forms related to licensed Alzheimer special care units/programs, as required by state law.

Employee Disqualifications	The DHSS does not timely process substantiated complaints of abuse, neglect or misappropriation of property through the DHSS Employee Disqualification Listing (EDL). During the audited period, from the day a complaint was received, it took the DHSS an average of 507 days for HCS cases and an average of 260 days for SLCR cases to make an EDL placement decision. Moreover, at least three complaint investigations were misfiled, including one which was misplaced for over 2 years. Such delays expose facility residents to contact with potentially inappropriate individuals.
Home-Based Elderly and Disabled Adults Complaints	HCS caseworkers did not always timely investigate complaints, obtain supervisory approval for unmet timeframes, or correctly enter data into the case files and the computerized case management system.

In the areas audited, the overall performance of this entity was **Fair**.\*

American Recovery and Reinvestment Act 2009 (Federal Stimulus)	Not applicable.
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\*The rating(s) cover only audited areas and do not reflect an opinion on the overall operation of the entity. Within that context, the rating scale indicates the following:

- Excellent:** The audit results indicate this entity is very well managed. The report contains no findings. In addition, if applicable, prior recommendations have been implemented.
- Good:** The audit results indicate this entity is well managed. The report contains few findings, and the entity has indicated most or all recommendations have already been, or will be, implemented. In addition, if applicable, many of the prior recommendations have been implemented.
- Fair:** The audit results indicate this entity needs to improve operations in several areas. The report contains several findings, or one or more findings that require management's immediate attention, and/or the entity has indicated several recommendations will not be implemented. In addition, if applicable, several prior recommendations have not been implemented.
- Poor:** The audit results indicate this entity needs to significantly improve operations. The report contains numerous findings that require management's immediate attention, and/or the entity has indicated most recommendations will not be implemented. In addition, if applicable, most prior recommendations have not been implemented.

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# Department of Health and Senior Services, Monitoring of Long-Term Care Facilities and Handling of Complaint Investigations

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# **THOMAS A. SCHWEICH**

## **Missouri State Auditor**

Honorable Jeremiah W. (Jay) Nixon  
and  
Margaret T. Donnelly, Director  
Department of Health and Senior Services  
Jefferson City, Missouri

We have audited certain operations of the Department of Health and Senior Services (DHSS) related to the monitoring of long-term care facilities and the handling of complaint investigations for the elderly and disabled adults in fulfillment of our duties under Chapter 29, RSMo. The scope of our audit included, but was not necessarily limited to, the years ended June 30, 2010 and 2009. The objectives of our audit were to:

1. Evaluate the department's compliance with certain statutory and federal requirements regarding inspections and surveys of long-term care facilities.
2. Evaluate the department's compliance with certain statutory requirements regarding the investigation and processing of complaints affecting the elderly or disabled in long-term care facilities or receiving home and community services.
3. Evaluate the economy and efficiency of certain management practices and operations related to the monitoring of long-term care facilities and handling of complaints affecting the elderly and disabled.

Our audit determined the DHSS has not complied with certain requirements for the frequency of inspections and the timeliness of certain inspection tasks and has not adequately complied with certain other mandates. We determined the DHSS has not always complied with certain requirements for the timeliness of complaint investigation tasks. Additionally, the DHSS has not always timely investigated and reviewed cases requiring referral to the employee disqualification list.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.



Thomas A. Schweich  
State Auditor

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# Department of Health and Senior Services, Monitoring of Long-Term Care Facilities and Handling of Complaint Investigations

## Introduction

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### **Background**

The Department of Health and Senior Services (DHSS) licenses and inspects long-term care facilities and investigates complaints affecting the elderly and disabled.

### Organizational information

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 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 elderly persons while maximizing independence for these older Missourians.

### Section for Long-term Care Regulation

The Section for Long-term Care Regulation (SLCR), located organizationally under the DHSS Division of Regulation and Licensure, is responsible for conducting surveys of federally certified long-term care facilities; state inspections of other long-term care, residential care, and assisted living facilities; and investigating complaints regarding those facilities. The SLCR has seven regions across the state that are headquartered in Springfield, Poplar Bluff, Kansas City, Cameron, Macon, Jefferson City, and St. Louis. The SLCR works with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to determine Medicaid/Medicare certification of facilities. In addition, the section reviews and approves architectural plans for proposed long-term care facilities, provides data for certificate of need determinations, and develops and implements appropriate rules and regulations in accordance with the Omnibus Nursing Home Act.

### Central Registry Unit

The Central Registry Unit (CRU), a unit within the DHSS Division of Senior and Disabilities Services (DSDS), maintains the Elder Abuse and Neglect Hotline and receives reports of alleged abuse, neglect, or financial exploitation of persons 60 years of age or older and other eligible adults between age 18 and 59 with substantial mental or physical impairment. The CRU was established pursuant to a state law which requires the department to maintain a central registry capable of receiving and maintaining reports received in a manner that facilitates rapid access and recall of the information reported, and of subsequent investigations and other relevant information.

### Bureau of Home and Community Services

The Bureau of Home and Community Services (HCS), located within the DSDS, is responsible for services and programs directly administered by the DSDS involving eligible persons 60 years of age or older and adults with disabilities between the ages of 18 and 59. The HCS has five regions across the state that are headquartered in Springfield, Cape Girardeau, St. Louis,



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SLCR surveys,  
inspections, and complaint  
investigations

Kansas City, and Columbia. Services such as personal care, homemaker, chore, nursing, respite, adult day health care, counseling, and consumer-directed services are made available to the elderly and persons with disabilities in their homes. When abuse complaints are reported, the HCS conducts investigations and provides necessary protective services. Generally, to be eligible for services, adults must meet specific guidelines pertaining to protective, economic, social, and care needs. Through a comprehensive investigative or assessment process, the HCS determines the intervention and/or services necessary to meet the needs of each eligible adult. The bureau is also charged with the oversight of in-home service providers, consumer-directed vendors, counseling providers, and residential care facility personal-care providers who deliver services to clients/consumers of the DSDS.

Under federal regulations and state statute, the SLCR is responsible for conducting federal surveys and state inspections on all licensed long-term care facilities in the state and investigating complaints related to those facilities for compliance with federal and state health and safety standards. Compliance with those standards is necessary for facilities to be certified to participate in Medicare and Medicaid programs and licensed to operate in the state. The facilities are licensed according to the level of care provided to residents. Nursing facilities provide long-term care for elderly persons requiring the most intensive care needs. The numbers of long-term care facilities by type at June 30, 2010, were as follows:

Type	Number
Skilled nursing	497
Intermediate care	32
Residential care	435
Assisted living	168
Total	1,132

All of these facilities are required by state law to be licensed by the SLCR to operate in the state and must comply with state regulations regarding resident care and safety. Additionally, about 500 of the nursing facilities and intermediate care facilities are certified by the CMS to participate in the Medicare and/or Medicaid programs and must comply with federal regulations related to resident care and safety.

