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An Audit Report on
**Nursing Facility Complaint
Processing at the Department of
Aging and Disability Services**

August 2011
Report No. 11-047



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Overall Conclusion

The Department of Aging and Disability Services (Department) promptly screens and accurately prioritizes the complaints it receives about nursing facilities prior to referring complaints to its regional offices for investigation.

Between September 1, 2007, and February 24, 2011, the Department:

- Complied with federal requirements for the timeliness of complaint investigation for 97.1 percent of the high-priority nursing facility complaints it received.
- Complied with state requirements for the timeliness of complaint investigation (which are more strict than federal requirements¹) for no more than 73.1 percent of high-priority nursing facility complaints it received.

Because the Department's Compliance, Assessment, Regulation, and Enforcement System (CARES) does not capture the time of day when investigators enter nursing facilities, it is not possible to precisely calculate compliance with the state requirement to begin investigations within 24 hours of receiving a high-priority complaint.² The Department considers a high-priority complaint investigation to be in compliance with state timeliness requirements if it begins the investigation by the end of the next working day after its intake staff have evaluated the complaint and referred it to the appropriate regional office.

Background Information

The Department of Aging and Disability Services (Department) regulates nursing facilities and investigates complaints it receives about those facilities. A complaint is any allegation the Department receives other than an incident reported by a nursing facility.

Nursing facilities are residential facilities that provide care for individuals whose medical condition requires the skills of licensed nurses on a regular basis. As of August 31, 2010, there were 1,194 nursing facilities in Texas with a total occupancy of 88,432 residents.

In fiscal year 2010, the most frequent complaints regarding nursing facilities (in order) involved neglect, resident rights and client protections, activities of daily living, quality of care, quality of life, environment, medications, sufficient staff, administration, and pressure sores.

From September 1, 2007, through February 24, 2011, the Department received and investigated 74,566 allegations. It substantiated 7,418 (9.9 percent) of those allegations.

Source: The Department's *Regulatory Services Annual Report (FY2010)* and data from the Department's Compliance, Assessment, Regulation, and Enforcement System (CARES).

¹ The U.S. Centers for Medicare and Medicaid Services' *State Operations Manual* requires the Department to investigate immediate jeopardy complaints within two working days of receipt of the information. Texas Health and Safety Code, Section 242.126, requires the Department to begin an investigation of a high-priority complaint within 24 hours of receipt.

² When calculating the rate of compliance with state timeliness requirements, auditors considered all investigations that began by the end of the next calendar day after the Department received a complaint to meet the timeliness requirements. That methodology resulted in a maximum estimated compliance rate, and the actual compliance rate could be lower.

To improve the effectiveness of complaint investigations, the Department should strengthen its monitoring of the complaint investigations that its regional offices conduct. For example, the Department should maintain adequate information in CARES to enable it to monitor regional office compliance with investigation and reporting requirements.

The Department also should strengthen its long-term care ombudsman function to enable it to more efficiently address less serious complaints. The Department contracts with the 28 area agencies on aging (AAAs) in Texas to provide ombudsman services, and it should strengthen its monitoring of AAAs to ensure that they recruit enough volunteers to effectively deliver ombudsman services. The Department also should strengthen coordination between AAAs, volunteers, and Department investigators so that (1) information that AAAs and volunteers gather will be more useful to Department investigators and (2) Department investigators will use the services of the AAAs and volunteers more effectively during their investigations. In addition, the Department should better ensure that the AAAs and volunteers offer sufficient technical support to residents and their family members who wish to form resident and family councils.

The Department takes actions against nursing facilities at which it identifies deficient practices—through imposing administrative penalties, civil monetary penalties, denial of license, involuntary trusteeship, and suspension of admission—but it rarely terminates its contracts with nursing facilities. In fiscal year 2010, the Department recommended contract termination for 372 nursing facilities. However, it reconsidered or rescinded all but one of those terminations. According to the Department, in fiscal year 2011, it referred two high-profile cases involving resident deaths at nursing facilities in Brownfield and Amarillo to the Office of the Attorney General, which filed suits against those nursing facilities to assess state civil penalties. Subsequent to the conclusion of fieldwork on this audit, but before this audit report was released, the Office of the Attorney General also announced indictments of staff of the Brownfield nursing facility on criminal charges.

Auditors communicated other, less significant issues to the Department's management separately in writing.

Summary of Management's Response

The Department agreed with the recommendations in this report.

Summary of Information Technology Review

Auditors performed a limited review of controls over CARES related to the intake, investigation, and enforcement activity resulting from nursing facility complaints. That work included reviewing user access, exception reporting, data input controls, and tests of data for completeness and reasonableness. Auditors

determined that controls and data were sufficient for the purposes of this audit. However, auditors identified the following issues:

- CARES does not have a data field for tracking the time of day an investigator enters a nursing facility to begin the investigation of a complaint (see Chapter 2-A for additional details).
- CARES allows the same intake supervisor to complete the intake of a complaint and perform a quality assurance review on that complaint intake (see Chapter 1 for additional details.)

