REVIEW OF THE
DIVISION OF AGING'S
MONITORING OF NURSING HOMES
AND
HANDLING OF COMPLAINT INVESTIGATIONS

From The Office Of State Auditor
Claire McCaskill

Report No. 2000-13
March 1, 2000

AUDIT REPORT

Office Of The
State Auditor Of Missouri
Claire McCaskill

March 2000

FACT SHEET

The following problems were discovered as a result of an audit conducted by our office of the Division of Aging's monitoring of nursing homes and handling of complaint investigations.

INSPECTIONS FOUND TO BE PREDICTABLE

Our audit determined serious problems with inspections of nursing homes. Many citizen complaints received by our office allege that nursing home facilities were aware, or could predict, when the next inspection would occur. Those complaints further allege that facilities often make temporary or cosmetic changes in their staffing levels, physical environment, and quality of care in an effort to mask underlying systemic problems.

Division of Aging personnel acknowledged that it is not unusual for staffing levels to increase once an inspection begins and that this practice results in a skewed picture of actual facility staffing. Scheduling inspections in a somewhat predictable pattern tends to offset the unannounced aspect of the surveys and inspections and provides facilities the opportunity to make temporary improvements in staffing levels and the condition of the facility to coincide with the expected date of the inspection. During our review we noted several examples of the inspection order and/or inspection dates of facilities being very patterned.

In September 1998, the Division of Aging adopted a revised inspection scheduling policy designed to reduce the predictability of facility inspections. The Division of Aging should continue to identify and implement ways in which the predictability of the inspections could be reduced by varying the chronological order and timing of inspections.

MINIMUM INSPECTION REQUIREMENTS NOT BEING MET/ADDITIONAL INSPECTIONS DO NOT OCCUR

Our review also revealed several other problems related to the inspection process. The Division of Aging has not been able to make the minimum number of inspections required by law, much less perform additional inspections. Nevertheless, the Division of Aging rarely performs additional inspections. It would appear the Division of Aging could identify the chronically poor performing facilities and subject these facilities to additional onsite inspections. Additional inspections may help identify deficient conditions in a more timely manner and help force poor performing facilities to maintain a higher level of care throughout the year. Three examples of inspections not being adequately performed or documented, and/or deficiencies being inappropriately removed from the inspection report were noted. In addition, Division of Aging tended to cite more deficiencies when federal inspectors were present.

FAILURE TO INVESTIGATE COMPLAINTS IN A TIMELY MANNER

The Division of Aging does not always initiate complaint investigations in a timely manner. Complaint investigation reports are not submitted to the central office in a timely manner, particularly for complaints assigned the Springfield, St. Louis, and Kansas City Regional Offices. Numerous other problems regarding complaint investigations were noted at the Kansas City Regional Office including instances where the reporter of the complaint was not properly notified as required by state law. Also, facilities which correct the cause of the violation before the complaint investigation occurs cannot be sanctioned unless there is serious harm or injury.

(over)

The division does not study the sanctions imposed on nursing homes to determine which are most effective in bringing these facilities into compliance with standards. According to the division, one of the state's sanctions available, a monetary penalty, is currently too burdensome to be effective. In addition, plans facilities submit to correct sub-standard conditions often were not effective to prevent a repeat deficiency, or the plan of correction was not implemented.

MINIMUM STAFFING REQUIREMENT FOR NURSING HOMES SET ASIDE

Our audit also reviewed the Division of Aging's work as it related to the adequate staffing of nursing homes. Many complaints received by our office alleged facilities were understaffed which resulted in inadequate care provided to their residents. State law requires the Division of Aging to set minimum staffing requirements. However, in September 1998, the division rescinded the minimum staffing requirement which was too low to provide adequate care to nursing home residents. Since there no longer is a minimum staffing ratio which addresses the number and qualifications of direct resident nursing care, this action contradicted state law. The Division of Aging should establish a reasonable minimum allowable staffing requirement that also clearly establishes that additional staffing may be necessary based on resident dependency levels. The audit also recommended the division compare actual staffing hours at facilities to staffing levels recommended by the new system under development.

The audit noted that a statistic, provided by the Division of Aging in a response to an audit recommendation, regarding the number of facilities cited for inadequate staffing (229 of 491, or 47%) is misleading as it also includes cites for staff qualification and training issues. According to a June 1999 report generated by Division of Aging from the Online Survey and Certification Reporting System (OSCAR), only 42 of 492 (8.5%) facilities were cited for inadequate staffing during the most current survey.

MANY DISQUALIFIED FROM WORKING WITH CHILDREN AND MENTALLY HANDICAPPED FOUND TO BE WORKING IN NURSING HOMES

The Division of Aging is required to maintain a listing of persons who have abused, neglected, or exploited the elderly and disabled. Nursing homes, residential care facilities, businesses who hire nurses aides, hospitals, and home health agencies are prohibited from hiring anyone on the employee disqualification listing (EDL). We identified 21 instances in which a nursing home or in-home care provider under contract with the department had hired a person listed on the EDL. The Division of Aging does not always issue a deficiency to facilities that hire persons listed on the EDL. We also noted the Division of Aging does not have adequate procedures in place to identify employers who do not perform criminal background checks.

More than 1,100 persons listed in the Department of Mental Health employee disqualification listing and the Central Registry of Child Abuse and Neglect were working in nursing homes or at in-home care providers. In addition, instances were noted in which persons listed on the Aging and Mental Health listings and within the abuse and neglect registry were working in other inappropriate work settings. These concerns will be addressed in a subsequent report to be issued by the State Auditor.

IMPORTANT: Immediate legislative action regarding at least two major findings of this audit are needed to better insure the quality of care for those dependent upon nursing homes as well as Division of Aging supervision of those facilities.

- Current state law allows nursing homes to avoid all fines and penalties if they correct reported violations by the time the division reinspects the nursing home on all violations except those that result in a serious physical injury. In addition, statutory provisions for penalties as they relate to repeat violations or problem homes are inadequate. As a result, penalty provisions are lacking and grossly inadequate.

- Also, this audit points out that the Division of Aging is unable to disqualify individuals from nursing home employment who are prohibited from working with children and/or the mentally handicapped. Consequently, it is vitally important appropriate legislation be enacted to better insure the quality of care and safety of nursing home residents.

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DIVISION OF AGING'S
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HANDLING OF COMPLAINT INVESTIGATIONS

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CLAIRE C. McCASKILL
Missouri State Auditor

Honorable Mel Carnahan, Governor
and
Gary J. Stangler, Director
Department of Social Services
and
Richard Dunn, Director
Division of Aging

We have conducted a review of the Division of Aging's monitoring of nursing homes and handling of complaint investigations. The objectives of this review were to:

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

2. Review and evaluate the division'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.

Our review was made in accordance with applicable generally accepted government auditing standards and included such procedures as we considered necessary under the circumstances. In this regard, we reviewed applicable state and federal laws, we interviewed applicable personnel and inspected relevant records and reports of the Division of Aging, some nursing homes, and advocacy groups. We also received significant input from concerned citizens who had contacted our office with additional information about various nursing homes and Division of Aging practices.

As part of our review, we assessed the Division of Aging's 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. In order to assess control risk, we performed tests of controls to obtain evidence regarding the effectiveness of the design and operation of certain policies and procedures.

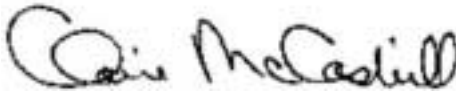
The accompanying Background Information is presented for informational purposes. This information was obtained from the Division of Aging and was not subject to the procedures applied in the review of the Division of Aging's monitoring of nursing homes and handling of complaint investigations.

224 State Capitol • Jefferson City, MO 65101 • (573) 751-4824 • FAX (573) 751-6539
Truman State Office Building, Room 880 • Jefferson City, MO 65101 • (573) 751-4213 • FAX (573) 751-7984

Our review 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 Background Information is presented for informational purposes. This information was obtained from the Division of Aging and was not subject to the procedures applied in the review of the Division of Aging's monitoring of nursing homes and handling of complaint investigations.

The accompanying Management Advisory Report presents our findings and recommendations arising from our review of the Division of Aging's monitoring of nursing homes and handling of complaint investigations.



Claire McCaskill
State Auditor

September 17, 1999 (fieldwork completion date)

The following auditors participated in the preparation of this report:

Director of Audits:	Kenneth W. Kuster, CPA
Audit Manager:	John Luetkemeyer, CPA
In-Charge Auditor:	Dennis Lockwood, CPA
Audit Staff:	Patrick Devine, CPA
	Tirenna Miller
	Amanda George

BACKGROUND INFORMATION

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING
MONITORING OF NURSING HOMES
AND
HANDLING OF COMPLAINT INVESTIGATIONS
BACKGROUND INFORMATION

The Division of Aging (DA) of the Department of Social Services was created on October 1, 1979 by executive order. On August 13, 1984, the DA was statutorily established by Section 660.050, RSMo. It serves as the central agency to coordinate 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 DA promotes public awareness of the needs and abilities of older persons while maximizing independence for older Missourians.

In accordance with the Omnibus Nursing Home Act, the DA is responsible for assuring the safety, health, welfare, and rights of persons residing in institutional facilities. The division has the legal authority to intervene in cases where abuse, neglect, or exploitation occurs among institutionalized elderly or disabled persons. The Institutional Services Unit conducts inspections of nursing homes and residential care facilities, conducts investigations of complaints of abuse or neglect at long-term care facilities, develops and implements appropriate rules and regulations in accordance with the Omnibus Nursing Home Act, and along with the U.S. Department of Health and Human Services, recommends Medicaid/Medicare certification of intermediate care and skilled facilities. In addition, the division assesses eligibility for Medicaid and cash grant assistance for long-term care residents, licenses nursing home administrators, reviews and approves architectural plans for proposed long-term care facilities, and provides data for certificate of need determinations.

The Home and Community-Based Services Section, includes the Missouri Care Options program, which is a comprehensive and coordinated approach to support elderly and disabled persons in their homes and communities. This section conducts investigations of complaints of abuse, neglect, or exploitation for the elderly and disabled who are not residing in institutional facilities and provides screening, assessment, and protective services if needed. The Older Americans Act unit monitors and provides guidance to the Area Agencies on Aging which operate various home and community programs for the elderly and disabled. The State Long-term Care Ombudsman provides oversight and assistance to the ten regional ombudsman programs, ensures complaints received by the office are investigated and coordinates the activities with other advocacy groups.

During the year ended June 30, 1999, there were about 1,250 licensed facilities, and the DA received about 7,400 Institutional Services complaints and about 14,000 Home and Community Services complaints.

MANAGEMENT ADVISORY REPORT SECTION

Management Advisory Report -
State Auditor's Recommendations

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SUMMARY OF FINDINGS

1. Inspections (pages 9-20)

The Division of Aging (DA) does not appear to utilize its centralized data base to monitor compliance with state laws regarding the timing of facility inspections. In addition, the DA failed to conduct required inspections of these facilities. The DA schedules inspections in a somewhat predictable manner. The DA does not compare the results of its inspections to regional or national statistics. A direct correlation between the number of deficiencies cited and the presence of federal inspectors was noted. Examples of inspections not being adequately performed or documented, and/or deficiencies being inappropriately removed from the inspection report were noted.

2. Complaint Investigation Processing and Procedures (pages 20-28)

The DA does not always initiate complaint investigations in a timely manner. Complaint investigation reports are not submitted to the central office in a timely manner, particularly for complaints assigned the Springfield, St. Louis, and Kansas City Regional Offices. Numerous other problems regarding complaint investigations were noted at the Kansas City Regional Office. Also, facilities which correct the cause of the violation before the complaint investigation occurs are rarely sanctioned.

3. Report Deficiencies, Sanctions, and Corrective Action (pages 28-35)

The DA does not study the effectiveness past sanctions have on future compliance by facilities, and does not always consider a facility's history of past noncompliance when determining sanctions. The federal civil monetary penalty (CMP) appears to have been an effective sanction; however, the state CMP process is too onerous and burdensome. Plans of Correction (POC) submitted by facilities which have been cited for deficiencies are often ineffective and/or the POC is not properly monitored for compliance.