Surveys and inspections

The SLCR is required by Section 198.022, RSMo, to conduct at least two inspections annually of all licensed facilities and by the Social Security Act to conduct a survey of all certified facilities at intervals of no longer than 15 months. One of these required inspections is designated the annual or "full" inspection, which determines whether the facility is in compliance with all state licensing and provision of care requirements. The "interim" inspection (also known as the second inspection) is an abbreviated inspection that





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focuses on certain quality of care issues. Section 198.526, RSMo, allows the SLCR to perform only one inspection annually for those facilities found to be in substantial compliance with requirements based on previous inspections and complaint investigations. For certified facilities, the SLCR conducts the survey and state inspection simultaneously. The SLCR reported 999 surveys and full inspections were performed at certified facilities, 1,261 full inspections were conducted at facilities that are not certified, and 1,510 interim inspections were performed for all facility types during state fiscal years 2010 and 2009. The SLCR reported 279 interim inspections were not performed, as allowed by statute, during the 2 year period because the facility was determined to be in substantial compliance with licensing and operational requirements. The SLCR also reported interim inspections, although required, were not conducted at 471 facilities in fiscal year 2010.

Inspection and survey procedures are outlined in the SLCR Administrative Policy and Procedures manual and the State Operations Manual (SOM), developed by the CMS for use by the states in certifying facilities for participation in the Medicare and Medicaid programs. SLCR policies and the SOM require inspection and survey tasks be completed within designated timeframes as follows:

- Statement of deficiencies: SLCR surveyors/inspectors record noted facility non-compliance with state and/or federal resident care and safety requirements on a statement of deficiencies (SOD) and provide the SOD to the facility. Deficiencies are classified based on the scope and severity of the violation using federal and state classification systems. Except for the most serious violations, which require immediate notification and correction, the SLCR must provide the SOD to the facility within 10 working days of the exit conference at which problems noted during the survey or inspection are discussed. For survey revisits, the SOD must be completed within 70 days of the initial survey exit.
- Plan of corrections: Facilities are required to prepare a written plan of corrections (POC) to each cited deficiency on the SOD and provide the POC to the SLCR within 10 calendar days or 10 working days of delivery of the SOD for the survey or inspection, respectively. The SLCR must evaluate the POC and notify the facility whether the POC is acceptable or requires amendment within 10 calendar days or 10 working days of receipt of the POC for surveys or inspections, respectively.
- Revisit: After the POC is accepted, the SLCR determines whether a revisit is needed to ensure the facility has achieved compliance. The SLCR considers the nature and severity of the deficiencies in making



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this determination. If a revisit is necessary, it must be conducted within 60 calendar days of the survey exit or, for inspections, within 90 calendar days of the inspection exit except for minor violations where 120 calendar days is allowed.

- Inspection documentation: In addition to the SOD and the POC, the surveys and inspections are documented on various forms, letters, and notes and this documentation constitutes the inspection packets. The documentation is completed and reviewed at the regional offices and required information is entered into the federal survey system. The packets are then provided to the central office for review, additional data entry into the federal system, scanning, and filing. For federal surveys, an initial survey packet is to be completed within 40 calendar days of the survey exit and the final packet completed within 30 days of the final survey action. For inspections, the inspection packet is to be completed within 30 days of final inspection action.

## Complaint investigations

The SLCR investigates complaints about long-term care facilities. Complaints about long-term care facilities made to the Elder Abuse and Neglect Hotline are forwarded by the CRU to the section for investigation. In accordance with 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 into one of seven categories based on severity. The complaint descriptions for the three most serious complaint categories, as well as SLCR policy timeframes for conducting the initial on-site visits and exiting or finishing the on-site investigation, are as follows:

- Priority A: These complaints contain allegations of immediate jeopardy and SLCR policy requires the on-site visit be conducted within 24 hours and the investigation exited within 30 calendar days of complaint receipt.
- Priority B: These complaints contain allegations of actual harm that do not indicate ongoing immediate jeopardy and SLCR policy requires the on-site visit be conducted within 10 working days and the investigation exited within 45 calendar days of complaint receipt.
- Priority C: These complaints contain other allegations of resident harm that do not rise to the level of A or B and SLCR policy requires the on-site visit be conducted within 30 calendar days and the investigation exited within 90 calendar days of complaint receipt.

Complaint investigation procedures are outlined in SLCR policy and the SOM. During fiscal years 2010 and 2009, 13,595 complaints about facilities were received as summarized below.



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Priority	Year Ended June 30,	
	2010	2009
A	378	501
B	2,882	3,181
C	2,318	2,519
Others	939	877
<b>Total</b>	<b>6,517</b>	<b>7,078</b>

External and internal oversight

The CMS and the SLCR Quality Assurance Unit (QAU) perform various oversight functions of surveys/inspections and complaint investigations.

The CMS establishes performance standards for determining the adequacy of the SLCR survey performance. The CMS gathers data to measure these standards by reviewing data related to the timing of surveys and complaint investigations and by testing complaints and surveys. Annually, the CMS tests 40 complaint investigations for propriety and 5 percent of surveys for federal validation. Federal validation of surveys is done through: (a) comparative surveys, in which a CMS team conducts an independent survey within 60 days of the state survey (to compare results), and (b) observational surveys, in which a CMS team accompanies the state team to observe the process of the state team. The SLCR is required to implement corrective measures for inadequate performance.

The QAU performed reviews of the propriety of complaint investigation and SODs. The QAU reviewed the documentation for 91 complaint investigations in 2009 and 121 complaint investigations in 2010 for proper investigative procedures and documentation. During the year ended June 30, 2010, the QAU reviewed 77 SODs arising from inspections and surveys for proper content, clarity, and accuracy.