Summary of Objective, Scope, and Methodology

The objective of this audit was to determine whether the Department has processes and controls to help ensure that it screens, investigates, and resolves complaints regarding nursing facilities in a timely manner and in compliance with applicable laws, policies, and procedures.

The scope of this audit covered September 1, 2007, through February 24, 2011, and included areas involved in the nursing facility complaint process from intake through resolution.

The audit methodology included collecting information and documentation related to the complaint intake, investigation, and enforcement processes; conducting interviews with intake, regulatory services, and the state long-term care ombudsman; observing processes; analyzing data from CARES; analyzing and evaluating the results of testing; and reviewing policies, procedures, the Texas Administrative Code, and statutes.

Auditors assessed the reliability of CARES data by interviewing data management personnel, reviewing processes that limit access to authorized users, and reviewing reports provided to Department management that mitigate the risk of inaccurate or incomplete data in the system. Auditors assessed the completeness of CARES data by reviewing a query used to pull data, reviewing selected fields for blank entries and invalid codes, and comparing complaint and intake record totals to materials the Department previously published. Auditors determined that the data was sufficiently reliable for the purposes of this audit.

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Detailed Results

Chapter 1

The Department Processes Complaint Intakes and Prioritizes Complaints About Nursing Facilities Accurately and in a Timely Manner

The Complaint Intake Process

The Department receives complaints primarily through a dedicated, toll-free complaint telephone line that is staffed Monday through Friday from 8:00 a.m. to 5:00 p.m. The Department also receives complaints through voicemail (available 24 hours a day), email, regular mail, fax, and referrals from other agencies.

Department intake staff gather information from the complainant and enter it directly into CARES. Intake staff assign a priority to the complaint based on the information received.

Quality assurance staff then review the completed intake information for accuracy and send it electronically to a regional office for investigation. For high-priority complaints, quality assurance staff also telephone a regional office.

Source: The Department.

The Department of Aging and Disability Services (Department) processes the intake of nursing facility complaints accurately and in a timely manner. The Department also has established adequate complaint intake procedures to help ensure that it promptly and appropriately prioritizes nursing facility complaints before it refers them to regional offices for investigation.

The Department completed complaint intakes in a timely manner. Between September 1, 2007, and February 24, 2011, the Department completed 98.6 percent of complaint intakes within two working days of receipt, as required by federal guidelines.³ To meet state requirements for investigation of high-priority complaints within 24 hours (see Chapter 2-A), intakes for high-priority complaints need to be completed more quickly than intakes for lower priority complaints; however, there are no federal or state timeliness requirements specifically for the intake of high-priority complaints.

The Department accurately determined the priority level of nursing facility complaints. The Department received a score of 97.5 percent on the U.S. Centers for Medicare and Medicaid Services' (CMS) state performance standards review for accurately prioritizing complaints in fiscal year 2010. That score exceeded the 90 percent minimum that CMS requires.

The Department has processes to help ensure that it completes complaint intakes accurately and in a timely manner. The Department ensures that it completes complaint intakes in a timely and accurate manner through:

- Training intake staff on procedures, data entry, and how to gather appropriate information from a complainant.
- Listening to live telephone calls and monitoring information that intake and quality assurance staff document in the Compliance, Assessment, Regulation, and Enforcement System (CARES).

³ The U.S. Centers for Medicare and Medicaid Services' *State Operations Manual* (SOM), which includes federal guidelines for nursing facility complaint intake, requires the Department to screen complaints and determine priority within two working days of receipt for complaints that are not high-priority.

- Performing quality assurance reviews on completed complaint intakes. Between September 1, 2007, and February 24, 2011, the Department performed quality assurance reviews on 25,557 (91.1 percent) of the 28,064 complaint intakes.

Complaint intake supervisors can both enter and review a complaint intake record.⁴ Between September 1, 2007, and February 24, 2011, 2,507 (8.9 percent) of the 28,064 complaints were entered and reviewed by the same complaint intake supervisor, without a secondary review of the intake. This increases the risk that the complaint priority may not be determined correctly; however, that risk is mitigated by (1) the Department's quarterly audits of a sample of complaint intakes and (2) having a tenured supervisory staff.

Recommendation

The Department should ensure that complaints that are entered by a complaint intake supervisor are routed to other supervisory staff for a quality assurance review prior to the Department notifying a regional office about the complaint.

Management's Response

While systems and controls are in place to ensure intakes are randomly selected for quality reviews, including intakes completed by Consumer Rights and Services management staff, intakes will be reviewed by another manager to verify compliance prior to final disposition. Quality Monitoring activities and initiatives will continue to be reviewed and assessed on an ongoing basis to determine effectiveness for measuring processes and performances for all Consumer Rights and Services staff.