4. Staffing of Nursing Homes (pages 35-42)

The DA rescinded minimum staffing requirements. This action appeared to contradict the intent of state law. In addition, the rescinded staffing requirement appears to have been too low to provide adequate care to nursing home residents. A new system being developed provides an estimate of the actual hours of nursing care needed to meet the needs of the actual residents in a specific nursing home. The DA needs to compare staffing levels recommended by this system to actual staffing information from the facilities. DA surveyors do not review facility staffing levels and

compare them to any minimum standard or industry benchmark. The DA did not sanction a facility to the fullest extent warranted when a widespread pattern of understaffing existed.

5. Employee Disqualification Listings, Central Registry, and Criminal Backgrounds (pages 42-47)

The DA is required to maintain a listing of persons who have abused, neglected, or exploited the elderly and disabled. Nursing homes, residential care facilities, businesses who hire nurses aides, hospitals, and home health agencies are prohibited from hiring anyone on the employee disqualification listing (EDL). We identified 21 instances in which a nursing home or in-home care provider under contract with the department had hired a person listed on the EDL. The DA does not always issue a deficiency to facilities that hire persons listed on the EDL. In addition, the DA does not have adequate procedures in place to identify employers who do not perform criminal background checks. More than 1,100 persons listed in the Department of Mental Health employee disqualification listing and the Central Registry of Child Abuse and Neglect were working in nursing homes or at in-home care providers. In addition, instances were noted in which persons listed on the Aging and Mental Health listings and within the abuse and neglect registry were working in other inappropriate work settings.

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MANAGEMENT ADVISORY REPORT

1. Inspections

Under federal and state regulations, the Division of Aging (DA) is charged with the responsibility to conduct inspections of licensed nursing homes and residential care facilities. Currently there are about 1,250 of these facilities operating within the state. Federal regulations require nursing homes that are certified to participate in the Medicare and Medicaid programs to be subjected to an 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 subjected to at least two inspections annually. Under DA policies, one of those inspections, designated a "full" inspection, must determine whether the facility is in full compliance with all state licensing and provision of care requirements except those reviewed during the interim inspection. The DA usually performs the "full" inspection and the federal inspection at the same time. DA policy requires the second annual state inspection process, designated the "interim" inspection, to focus on quality of care from an outcome perspective and compliance with six statutorily mandated areas (surety bonds, nurse aides training, resident funds, operational policies, grievance system, licensed administrator), and the federal Patient Self-Determination Act. Section 198.032, RSMo 1994, requires inspection reports to be centrally filed in a manner that facilitates rapid access and to be available to the public for examination and copying.

Our review of the DA's inspection process noted the following areas of concern:

A. For inspections where deficiencies are found, the results of both full and interim state inspections are documented on a DA-107 form. If no deficiencies are found, the inspection is documented on a DA-102 form. The forms along with any necessary statements of deficiencies, plans of correction, and required letters of the inspection results make up an inspection report packet and those packets are submitted to the Central Office for data entry to DA's centralized data base and filing in the central file room. The DA policy regarding submission of completed federal inspection packets is to submit the packet, except in rare instances, within 90 days following the exit conference.

   The DA does not appear to utilize its centralized data base to monitor compliance with state laws regarding the timing of facility inspections. We reviewed inspections completed for state fiscal years (SFYs) 1998, 1997, and 1996, and noted that inspection reports are often not submitted to the Central Office in a timely manner. We identified 81 inspection reports, some dating back to SFY 1996, for which the inspection had been completed but

the inspection report had not been submitted to the Central Office. We also identified 102 inspection reports which had been submitted to the Central Office but the results had not been entered into the DA's computerized data base. Because inspection reports are not submitted to and entered into the database maintained by Central Office timely, the DA is unable to rely on the system to properly monitor and ensure inspections mandated by state law have been performed. In addition, the reports that are not filed with the Central Office are not centrally filed and therefore do not appear to be readily accessible to the public as required by Section 198.032, RSMo 1994.

B. Because the DA's system does not maintain the current status of facility inspections, we asked the DA to research inspection records to determine if the DA was in compliance with state inspection requirements for SFY 1999. The DA determined it had failed to conduct 53 full and 363 interim inspections during SFY 1999. As a result, it appears the DA is not in compliance with the state law regarding inspections for nursing homes and residential care facilities.

We compared the listing of facilities that did not receive a required inspection in SFY 1999 to the listing of facilities that had been issued a notice of noncompliance by the DA since 1997. A notice of noncompliance is only issued to a facility that was cited for a Class I violation or had a Class II violation that had not been corrected by the time of the revisit. A Class I violation is one which presents either an imminent danger to the health, safety, or welfare of any resident, or a substantial probability that death or serious physical harm would exist. A Class II violation would have a direct or immediate relationship to the health, safety, or welfare of any resident, but which does not create imminent danger. We determined twenty-three of the facilities that did not receive the required inspection had at least two notices of noncompliance issued in the last three years. One of those facilities had not received either the full or interim inspection.

The DA attributed some degree of the missed inspections to the significant increases in the number of serious complaints in SFY 1999 which required extensive investigations by DA inspectors. The total number of complaints received by the DA increased 9 percent from SFY 1997 to SFY 1998 and 21 percent from SFY 1998 to SFY 1999. In addition, the DA stated a substantial increase in the number of notices of noncompliance issued in the last two years required significant additional inspector time to write up the deficiencies, monitor those facilities, and provide testimony at hearings on the enforcement actions resulting from those notices.

The DA should take immediate action to comply with state law regarding the inspection of nursing homes and residential care facilities.

C. We also examined inspection reports for SFYs 1998, 1997, and 1996. The DA was unable to provide documentation that any inspection, either full or interim, had been conducted at two intermediate care facilities in SFY 1996 or at one residential care

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.

The DA maintains that inspectors were at these facilities and offered employee time records to verify their contention. However, without a completed inspection report, the DA is not in compliance with state law and there is no documentation that completed inspections were properly performed. In addition, written inspection reports are necessary to apprise the public whether facilities are in compliance with various state and federal regulations.

D. Section 198.022, RSMo 1994, requires the DA to make **at least** two inspections per year. This statute also allows the DA to make as many inspections as it deems necessary. As noted above, the DA has not even been able to make the minimum number of inspections required by law, much less to perform additional inspections. Nevertheless, the DA rarely performs additional inspections. It would appear the DA could identify the chronically poor performing facilities and subject these facilities to additional onsite inspections. Additional inspections may help identify deficient conditions in a more timely manner and help force the poor performing facilities to maintain a higher level of care throughout the year.

E. Federal and state regulations require inspections to be unannounced and unpredictable. Many citizen complaints received by both our office and the DA allege that facilities were aware of or could predict when the next inspection would occur. Those complaints further allege that facilities often make temporary or cosmetic changes in their staffing levels, physical environment, and quality of care in an effort to mask underlying systemic problems when the facility thought the inspection was pending. DA personnel acknowledged that it is not unusual for staffing levels to increase once an inspection begins. Scheduling inspections in a somewhat predictable pattern tends to offset the unannounced aspect of the surveys and inspections. During our review we noted several examples of the inspection order and/or inspection dates of facilities being very patterned.

Predictable inspections provide facilities the opportunity to make temporary improvements in staffing levels and the condition of the facility to coincide with the expected date of the inspection. In September 1998, the DA adopted a revised inspection scheduling policy. Under the revised policy, regions are to vary the geographical ordering of the inspections. Also, to further decrease the predictability of inspections, the DA starts at least 10 percent of the inspections in the evening or night hours or on weekends.

The DA should continue to identify and implement ways in which the predictability of the inspections could be reduced by varying the chronological order and timing of inspections.

F. During the inspection process, inspection staff review 190 areas or categories to identify violations of state and federal regulations. Violations noted in these categories are called deficiencies. We obtained a September 1999 On-line Survey and Certification Reporting System (OSCAR) summary report of deficiencies issued to the certified facilities. The report included summarized data on 559 skilled nursing facilities (SNFs) in the state which included approximately 490 facilities inspected by DA. The other SNFs are hospital based and are inspected by the state's Department of Health. This summary report revealed the percentage of homes cited for the 190 categories by region, state, and the national average. We noted the DA cited certified facilities at a rate 5 percent higher than the national average for four of the 190 categories. The cite rate was 5 percent below the national average rate for nine categories. The total number of facility/cites for the state was 2,475, with 559 facilities, for an average cite rate of 4.43 deficiencies per facility for Missouri. The national average cite rate per facility is 5.36 deficiencies per facility. The DA had not studied this readily available report in any detail and could not explain why the DA average cite rate per facility was lower than the national average. While the difference between the cite rate of Missouri and the nation was often slight, the DA was below the national average in 155 categories, the same for two categories, and above for only 33 categories.

We also reviewed the variations in the cite rates among the seven regions within the state. The lowest cite rate was Region 1 in Southwest Missouri at 3.36 cites per facility. Region 4 in Northwest Missouri averaged 7.25 cites per facility. Again DA has not studied the variation between regions in much detail. Industry officials and advocates for the elderly have stated one of their biggest concerns with the DA inspection program is the apparent lack of consistency between inspections and the variations in interpretation and enforcement efforts between regions.

The DA should study 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. The U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), the federal oversight agency, conducts two types of federal monitoring surveys (FMS) to determine if the DA is complying with the federal inspection process.

HCFA performs observational inspections and accompany the DA inspectors during the actual onsite inspection process. HCFA provides guidance and advice to the state inspectors to help them improve their inspection technique. We identified 31 facilities that had been subjected to an observational FMS during the period April 1996 through November 1999, and for which we could compare the number of deficiencies noted to the previous DA inspection. More deficiencies were cited during the FMS than the previous DA inspection for 19 of the 31 facilities. One facility increased from 5 to 45

deficiencies. In total, 208 deficiencies were cited during the previous DA inspection and 320 were cited at the subsequent FMS.

HCFA inspectors also conduct comparative or look behind inspections in which the federal inspectors conduct a separate inspection and compare their results to the results of the state inspection. HCFA then provides the DA with follow-up reports that identify areas in which the DA should consider providing additional training to inspection staff.

In a United States General Accounting Office (GAO) report issued in November 1999, the GAO concluded that HCFA's presence during surveys is likely to make state surveyors more attentive to their inspection tasks than they would be if they were not being observed. The report also contained the following example related to a Missouri nursing home:

> "...surveyors from HCFA's Kansas City region found 24 deficiencies in a Missouri nursing home that state surveyors did not identify during their survey conducted about 6 weeks earlier. One of these deficiencies identified six residents whose nutritional status was not being adequately assessed by the nursing home, resulting in significant weight loss in several cases. One resident lost 19 percent of his weight between June and October 1998. His weight at the time of HCFA's survey was 93 pounds, which HCFA indicated was significantly below the resident's minimally acceptable body weight of 108 pounds. Fewer than 4 months after his admission to the nursing home, this resident also had developed two moderately severe pressure sores, which the home was inappropriately treating with a cream the manufacturer stated was not intended to heal pressure sores but rather to prevent irritation to the skin. According to HCFA surveyors, these deficiencies affecting multiple residents should have been evident at the time of the state's survey, but the state surveyors did not cite them."

An increase in the number of deficiencies cited when HCFA inspectors are available for guidance and advice may indicate a need for additional training for state inspectors.

H. A statement of deficiencies (SOD) is prepared by the inspection team members who were present during the onsite inspection or complaint investigation. The SOD is then reviewed by the team supervisor and at least one other ranking manager, often the regional supervisor. The supervisory review is intended to ensure the SOD meets the technical writing standards, appears to be complete and accurate, and is based upon clear and convincing evidence that the violations noted were in fact violations and were well

supported by the facts and examples used. When the supervisory review is complete, the SOD is sent to the facility's management.