HCS complaint investigations

The HCS is responsible for recording and investigating complaints regarding reported adults made to the Elder Abuse and Neglect Hotline maintained by the CRU. Reported adults are persons aged 60 or over and adults age 18 to 59 with disabilities. The HCS investigates to determine if protective services are needed for the reported adult. Upon receipt, the CRU classifies the reports into three classes based on the severity of the alleged risk to the reported adult and the classification dictates the required promptness of the investigation. Class I reports are allegations that, if true, present either an imminent danger to the health, safety or welfare of a reported adult or a substantial probability that death or serious physical harm will result. Class II reports contain allegations of some form of abuse, neglect or exploitation but do not allege or imply a substantial probability of immediate harm or danger. Class III reports are those for which HCS protective service involvement is not required or which contain vague information insufficient to make a determination of risk. After classification, the reports are sent to one of the HCS regions for investigation. The HCS



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Protective Service manual requires the caseworker make an initial visit to the reported adult within 24 hours for class I reports. For class II reports, the caseworker must initiate the investigation within 48 hours by contacting the reporter and make an initial visit to the reported adult within 7 days. Class III reports require no investigation. The HCS manual requires the class I and II investigations be closed within 90 days and supervisor approval obtained when the policy timeframes cannot be accomplished. Reports received requiring investigation during the years ended June 30, 2010 and 2009, were as follows:

Class	Year ended June 30,	
	2010	2009
I	2,922	2,842
II	20,279	18,954
Total	23,201	21,796

Complaints referred for  
EDL determination

Various sections of state law require the department to maintain an Employee Disqualification List (EDL). The EDL includes the names of persons who have been finally determined by the DHSS, pursuant to Section 660.315, RSMo, to have recklessly, knowingly, or purposely abused or neglected, or to have misappropriated any property or funds, of a long-term care facility resident or in-home services client. Long-term care facilities and in-home services providers are prohibited from employing any person whose name appears on the EDL. In most instances, the EDL review process begins with a complaint made to the CRU hotline which is then investigated by SLCR or HCS regional staff depending on whether the complaint relates to a long-term care facility or in-home service provider, respectively. For substantiated cases of abuse, neglect, or misappropriation of property, the regional staff label the cases for EDL referral and send them to the central office (CO) staff of the SLCR and the HCS for review. If the CO staff determine a case should be considered further for EDL referral, 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/she may request a hearing with the department. In addition, persons placed on the EDL following the hearing shall have the right to seek judicial review as provided under Chapter 536, RSMo. SLCR policy requires regional staff submit the file to CO within 30 days of the last investigative action. HCS policy requires regional staff complete all complaint investigations within 90 days of complaint receipt.

During the 2 years ended June 30, 2010, 886 EDL cases were reviewed by CO staff of the HCS and the SLCR and 571 EDL cases were further reviewed by DHSS legal staff.



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SLCR and HCS workload and staffing

Both SLCR and HCS officials cited the need for additional staffing to meet the statutory requirements for the frequency of inspections and the timeliness of complaint investigations. DHSS officials indicated staff reductions and difficulty in attracting and retaining staff impacted their ability to complete statutory mandates and policy goals including performance of interim inspections at SLCR licensed facilities, and completion of both SLCR and HCS complaint investigations within established timeframes. As a result, DHSS officials indicated it has been necessary to prioritize assignments and the timeliness and the ability to address lower priority work has suffered.

SLCR staffing and workload

SLCR officials indicated, following the significant increase in inspector and surveyor staff in state fiscal year 2008, the SLCR was able to meet the workload. However, officials indicated the SLCR experienced a significant increase in the number of complaints in 2009 while also experiencing problems with attracting and retaining qualified inspectors and surveyors. In early 2010, SLCR officials determined they would be unable to accomplish all required tasks. Licensed facilities, complaint investigations, and, actual and budgeted full time equivalent (FTE) surveyors/inspectors were as follows:

	Year Ended June 30,				
	2010	2009	2008	2007	2006
Licensed facilities	1,132	1,128	1,149	1,149	1,168
Complaints	6,516	7,078	6,531	6,479	5,868
FTE Actual	202	204	202	176	166
FTE Budgeted	225	229	233	249	196

The SLCR policy for prioritizing the scheduling assignments, when necessary, is as follows:

Priority	Assignment
1	Priority A complaint investigations
2	Priority B complaint investigations
3	Recertification surveys
4	Full inspections
5	Revisits and follow-up surveys
6	Priority C complaint investigations
7	Complaints about unlicensed facilities
8	New facility licensure inspections
9	Initial certification surveys
10	Other complaint investigations and second inspections



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HCS staffing and workload

A HCS study, reported in the fiscal year 2010 departmental budget request of the DHSS, determined its staff workloads for fiscal year 2010 would exceed caseload standards and projected a staffing deficit of about 115 staff to accomplish its workload. HCS investigations were as follows:

	Year Ended June 30,				
	2010	2009	2008	2007	2006
Total investigations	23,201	21,796	19,442	17,879	16,045

The HCS requested additional staffing for the fiscal year ended June 30, 2010, that was not funded. However, beginning in fiscal year 2011, the General Assembly addressed the staffing deficit by authorizing the department to contract for assessment services which the DHSS estimated would reduce total staff workload by 33 percent.

**Scope and Methodology**

Our methodology included the following procedures:

- Reviewing written policies and procedures and relevant statutes and regulations.
- Interviewing various personnel of the SLCR, the CRU, and the HCS.
- Reviewing the survey and/or inspection files for a sample of 60 surveys and/or full inspections (27 federally certified facilities and 33 state licensed only facilities).
- Reviewing the complaint investigation files for a sample of 60 priority A, B, and C complaints investigated by the SLCR.
- Reviewing the complaint investigation files for a sample of 60 class I and II complaints investigated by the HCS.
- Reviewing the EDL-referral files for 11 complaints that were referred by the HCS and the SLCR for consideration for addition to the EDL.
- Reviewing databases provided by the SLCR of complaint investigations and surveys and inspections.
- Reviewing databases provided by the HCS of complaint investigations.
- Reviewing databases provided by the DHSS of complaints referred for EDL consideration by the HCS and SLCR regional offices.
- Reviewing databases provided by the SLCR of deficiencies cited during inspections and complaint investigations.



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- Reviewing the results of monitoring, oversight, and testing of SLCR surveys and complaint investigations by the CMS.
- Reviewing the results of QAU reviews of the SLCR complaint investigations and SODs.
- Reviewing other pertinent documents as necessary.

The audit focused on current procedures, procedures during the years ended June 30, 2010 and 2009, and investigations of complaints and inspections and surveys of long-term care facilities during the years ended June 30, 2010 and 2009.

Department of Health and Senior Services, Monitoring of Long-Term Care Facilities and Handling of Complaint Investigations  
 Management Advisory Report - State Auditor's Findings

**1. Surveys and Inspections of Long-term Care Facilities**

The Section for Long-term Care Regulation (SLCR) did not inspect some long-term care facilities when required. Additionally, the SLCR surveyors and inspectors did not always perform survey and inspection tasks within the required timeframes.

**1.1 Frequency of inspections**

During the year ended June 30, 2010, the SLCR did not perform 471 of 1,132 (42 percent) second inspections of facilities as required by Section 198.526, RSMo. DHSS officials indicated the SLCR did not perform these second inspections due to staff vacancies; difficulties in attracting and retaining qualified candidates; and the significant training and oversight required for new employees before they are fully functional. The SLCR, based upon its established priorities, began performing second inspections only in conjunction with complaint investigations, and as result, 471 facilities did not receive a second inspection. Sixty-one facilities that did not receive a second inspection had a recent history of substantiated Class I violations and state and federal sanctions, such as denial of payment for new admissions and civil monetary penalties. The following table reports the number of facilities by type that did not receive a required second inspection in fiscal year 2010:

Facility Type	Number
Skilled nursing	151
Intermediate care	11
Residential care	221
Assisted living	88
Total	471

Frequent inspections of long-term care facilities are needed to ensure the facilities are in compliance with resident health and safety requirements. The Department of Health and Senior Services (DHSS) should analyze utilization of current staff resources and present options to the legislature regarding responsibilities currently required by state law.