It should also be noted that during the period reviewed, the agency exceeded the Centers for Medicaid and Medicare Services performance standards for the prioritization and triage of complaints.

Target Implementation Date:

September 1, 2011

Responsible Party:

Director, Consumer Rights and Services

⁴ According to the Department, this can occur when there are staffing shortages and when the Department receives a complaint outside of regular business hours.

The Department Should Improve the Timeliness of High-priority Complaint Investigations at Nursing Facilities and Strengthen Its Monitoring of Regional Offices and Its Long-term Care Ombudsman Function

The Department should improve the timeliness of its response to high-priority nursing facility complaints to comply with the state requirement to begin investigations within 24 hours of receiving those complaints. To monitor compliance with timeliness requirements, the Department must capture additional information about when investigation teams enter nursing facilities to begin investigations. Between September 1, 2007, and February 24, 2011, the Department complied with federal requirements for the timeliness of complaint investigation for 97.1 percent of the high-priority nursing facility complaints it received. It complied with stricter state timeliness requirements for no more than 73.1 percent of high-priority complaints during that same time period.

The Department also should strengthen its monitoring of nursing facility complaint investigations by using information already available in CARES to help it identify best practices and address inconsistencies in its regional offices' investigations of complaints at nursing facilities. Monitoring differences among the regional offices is important because some regional offices vary significantly in the frequency with which they substantiate allegations made through complaints.

Additionally, the Department should strengthen its long-term care ombudsman function to better ensure that it efficiently addresses less serious nursing facility complaints. Department ombudsman staff also should strengthen monitoring of the 28 area agencies on aging with which the Department contracts to deliver ombudsman services at nursing facilities.

Chapter 2-A

The Department Should Improve Compliance with State Timeliness Requirements for Its Investigations of High-priority Complaints at Nursing Facilities

Between September 1, 2007, and February 24, 2011, the Department complied with federal requirements⁵ to begin high-priority nursing facility complaint investigations within two working days of receipt for 97.1 percent of the high-priority nursing facility complaints it received. In that same time period, the Department complied with stricter state requirements⁶ to begin investigations

⁵ The U.S. Centers for Medicare and Medicaid Services' *State Operations Manual* requires the Department to investigate immediate jeopardy complaints within two working days of receipt of the information.

⁶ Texas Health and Safety Code, Section 242.126, requires the Department to begin investigations of high-priority nursing facility complaints within 24 hours of receipt.

of high-priority nursing facility complaints within 24 hours of receipt for no more than 73.1 percent of high-priority complaints.

The Department does not capture information in CARES that would enable it to accurately calculate, monitor, and report its compliance with state timeliness requirements for investigation of high-priority complaints at nursing facilities. Specifically, CARES does not capture the time of day when Department investigators enter a nursing facility in response to a complaint.

The Department's methodology for determining the timeliness of high-priority investigations is not consistent with state requirements.

The Department makes the following assumptions when it calculates its compliance with state requirements for high-priority nursing facility complaints:

- The 24-hour time period within which state requirements specify the Department must begin its investigation of a high-priority complaint starts at the end of the complaint intake process, not at the time the Department receives a complaint. The average time to complete the intake of a high-priority complaint is 14.4 hours.
- Investigation response time complies with state requirements if an investigation of a high-priority complaint begins by the end of the next working day after the Department completes its complaint intake procedures.

The first assumption listed above is inconsistent with the state requirement, which (1) requires investigations to begin within 24 hours of receiving a high-priority complaint and (2) does not specifically provide additional time for the intake process. The second assumption listed above is necessitated by the fact that CARES does not capture the time of day when investigators enter nursing facilities to begin investigations.

The maximum timeliness compliance rate of 73.1 percent for high-priority nursing facility complaints that auditors calculated assumes that the 24-hour time period begins when the Department receives a complaint. Auditors could not calculate the actual compliance rate because, as discussed above, CARES does not capture the time of day when Department investigators enter a nursing facility in response to a complaint.

Recommendations

The Department should:

- Ensure that CARES captures the time of day when Department investigators enter a nursing facility in response to a complaint so that it can determine whether it is complying with state requirements regarding the investigation of high-priority complaints.
- Ensure that it complies with the state requirement to begin investigations within 24 hours of receiving high-priority complaints at nursing facilities.
- Consider working with the Legislature to establish (1) the appropriate amount of time for processing a high-priority complaint intake prior to referring the complaint to a regional office for investigation and (2) whether the time for complaint intake should be included within or excluded from the 24-hour time period for beginning an investigation.

Management's Response

Systematic and programming changes are required to ensure that CARES captures the time of day when department investigators enter a nursing facility. Feasibility for the addition of this data field in CARES will be referred to Information Technology for consideration and is contingent upon funding and agency resources. The Department is currently exploring an alternative system for tracking all intakes; however this option is also based on funding and resources.