If the facility's management disagrees with the violations noted in the SOD, they can request an informal dispute resolution conference (IDR). The IDR process allows the facility to present additional evidence to show that any particular deficiency cited was not a violation or was not as serious as the inspectors indicated. Representatives of the facility, and often their attorneys, meet with several DA management and usually members of the inspection team. The DA then decides whether to uphold the deficiency, remove the deficiency, or lower or raise the severity level at which the deficiency is cited. IDR's are recorded and summary notes are made to document the decisions made.

We reviewed more than 100 SODs and generally found them to meet the supervisory review criteria noted above. We noted many instances in which one or more proposed deficiencies had been deleted by a supervisor. In most instances where a proposed deficiency had been deleted, the supporting evidence for the deficiency was marginal, the examples were weak, or it was decided to issue the deficiency under a different category. However, we noted two SODs which were extensively revised by DA management:

1) In December 1998, the inspection team conducted a survey and on December 22 an SOD was hand carried to the facility which identified fourteen violations of federal regulations, two violations of the Life Safety Code, and ten violations of state regulations. On December 28, the facility owner and the administrator met with DA management to protest the deficiencies and requested an IDR.

   Instead of proceeding with the IDR process for the initial SOD, DA management decided that Central Office staff would conduct a review of documents and an on-site visit to interview staff, residents, and make observations of the facility. On December 29, a member of the Central Office staff visited the facility. On December 30, the facility's law firm presented a formal request for an IDR to the regional manager. On January 2, the DA issued a letter stating the results of the inspection had been revised and the facility was determined to be deficiency free.

   Subsequent to DA's January 1999 decision to issue a deficiency free report to the facility, the DA returned to the facility in April 1999 to conduct a complaint investigation. This investigation resulted in the DA citing the facility for three federal and five state deficiencies, including four Class I deficiencies, and recommending a federal CMP of $7,050 per day for 15 days. The facility has since requested an IDR.

2) In November 1998, the DA conducted a inspection and prepared an SOD, dated December 10, citing eleven federal and nine state and two life safety code

violations. The facility, through its attorney in a letter dated January 6, 1999, protested the citations and requested an IDR. DA management began an in-depth review of the SOD and the inspectors' workpapers, and held discussions with the inspection staff. After the initial review by an upper level management official, the number of deficiencies was reduced to six federal and six state deficiencies. The facility continued to protest and by January 22, 1999, the DA agreed to reduce the number of deficiencies to three federal and four state violations.

In late January, the regional manager and the upper level management official who had conducted the in-depth review of the SOD visited the facility and interviewed the residents identified in the remaining federal categories. The DA official stated that the residents were impaired, confused, or demented to the point that any statement by those residents could not be relied upon. On February 15, 1999, the DA issued the facility a letter stating that all proposed deficiencies had been deleted. Again the formal IDR process was not utilized in this instance.

The above instances indicate that either the DA inspection team did not adequately perform and/or document the results of the inspections, or the DA management inappropriately removed some deficiencies initially cited by the inspection team. DA management stated the reasons for the significant changes to these SODs related to insufficient documentation of findings and problems associated with report writing. Full and complete documentation as to why changes were made to the SODs is not available. One method to provide that documentation is for the DA to follow its established process for resolving disputed deficiencies.

3) We also reviewed a summary of a DA official's review of another inspection. After the inspection had been completed and the SOD prepared, a complaint alleged to DA management that the inspection had not been conducted properly, that information provided to the inspector was ignored, and that some deficiencies that existed had not been cited. The DA official's summary indicated that at least three Class I violations were well documented in the inspector workpapers but no violation was issued. Those violations were inadequate staffing, the facility administrator's failure to report a broken arm to the DA hotline, and failure to provide a pureed diet as ordered by a doctor which resulted in a resident choking to death. The DA provided the inspection team with additional training as a result of its internal review.

The DA should establish appropriate review procedures to ensure SODs contain all deficiencies identified by the survey team. In addition, the DA should continue to identify additional training needs and provide training to inspector staff.

WE RECOMMEND 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.

AUDITEE'S RESPONSE

A. During State Fiscal Year 1998, the division entered 2,422 (98.6%) of the state licensure full and second inspections into the central data base; 2,591 (98.9%) during SFY 1997 and 2,394 (99.0%) during SFY 1996. We agree that 81 or 1.1% of the inspection reports over the three year period were retained in our regional offices and that 102 or 1.4% of the reports over the three year period were in central files without being entered into the CRANE system. As a result of the auditor's recommendations, we have taken action to strengthen our internal controls over entry of data into the CRANE system; CRANE report review by regional managers and subsequent submission of the paper file to the central file unit. DA working with consumers and the long-term care industry noted the shortcomings in the federal On-line Survey, Certification and Reporting (OSCAR) System and began developing and implementing a new state system, the Automated Licensure, Inspection, Certification Environment (ALICE) under a five (5) year plan that began in 1996. The system will result in a centralized data base designed to support all primary agency operations and meet federal and state data collection requirements.

The division is complying with the requirement of making reports available to the public. State law requires the division to make inspection reports and written reports of investigations of complaints, of substantiated reports of abuse and neglect received in accordance with section 198.070, RSMo and complaints received relating to the quality of care of facility residents accessible to the public. These reports are to be available for examination and copying, provided that such reports are disclosed in a manner that does not identify the complainant or any particular resident. Records and reports are to clearly show what steps the division and the institution are taking to resolve problems indicated in the inspections, reports and complaints. Additionally, the federal State Operations Manual

(SOM) indicates that information from the survey process may be provided to interested parties within 14 calendar days after the information is made available to the facility. Provisions of the Federal Freedom of Information Act (FOIA) require that when a request to disclose related to the federal Medicare/Medicaid facilities is received, the information be released within 10 working days or if this is not possible, the requestor be notified within 10 working days when the information will be released.

Routinely, survey and inspection packets including complaint investigations are retained in the regional office until the survey or inspection process including the facility's submission of a plan of correction is complete (including any resulting informal dispute resolution or facility revisit). Our process has been to promptly notify the requestor of information when the information is not yet in the central file or not yet accessible by the public and provide a date when the information will be provided. Virtually every file has to be reviewed prior to release to the public to ensure that the federal and state requirements related to confidentiality of client specific information are met. Central files bases the date provided to the requestor upon the federal requirement that the facility receive the information 14 days prior to its' public release and the state requirement for accessibility. As necessary to meet the needs of individual requestors, central files will ask the region to fax or next-day mail releasable material. Allowable information is then made available to the requestor after resident specific information is removed. Again, the division believes the federal and state requirements to provide ready access to information within reasonable timeframes are being met through this process.

B. *DA concurs that we did not meet the state requirement for two state inspections per year, one of which is an interim inspection in State Fiscal Year 1999. The division completed in State Fiscal Year 1999 full licensure inspections including adult day care programs for 1,173 or 95% of the facilities and programs in the state. Additionally, the division completed a total of 762 or 62% of the required interim inspections. During State Fiscal Year 1999, the division began responding to a dramatic increase in nursing home violations. The number of state notices of noncompliance nearly doubled from 110 to 211. The number of Medicare/Medicaid facilities cited for substandard quality of care nearly tripled from 31 to 90. The number of Medicare/Medicaid facilities cited for immediate jeopardy nearly quadrupled from 20 to 73. The division requested HCFA impose denial of payment on 63 facilities for new Medicare/Medicaid admissions and requested HCFA impose Civil Monetary Penalties (CMPs) 51 times against 30 facilities. Complex cases involving these legal actions (See Chart 2) routinely result in up to an additional 300 hours of staff time per instance. Staff time is spent conducting investigations into allegations of abuse/neglect, copying reports, letters and other material requested through discovery, responding to interrogatories, being deposed, participating in administrative meetings and hearings and preparing materials for employee disqualification list referrals.*

Institutional Services management staff decided that should any requirements not be met we would not meet the state licensure requirement for a second visit. Additionally, full

inspections would be conducted in conjunction with the federal certification survey in Medicare/Medicaid facilities, even if the state 12 month timeframe was exceeded. This ensured that the top federal priority for completion of all Medicare/Medicaid certification surveys within a 12 month average (surveys conducted between 9 and 15 months) was met. Further, we began researching alternative methods to meet the state licensure requirement, such as use of outside contractors. We were unable to find a viable alternative due to the training timeframes (i.e., 9 to 12 months for a fully trained surveyor) for inspection staff.

C. *The division's policy has been to maintain copies of all inspection and complaint reports, other than those specifically required to be purged (i.e., unsubstantiated reports of abuse/neglect). State statute at 198.032, RSMo, sets forth requirements for maintaining those records related to facilities "noncompliance". Language is specific in that records and the steps the division and the institution are taking <u>to resolve problems indicated in the inspections, reports and complaints</u> are kept and available to the public or where substantiated abuse/neglect was found. Until House Bill 316 was passed during last year's legislative session, statute had been silent as to the requirement for the division to maintain a history of compliance at a facility.*

During the three year period (SFY 1996 through SFY 1998), the division completed and is able to produce hard copies of 7,407 full and interim inspections. As stated in the auditor's report, we were unable to provide copies of 23 full and 68 interim inspections or 1.2% of the total inspections completed. As noted in the auditor's report, the division was able to show through time reports that survey staff were in the facilities during the applicable time frame. We are reviewing and will strengthen our documentation policies to ensure that all copies of documents are entered into the central data base and copies maintained in our central file unit.

D. *During State Fiscal Year (SFY) 1999, the division conducted a combined total of 3,368 federal surveys, state licensure full and interim inspections and revisits associated with the survey or inspection event. Division staff monitor "poor performing facilities a number of times a year by conducting:*

- *full inspections;*
- *interim inspections;*
- *revisits after issuance of a Statement of Deficiencies;*
- *complaint investigations;*
- *monitoring for up to 24 hours per day if warranted to safeguard residents; and/or*
- *a second full annual survey required by HCFA for two "poor performing" facilities under the President's Nursing Home Initiatives.*

Currently, the Division of Aging, Institutional Services section has a total of 158 full time inspection staff. These staff are responsible for conducting state licensing activities, federal surveys and complaint investigations in the over 1,230 facilities statewide. A budget request has been submitted to the Legislature supporting additional inspectors enabling the division

to provide the statutorily required inspections. We remain committed to meeting the state requirement for two inspections per year. We will continue to explore opportunities to spend more time in poor performing facilities.

E. *Due to the number of times DA staff are in facilities, predictability is somewhat inherent in the process, but we have taken actions to control for this tendency. Additionally, the state law for two inspections within a twelve month period (state fiscal year) and federal requirements related to survey averages and revisit timeframes (i.e., revisit near the time the facility alleges all corrections have been made) further increase the predictability of our visits. We concur with the goals of reducing the predictability of inspections and of fostering a highly qualified and competent survey staff having access to all information available to support their work.*

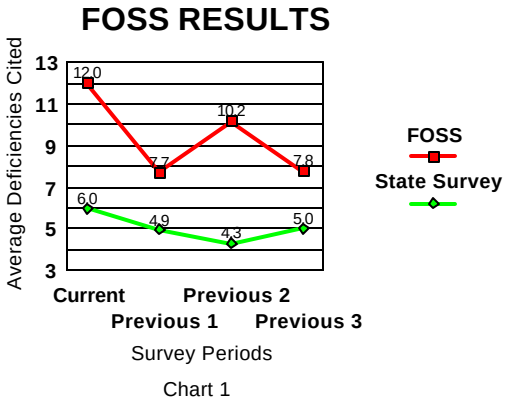

Chart 1

F. *DA does review national and regional deficiency rates and patterns. The HCFA Online, Survey, Certification and Reporting (OSCAR) system serves as a starting point for our review, but has historically proven unreliable as a predictor of survey staff ability or facility status. Data available through the OSCAR system is limited to information collected during the latest four (4) annual facility surveys (routinely covering 48 months) and four (4) complaint investigations (routinely covering less than 6 months in a poor performing facility). DA has determined that we must examine multiple variables to make accurate assessments of facility performance and survey staff technical ability.*

G. *During the current survey cycle, the division cited more deficiencies in 247 facilities than in the prior year, cited the same number of deficiencies in 64 facilities, cited a decreased number of deficiencies in 160 facilities and did not have two years data available for comparison in 14 facilities (excluding facilities where federal surveyors were present during either the current or previous process.) . This chart compares results of the Federal Observational Survey activity (on average 22 surveys per year) and state survey agency activity (on average 444 per year) in Missouri during the past three years.*

DA agrees that there are significant differences in the citation rates of the current FOSS and previous 2 FOSS surveys as compared to the state average of a much larger population of surveys. Given the number of surveys conducted and this 4 year period, DA is more consistent in our citation rate than HCFA. The federal Health Care Financing Administration (HCFA) is responsible for providing the training including training plans and materials for survey staff. HCFA administers the Surveyor Minimum Qualification Test (SMQT) which is required to be passed by all qualified surveyors. HCFA has routinely performed the FOSS in facilities that <u>do not</u> have histories of being "deficiency free". HCFA prefers their staff monitor in facilities with some level of noncompliance in their history. Therefore, we do not agree that the sole reason for the difference in the citation

rate is a result of the presence of federal surveyors and in fact, has more to do with conditions present in the facilities selected.