**1.2 Untimely survey and inspection tasks**

The SLCR has not always completed survey and inspection tasks within the required policy timeframes.

**Statements of deficiencies (SODs)**

The survey/inspection team did not always prepare SODs within policy timeframes. SLCR policies require SODs be provided to the facility within 10 working days of the survey/inspection exit and for survey revisits within 70 calendar days of the survey exit. Of the 60 surveys and inspections we tested, 48 surveys and inspections resulted in the preparation of an SOD. Of those SODs, 4 SODs (or 8 percent) were sent to the facility from 1 to 6 working days after the expiration of the policy timeframe.





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Management Advisory Report - State Auditor's Finding

Plans of correction (POC)

Facility POCs were not always timely accepted or rejected by the SLCR. SLCR policies require the surveyors/inspectors notify the facility within 10 calendar days (for surveys) and 10 working days (for inspections) whether the POC has been accepted or rejected. Of 48 surveys and inspections that resulted in SODs, SLCR surveyors/inspectors exceeded the policy timeframes for accepting or rejecting the POC for 8 (17 percent). In these cases, the surveyors/inspectors exceeded the policy timeframes from 1 to 5 calendar days. In one of these cases, the surveyor/inspector rejected the POC and required the facility develop an amended plan.

Revisits

SLCR surveyors/inspectors did not always conduct timely revisits of facilities to ensure corrective measures were taken in response to a SOD or did not always make timely decisions about the need for a revisit. SLCR policies require revisits be performed within 60 days of survey exits and 90 days of inspection exits (or 120 days for minor violations). We tested 44 cases where SLCR policy would require a revisit be considered. The surveyor/inspector exceeded the policy timeframe for conducting the revisit or determining a revisit was not needed by 2 to 10 calendar days in 5 of the 44 (11 percent) surveys or inspections tested. In one of these revisits, the surveyor/inspector found the facility was still not in compliance with requirements and a subsequent SOD and POC were required.

Survey/inspection packets

Staff in the regional offices did not always submit survey/inspection packets to the central office within the policy timeframes. SLCR policies require initial survey packets be completed within 40 days of the survey exit and the final survey packet be completed within 30 days of the final survey action. SLCR policies require inspection packets be completed within 30 days of the final inspection action. Of 60 survey/inspections tested, 19 packets (32 percent) were not submitted within policy timeframes. Exceptions ranged from 4 days to 142 days late.

Impact of untimely tasks

Monitoring activities of the regional offices and central office have not been sufficient to ensure compliance with established survey/inspection timeframes. A SLCR official indicated the regional offices and central office have monitoring systems to track the timely completion of tasks. For example, central office staff produce weekly reports of pending revisits for certified facilities and monthly reports of pending survey/inspection packets and notify the regional offices of revisits or packets due. However, audit results indicate additional efforts are needed to comply with policy timeframes. The SLCR attributes noncompliance to staffing and workload issues in the regions. The completion of the SODs, review of the POCs, and performance of the revisits have effects on the timing of the completion of corrective actions by the facilities, and the timeliness of these tasks is important to ensure proper resident care and safety.



Similar conditions  
previously reported

Similar conditions were noted in previous reports.

Recommendations

The Department of Health and Senior Services:

- 1.1 Conduct inspections as required by law. In addition, the DHSS should analyze utilization of current staff resources and present options to the legislature regarding responsibilities currently required by state law.
- 1.2 Complete survey and inspection tasks within the policy timeframes.

Auditee's Response

1.1 *DHSS concurs with this recommendation. DHSS' Scheduling of Assignments policy (#101.00) is used to set work priorities. Priority is given to investigation of complaints involving allegations of immediate jeopardy or significant harm and annual or full inspections. Second inspections are a lower priority on the list of required assignments. It should be noted that every facility received a full inspection in both fiscal years 2009 and 2010. Beginning in Fiscal Year 2012, DHSS has given increased priority to conducting second inspections in those facilities with Class I or Uncorrected Class II deficiencies within the past two fiscal years. DHSS will continue to analyze utilization of staff resources.*

1.2 *DHSS concurs with this recommendation:*

- *Statements of Deficiencies (SOD) - DHSS makes every attempt to prepare SODs within policy timeframes. In rare circumstances, DHSS exceeds the required timeframe in order to ensure the SOD is a comprehensive, complete, defensible document.*
- *Plans of Correction (POC) - DHSS strives to ensure all POCs are accepted within the required timeframes. DHSS will consider revising the POC policy to reflect ten working days to accept/reject the POC to be consistent across facility types.*
- *Revisits - It should be noted that the revisit that resulted in additional deficiencies was started within required timeframes, but due to complaints received after the start of the revisit, DHSS was unable to complete the revisit and investigate the complaints within required timeframes.*
- *Survey/Inspection Packets - DHSS revised the survey/inspection packet policy in June 2010. Rather than submitting the entire survey/inspection packets to the central office, the regional offices now submit a smaller set of forms. This change resulted in quicker processing times and reduced postage costs. The regional offices*



*retain the full survey/inspection packets. DHSS will consider revising the survey/inspection packet policy to be consistent with CMS Performance Standard requirements that require information to be entered in the federal system within 70 calendar days of the exit conference.*

## 2. Complaint Investigations of Long-term Care Facilities

SLCR staff did not always conduct on-site complaint investigations within policy timeframes, promptly notify the reporter and/or facility of the investigation results, or enter investigation dates accurately and promptly in the Automated Survey Processing Environment (ASPEN) Complaint Tracking System (ACTS). Additionally, the SLCR has not fully addressed staffing and workload disparities in its regions.

### 2.1 Untimely complaint investigation tasks

The SLCR has not always completed complaint investigation tasks within the required policy timeframes.

#### On-site investigations

The SLCR surveyor/inspector did not always begin the on-site investigation within policy timeframes. The policy requires onsite investigations to be started within 24 hours, 10 days, and 30 days for priority A, B, and C complaints, respectively.

Based on data on the ACTS, the computerized system used by the SLCR for recording complaint investigations, on-site investigations were not always initiated within policy timeframes for priority A, B, and C complaints received during the 2 years ended June 30, 2010, as follows:

Complaint priority	Total investigations	Untimely on-site investigations	Error rate
A	879	1	0.0%
B	6,063	475	7.8%
C	4,837	1,429	29.5%

#### Notifications of results

The SLCR surveyor/inspector did not always notify the reporter or facility of the complaint investigation results within policy timeframes. SLCR policy requires the reporter, if an address is known, and the facility, when no deficiencies are found, be notified of the complaint investigation results within 14 calendar days of the exit. The following was noted during our test of 60 complaints:

- The letter to the reporter was untimely in 9 of 29 (31 percent) complaints for which a letter to the reporter was required, with exceptions ranging from 1 to 58 days late.