As SAO currently interprets the statute, it does not allow for instances when reports are received and additional information or clarification is required prior to making final prioritization determination. In an ongoing effort to decrease the triage time-frame and to alert regional offices as quickly as possible, allowing the maximum time possible for an investigation to begin, Regulatory Services and Consumer Rights and Services management will discuss options for providing preliminary notice of a potential priority I investigation as early in the intake process as possible to alert regional offices of the need to redirect staff.

The Department will work with the legislature to clarify reporting and response time requirements.

Target Implementation Date:

November 30, 2011 – Submit request for IT feasibility study of CARE system changes.

March 31, 2012 – Explore alternative tracking system and regional office notification feasibility.

On going – Obtain legislative clarification.

Responsible Parties:

Director, Survey Operations, Regulatory Services

Director, Consumer Rights and Services

Director, Center for Consumer and External Affairs

Information Resources Manager

Chapter 2-B

The Department Should Strengthen Its Monitoring of Regional Offices' Nursing Facility Complaint Investigations

Using available information in CARES, the Department should strengthen monitoring of its regional offices so that it can identify best practices for nursing facility complaint investigations and factors that may affect the quality of investigations. Significant differences in the results of nursing facility complaint investigations exist among some regional offices. For example, two regional offices vary significantly from the state average in terms of the number of allegations they substantiate through their investigations of complaints.⁷

Using CARES to Monitor Regional Offices

CARES contains extensive information about nursing facility complaints, investigations, deficiencies, and enforcement actions that the Department could use to compare the investigation results and staffing practices of its regional offices.

Source: CARES.

Table 1 on the next page shows the allegation substantiation rates for the Department's regional offices from September 1, 2007, to February 24, 2011. The regional offices responsible for regions 2, 9, and 10 substantiate significantly more allegations (14.8 percent) than the state average (9.9 percent). The regional office responsible for region 11 substantiates significantly fewer allegations (5.4 percent) than the state average.

⁷ Nursing facility complaints often include multiple allegations. Substantiation rates in this chapter represent the number of allegations the Department substantiated compared with the total number of allegations the Department investigated.

Table 1

Allegation Substantiation Rates by Region September 1, 2007, through February 24, 2011		
Region Number	Regional Office Location	Allegation Substantiation Rate
1	Lubbock	10.7%
2, 9, and 10	Abilene, El Paso	14.8%
3	Arlington	10.9%
4 and 5	Tyler, Beaumont	10.4%
6	Houston	8.8%
7	Austin	9.9%
8	San Antonio	8.0%
11	Corpus Christi	5.4%
State Average ^a		9.9%
^a From September 1, 2007, through February 24, 2011, the Department received and investigated 74,566 allegations. It substantiated 7,418 (9.9 percent) of those allegations.		

Source: CARES.

Strengthening monitoring of regional offices could help the Department identify best practices and ensure that it conducts consistent, high-quality nursing facility complaint investigations statewide. Better monitoring of regional office investigation practices also could help the Department identify underlying causes for regional office differences and help it more efficiently use limited resources available for investigations.

The Department should monitor available information to identify and follow up on differences in how regional offices investigate nursing facility complaints.

The following are examples of available information the Department could consider using to strengthen its monitoring of regional offices:

- Information on investigator tenure. Statewide, the average tenure (combined years of experience) of the Department’s nursing facility complaint investigation teams has decreased from 14.0 years in fiscal year 2008 to 9.2 years in fiscal year 2011 (through February 24). In addition:
 - Tenure for teams that investigate high-priority complaints varies significantly. For example, tenure for teams investigating high-priority nursing facility complaints averaged 18.6 years in region 1 and 6.7 years in region 11.

- Statewide, investigation team tenure is lower for investigation of high-priority complaints than for investigation of low-priority complaints. The average team tenure for investigation of high-priority complaints is 10.3 years, but the average team tenure for investigation of lower-priority complaints ranges from 14.9 years to 16.3 years.⁸
- Information on investigation team size. Region 11, which had the lowest substantiation rate for allegations about nursing facilities, had the highest percentage of complaint investigations conducted by a single investigator. Region 11 conducted 93.6 percent of its investigations in fiscal year 2011 (through February 24, 2011) with a single investigator. Statewide, the percent of investigations the Department conducted with a single investigator increased from 59.3 percent in fiscal year 2008 to 76.7 percent in fiscal year 2011 (through February 24, 2011).
- Information on regional office compliance with investigation reporting requirements. Investigators are required to report the results of an investigation to the nursing facility within 10 working days of completing an investigation. However, the Department is not able to monitor its regional offices' compliance with that requirement because the regional offices frequently do not enter information in CARES regarding their compliance with that requirement. Strengthening monitoring to ensure that regional offices enter information into CARES would help the Department improve regional office compliance with investigation reporting requirements.