DA disagrees that federal comparative surveys are comparable to state surveys of the same facility. Federal comparative surveys are completed using different criteria and resources than those set forth by HCFA for state survey agency use. Differences include: utilization of different numbers and types of survey staff; use of different samples of residents; reviews of different areas of resident care; the periods of time surveyed are not the same and findings from the federal comparative survey are not required to be legally defensible.

H. *DA has reviewed the two (2) examples (from the sample of 100) noted in the state auditor's review which relates to inappropriately removed deficiencies and DA was unable to make a similar determination from the information available. We noted that staff failed to adequately provide written documentation for removal of some deficiencies, however, upon interviewing those staff responsible, we determined their actions were within their scope and authority. DA's standard operating procedure allows for central office reviews including administrative reviews of statements of deficiencies (SODs) to determine, if errors have occurred in the survey process and to determine if supporting documentation and evidentiary matter is sufficient to warrant inclusion of a finding in the SOD. DA does not concur with the state auditor's opinion that management staff do not have the authority to review work of subordinates and make management decisions about the ability of the agency to sustain the conclusions reached. The division agrees that changes to SODs need to be adequately documented. We have reviewed the central office administrative review and quality assurance processes and have strengthened our internal controls over documentation requirements for these processes including feedback to field survey staff.*

AUDITOR'S COMMENT

H. The DA's contention that it is our position that the DA management should not review and make management decisions regarding the work of inspection staff is inaccurate. Obviously, it is necessary to review the adequacy of the work of inspection staff. However, it is also necessary for the DA to adequately document why changes, especially such extensive changes, are necessary to SODs. The need for this documentation is further magnified when the dispute resolution process is not used or avoided.

2. Complaint Investigation Processing and Procedures

The DA is responsible for recording, investigating, and reporting the results of complaints made to the DA's elderly abuse hotline. Complaints are assigned to the Institutional Services (IS) section if the allegation concerns a nursing home or residential care facility or one of their residents. The DA received 7,399, 6,091, and 5,591 institutional complaints in SFYs 1999, 1998, and 1997, respectively. The Home and Community (HCA) section handles complaints for other clients or

potential clients of the DA. The DA received 14,099, 13,386, and 12,623 home and community complaints in SFYs 1999, 1998, and 1997, respectively.

Institutional Services complaints are classified in four categories, abuse and neglect (A/N), and Classes I, II, and III. Abuse is defined as the infliction of physical, sexual, emotional, or financial harm or injury. Neglect is the failure to provide services when such failure presents either an imminent danger to the health, safety, or welfare or substantial probability of death or serious physical harm. The classification of complaints is consistent with the standards defined in Section 198.085, RSMo Cumulative Supp. 1999. A Class I violation is one which presents either an imminent danger to the health, safety, or welfare of any resident, or a substantial probability that death or serious physical harm would result. A Class II violation would have a direct or immediate relationship to the health, safety, or welfare of any resident, but which does not create imminent danger. A Class III violation would have an indirect or potential impact on the health, safety, or welfare of any resident. Section 198.088, RSMo 1994 requires the DA to promptly review A/N, Class I and Class II complaints. Section 198.070 (5), RSMo 1994, requires DA to initiate investigation of A/N complaints within 24 hours and to notify the next of kin or responsible party as soon as possible, and to further notify them whether the report was substantiated or unsubstantiated.

For Institutional Services complaints, DA policy requires a completed investigation report for A/N and Class I complaints to be submitted to the Central Office within 60 days. Reports of Class II and III complaints are due at 120 and 150 days after receipt, respectively. With the exception of unsubstantiated A/N complaints, Section 198.032(2), RSMo 1994, requires written reports of investigations of complaints to be accessible to the public for examination and copying, provided such reports are disclosed in a manner which does not identify the complainant or any particular resident. By DA policy, HCA complaint reports are due within 90 days after receipt of the complaint. We reviewed the handling of complaints and noted the following concerns.

A. The DA does not always initiate complaint investigations in a timely manner. DA policy, and in some cases state law, requires complaint investigations of abuse and neglect and Class I complaints to be initiated within 24 hours of the initial receipt of the complaint, Class II complaints to be initiated within 90 days, and Class III complaints to be initiated at the next visit to the facility. According to DA records, in SFY 1999 the DA failed to initiate complaint investigations within these timeframes 5.6 percent of the time for A/N, 6.4 percent for Class I, 5.1 percent for Class II, and 1.5 percent of the time for Class III.

   Delayed initiation often makes it more difficult to determine whether an incident or violation actually occurred. As a result, the DA should ensure complaint investigations are initiated timely.

B. We obtained the DA's report of overdue complaints dated May 10, 1999 and noted 1,657 complaints for which a completed summary report had not been submitted to the Central Office within the timeframes required by DA policy. Of these 1,290 were institutional

service complaints and were at least 120 days past the due date, including nine which had been received in 1996 and 108 which had been received in 1997.

The overdue complaint investigation report is produced monthly and distributed to the regions. The regions are to review the report and take necessary action to complete the investigation and submit any overdue reports. Apparently, overdue reports are given a very low priority by the regions. During our audit, our office had received numerous complaints from citizens stating that DA was unresponsive or untimely in their complaint investigations. The following table indicates the reports which were 120 days overdue by institutional service complaint type and region.

Division of Aging 120 Day Overdue Institutional Services Complaint Investigation Reports (as of May 10, 1999)

Complaint Type	Region #1 Springfield	Region #2 Poplar Bluff	Region #3 Kansas City	Region #4 Cameron	Region #5 Macon	Region #6 Jefferson City	Region #7 St Louis	Total
A/N - Abuse & Neglect	18	0	41	0	3	0	26	88
Class I - imminent danger	53	0	101	2	2	0	78	236
Class II - direct relationship	180	0	373	3	4	1	288	849
Class III - indirect impact	24	0	77	0	0	0	16	117
Totals	275	0	592	5	9	1	408	1290
Percentage of the total past due	21.3	0.0	45.9	0.4	0.7	0.1	31.6	100.0

Division of Aging Total Number of Institutional Services Complaints Received

State Fiscal Year								
1997	845	405	1175	304	275	527	2060	5591
1998	941	437	1424	325	323	547	2094	6091
1999	1140	532	1615	397	384	705	2626	7399
Three year total	2926	1374	4214	1026	982	1779	6780	19081
Percentage of total received	15.3	7.2	22.1	5.4	5.1	9.3	35.5	100.0

1) As is evident from the table, timely completion of institutional complaint reports was a significant problem in DA state regions 1, 3, and 7 (and particularly in Region 3). We attempted to review the more serious complaints in those regions to determine whether the DA had investigated the complaints. There were 85 A/N and 232 Class I complaints which were at least 120 days overdue from these three regions.

   At our request, the regional offices researched their files and provided the exit date and complaint conclusion status for the missing reports. The exit date is the date on which the DA discussed the resolution of the complaint with the facility administrator or representative. Of the 317 complaints which were at least 120 days overdue, the time between the initial complaint date and the exit date exceeded six months for 26 of these complaints and one year for 3 complaints.

2) We waited one month and then requested the DA provide the completed complaint investigation reports for the 317 A/N and Class I complaints which were at least 120 days overdue at the time of our earlier inquiry. Region 1 and Region 7 had submitted the overdue investigation reports, however, Region 3 failed to submit completed reports for 30 A/N and 68 Class I complaints. According to DA staff from Region 3, almost all of the missing complaints had been determined to be invalid or the allegation could not be verified. Even if a complaint is determined to be invalid or the complaint could not be verified, an investigation report is still required.

The following is an example of one of the complaints which is not supported by an investigation report:

- One A/N complaint received December 1998 alleged that in October 1998, a legally blind woman with a broken ankle was being transferred by an employee to her bed and the employee caused her to fall to the floor. That employee yelled at her to get up and while she was trying to get up the employee twisted her causing her to break her knee and again she fell to the floor. A second employee then came into the room and both employees yelled at the woman to get up. The woman underwent surgery to repair the knee later that day. DA staff from Region 3 indicated the complaint was exited in April 1999 and the complaint was determined to be invalid. The facility named in the complaint was also named in four other missing complaint investigation reports.

Without completed investigation reports there is no assurance the complaints were investigated properly and timely, the conclusion status was reasonable, or that any appropriate enforcement action was taken. In addition, the missing reports will not be part of the public record as required by state law.

3) We compared the conclusion status of the 120 day overdue A/N and Class I complaints from Region 3 and noted that those reports were determined to be invalid 75 percent of the time. We noted that the average statewide rate over the last three years for which complaints were determined to be invalid was 31 percent for A/N and 46 percent for Class I complaints. Delay of investigations and completion of reports appeared to result in a decreased ability to identify valid complaints and therefore take any appropriate protective or enforcement action. As in any investigatory process, evidence is lost and memories fade, and involved parties lose interest with the passage of time.

4) Of the 98 missing Region 3 reports, 62 complaints arose from a Medicare and/or Medicaid certified facility. Under the State Operations Manual Section 7700, the completed complaint investigation report must be made on Form HCFA-562 and

entered into the OSCAR system within 90 days of the completion of the investigation (exit date) regardless of whether the complaint is substantiated or unsubstantiated.

5) We noted five instances in which a completed investigation report from Region 3 for the 120 day overdue complaints concluded that due to the excessive length of time that had passed since receipt of the report, the DA would not send the letter to the resident's family or the reporter as required by state law. Two examples of complaints where the reporter was not contacted follows:

- The first complaint, received May 2, 1996, alleged a resident was admitted to a hospital with unexplained injuries in February 1996 and was readmitted to the hospital in April 1996 and some of the resident's personal property had disappeared. The report indicated the DA conducted an on-site investigation and determined the complaint was invalid. The complaint was exited May 8, 1996. The investigator completed the report March 29, 1999, and the supervisor approved the report April 4, 1999. No letter was sent to the reporter due to the age of the complaint.

- The second complaint received October 14, 1996, indicated a resident had a black eye of unknown origin. The report indicates the investigation was initiated within 24 hours and the investigator was unable to verify the cause of the injury. The complaint was "reinvestigated" on March 25, 1999, and exited that day. The report was completed on March 29 and approved April 1, 1999. No letter was sent to the reporter due to the age of the complaint.

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

C. We noted that of the total 2,165 A/N complaints received in the SFYs 1999, 1998, and 1997, the complaint investigation report was assigned the "B" status (valid but corrected by time of investigation) 508 times (23 percent) and, of 3,285 Class I complaints, the "B" status was assigned 547 times (17 percent). The "B" status is to be assigned when the allegation in the complaint is valid or a regulatory violation has occurred but the DA cannot determine the harm or serious violation was clearly the fault of the facility. In each instance, there were one or more residents who were exposed to actual or potential serious harm. The "B" status is also assigned if the facility has taken corrective action by the time the DA

can investigate. This is often termed past noncompliance. Only in the most severe incidents does the "B" status noncompliance result in any punitive action against the facility. The following is an example of a complaint assigned the "B" status as well as not timely investigated:

- A resident who had a history of attempted and successful elopements from the facility was identified as missing at 8:40 p.m. The resident was returned to the facility at 1:40 a.m. by local police. This resident suffered from dementia and heart problems. The complaint was received on March 3, 1997. The complaint was investigated in December 1998 and was exited in January 1999. The facility was not issued a statement of deficiencies nor had any sanction imposed because of this incident. The resident was moved to another facility sometime after the elopement but before the investigation was conducted. The facility also had added a locked unit for residents having elopement risks.