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- When no deficiencies were found, the letter to the facility was untimely for 16 of 49 (33 percent) complaints with exceptions ranging from 1 to 266 days late.

By not sending out the required notification timely, the reporter and facility remain unaware of the official outcome of the investigation. A SLCR official indicated these problems were due to workload issues.

The SLCR should strive to meet the investigative timeframes to ensure residents are safe from harm, deficiencies are promptly identified and corrected, and the reporter is promptly notified of the investigation results. Delayed initiation can make it more difficult to determine whether an incident or violation actually occurred. Also, any delay in the initiation of the on-site investigation would delay the communication of deficiencies to the facility and therefore delay needed corrective action by the facility.

## 2.2 Reports to monitor timeliness

The effectiveness of SLCR reports to monitor timeliness of tasks have been reduced due to incorrect dates and untimely entry of data. From the ACTS data, weekly reports of incomplete complaint investigations are produced for review by the regional supervisors and the SLCR Quality Assurance Unit (QAU) and year-end reports of the timeliness of on-site investigations are produced for review by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and the QAU.

### Incorrect entries

The date of commencement of the on-site complaint investigation was sometimes incorrectly recorded on the ACTS. For priority A, B, and C complaints received during the 2 years ended June 30, 2010, the ACTS data included about 1,400 records (12 percent of the population) for which the starting date of the complaint investigation was earlier than the date the complaint was received. A SLCR official indicated this occurs when a complaint is received that relates to an earlier complaint with an ongoing investigation. However, due to this practice, the SLCR is unable to determine whether complaint investigations were initiated within policy timeframes. Additionally, for 3 of 60 complaints tested, the on-site investigation date was incorrectly recorded on the ACTS due to data input errors, according to a SLCR official.

Staff in the regional offices enter the on-site date based on the investigation documentation prepared by the surveyor. A SLCR official indicated that ACTS data is periodically verified to the complaint investigation documentation by central office staff. Our review indicates these actions have not effectively eliminated the on-site date errors. Incorrect on-site dates make the ACTS data less useful as a tool for monitoring the timeliness of complaint investigations. The SLCR should review the ACTS for correct on-site dates and make appropriate corrections.



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Untimely entries

Some information related to complaint investigations was not promptly entered into the ACTS. According to ACTS data as of June 30, 2010, 171 complaints had no recorded investigation start date despite the deadline for the initiation of the complaint investigation having passed. Of these, 165 complaints originated within Region 7.

We also noted 125 complaints where the time frame for the exit of the investigation had been exceeded; 118 of these complaints, or 94 percent, were for Region 7. A SLCR official told us an exit had already occurred for 8 of these complaints, ranging from about 1 month to about 6 months prior, but the investigation results and completion had not yet been entered into the ACTS. According to SLCR officials, the delays pertain to unsubstantiated complaints with no SODs and documenting the results of these investigations is given lower priority than investigating new complaints and reporting deficiencies resulting from complaint investigations. SLCR officials also indicated staff workload, especially in Region 7, has caused the untimely entries. Due to these staff workload issues, the QAU assisted Region 7 with data entry on complaint investigations for much of 2009. In addition, the section instituted new requirements for regional supervisory staff to review the ACTS data weekly for incomplete or missing information. It appears the new requirements have significantly reduced the amount of incomplete or missing information, except in Region 7.

For SLCR management and other supervisory officials to have up-to-date information to monitor the status of complaint investigations, all actions and supporting information related to investigations should be entered in the ACTS system on a timely basis.

2.3 Region 7 staffing and  
workload

According to a SLCR official, the section has historically had difficulty hiring and retaining staff for Region 7. Region 7 is responsible for the city of St. Louis and the counties of St. Charles, St. Louis, and Jefferson. This region was responsible for about 20 percent of total licensed facilities and about 19 percent of SLCR staff were assigned to the regional office. However, during the years ended June 30, 2010 and 2009, about 32 percent of facility complaints pertained to Region 7 facilities.

SLCR staff from other regions and central office have assisted Region 7 with its workload in recent years. To reduce the Region 7 workload, effective July 1, 2011, the SLCR reassigned 30 facilities in St. Charles County to Region 5. The SLCR official indicated further regional changes may also be made. The SLCR should review the staffing and workload of the regional offices and consider further realignments to enhance the efficiency and effectiveness of regional staff and ensure uniformity in workload and timely completion of complaint investigation tasks.



Similar conditions  
previously reported

Similar conditions were noted in previous reports.

## Recommendations

The Department of Health and Senior Services:

- 2.1 Conduct complaint investigation tasks within policy timeframes.
- 2.2 Ensure the ACTS contains accurate on-site dates and timely data on investigation results.
- 2.3 Review regional workloads and staffing and make changes to enhance efficiency and effectiveness and more uniformly distribute workload.

## Auditee's Response

- 2.1 *DHSS concurs with this recommendation. It should be noted that the vast majority of time frames not met involved priority C complaints, which do not involve allegations of immediate jeopardy or significant harm. DHSS gives priority to complaints alleging immediate jeopardy or significant harm.*
- 2.2 *DHSS concurs with this recommendation. A variety of reports are utilized to identify inaccurate data entry and correct errors. DHSS conducts annual statewide regional complaint training for staff. The training conducted during the summer of 2011 addressed timely and accurate data entry. DHSS will continue working with staff to enter required data in the ACTs database promptly and accurately.*
- 2.3 *DHSS concurs with this recommendation. Effective July 1, 2011, St. Charles County was transferred from the St. Louis region to the Macon region to reduce workload disparities in the St. Louis region. DHSS will continue to evaluate workload levels of each region and make workload and/or staffing adjustments as appropriate.*

## 3. Performance Reviews

SLCR surveyors cited fewer deficiencies than federal surveyors during comparative surveys and concerns were noted by the CMS and QAU during reviews of SLCR complaint investigations. The SLCR does not routinely prepare performance evaluations of its survey employees pursuant to the Missouri On-site Survey Evaluation Process (MOSEP), as required by state law.