The Department should consistently evaluate its investigators.

At the time of this audit, the Department had not prepared annual performance evaluations in a timely manner for 10 (28.6 percent) of 35 sampled investigators as required by the Health and Human Services Commission's *Human Resource Manual*. In addition, the sampled performance evaluations that regional office supervisors provided to investigators varied significantly in the quality of feedback. One regional office also used performance standards that were not consistent with standards that other regional offices used to evaluate investigators.

Given the decrease in tenure among investigators discussed above, it is important for the Department to provide investigators with consistent annual evaluations about their performance.

⁸ The Department has three categories of lower-priority nursing facility complaint investigations. Time lines for beginning those investigations range from 14 days to 45 days after the Department receives the complaint.

Recommendations

The Department should:

- Use available data to monitor differences in regional office complaint investigations at nursing facilities, and ensure that regional offices use effective investigation practices.
- Ensure that (1) regional offices enter sufficient information into CARES about when investigators send the results of complaint investigations to nursing facilities, and (2) it reports the results of complaint investigations to nursing facilities within 10 working days.
- Conduct annual performance evaluations for all investigators, using consistent performance standards.

Management's Response

Regulatory Services' State Office Compliance & Oversight team will initiate a planned schedule and methodology for gathering information relevant to regional complaint investigation, staffing, and documentation practices. To date, reporting templates have been standardized, a Complaints Investigation Manual for nursing facility surveyors has been updated and posted online for program wide access, complainant letters have been standardized, and a complaint Investigation Workgroup continues to identify best practice models for replication.

Regional offices will continue to be provided support and direction for thorough, timely and appropriate data entry into the state and federal automated tracking systems

Clarification regarding consistent performance standards was provided to the Regional Regulatory Services management team, and all staff evaluations were current as of May 2011. Managers were instructed to run performance management reports from the AccessHR system at least semi-annually to ensure the evaluations remain current.

Target Implementation Date:

November 30, 2011

Responsible Party:

Director, Survey Operations, Regulatory Services

The Department Should Strengthen Its Long-term Care Ombudsman Function to Enhance How It Addresses Nursing Facilities Complaints

The Long-term Care Ombudsman Function

The Department's Long-term Care (LTC) Ombudsman (ombudsman) program provides services that identify, investigate, and resolve complaints made by or on behalf of residents of nursing facilities and assisted living facilities.

Approximately 895 volunteers and the equivalent of 56 full-time staff (at the Department and the area agencies on aging) serve as certified LTC ombudsmen across Texas. Ombudsmen are advocates for residents of nursing facilities and assisted living facilities.

Area Agencies on Aging

The 28 area agencies on aging in Texas provide services to help older Texans, their family members, and caregivers receive the information and assistance they need to locate and access community services.

Sources: The Department and the Department's *Reference Guide* for 2011, pages 16 and 18.

The Department's Long-term Care Ombudsman (ombudsman) advocates for nursing facility residents in licensed nursing facilities. The Department delivers ombudsman services through contracts with 28 area agencies on aging (AAAs).⁹ (Appendix 3 includes a map of the AAA regions.) AAAs and volunteers address complaints in nursing facilities and seek to empower nursing facility residents and family members by providing technical assistance in forming resident and family councils. Unlike Department investigators, AAAs and volunteers cannot investigate complaints related to abuse and neglect of nursing facility residents, and they have no enforcement power.

The Department should strengthen its monitoring of the AAAs with which it contracts to ensure that they recruit enough volunteers to effectively deliver ombudsman services throughout the state. The Department also should strengthen coordination between AAAs, volunteers, and Department investigators so that (1) information that AAAs and volunteers gather will be more useful to Department investigators and (2) Department investigators will use the services of the AAAs and volunteers more effectively during their investigations. Finally, the Department should better ensure that AAAs and volunteers offer sufficient technical support to residents and their family members who wish to form resident and family councils.

The Department should ensure that AAAs have sufficient resources to deliver ombudsman services.

The Department should strengthen its monitoring of AAAs to help ensure that it meets its goal of having at least one AAA volunteer for each licensed nursing facility in the state. As of the end of fiscal year 2010, there were approximately 895 AAA volunteers and 1,194 licensed nursing facilities.

As of February 2011, 9 (32.1 percent) of the 28 AAAs have at least 1 volunteer for every nursing facility in their areas. Five AAAs (17.9 percent) have fewer than 1 volunteer for every 2 nursing facilities. Meeting the Department's goal of having one volunteer for each nursing facility could (1) strengthen relationships among AAAs, volunteers, nursing facility residents and their family, and staff in the nursing facilities and (2) facilitate local efforts to resolve problems without resorting to complaint investigations.

⁹ According to the Department, three AAAs subcontract with other organizations for ombudsman services.