As noted in the definitions above, a valid A/N or Class I situation has presented an imminent danger or substantial probability of death or serious harm to a resident. Nursing home operators and administrators are charged with the responsibility to provide 24-hour protective oversight to all residents and should be able to recognize conditions and potential problems with employees and with residents that could lead to actual harm. While use of the "B" status may be appropriate in very limited circumstances, it would appear that with effective oversight, facilities could prevent many of those incidents from ever occurring in the first place.

The DA should reexamine the policies related to enforcement actions following the determination that an abuse or neglect incident or a Class I violation occurred, but the facility had taken corrective action before the investigation was completed. The DA should consider stronger enforcement actions which may lead facilities to develop additional preventive measures which could reduce the number and severity of incidents in which nursing home residents are exposed to actual or potentially serious harm.

D. If a nursing home questions the appropriateness or validity of a deficiency which resulted from an inspection, survey, or complaint investigation it may appeal the deficiency through the IDR hearing. However, no such process exists for complainants who wish to appeal the result of an investigation. The state of Illinois established an administrative hearing process for complainants who are dissatisfied with the results of a complaint investigation. During the course of our review, we received many complaints from citizens who alleged the DA did not thoroughly investigate complaints.

The DA should study the merits of establishing a similar process.

WE RECOMMEND 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.

AUDITEE'S RESPONSE

A. A total of 7,399 reports of elder abuse, neglect or exploitation and/or regulatory violations within long-term care facilities were received during State Fiscal Year (SFY) 1999; 6,091 in 1998 and 5,591 in 1997. During SFY 1999, staff initiated within 24 hours 3,511 of these reports. Changes to the federal complaint process and inclusion of additional steps in the survey process have significantly increased the hours DA staff spend meeting federal survey requirements, limiting the time available for complaint investigations. Complaint reports have continued to increase and the time allowed for initiation of certain types of complaints has been reduced. DA staff are now required to spend on average an additional 16 hours on each annual survey (including off-site preparation time). While DA believes the changes in the federal survey process will allow us to better assess and focus on facility noncompliance, it has taken time away from the complaint investigation process. The Health Care Financing Administration (HCFA) continues to prioritize completion of annual surveys above complaint investigations. We believe delaying a complaint investigation to meet other HCFA mandated requirements <u>may result</u> in poor resident outcomes and in our staff being unable to adequately investigate, document (including collection of evidence), report and take appropriate enforcement actions against the facility. It is essential that we have adequate staff to investigate certain complaint reports immediately. Unfortunately, as in past years, HCFA continues to increase workload requirements while not meeting the staff and other resource needs of the state survey agencies. This year, HCFA was unable to provide nearly $600,000 of the division's budget request that would have allowed an increase in the number of field survey staff to ensure our compliance with these new or revised federal mandates including timely initiation and investigation of complaints.

The division had identified problems with the complaint process prior to the auditor's review and therefore, we concur with the auditor's recommendations. In State Fiscal Year (SFY) 1996, DA staff identified the need for sweeping revisions to the complaint system. Beginning

in SFY 1997, the division conducted internal reviews and convened focus groups to clearly identify issues and to make recommendations for systemic revision. Requests for budget appropriation for additional staff were made in 1998 and 1999 to obtain sufficient numbers of staff to implement the recommended revisions. These requests were partially funded. In addition, plans were made to replace the antiquated Central Registry for Abuse, Neglect and Exploitation (CRANE) system, through which all complaint reports are reported, tracked and documented. Until the new system comes on-line, an interim tracking and monitoring system has been implemented. The new on-line system is currently in the preliminary testing phase.

In mid-SFY 1999, the division began phasing in region-by-region a new complaint investigation process including a case management approach to ensure that complaint investigations are initiated timely and at a minimum, a call is placed to the reporter to determine the need for an immediate on-site visit. This process change resulted in increased community participation (family, friends, facility operators and other concerned individuals) in bringing to positive resolution issues affecting the day-to-day lives of facility residents.

B&C. We do concur that additional improvements are needed to the complaint system. The division took immediate action following discussions with state auditor staff to:

- *Designate a central office complaint coordinator and monitor to ensure complaint investigations are timely handled; reporters are called; required notices are mailed; and complaint investigation data is received and entered into the system.*
- *At least quarterly, monitor quality through a random selection of completed complaint reports. Comparisons of the selected reports to established quality assurance criteria will be completed; feedback to survey staff will be provided and training will focus on areas needing improvement.*
- *Initiate a management and internal control review of complaint processing in the Kansas City Regional Office to be followed by reviews in St. Louis and Springfield.*
- *Request funds in a State Fiscal Year 2001 new budget decision item to provide investigative skills training (24 hours) at this year's annual conference for all staff and to provide for an advanced course in the spring of 2001 for supervisors and full-time complaint investigators.*

As noted above, the division agrees that timely investigation of complaints is essential to ensuring an accurate reporting of the events that resulted in the complaint being filed. However, in order to meet the federal program mandates and state inspection requirements, as well as time frames for completion of complaint investigations, additional resources are needed to ensure <u>all</u> time frames are met. The Health Care Financing Administration continues to prioritize the completion of the annual survey ahead of completion of complaint investigations. The division <u>continues</u> to request annually through the state and federal budget processes funds for additional survey staff. Historically, we have not been successful in obtaining sufficient resources to meet the increasing need.

DA has reviewed our policies related to enforcement actions when corrective action has taken place before the investigation was completed. Our policies currently comport to the federal and state enforcement action requirements. From past and continuing experience, DA -- in following the required administrative process -- has found in specific cases where corrective action has taken place that we have been unable to successfully sustain cases brought forward for action when the facility has taken corrective action. DA notes that on January 18, 2000, the Missouri Court of Appeals, Western District, decided State of Missouri, Department of Social Services, Division of Aging v. Carroll Care Centers, Inc., -- S.W.2d --, WD56714 (Mo. App. Jan. 18, 2000), holding that it was proper to dismiss a CMP claim if the nursing home has corrected a cited deficiency at the time of reinspection. Here, the deficiency had been corrected by the time of reinspection. In such a case, the State's claim for sanctions was not authorized.

We continue to explore a wide range of sanction options and other initiatives to increase the quality of care provided to residents of long-term care facilities.

D. We agree that families must be involved in resolving complaints. Beginning in SFY 2000, the division is implementing an Informal Dispute Resolution (IDR) project to informally resolve issues through face-to-face contact with a facility resident, their family members or guardians when the resident is the subject of a complaint investigation or cited in a facility inspection or survey completed by the division pursuant to chapter 198, RSMo. The primary purpose of the meeting will be to gather additional information and bring to a satisfactory conclusion the resident or families concerns.

AUDITOR'S COMMENT

C. In regards to the appellate court's decision, if changes to current law are necessary for the DA to sanction or fine facilities for "B" status complaints, we suggest the DA seek such legislation.

3. Repeat Deficiencies, Sanctions, and Corrective Action

When a facility is found either during the regular inspection process or during a complaint investigation to have violated federal or state regulations, a statement of deficiencies is prepared and there are various enforcement options available to the DA. Under federal requirements, each deficiency is classified into one of 190 categories or tags. Tags are assigned a score of A through L depending on the severity of the problem and how many residents are affected. This is called the scope and severity grid score. An A level deficiency is one which was an isolated occurrence and which has caused no actual harm with potential for minimal harm. An L level deficiency is one where the deficiency was noted in a widespread pattern of actual harm resulting in immediate jeopardy to multiple residents' health and safety.

Under current guidelines, the DA may request federal sanctions based upon the scope and severity score and whether the deficiency is corrected or uncorrected at the time of the revisit. For all deficiencies at or above the D level, the facility is not in substantial compliance with federal regulations and the DA recommends denial of payments for new admissions. The DA may also request civil monetary penalties (CMP) ranging from $50 to $3,000 per day. However, facilities are given three months to correct the deficiency and if corrected within that time federal sanctions are not imposed. If some deficiencies are not corrected in the three-month period, denial of payment for new admissions is to be imposed and the facility may be granted up to an additional three months to complete correction of the remaining deficiencies. If deficiencies are not fully corrected within six months, the facility is to be terminated from the Medicare and Medicaid programs. Some categories of deficiencies at the F or higher level, if noted in two consecutive inspections, will result in designation as a poor performing facility. That designation results in the facility losing the grace period to correct deficiencies before a sanction is imposed. All immediate jeopardy deficiencies, scores of J, K, or L, require appointment of temporary management or termination within 23 days and CMP ranging from $3,050 to $10,000 per day may be imposed. If correction of the deficiencies occurs before the termination date and the facility is found to be in substantial compliance, the facility is allowed to continue participation in the Medicare/Medicaid program.

The DA requested 73, 18, 29, and 13 federal sanctions related to inspections and complaint investigations conducted during SFYs 1999, 1998, 1997, and 1996, respectively.

For each federal level of deficiency, there is a corresponding state regulation and in addition to the federal sanctions, the DA may also assess state sanctions for these deficiencies. Violations may result in state sanctions which include issuance of a notice of noncompliance, consent agreements, voluntary closure, license denial, revocation or surrender, receiverships, forced monitoring, and loss of the ability to provide in-facility nursing assistant training programs. As under federal regulations, facilities are allowed to correct lower level deficiencies by the time of the revisit, and if they do, no sanctions are imposed.

The DA issued 211, 87, 70, and 60, notices of noncompliance during SFYs 1999, 1998, 1997, and 1996, respectively. In addition to the notices of noncompliance, the state imposed additional sanctions on facilities 53 times during this 4 year period. Those additional requirements resulted in closure, voluntary or involuntary, of 16 facilities.

We noted the following examples where sanctions were ineffective in preventing identical deficiencies, and where the same facilities were cited for numerous deficiencies, year after year:

- Of the 490 certified facilities in the state, 90 were issued a repeat deficiency under the same tag number in the two most recent inspections. In addition, 28 facilities had been cited under the same tag in the three most recent inspections, and 13 facilities had been issued the same repeat deficiency in each of the four most recent inspections. 43 of the 90

facilities had from two to five repeat deficiencies, and 9 of the 90 facilities had from six to as many as thirteen repeat deficiencies.

- Four facilities had at least ten deficiencies in each of its last four inspections.

- There were over 200 inspections where a facility had 10 or more deficiencies but a federal or state sanction was not issued.

- One facility had been cited for 111 deficiencies in its last four inspections.

We offer the following comments designed to help correct the above examples:

A.1. The DA does not review the effect of any sanction on the subsequent performance of the facility. In addition, the DA does not verify that the state's Medicaid agency imposed the denial of payment sanction on a facility, or whether the denial of payment resulted in an actual financial penalty on the facility. The DA should study the sanctions imposed to determine which sanctions are most effective in bringing facilities into compliance.

2. The DA does not always consider a facility's history of past noncompliance when determining the sanction to be requested. For the facilities subjected to more than one sanction in the four-year period, the subsequent sanction was a higher level sanction in only 13 of 29 instances. While the underlying circumstances resulting in the sanctions varied greatly, it would appear that a facility with a recent history of noncompliance should be sanctioned at or near the maximum level allowed.

3. From the list of federal sanctions requested by the DA since July 1995, we identified 18 facilities that had been sanctioned as a result of an inspection and have since been subjected to a subsequent inspection. The number of deficiencies cited against each of the 18 facilities at the first inspection as compared to the subsequent inspection decreased for 13 of the 18 facilities. In four instances, facilities went from more than ten deficiencies to deficiency free. In another five instances, the number of deficiencies issued at the subsequent inspection dropped by at least one half. In six of the nine instances where the decrease in the number of deficiencies was significant, the sanction imposed was a CMP. In each of the five instances where the number of deficiencies increased, the sanction applied was denial of payment for new admissions.