Federal comparative surveys

The CMS conducted 48 comparative surveys for life safety regulation compliance and 8 comparative surveys for health care regulation compliance during the 2 years ended June 30, 2010. Federal surveyors cited more deficiencies in their survey of the 56 facilities than the SLCR staff cited in surveys of the same facilities. The federal surveyors noted 317



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deficiencies (292 during life safety code comparative surveys and 25 during health care comparative surveys) that were not cited by the SLCR surveyors. According to the CMS surveyors, most of the 317 deficiencies should have been cited by the SLCR surveyors based on the evidence that was or should have been available at the time of the SLCR survey. The different results in the surveys conducted by the federal surveyors and SLCR surveyors could be partially due to changed conditions between the two survey dates and different resident samples chosen during the two surveys. The SLCR provided individual and group training sessions to surveyors related to the comparative survey results. However, the results suggest more training may be needed for SLCR staff to ensure SLCR surveyors are properly identifying and citing deficiencies.

A similar condition was noted in our three previous audit reports.

Complaint investigations

The QAU and the CMS have noted concerns with the quality of the SLCR complaint investigations. Reviews of complaint investigations performed separately by the QAU and the CMS both indicated that, based on the investigation documentation, resident samples were sometimes too small and observations, record reviews, and interviews related to resident samples were sometimes not relevant to adequately determine the facility's compliance with requirements pertaining to the complaint allegations. The SLCR responded to the review results with individual and group training and subsequent review results seem to have improved for the reviews conducted during the 2 years ended June 30, 2010. However, the recent results suggest that further training is needed to ensure complaint investigations are conducted and documented properly.

Missouri On-site Survey  
Evaluation Process

The SLCR does not routinely prepare performance evaluations of its survey employees pursuant to the Missouri On-site Survey Evaluation Process (MOSEP), as required by state law.

Legislation passed in 1999 established the MOSEP to identify education and training needs for state surveyors and to ensure the uniform application of regulation standards in long-term care facilities throughout the state. Section 198.527, RSMo, requires the department to periodically evaluate its surveyors regionally and statewide to identify any deviations or inconsistencies in regulation application, and based on this evaluation, develop and implement additional training and knowledge standards. MOSEP evaluations are to include an on-site observation of employees performing survey tasks and consider overturned informal disputes. A SLCR official indicated that all surveyors are evaluated annually and on-site evaluations are sometimes performed and used in the annual evaluations. In addition, the SLCR indicated, that due to staffing limitations, it has not been able to conduct regional and statewide analysis of surveyor evaluation



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results to identify education and training needs that could result in more uniform application of state regulation standards.

This condition was also noted in our prior audit report.

## Recommendation

The Department of Health and Senior Services continue to evaluate the results of comparative surveys and reviews of complaint investigations in designing future staff training. In addition, the DHSS should complete the staff performance evaluations pursuant to the MOSEP program as required by state law.

## Auditee's Response

*DHSS partially concurs with this recommendation. As outlined in the audit report, DHSS has conducted individual and group training sessions related to the comparative survey results and complaint investigations. DHSS agrees the Missouri On-site Survey Evaluation Process (MOSEP) could be a useful education/training tool for its surveyors. However, DHSS utilizes other methods to evaluate staff that can be accomplished with existing resources. DHSS supervisors in each region monitor staff continually and conduct regular onsite reviews of each surveyor's performance. Annual employee performance appraisals are completed based on the monitoring of staff performance throughout the year.*

*It should be noted that the mandate associated with MOSEP was not funded when the requirement was enacted in 1999. Implementing MOSEP without additional state funding would require reassignment of staff from critical licensure, survey and complaint duties.*

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## 4. Staffing at Nursing Facilities

The SLCR has no minimum direct care or nursing staffing standard in place for nursing facilities. Section 198.079, RSMo, requires the SLCR to promulgate reasonable standards and regulations related to the number and qualifications of employees and contract personnel having responsibility for any service provided for residents in intermediate care and skilled nursing facilities. However, the current Code of State Regulations (CSR), 19 CSR 30-85.042 (37), only requires nursing facilities to employ nursing staff "in sufficient numbers and with sufficient qualifications" to meet resident needs. This is subjective and open to interpretation of the state surveyor staff. Prior to September 30, 1998, Missouri had minimum nursing staff requirements in place for a number of years. However, on that date, the minimum standards were rescinded from state regulations. According to a report issued in 2008<sup>1</sup>, 42 states have some form of minimum direct care or nursing staff requirements exceeding the requirements in Missouri. The SLCR cited 17 nursing homes for inadequate staffing (deficiency tag number F-353) in fiscal year 2010. Three homes were cited twice during

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<sup>1</sup> Harrington, C. *Nursing Home Staffing Standards in State Statutes and Regulations*, University of California, San Francisco, CA., January 2008





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that period. Eighteen deficiencies were cited on the deficiencies matrix at levels D, E, or F (no actual harm), 1 was cited at level H (a pattern of actual harm), and 1 was cited at the most serious level, level L (a widespread pattern of actual harm). According to SLCR personnel, some facilities continue to bring in additional staff during inspections. This practice could temporarily hide or mask an understaffing problem, and may result in no staffing deficiency being cited and potential future negative resident outcomes.

We obtained staffing time information self-reported by nursing homes for the month of April 2011 from the CMS website<sup>2</sup>. That information included the number of nursing hours per resident day for the 2 weeks prior to the most recent survey for about 500 Missouri nursing homes. The CMS also reported an estimated level of expected nursing hours per resident day necessary to provide adequate resident care, based upon the RUG-53 (Resource Utilization Group) staff time values for residents in the nursing home at the time of the survey. The expected hours reported were for the quarter that included the survey period and would not necessarily reflect staffing needs at the time of the survey. The CMS also calculated an adjusted hours per resident day figure which was based upon the ratio of actual to expected hours per day times the national average hours per day for each category. This calculation benefitted homes that staffed at higher levels for some categories and reduced the adjusted hours for homes that were staffing significantly under the expected staffing levels in other categories.

Our analysis of Missouri data noted 158 nursing homes provided at least 30 minutes per resident day less than the expected nursing hours staffing level and 35 homes provided at least 30 minutes less than the adjusted nursing hours staffing level. We also noted 116 homes provided fewer hours than both the expected and adjusted nursing hours and 3 of the 116 homes provided at least 30 minutes less than both measures. It appears that facility staffing may not be adequate for a significant number of Missouri nursing homes. Adequate facility staffing is important for quality resident care and minimum nursing staff requirements may be helpful in reducing the number of homes with less than expected or adjusted nursing hours.

A similar condition was noted in previous audit reports.

## Recommendation

The Department of Health and Senior Services re-establish minimum staffing standards for nursing facilities.