The Department should strengthen coordination between AAAs, volunteers, and nursing facility investigators.

Department investigators do not regularly consider information from AAAs and volunteers when they investigate nursing facility complaints. Although 9 (30.0 percent) of 30 investigation packets that auditors tested contained evidence indicating that investigators had contacted the AAAs, none of the packets contained evidence that investigators used that information to draw conclusions about the validity of the allegations they investigated. The Department should strengthen coordination between its investigators, AAAs, and volunteers so that:

- AAAs and volunteers enhance their awareness regarding the types of information about nursing facility practices that may be valuable to investigators who review allegations.
- Investigators better use AAAs' and volunteers' knowledge of and experience with specific nursing facilities.

Better coordination among AAAs, volunteers, and Department investigators may also increase the likelihood that investigators substantiate legitimate allegations when they investigate complaints at nursing facilities. Additionally, this coordination may empower AAAs and volunteers to resolve more issues by working directly with residents and nursing facility administrators, which could reduce the volume of complaints that investigators must address.

The Department's ombudsman should better ensure that it provides technical assistance to individuals who wish to form resident and family councils at nursing facilities.

The Older Americans Act of 1965 requires the Department's ombudsman to provide technical assistance to nursing facility residents and family members to help them form or improve resident and family councils. Effective resident and family councils empower residents and family members by providing them with a forum through which they can speak on their own behalf regarding nursing facility practices and communicate directly with other residents, family members, and nursing facility staff.

The Department does not sufficiently monitor AAAs and volunteers to ensure that they provide adequate assistance to residents and family members who wish to form resident and family councils or make existing resident and family councils more effective. The Department does not track which nursing facilities have functioning resident and family councils so that it can better direct limited oversight resources to nursing facilities with the greatest needs.

Having effective resident and family councils may reduce the volume of nursing home complaints the Department investigates. Having effective resident and family

councils leverages the resources of individuals with the most to gain to improve the quality of care in nursing facilities. In addition, having more active resident and family councils could reduce the volume of complaints the Department investigates because resident and family council members acting collectively may be able to resolve problems by working directly with nursing facility administrators.

The Department's investigators should consider information that resident and family councils develop. The Department's investigators do not regularly consider information from resident and family councils when they investigate complaints. Only 1 (3.3 percent) of 30 investigation packets auditors tested contained evidence that the investigator reviewed minutes from resident and family council meetings.

The Department should ensure that AAAs and volunteers work with members of family and resident councils to better document discussions about nursing facility quality of care and compliance with requirements in resident and family council meeting minutes. AAAs and volunteers also should work with Department investigators to make the information that resident and family councils develop as useful as possible for investigations.

Recommendations

The Department should:

- Monitor AAAs to ensure that they have enough volunteers to meet the Department's goal of having at least one volunteer for every nursing facility.
- Strengthen coordination among Department investigators, AAAs, and volunteers to ensure that AAAs, volunteers, and family and resident council members develop information that is useful to investigators.
- Ensure that investigators routinely use information from AAAs, volunteers, and family and resident councils when investigating complaints about nursing facilities.
- Monitor the existence and effectiveness of family and resident councils in all nursing facilities, and direct AAAs and volunteers to nursing facilities with the greatest need for technical assistance in forming family and resident councils.
- Consider expanding the Department's state office ombudsman resources to strengthen monitoring and coordination with AAAs and volunteers.

Management's Response

The Department agrees having at least one volunteer for every nursing facility is a worthy goal and would positively impact the quality of life for residents. The office of the State Long-term Care Ombudsman currently monitors AAAs through the evaluation of a performance measure that tracks the number of active certified ombudsmen. This is compared with numbers of nursing facilities on a quarterly and annual basis.

We will closely monitor the number of volunteers at each AAA and provide technical assistance to the AAAs to help them attract, train, and retain a quality volunteer force in an effort to increase the number of ombudsmen.

The Department will conduct additional analysis to monitor resident and family council attendance by facility and provide this information to the AAAs in an effort to monitor where councils exist and identify facilities where the ombudsman is not providing technical assistance.

A new ombudsman certification training manual is complete and will be effective on September 1, 2011. The manual includes a chapter dedicated to resident and family councils. All current certified ombudsmen and new trainees in the program will be trained on the content. If funding is available, additional materials to support and strengthen councils will be developed and distributed through the AAAs.

The office of the Ombudsman and Regulatory Services will work together to determine ways to strengthen coordination between ombudsmen and investigators. Regulatory staff will ensure any changes in the investigative process are communicated to ombudsmen. The office of the Ombudsman will train ombudsmen to inform council leaders on the regulatory investigation process and on effective methods of providing information to investigators.

The office of the Ombudsman and Regulatory Services will discuss ways to ensure Department investigators use information provided by ombudsmen and address any changes needed in their existing program agreement. The Department will seek input from local ombudsmen and regulatory staff and inform them of any changes in protocol.