   We also noted 12 of the 18 facilities had been issued a total of 40 repeat deficiencies. Only one of the seven facilities that had been subjected to a CMP had a repeat deficiency in the subsequent inspection. Based on these results, it appears that the imposition of CMPs may have a greater deterrent on facility noncompliance than the denial of payment for new admissions sanction.

The DA should track sanctions to determine which are most effective in reducing noncompliance and ensure a facility's history of noncompliance is considered when determining future sanctions.

B. As noted above, federal sanctions, particularly CMP, appear to be effective in deterring noncompliance. Section 198.067, RSMo, has, since 1989, allowed the DA to seek state CMP for regulatory violations that remain uncorrected or not in accordance with the accepted plan of correction at the time of the reinspection. The DA has not pursued civil monetary penalties for regulatory violations except in a limited number of instances.

Section 198.067, as revised in 1998, allows the DA to seek CMP of up to $10,000 per day if there was a violation of a Class I standard and a resident suffered serious physical injury or abuse of a sexual nature regardless of whether the facility had corrected the violation. As of August 1999, 25 cases had been referred to the Division of Legal Services and nine cases had been filed in circuit court. However, CMP has only been collected in one case and this was the result of a negotiated settlement. DA officials stated that their ability to effectively seek state CMP is hampered by the onerous process of filing cases in the circuit courts, which requires a very significant commitment of DA staff resources.

Other states have and use the authority to impose state civil monetary penalties. In Kansas the imposition of CMP is an administrative process with right to appeal to the courts. We also obtained a study [Rudder, C., Phillips, C. (1995) *The Nursing Home Enforcement System in New York State - Does It Work:* Nursing Home Community Coalition of New York State] of New York nursing homes and that state's enforcement process. That study also indicated a strong relationship between the imposition of state CMP and the number of deficiencies found during subsequent inspections.

Since the imposition of CMP appears to be effective in bringing facilities into compliance, and to provide nursing home residents the maximum degree of protection and highest levels of care practicable, the DA should request the legislature change the state CMP process so it is not overly burdensome and costly.

C. When a deficiency is identified during the inspection process, the DA, within 10 days after the inspection is completed, is to issue a Statement of Deficiencies (SOD). All deficiencies noted during each inspection are contained in the SOD. The facility must, within 10 days after receiving the SOD, then prepare a Plan of Correction (POC) in which the facility indicates the actions it will take to correct the current problem and the programmatic or systemic changes it will make to help ensure the problem does not recur. The State Operations Manual requires the plan of correction to include how the corrective action will be accomplished for those residents found to have been affected by the deficient practice, how the facility will identify other residents having the potential to be affected by the same deficient practice, what measures will be put into place or systemic changes made to ensure the deficient practice will not recur, and how the facility will monitor its corrective

actions to ensure the deficient practice is being corrected and will not recur. We reviewed the POCs for three repeat tags, inadequate staffing, activities of daily living (ADL), and pressure sores. The following table summarizes the POCs reviewed:

Tag No.	Tag Description	Number of Facilities with Repeat Deficiencies	POCs Reviewed
F353	Inadequate Staffing	3	7
F312	Activities of Daily Living	18	41
F314	Pressure Sores	17	37

Our review of the 85 POCs resulted in the following concerns:

- 37 of the POCs did appear to meet the preceding requirements and yet the facility was cited for a repeat deficiency. In these instances it appears the facility failed to monitor compliance with the POC as required.

- Several of the POCs for a subsequent violation contained almost identical wording to the prior POC that had most recently failed.

- We questioned whether 11 other POCs could reasonably be expected to prevent a repeat deficiency. For six of these POCs, the POC only addressed the specific residents currently affected, but did not incorporate a systemic change or identify how the facility would monitor compliance with the plan of correction. In each of these six instances, the facility was cited for a repeat deficiency.

- If the facility was cited for insufficient staffing, the POC often did not state whether the facility would add staff and/or did not provide details regarding the staffing levels the facility would provide in the future. Instead the POC simply stated the facility would provide sufficient staffing to meet the needs of the residents. In these instances, it is not possible to monitor whether the deficiency was adequately addressed.

Currently, facilities are not cited for failure to continually monitor compliance with the POC. Once the DA accepts the POCs, the DA conducts an on-site reinspection to

determine that the facility has implemented the POC. The DA does not monitor further compliance with the POC. If the same violations are noted during subsequent complaint investigations or interim inspections, the cycle starts over again.

The DA should ensure POCs fully meet the established criteria including methodologies for facilities to monitor their continued compliance with the POC, and should ensure the POCs adequately address any systemic deficient conditions. In addition, the DA needs to ensure POCs can reasonably be expected to correct the deficiency and not accept POCs which have failed in the past. The DA should also develop procedures to continually monitor compliance with POC provisions for facilities with a history of repeat or numerous deficiencies.

WE RECOMMEND 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.

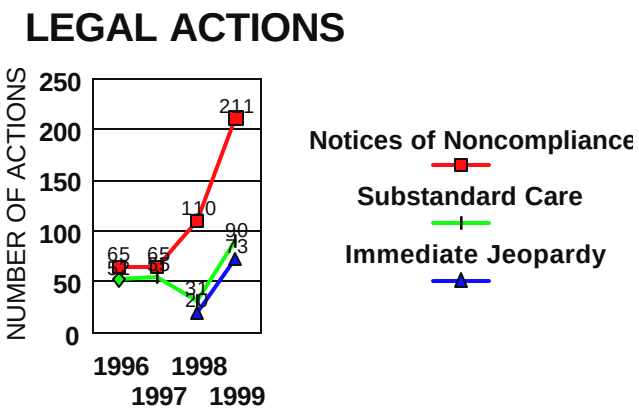

Chart 2

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.

AUDITEE'S RESPONSE

A.1-3. DA does review and consider the effect past sanctions have on future compliance, as applicable. Frequently, when facilities are assessed as being significantly out-of-compliance, a change in owner/operator/management company or reorganization of the corporation occurs resulting in a new state licensure application. The "new entity" no longer carries with it the previous history of noncompliance. The division believes statutory change is needed to address this issue.

During SFY 1999, the division requested HCFA impose denial of payment on 63 facilities for new Medicare/Medicaid admissions and requested HCFA impose Civil Monetary Penalties (CMPs) 51 times against 30 facilities. The division has found state licensure actions more timely address facility noncompliance than alternative federal sanctions. In SFY 1999, the division took the following state licensure actions including: 211 state notices of noncompliance, 50 probationary licenses (issued due to legal action), 21 consent agreements and 11 receiverships. This chart details legal action increases during the period SFY 1996 through 1999.

The division currently has requested imposition of a total of $5,414,305 in federal CMPs against 61 homes going back as far as 1996. HCFA has collected a total of $1,001,670. The division currently has requests for imposition of a total of $824,175 in state CMPs. DA agrees the CMP process could be an effective sanction. As noted in a recent General Accounting Office (GAO) report, for the federal CMP process to be effective the backlog of civil monetary penalties will need to be reduced or much of the CMPs deterrent effect will be lost.

GAO stated that "weaknesses remain in the deterrent effect of termination [from the Medicare/Medicaid programs], including the lack of a tie to poorly performing facility status for reinstated homes and the limited reasonable assurance period for monitoring terminated homes before reinstating them." The Division does review and consider the effect past sanctions have on future compliance, as applicable. Facilities assessed as being significantly out-of-compliance frequently have a change in operator or owner resulting in a new Medicare/Medicaid participation agreement and issuance of a new state license. At that time, the past history of noncompliance associated with the former owner or operator cannot be considered against the "new" organization. The division believes recent changes in the HCFA State Operations Manual to limit the facilities' opportunity to correct deficiencies may reduce "roller coaster" compliance.

The division is putting into place the following to address the auditor's recommendations:

- *Not issuing operating licenses as they come due, if there is a current class I or class II deficiency and/or if upon review the facility has a history of noncompliance or the violations cited are repeat violations.*
- *Issuing only a temporary operating permit (TOP) if a complaint against a facility has not been investigated at the time the license is due. If deficiencies are cited at a class I or class II standard as a result of the complaint investigation, and/or the operator has a history of noncompliance or the violations are repeat in nature, his or her license will then be denied.*
- *Offering operators an opportunity to enter into a consent agreement in an attempt to achieve a permanent resolution to their compliance problems and thereby improve care and/or conditions for residents.*
- *Citing administrators, as appropriate, for failing to maintain compliance to regulatory requirements when class III violations are cited repeatedly. Repeat class*

III violations can then result in an uncorrected class II notice of noncompliance and the operator will be required to correct or face termination from the program.

- *Amending our policy related to requests for imposition of sanctions to require an automatic increase in the sanctioning request whenever a recurrence of a violation occurs. However, DA only makes recommendations HCFA has final authority over the sanction to be imposed.*

B. The division will continue to work closely with the legislature to enhance and improve the state civil monetary penalty process to bring about immediate action against facilities that fail to meet state licensing requirements.

C. The division has been meeting federal guidelines related to plans of correction. We agree the federally required plan of correction process has not been effective and has resulted in confusion for state survey agencies, facilities and consumers. When involving Health Care Financing Administration (HCFA) staff in discussions related to the acceptance of plans of correction, division staff have been told to accept plans of correction that meet the federal criteria, but are identical or nearly identical to plans previously submitted by noncompliant facilities. Effective January 14, 2000, HCFA has provided additional guidance, clarification and modification to the enforcement guidelines contained in the State Operations Manual including those related to accepted POCs. The division believes this information will enable us to address the majority of issues contained within the state auditor's recommendations for POCs.

The division is currently:

- *Reviewing a sample of plans of correction from each region on a monthly basis to ensure consistency in application between regions and that plans meet the federal enforcement guidelines.*
- *Developing and implementing by the annual surveyor's training a session devoted entirely to plans of correction and adherence to the criteria set forth in the State Operations Manual.*
- *Including in the division's new automated system a report for review on-line of facility plans of correction allowing for ready comparison of corrective action plans over time to ensure facilities do not submit identical plans.*
- *Developing and implementing a process to allow electronic submission of plans of correction from facilities to allow more timely responses from the facility and state survey agency.*

4. Staffing of Nursing Homes

One nationally recognized study [Harrington, C., Zimmerman, D., Karon, S., Robinson, J., and Beutel, P. (1999) *Nursing Home Staffing and Its Relationship to Deficiencies*: Report Prepared for the Health Care Financing Administration. San Francisco, CA: University of California.

Madison, WI: University of Wisconsin] indicated, "...fewer number of RN staff hours were associated with more quality of care deficiencies. Fewer nursing assistant hours, as expected, had a consistent, significant negative relationship with total, quality of care, and quality of life deficiencies."

Another study, commissioned by an employees' union [McDonald, I., Muller, A. (1998) *The Staffing Crisis in Nursing Homes: Why Its Getting Worse and What Can Be Done About It:* Service Employees International Union] indicates the effects of inadequate staffing in nursing homes:

"Nursing home workers tell us that when not enough aides are scheduled, and workers that can not come in are not replaced, residents do not get the care they need:

- Residents do not get turned or repositioned every two hours.
- Residents are not fed properly.
- Residents do not have their hygiene needs met.
- Residents are not walked or given adequate range of motion exercises.

As a result:

- They develop bedsores or are unnecessarily restrained.
- They lose weight and may become malnourished.
- They lie in their own urine and feces.
- They develop contractures or suffer other deterioration."

We visited five nursing homes and calculated the total hours of direct care per resident for a three month period surrounding the most recent inspection conducted at each facility. Direct care staffing levels in these homes varied from 2.48 to 3.53 hours per resident day. We noted the following staffing observations related to these visits:

- The facility with the highest staffing level was issued two deficiencies in the most recent inspection, the facility with the next highest staffing level had no deficiencies noted, and the three facilities with the lower staffing levels had from 5 to 9 deficiencies.