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<sup>2</sup> <http://www.cms.gov/CertificationandCompliance/Downloads/staffingdatafile.zip>. Accessed May 3, 2011



## Auditee's Response

*DHSS does not concur with this recommendation. DHSS believes establishing minimum staffing standards may actually make citations for quality of care more difficult when facilities meet the minimum staffing standards but are providing poor quality of care. DHSS believes that in order to be effective, minimum staffing ratios must consider factors such as acuity level of the residents and the training and competency of staff. As the acuity level of residents changes and/or staff turnover occurs, the frequency and type of nursing services and other staffing required may also change. Currently, DHSS evaluates the adequacy of nursing staff based on the care needs of the residents and any negative outcomes based on the staffing in the facility. The audit report references data from CMS regarding expected and adjusted nursing hours. However, like DHSS, CMS has not mandated a minimum nursing staffing ratio.*

## 5. Alzheimer's Special Care Units

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

Some long-term care facilities have established special units or programs to care for individuals who have been diagnosed with Alzheimer's disease or a related disorder. As of June 2010, 217 of the 1,132 licensed facilities (19 percent) had an Alzheimer special care unit or program.

Section 198.510, RSMo, requires that any such facility disclose the form of care or treatment provided that distinguishes that unit or program as being especially applicable, or suitable, for persons with Alzheimer's disease or dementia. This disclosure is to be made to the department (the DHSS) which licenses the facility. According to that statute, this disclosure should be made on a form developed by the department and include an explanation as to how the care is different from the rest of the facility in various areas including, but not limited to, the unit/program's overall philosophy and mission, assessment and establishment of a patient care plan, staff training and continuing education practices, the costs of care and any additional fees, and safety and security measures. A copy of this disclosure form is to be given to the patient and the patient's family at the time of admission.

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

We were told that during the license renewal process, the Licensure Unit receives these forms with the license renewal requests and turns the forms over to the Policy Unit for review. The Policy Unit reviews the forms for



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missing information or obvious errors, but no other procedures are performed to verify the accuracy of the disclosure form as part of the licensing process.

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

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

As a result of this situation, there is not adequate assurance the Alzheimer Special Care disclosure forms submitted by the applicable facilities to the department and distributed to the applicable patients/families accurately reflect the special care and operating practices at those facilities. Consequently, patients/families may not have accurate and complete information upon which to make their placement decision.

This condition was also noted in our prior audit report.

## Recommendation

The Department of Health and Senior Services review its current practices related to the verification and review of Alzheimer special care units/programs and the disclosure forms which are submitted by the applicable facilities. Steps should be taken to ensure the disclosure forms accurately reflect the care and practices at those facilities.

## Auditee's Response

*DHSS concurs with this recommendation, and will consider options that better provide for review and verification of the disclosure form. DHSS examines the form for content, but does not verify all information contained on the form. However, DHSS determines if residents of special care units are receiving the appropriate care in accordance with each resident's care plan during onsite inspections. DHSS staff will cite a facility for failure to provide the appropriate care.*



## 6. Employee Disqualifications

The DHSS has not processed substantiated complaints of abuse, neglect, or misappropriation of property through the DHSS Employee Disqualification Listing (EDL) review process in a timely manner.

### Case processing

The DHSS process for investigation and review of complaints requiring EDL consideration often resulted in an untimely EDL placement decision and DHSS processing timeframes and goals were often exceeded. During the 2 years ended June 30, 2010, the average number of days from complaint receipt to an EDL placement decision was 507 days for the 240 Bureau of Home and Community Services (HCS) cases, and 260 days for the 331 SLCR cases.

We reviewed the case files for 11 (2 HCS and 9 SLCR complaints) of the 571 cases and noted policy timeframes or processing timeliness goals were often not met during each phase of the process.

Item number	Region	Regional Investigation (days)	Central Office Review (days)	Legal Review (days)	EDL Placement Decision
1	HCS region 3	275	82	273	Not placed
2	HCS region 2	295	90	20	EDL - permanent
3	SLCR region 7	276	35	40	Not placed
4	SLCR region 7	276	35	40	EDL - 2 years
5	SLCR region 2	45	133	166	EDL - 5 years
6	SLCR region 4	135	25	132	Not placed
7	SLCR region 7	279	35	27	Not placed
8	SLCR region 6	64	20	364	EDL - 7 years
9	SLCR region 7	318	68	23	EDL - 3 years
10	SLCR region 7	846	77	24	EDL - 3 years
11	SLCR region 5	119	94	43	EDL - 2 years

Timeframes and processing goals for EDL complaint investigations were exceeded.

- The regional investigation process exceeded the HCS 90 day policy timeframe to complete the complaint investigation for both HCS complaints reviewed.
- The regional investigation process exceeded the SLCR policy timeframe to complete the investigation report for eight of the nine SLCR cases.
- In all cases, the central office processing goal of 14 days was exceeded.



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- While the DHSS has no processing timeliness goals or policies for legal review, the days for legal review exceeded 130 days in four cases.

DHSS officials attributed delays to excessive workload of regional staff or central office staff, a filing error by SLCR staff, and delays while the regional or legal staff awaited the outcome of investigations by law enforcement or circuit court cases before proceeding with the EDL referral as the outcome of those outside actions would impact the EDL decision by the DHSS.

DHSS procedures to monitor the cases for timely processing have not prevented delays. Cases received by the central office are tracked and monthly reports of outstanding cases are produced. As of June 1, 2010, 37 (25 HCS and 12 SLCR) of the 100 outstanding cases had been received by the central office more than 1 month previously. The SLCR and the HCS have recently made, or are considering, changes that may help address the staffing and workload issues impacting regional office investigations of complaints for EDL referral. The SLCR and the HCS should consider additional staffing options to improve the timeliness of the reviews by central office.

Misfiled and untimely processed cases

The DHSS does not have adequate controls to ensure all EDL-referred cases are processed. Central office staff have no review procedures to ensure all complaints intended for referral to central office from the SLCR regional offices are received and input into the central office computer system. In 1 of 11 cases tested, the complaint investigation file was intended to be referred for EDL review but was misfiled by the regional office. As a result, the central office did not review the complaint file until nearly 2 years later. The complaint, received in June 2007, was investigated in September 2007, but the misfiling was not discovered until October 2009 when the SLCR regional office received another complaint regarding the same alleged perpetrator. At that time, the DHSS processed the original complaint and the perpetrator was placed on the EDL in April 2010. The perpetrator was employed by long-term care facilities until the April 2010 disqualification.

In September 2010, the QAU discovered two additional SLCR complaint files received between January 2009 and September 2010, that were intended for EDL referral but had been misfiled. The QAU intends to begin performing monthly reviews to ensure SLCR complaints intended for EDL referral have been received by the SLCR central office.

Resident protection

The purpose of the EDL procedure is to protect residents in long-term care facilities and individuals receiving in-home services from disqualified caregivers. An untimely EDL referral process allows potentially inappropriate individuals to continue to have patient contact. The importance of prompt processing of EDL cases is recognized by the SLCR



as its workload prioritization policy ranks investigating priority A complaints with allegations of abuse and neglect as the highest priority task. The DHSS should address the workload issues, process EDL cases in a more timely manner, and frequently review records of complaints to ensure potential EDL cases were processed properly.