The Department agrees with this recommendation and has evaluated the need for additional resources for the office of the Ombudsman. One FTE will be transferred to the program to improve monitoring and coordination with AAAs.

Target Implementation Date:

December 31, 2011 – Monitoring number of volunteers by facility.

September 30, 2012 – Analysis of council attendance and need for technical assistance, new manual and training conducted.

July 31, 2011 – Coordination with Investigators and training to councils.

December 31, 2011 – Coordination with Regulatory Services regarding use of information from local ombudsman.

January 31, 2012 – Additional resources.

Responsible Parties:

State Long-term Care Ombudsman, Center for Consumer and External Affairs

Director, Survey Operations, Regulatory Services

The Department Takes Action Against Nursing Facilities for Deficiencies It Identifies During Complaint Investigations, But It Rarely Terminates Contracts with Nursing Facilities That Have a Pattern of Serious Deficiencies

Between September 1, 2007, and February 24, 2011, the Department substantiated 7,418 (9.9 percent) of the 74,566 allegations it received through complaints about nursing facilities.¹⁰ The Department took action against the nursing facilities for 3,324 (44.8 percent) of the 7,418 substantiated allegations. Although the Department takes a variety of actions against nursing facilities, it rarely terminates contracts with nursing facilities.

The Department takes a variety of actions against nursing facilities. The Department can take action against a nursing facility after Department staff in Austin have reviewed the deficiencies identified at a nursing facility. Nursing facilities can appeal those actions; therefore, the Department does not assess all actions it initially imposes.

In fiscal year 2010, the Department took action against nursing facilities through the use of administrative penalties¹¹, civil money penalties¹², denial of license, involuntary trusteeship, and suspension of admission. According to the Department's *Regulatory Services Annual Report (FY2010)*, in fiscal year 2010, the Department imposed 249 civil money penalties totaling approximately \$4.2 million and 40 administrative penalties totaling approximately \$1 million (see Appendix 5 for more details on actions the Department took against nursing facilities in fiscal year 2010).

The Department rarely terminates contracts with nursing facilities that have repeated, serious deficiencies.¹³ The Department often initiates the process of terminating contracts with nursing facilities because of deficiencies it identifies during its inspections and complaint investigations. In those cases, the Department provides nursing facilities an opportunity to correct deficiencies to avoid contract termination. If nursing facilities take advantage of the opportunity to correct deficiencies, they can avoid contract termination. In fiscal year 2010, the Department recommended contract termination for 372 nursing facilities. However, according to the Department, it reconsidered or rescinded all but one of those terminations.

¹⁰ A single complaint can involve multiple allegations.

¹¹ Administrative penalties are for violations of state licensing requirements.

¹² Civil money penalties are for violations of federal requirements or Medicaid contract requirements.

¹³ Deficiencies resulting in category 2 or category 3 actions as described in the U.S. Centers for Medicare and Medicaid Services' *State Operations Manual (SOM)*. See Appendix 6 for more details.

**Excerpt from
Texas Human Resources Code,
Section 32.021(m)**

Notwithstanding any provision of law to the contrary, the department shall terminate a nursing facility's provider agreement if the department has imposed required Category 2 or Category 3 remedies on the facility three times within a 24-month period. The executive commissioner of the Health and Human Services Commission by rule shall establish criteria under which the requirement to terminate the provider agreement may be waived.

**Criteria for Waivers of Nursing
Facility Contract Terminations**

The Department may waive termination of a nursing facility's contract when the nursing facility has received a Category 2 or 3 remedy [action] three times within 24 consecutive months. The Department may consider one or more of the following: (1) the history of violations committed by the nursing facility and the resulting action compared with the history of violations committed by other nursing facilities that received such remedies; (2) the history of ownership of the nursing facility when the actions were imposed; or (3) the efforts the nursing facility has made to correct the violations that resulted in the imposition of the remedies.

Source: Title 40, Texas Administrative Code, Section 19.2146 (e).

Additionally, the Department has established rules that allow it to waive termination of nursing facility contracts that it would otherwise be required to terminate under the requirements of Texas Human Resources Code, Section 32.021(m) (see text boxes for details). Between September 1, 2007, and February 24, 2011, the Department identified three or more repeated serious deficiencies within a 24-month period at 452 nursing facilities.¹⁴ According to Texas Human Resources Code, Section 32.021(m), the Department should terminate the contracts with those 452 nursing facilities unless they meet criteria for waiving termination. The Department asserts that it waived contract terminations for all 452 nursing facilities and did not document its reasons for the termination waivers.

The Department waives contract termination and gives nursing facilities multiple opportunities to correct serious deficiencies. Waiving contract termination increases the risk that nursing facilities with serious deficiencies could continue to operate.

Recommendation

The Department should document its reasons for waiving nursing facility contract terminations.