- The direct care staffing levels for days when DA conducted its inspections were between 5 and 26 total hours per day higher than the three month average staffing level. One facility brought in two senior nursing staff from a nearby facility for the inspection. Another facility flew in 4 staff to coincide with our on-site visit. DA personnel told us it is common practice for facilities to increase staffing levels during inspections.

- Each of the five facilities had days where their direct care staffing level was below that of the Veterans Administration proposed minimum staffing level of 2.5 hours per resident day. One of the facilities operated below that standard for 64 of the 90 days reviewed.

C Direct care staffing levels in July 1999 were .21 to .46 hours per resident day lower than during January 1999 for the five facilities.

Many complaints received by our office alleged facilities were understaffed which resulted in inadequate care provided to its residents. We noted the following concerns regarding the DA's policies and procedures regarding staffing in nursing homes.

A. Effective September 30, 1998, the DA rescinded the minimum nursing staff requirements from the Code of State Regulations (CSR), 13 CSR 15-14.042(37). Previously, nursing homes were required to maintain minimum nursing staff to resident ratios of one staff to each 10 residents on the day shift, one to 15 on the evening shift and one to 20 on the night shift. Those minimum ratios were established in 1958 and had not been changed since that time.

The old minimum staffing standards appear to be too low when compared to current industry benchmarks. DA officials also indicated they believed the old standard was too low and problem facilities were using the standard to defend themselves against staffing deficiencies cited by DA. DA officials estimated that on average about 1.85 hours per resident day of direct care nursing would have been required to meet the old requirement. One industry official with a large chain of nursing homes stated that his company attempted to maintain approximately 3 hours of direct nursing care per resident day to provide adequate resident care. The Veterans Administration has a proposed federal regulation that would require 2.5 hours of direct care per resident day in their homes. A review the annual Medicaid cost reports submitted to the Division of Medical Services (DMS) for 1997 and 1998 indicate the industry is averaging about 3.2 hours of direct care per resident day. One national study [Harrington, C., Carrillo, H., Thollaug, S., and Summpers, P., (1999). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-97.*: Report Prepared for the Health Care Financing Administration. San Francisco, CA: University of California.] of the data reported in the On-line Survey and Certification Reporting System (OSCAR) system indicates the national average direct care hours per day in 1995 and 1996 was 3.4 hours. A national advocacy group, the National Citizens Coalition on Nursing Homes, is proposing a minimum direct care staffing level of 4.13 hours per resident day.

The DA has taken the facility self-reported Minimum Data Set (MDS) resident dependency assessment information from the certified facilities and processed that information through a staffing algorithm. The results of the initial DA work indicated that 3 to 3.5 hours of direct care per resident day are necessary to meet the needs of residents in Missouri nursing homes.

Section 198.079, RSMo 1994, requires the DA 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. The current version of the state

regulation does require nursing homes to provide sufficient staff to enable residents to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. In homes with higher levels of resident dependency, additional staffing above the minimums would be required.

The actions by the DA to eliminate the minimum staffing ratios appear to contradict the intent of the state law. The DA has the authority and responsibility to determine reasonable staffing levels. The DA should consider establishing reasonable minimum staffing ratios.

B.1. Certified nursing homes in Missouri have been connected to a networked computer system developed by HCFA, the federal oversight agency, and operated by the DA since June 1998. Facilities must enter initial and quarterly resident assessment data for each resident. This data is referred to as the Minimum Data Set or MDS data. This data allows nursing home residents to be classed by 27 resource utilization groups. The DA processes this data through an accepted staffing algorithm methodology. This process produces an estimate of the actual hours of nursing care that would be necessary to provide adequate staffing to meet the needs of that nursing home's residents. In the near future, nursing homes will be able to access those staffing reports for use in scheduling the number and type of staff that should be sufficient to meet the needs of the residents. Texas has already adopted this technology. Many other states have similar processes under development. The DA should continue developing this process through which facilities are provided individualized estimates of recommended staffing levels based upon the resident dependency levels present in their home. The DA could also use this process to establish minimum required staffing levels discussed in Part A above.

2. The DA should develop a system which accumulates the actual staff hours at each facility. The DA could then identify homes that are operating significantly below appropriate staff levels. Using this information, the DA could prioritize the scheduling of pending inspections and complaint investigations to identify potential problems before they can result in negative outcomes for nursing home residents. The DA should also make actual direct care staffing information readily available to the public so that Missouri citizens can make better informed decisions on where to place loved ones.

C. Currently, DA inspectors do not review facility staffing levels and compare them to any minimum standard or industry benchmark. Instead, DA policy requires the inspectors to detect negative resident outcomes such as avoidable accidents, poor incontinence care, development of pressure sores, delayed meal services, delayed response time to call lights, dehydration, and weight loss. If those care indicators are found, then the DA will attempt to determine if they are caused by inadequate staffing levels, poor supervision of staff, or weak staff training and orientation programs. To ensure negative resident outcomes are avoided to the maximum extent possible, the DA should examine staffing levels to ensure facilities have adequate staff to meet the needs of residents.

D. Of the five facilities we visited, the facility with the lowest staffing level was cited in February 1999 for seven deficiencies including two which were assessed as having caused actual harm to residents. The DA cited this facility for inadequate staffing and for having staff that were not qualified for their assigned duties. However, this deficiency was cited at the G scope and severity level which is defined as having only isolated incidents which resulted in actual harm but no widespread pattern of understaffing. As a result, the facility was not sanctioned or subjected to a loss of reimbursements or CMP.

Ample evidence appears to have existed to cite the facility for a widespread pattern of understaffing. On February 23, 1999, a DA inspector observed the evening shift and determined resident needs were not being met due to inadequate staffing. Based on our calculations, the staffing level for this day was 2.58 direct care hours per resident day. The staffing level in this facility was below the 2.58 level for 68 of the 90 days we reviewed. This facility had also brought in two senior nursing staff from a nearby facility owned by the same company on this very shift. The statement of deficiencies issued for the inspection noted that two residents had endured a total of 28 falls in the preceding 83 days resulting in 15 injuries and at least three hospital visits. There had also been numerous complaints about call light response time, failure of staff to assist residents to bed and to the toilet, and not providing timely and thorough incontinence care.

This facility was then found to be in compliance at the revisit on April 15, 1999. On April 19, the DA received a complaint that the facility was again understaffed. The DA again returned to the facility to investigate the complaint and again cited the facility for inadequate staffing. This time the DA cited an E scope and severity level which indicates a widespread pattern, but that no actual harm to residents resulted. Since the deficiency was cited as no actual harm, the facility was again not subjected to further sanctions. The facility was revisited in June and found to be in compliance at that time. It should also be noted that the POC approved by the DA in response to the February inspection deficiency, stipulated the facility would staff at levels equal to the old minimum staffing level (1.85 hours per resident day). It is difficult to understand why the DA would have accepted this POC when DA officials also believed the old standard was too low.

The DA should ensure that facilities found to have widespread patterns of noncompliance with the staffing requirements are subjected to the maximum federal and state sanctions and civil monetary penalties warranted in the circumstances.

WE RECOMMEND 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.

AUDITEE'S RESPONSE

A. State law requires the division to issue standards and regulations related to the number and qualifications of employed and contract personnel having responsibility for any of the services provided for residents. DA does not concur with the state auditor's finding that the division appears to have contradicted state law. To the contrary, DA believes that it has complied with both the letter and spirit of the statute by requiring staffing levels which result in positive resident outcomes and which take into account the acuity levels of residents within the facilities. DA has minimum staffing levels determined by a ratio or number in those areas that lend themselves to establishment of a minimum by such a method. For example, life safety code including protective services at Title 13 Code of State Regulations (CSR) 15-14.022(57) uses a staff ratio and other professional staffing requirements found throughout 13 CSR 15-14.042 refer to the number of staff required. These regulations clearly set forth minimum staffing levels.

DA concurs the rescinded minimum nursing services and staffing ratio had become inadequate. The 1998 nursing services modification stating that "sufficient numbers and with sufficient qualifications to provide nursing and related services" adopts the federal philosophy of determining staffing needs based upon resident outcomes. DA believes the current state regulation is reflective of the national research community and HCFA focus on staffing a facility to meet individual resident care needs that should result in positive resident outcomes as appropriate for individual residents (i.e., maintain current condition, improve status or functioning or slow decline).

Deficiencies related to staffing levels, qualifications and/or training were cited in 229 of the 491 (47%) Medicare/Medicaid certified facilities during the current survey cycle. Beginning in September 1999, DA field staff began utilizing quality indicator information derived from the Minimum Data Set (MDS) assessment in the survey process (survey targeting based upon resident outcomes and acuity). Effective January 14, 2000, HCFA provided additional POCs enforcement guidance; the Division believes this information will address the majority of issues contained within the state auditor's recommendations for POCs.

B&C. In 1998, HCFA mandated collection of MDS information about residents in Medicare/Medicaid certified beds from all certified facilities and provided an automated system to collect the data. The MDS data can now begin being utilized for evaluation of the need for specific types and numbers of staff. The division continues working diligently with

the University of Missouri-School of Nursing to determine the best method to provide comparative feedback to nursing facilities and consumers related to acuity-based staffing versus actual staffing levels in Missouri facilities. It is likely, the Code of State Regulations will be modified as a result of the research being conducted.

The division has noted in the last year an increase in the number of facilities experiencing problems in hiring and retaining quality staff including certified nursing assistants. While staffing has been problematic in "poor" performing facilities for some time, we have seen an increase in staffing problems in facilities that historically have been "good" performers and believe that the current robust economy has reduced the number of individuals willing to work in the nursing home environment.

DA suggests that staffing ratios alone do not routinely take into consideration the acuity differences between individual residents and their need for specific types and levels of services. Multiple variables need to be considered when determining the staffing level and types in a nursing home. The division believes use of a ratio in determining types and levels of staff with a lack of consideration for the resident case-mix or acuity level in the facility will not ensure care needs of individual residents are met.

The period between 1990 and the present has seen a proliferation of differing opinions about the best methods to be used to determine staffing levels in nursing homes. Programs like Missouri Care Options (MCO) allow elderly people to remain in their homes longer. When poor health requires them to seek nursing home care, they often enter facilities requiring a higher level of care than experienced with new admissions in the past. Dramatic changes in the resident population of nursing homes have also resulted from hospital stays being minimized, more "sub-acute" care residents are being seen in the nursing home environment. With advances in medical technology allowing individuals to live longer, the result is heavier care situations continuing for longer periods of time.

Currently, there is no federal or state statutory requirements for survey and inspection staff to utilize a minimum standard or industry benchmark in their review of staffing levels. During the survey and inspection processes, field staff review resident outcomes to determine understaffing as required by the Health Care Financing Administration (HCFA). Field survey staff collect information about facility staffing for a two week period to be input into the federal On-line Survey, Certification and Reporting System. However, as noted by the auditor and many national studies, facilities appear to increase staff during the survey process. This results in a skewed picture of facility staffing for that two (2) week period. DA has requested in a new budget decision item for SFY 2001 four (4) auditors to assist field staff in performing survey and inspection activities including the review of records (i.e., payroll and staffing).

D. *The report notes that "Ample evidence appears to have existed to cite the facility for a widespread pattern of understaffing." In a review of the file, it was determined that DA*

survey staff followed the federal guidelines in making their determination of the scope and severity of the problem within the facility. If the file is reviewed with no knowledge of the required federal survey process, DA agrees the facility's historical file might raise questions. The federal process prevented the survey team from considering all relevant facts contained in the file and including that information in determining the scope and severity of the current incident; in all likelihood, a different conclusion would have resulted with inclusion of the additional information. The division remains gravely concerned about the federal process that results in closure of incidents at the time a facility revisit with deficiencies corrected occurs. We believe that broad revisions in the federal and resulting state process are needed to prevent facility "roller coaster" compliance from continuing. Field surveyors need to be able to include in their current incident process consideration of the facility's entire noncompliance history and repeat failure(s) to adhere to facility submitted corrective action plans that result in "poor" resident outcomes. We believe the Health Care Financing Administration (HCFA) in their recent changes to the State Operations Manual have taken initial steps to end the "roller coaster" effect and allow state survey agencies to address shortcomings in plans of correction related to systemic problems and quality assurance plans. However, we believe further modifications will be necessary to provide surveyors with sufficient tools and processes to ensure these facilities either correct their system problems or discontinue caring for the elderly and adults with disabilities.