## Recommendation

The Department of Health and Senior Services process cases involving EDL referral in a more timely manner and in accordance with policy timeframes and established goals and establish controls to ensure cases referred to the central office are received and processed timely.

## Auditee's Response

*DHSS concurs with this recommendation. DHSS implemented additional controls in October 2010 to ensure that all EDL complaints are routed appropriately prior to being filed. A monthly report was added to track when complaints are mailed by the regional office to the central office. The report identifies complaints that have not been submitted to the central office in a timely manner. Any discrepancies in the report are reviewed and resolved.*

*Also, DHSS implemented a new computer system (Case Compass) in August of 2011 that will replace the CRANE system. The system sends reminders to supervisors to ensure that appropriate review and follow up occurs.*

## 7. Home-Based Elderly and Disabled Adults Complaints

The HCS did not always investigate complaints within policy timeframes, obtain supervisory approval for unmet timeframes, or correctly record data in the case file and the computerized Central Registry for Abuse, Neglect and Exploitation (CRANE) case management system.

### 7.1 Untimely investigative tasks

HCS caseworkers did not always meet policy timeframes for the initiation of the investigations and initial visits to the reported adults and supervisory approval for these unmet timeframes was not always documented. Additionally, investigations were not always closed within policy timeframes.

#### Initiation of investigation

HCS caseworkers did not always meet policy timeframes for initiating the investigations and did not obtain documented supervisory approval for the unmet timeframe. For 1 of 60 complaints tested (2 percent) the investigation was initiated 3 days late. HCS officials indicated the delay was due to caseworker error. Additionally, in one complaint tested, HCS officials indicated the investigation was initiated by attempted contacts with the reporter; however, those contacts were not documented as required.

#### Contact with reported adult

HCS caseworkers did not always meet policy timeframes for conducting the initial visits with the reported adults and did not always obtain documented



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supervisory approval when timeframes were not met. For 9 of 60 cases tested (15 percent) the reported adult was not seen timely and for 3 of these exceptions supervisory approval for the unmet timeframe was not documented in the case file as required. For the three cases, the visit to the reported adult was 1 day late, 3 days late, or waived because the reported adult could not be located. HCS policy requires the caseworker obtain documented supervisory approval when the policy timeframes for visiting the reported adult or initiating the investigation cannot be accomplished.

To ensure the safety of the reported adult and comply with policy, the caseworkers should initiate the investigations and visit the reported adults within the policy timeframes or obtain documented supervisory approval for the unmet timeframe.

#### Case closures

HCS caseworkers did not always close cases within the 90 day timeframe required by policy. Upon completion of an investigation, caseworkers are required to finish preparing the necessary forms to document the investigations and record the results on the CRANE. For 10 of 60 cases tested, or 17 percent, the case was not closed within the 90 day policy timeframe. These 10 items ranged from 1 day late to 123 days late. HCS policies require the caseworkers record all investigative case actions on a form in the case file. We reviewed these forms for the tested cases and noted for each of these cases extended periods of inactivity, either during the investigation or after the investigation and prior to case closure, contributed to the untimeliness of the case closure.

Monitoring efforts have been insufficient to prevent the delays. Monthly reports of open cases are produced and distributed to supervisors for review. We reviewed the November 2010 report which indicated about 23 percent of the open cases had complaint receipt dates 90 days or more prior to the report date. Bureau officials also indicated that supervisors discuss each pending hotline case with caseworkers on a monthly basis. The HCS attributes the delays to excessive worker caseload.

The HCS should complete investigations within 90 days to ensure further protective services are established promptly if needed and information is available on the system for consideration in any subsequent reports affecting the same reported adult, and to comply with policy.

#### Contracting for assessment services

DHSS officials indicated HCS staff will no longer perform assessment duties beginning in 2011. Section 208.895, RSMo, as revised by Senate Bill No. 1007, Second Regular Session, 95th General Assembly, authorizes the department to use a contracted vendor to perform those services. As a result, HCS officials believe staff should have adequate time to complete complaint investigations within the established timeframes, once the contract is executed.



## 7.2 Data errors

We noted instances where case data was not accurately recorded in the case file and CRANE.

### Abuse Neglect and Exploitation scores

HCS caseworkers did not properly record the abuse, neglect, and exploitation (ANE) scores on the CRANE system and case file documentation for 13 of 60 items tested, (22 percent). HCS policy requires the caseworkers assign scores to represent the highest level of risk to the reported adults for abuse, neglect, and exploitation during the investigations. These scores are used in the evaluation of the need for further protective services for the reported adult. For the 13 items, the ANE score reported on the case file documentation differed from the score recorded on the CRANE. Incorrect ANE scores in the CRANE system reduce the ability of HCS management to monitor compliance with case handling policies and to ensure the appropriate level of HCS protective services are provided to the reported adult. HCS caseworkers should compare the ANE scores on the two sources to ensure accuracy.

### Incorrect dates

HCS caseworkers did not always correctly record the dates of the initial visits to the reported adults. For 2 of the 60 items tested (3 percent) the date of initial visit to the reported adult as recorded on the CRANE differed from the corresponding date recorded on the case file documentation. Additionally, we inquired about 33 other cases where the CRANE data indicated the reported adult was not visited or was not visited timely and HCS officials indicated the date visited was incorrectly recorded on 5 of these items and the reported adult was actually visited timely. To allow for proper monitoring of the timely visit to the reported adult, the HCS should compare the date of the initial visit between the case file and CRANE and correct any discrepancies.

## Recommendations

The Department of Health and Senior Services:

- 7.1 Ensure cases are investigated, documented, and closed timely and ensure supervisory approval is obtained and documented for cases where policy timeframes are not met for initiation of the investigation and initial visit to the reported adult.
- 7.2 Ensure the ANE score and date of initial visit to the reported adult are correctly recorded in the case file and CRANE.

## Auditee's Response

- 7.1 *DHSS concurs with this recommendation. DHSS implemented a contract with a third party on May 19, 2011 to perform all of the assessments for home and community based services. This allowed state staff to devote more time to abuse, neglect and exploitation investigations. While the contract was terminated on August 31, 2011 due to failure of the contractor to perform required duties, DHSS does not plan to have staff that conduct abuse, neglect and exploitation investigations resume assessment functions.*





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*Since the contract was terminated, temporary state staff have been hired to perform assessment functions.*

*Also, Case Compass includes features that remind supervisors to ensure that appropriate review and follow up occurs. If cases are not timely completed, an explanation is required by the field staff and supervisor.*

7.2 *DHSS concurs with this recommendation.*

*DHSS implemented a new computer system (Case Compass) in August of 2011 that will replace the CRANE system. Case Compass facilitates more timely data entry by DHSS staff since the same information no longer has to be entered in multiple databases. This not only enhances productivity, but reduces the likelihood of data entry errors.*