Additionally, the division has already taken the following actions based upon the auditor's recommendations:

- *Continue recommending sanctions for facilities who fail to adequately care or address the needs of residents in long-term care facilities, however, final disposition of these issues does not rest with the division. The division is responsible for making recommendations to HCFA and the Division of Medical Services, the state Medicaid agency.*
- *Amend the policy for imposition of sanctions to require an automatic increase in the sanctioning request whenever a recurrence of a violation occurs.*
- *Have provided initial training to survey staff on the changes in the State Operations Manual related to plans of correction.*

AUDITOR'S COMMENT

A&B. The current CSR addresses only minimum staffing requirements related to safety and protection of residents. It does not address the number and qualifications of direct resident nursing care services to be provided to residents. As a result, we do not believe the current CSR meets the letter or the intent of the law. The DA should give further consideration to establishing an absolute minimum allowable staffing requirement that also clearly establishes that additional staffing may be necessary based on resident dependency levels.

The statistic noted by the DA regarding the number of facilities cited for inadequate staffing (229 of 491, or 47%) is misleading as it also includes cites for staff qualification and training issues.

According to a June 1999 report generated by DA from the OSCAR system, only 42 of 491 (8.5%) facilities were cited for inadequate staffing during the most current survey cycle.

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

A.1. Various sections of state law require the DA 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 1994, 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. There are approximately 700 persons on the DA EDL. Nursing homes and residential care facilities, providers of in home services under contract with Department of Social Services (DSS), employers who hire nurses and nursing assistants for temporary or intermittent placement in health care facilities, entities approved to issue certificates for nursing assistants training, hospitals and related health services, and home health and hospice providers are prohibited by state law from employing any person on the DA EDL.

We matched persons on the DA EDL to 1998 employment information records and noted twelve persons were employed by a licensed nursing facility and nine persons were employed by an in-home health provider under contract with the DSS. The DA manually checks quarterly employment data for 25% of the persons listed on the DA EDL, however, this process failed to detect the instances noted above. The DA should develop an automated process to identify instances in which persons listed on the DA EDL are working for nursing homes, in-home service providers, and other entities prohibited from hiring those persons. Use of the automated process should result in the DA being able to identify all instances in which an employer inappropriately hired a person listed in the DA EDL.

2. Effective August 28, 1997, Section 660.317, RSMo Cumulative Supp. 1999, requires nursing facilities to perform criminal background tests before hiring applicants who will have direct contact with residents. Applicants who have been found guilty of certain felonies are prohibited by state law from such employment. Currently, the DA has no automated procedures in place to identify employers who are employing individuals with criminal backgrounds.

3. When the DA does identify an instance in which a facility has hired a person listed on the DA EDL, it does not always issue a deficiency. Hiring a person listed on the DA EDL can be cited by the DA as either a Class I or a Class II violation. If Class II violations are corrected by the time of the reinspection, no federal or state sanction or civil monetary penalty is imposed.

A Class II standard is defined as having a direct or immediate relationship to the health, safety or welfare of any resident, but does not create imminent danger. A Class I standard is defined as having either an imminent danger to the health, safety or welfare of any resident or a substantial probability that death or serious physical harm would result. It would appear that hiring a person who had in the past committed abuse or neglect would pose an imminent danger to the health, safety or welfare of residents. The DA should consider raising the violation for hiring a person listed on the DA EDL to a Class I level deficiency and fine or sanction deficient facilities accordingly.

4. When the DA discovers a DA EDL listed person has worked for an in-home personal care vendor, a violation of their contract with the DSS, the Home and Community Monitoring unit contacts the employer and requests copies of that employee's time and service records. The monitoring unit then determines the amount paid to the employer for visits performed by the employee listed on the DA EDL and requires the vendor to repay these amounts. We provided the DA with the list of nine instances which we had identified through the automated data match where a DA EDL person worked for an in-home vendor. The DA should contact these vendors and ensure applicable amounts are repaid.

B. The Department of Mental Health (DMH) also maintains, under Section 630.170, RSMo Cumulative Supp. 1999, a listing of persons convicted of patient, resident or client abuse. There are about 250 persons on this listing. We matched persons on the DMH EDL to 1998 employment information records and noted fifteen persons were working in a licensed nursing facility and three persons were working for an in-home health provider under contract with the DSS.

In our opinion, it does not appear appropriate for individuals who have abused or mistreated DMH clients to care for the elderly. The DA should develop an automated process to identify instances in which persons listed on the DMH EDL are working for nursing home operators and in-home care providers.

C. The Division of Family Services maintains the Central Registry of Child Abuse and Neglect (CA/N) which contains information relating to instances of actual and alleged child abuse. We requested names of persons listed within the registry which met the following criteria: the investigation conclusion date was in the last five years, the conclusion code was A (court adjudicated) or B (probable cause), the category of abuse/neglect was 1 (physical abuse), 2 (neglect) or 6 (sexual maltreatment), and the severity code was C (serious/severe), D (permanent damage) or E (fatal). Our request resulted in approximately 16,700 records of which 14,350 included a Social Security number for the perpetrator.

We matched persons from the information obtained from the CA/N registry to 1998 employment information records and noted 1,009 persons were working in a licensed

nursing facility and 108 persons were working for an in-home health provider under contract with the DSS that were on the registry.

In our opinion, it does not appear appropriate for individuals who have been found to have abused or mistreated children to care for the elderly. The DA should develop an automated process to identify instances in which persons found to have abused children are working for nursing home operators and in-home care providers.

In addition to the instances noted above, we identified numerous other instances of potentially inappropriate or questionable workplaces for persons on the above EDLs and/or CA/N registry. These potentially inappropriate workplace settings include instances of these persons working in schools, day care facilities, DMH facilities, DSS programs, and other direct care providers. These concerns will be included in a subsequent report to be issued by our office.

WE RECOMMEND 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 CA/N central registry, 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.

AUDITEE'S RESPONSE

A.1-3. State law requires facilities and in-home services providers not later than two days of hiring any person to request a criminal background check from the highway patrol and to make an inquiry to the department of social services as to whether the person is listed on the employee disqualification list. DA does not have the statutory authority to prohibit facilities from "hiring" individuals listed on the Division of Aging's Employee Disqualification Listing (DA EDL) or possessing a criminal background. When a facility fails to take appropriate and timely action to terminate an individual identified through the DA EDL and criminal background check processes or fails to complete the processes, DA has the statutory authority to cite those facilities for such violations.

DA concurs, at a minimum, a Class II violation occurs when a provider or facility fails to meet Section 660.317, RSMo 1998 that requires facilities to ensure individuals appearing on the DA EDL and/or having a criminal background are terminated in a timely manner. However, DA does not concur with the auditor's suggestion that identification of an individual as being on the DA EDL immediately rises to the level of "imminent danger" necessary to cite a Class I violation. Presently, individuals are placed on the DA EDL for recklessly, knowingly or purposely abusing or neglecting a resident while employed in any

facility pursuant to Section 198.070.12, RSMo or individuals are placed on the list for having misappropriated property or funds of a resident while employed in a facility pursuant to Section 198.090.15 RSMo. Since some individuals listed on the DA EDL are not on the list as a result of abuse/neglect violations, but rather are listed as a result of lesser crimes such as misappropriation of property, the determination of a violation at a higher than routine level (Class II found at 13 CSR 15-14.042 (19)) would be based upon evidence specific to the situation. Currently, the division has the ability to cite a Class I violation if it can be determined that a facility knowingly acted or omitted the EDL check or the criminal background check or performed the check and failed to take appropriate action. The Class I violation has been and will continue to be issued under 13 CSR 15-14.042 (16) to those providers and/or facilities that act in such a manner and where such circumstances can be proven and are legally defensible.

Additionally, in regard to the auditor's recommendation that fines and sanctions be increased for facilities who hired individuals on the DA EDL or having a criminal background, from past and continuing experience, DA -- in following the required administrative process -- has found in specific cases where corrective action has taken place that we have been unable to successfully sustain cases brought forward for action when the facility has taken corrective action. DA notes on January 18, 2000, the Missouri Court of Appeals, Western District, decided State of Missouri, Department of Social Services, Division of Aging v. Carroll Care Centers, Inc., -- S.W.2d --, WD56714 (Mo. App. Jan. 18, 2000), holding that it was proper to dismiss a civil monetary penalty (CMP) claim if the nursing home has corrected a cited deficiency at the time of reinspection. Here, the deficiency had been corrected by the time of the reinspection. In such a case, the State's claim for sanctions was not authorized.

The division concurs with the state auditor's recommendation for enhancement of existing procedures to identify instances in which persons listed on the Division of Aging Employee Disqualification Listing (DA EDL) are employed by providers prohibited from employing these individuals through an electronic process. While state statute places the responsibility for checking the EDL and the criminal background of individuals on the provider, current computer technology will allow for enhanced monitoring by the division of provider employment activity allowing for better identification of those facilities falling out of compliance.

The division has already taken the following steps to address the auditor's recommendations and to further strengthen our processes:

- *Established an automated process with the Department of Employment Security (MODES) for identification of instances in which those persons listed on the DA EDL are inappropriately working for nursing facilities, in-home service providers, or other entities prohibited from employing them.*
- *Reviewed and strengthened Institutional Services administrative processes and assigned processing of referrals to a single distinct EDL Unit.*

- *The division's responsibility is to adequately monitor the providers performance of these requirements. In order to ensure, division staff are meeting these monitoring and reporting requirements, we have:*
  - *Reviewed the field policy related to EDL and criminal background checks that requires inspection staff during inspections/surveys or complaint investigations, as appropriate, to check that the facility has an effective system, including written policies and procedures, which enables them to request and obtain information needed to make appropriate hiring/retention decisions in accordance with the requirements of Sections 660.315, RSMo and 660.317, RSMo 1998. We believe the field practice addresses the requirements related to our monitoring of compliance with EDL and criminal background checks.*
  - *Reaffirmed with administrative and field staff the requirement to cite a deficiency whenever a DA EDL violation occurs and recommend to HCFA and the Division of Medical Services, as appropriate, imposition of sanctions or state licensure action, whenever a provider licensed by the division fails to meet the requirements at Section 660.315, RSMo 1998 related to appropriate action when a determination is made that an individual appears on the DA EDL. Appropriate actions would be declining to employ the individual or termination of the individual whose name is listed on the DA EDL.*
- *Researched the availability of an automated process for verifying criminal background checks without successfully finding such a system within Missouri. We will continue exploring and monitoring options and new systems as they become available for automating the criminal background check process.*

B&C. *The Division concurs that legislative action will be needed to allow for verification of Department of Mental Health Employee Disqualification List (DMH EDL) and the Child Abuse and Neglect (C/AN) registry listings by division providers and facilities. While inclusion of these individuals on the DA EDL may further protect elderly and disabled adults in long-term care facilities, this issue would need to be addressed through the legislative branch who implement public policy through enactment of state law. DA believes the process of consolidation has begun with passage of the "Family Care Safety Registry and Access Line" (L. 1999 H.B. 490 & H.B. 308); that current computer technology will make information more readily accessible to the public; and that additional legislative action may be anticipated.*

AUDITOR'S COMMENT

A.3. The DA's response inaccurately implies that employment of individuals on the DA EDL is routinely cited as a Class I violation. In reality, if the DA detected instances of disqualified employees working at facilities through its quarterly match, no deficiency was cited if an inspection was not

ongoing, if no incident had occurred involving the employee, and if the facility agreed to terminate the employment of the individual.

In regards to the appellate court's decision, if changes to current law are necessary for the DA to sanction or fine facilities for hiring individuals listed on the DA EDL or those having a criminal background, we suggest the DA seek such legislation.

This report is intended for the information of the management of the Department of Social Services, Division of Aging, and other applicable government officials. However, this report is a matter of public record and its distribution is not limited.

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