Management's Response

Although the Department is in compliance with state and federal regulations and direction, it should be noted the Department agrees that documentation of reasons for not terminating contracts is necessary. The Department will begin more extensive documentation for enforcement actions in federal fiscal year 2012.

Since 1999 as a result of Texas Department of Human Services vs. Kemp Health Services, Inc., in the event of change in facility ownership the State is prohibited from considering lack of Medicaid compliance in enforcement actions against Medicaid contract successors. Additionally, direction received in 2001 from the Centers for Medicaid and Medicare prohibits the State from applying the "three-strike" rule against dually-certified nursing facilities.

Target Implementation Date:

September 1, 2011

¹⁴ Seventy-four (16.4 percent) of those 452 nursing facilities had at least 10 serious deficiencies between September 1, 2007, and February 24, 2011.

Responsible Party:

Director, Enforcement, Regulatory Services

Appendices

Appendix 1

Objective, Scope, and Methodology

Objective

The objective of this audit was to determine whether the Department of Aging and Disability Services (Department) has processes and controls to help ensure that it screens, investigates, and resolves complaints regarding nursing facilities in a timely manner and in compliance with applicable laws, policies, and procedures.

Scope

The scope of this audit covered September 1, 2007, through February 24, 2011, and included areas involved in the nursing facility complaint process from intake through resolution.

Methodology

The audit methodology included collecting information and documentation related to the complaint intake, investigation, and enforcement processes; conducting interviews with intake, regulatory services, and the state long-term care ombudsman; observing processes; analyzing data from the Compliance, Assessment, Regulation, and Enforcement System (CARES); analyzing and evaluating the results of testing; and reviewing policies, procedures, and statutes.

Auditors assessed the reliability of CARES data by interviewing data management personnel, reviewing processes that limit access to authorized users, and reviewing reports provided to Department management that mitigate the risk of inaccurate or incomplete data in the system. Auditors assessed the completeness of CARES data by reviewing a query used to pull data, reviewing selected fields for blank entries and invalid codes, and comparing complaint and intake record totals to materials the Department previously published. Auditors determined that the data was sufficiently reliable for the purposes of this audit.

Information collected and reviewed included the following:

- Policies and procedures related to complaint intake, investigation, enforcement, long-term care ombudsman, and records management.
- Annual reports for the long-term care ombudsman and regulatory services.

- Information from interviews with management and staff.
- Automated call distribution reports for complaint intake and documentation of complaint intakes deleted by quality assurance staff.
- Documentation of monitoring activities performed on intake specialists and investigators by the Department and the U.S. Centers for Medicare and Medicaid Services.
- Investigations data from CARES.
- Hard-copy investigation packets from Department regional offices.
- Reports for monitoring investigator citation frequency, timeliness, and travel expenses.
- Performance evaluations for investigators.
- Intake specialist, investigator, and ombudsman training materials.
- The Department's staff complaint log.
- The Department's *Nursing Facility Contracting Report*, which includes data related to enforcement actions and information about current activities and initiatives and is submitted to the Legislature.
- Employment dates for intake, investigation, and enforcement personnel.

Procedures and tests conducted included the following:

- Conducted interviews with Department staff to determine how complaints were received, screened, investigated, and resolved.
- Reviewed policies and procedures related to the complaint process.
- Reviewed complaint intake and investigator training for content.
- Observed data input of information into CARES by complaint intake, investigation, and enforcement staff and reviewed input controls.
- Analyzed complaint intake data in CARES for quality assurance reviews, timeliness, future dating, and priority code changes.
- Analyzed investigation data in CARES for complaint volume; investigation timeliness and duration; allegation type; substantiation rate; and investigation team size.
- Analyzed enforcement data in CARES for actions including monetary penalties and termination of provider agreements.

- Analyzed tenure and turnover of complaint intake, investigation, and enforcement staff.
- Tested hard copy investigation packets for evidence of intake and investigator timeliness, contact with ombudsman personnel, and the use of resident and family council meeting minutes.
- Tested investigator evaluations for content and consistency across regional offices.

Criteria used included the following:

- Title 40, Texas Administrative Code, Chapter 19.
- U.S. Centers for Medicare and Medicaid Services, *State Operations Manual*, Chapters 5 and 7.
- Texas Health and Safety Code, Chapter 242.
- Texas Human Resources Code, Chapters 32 and 101.
- Title 42, Code of Federal Regulations, Parts 431, 483, and 488.
- Texas Government Code, Chapter 531.
- The Older Americans Act of 1965.
- The Department's *Complaint Intake Guidebook*.
- The Department's *Quality Assurance Specialist Guidebook*.
- The Department's *Geriatric Investigation Handbook*.
- The Department's *Nursing Facility Enforcement Handbook*.
- The Department's policies and procedures.

Project Information

Audit fieldwork was conducted from April 2011 through June 2011. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

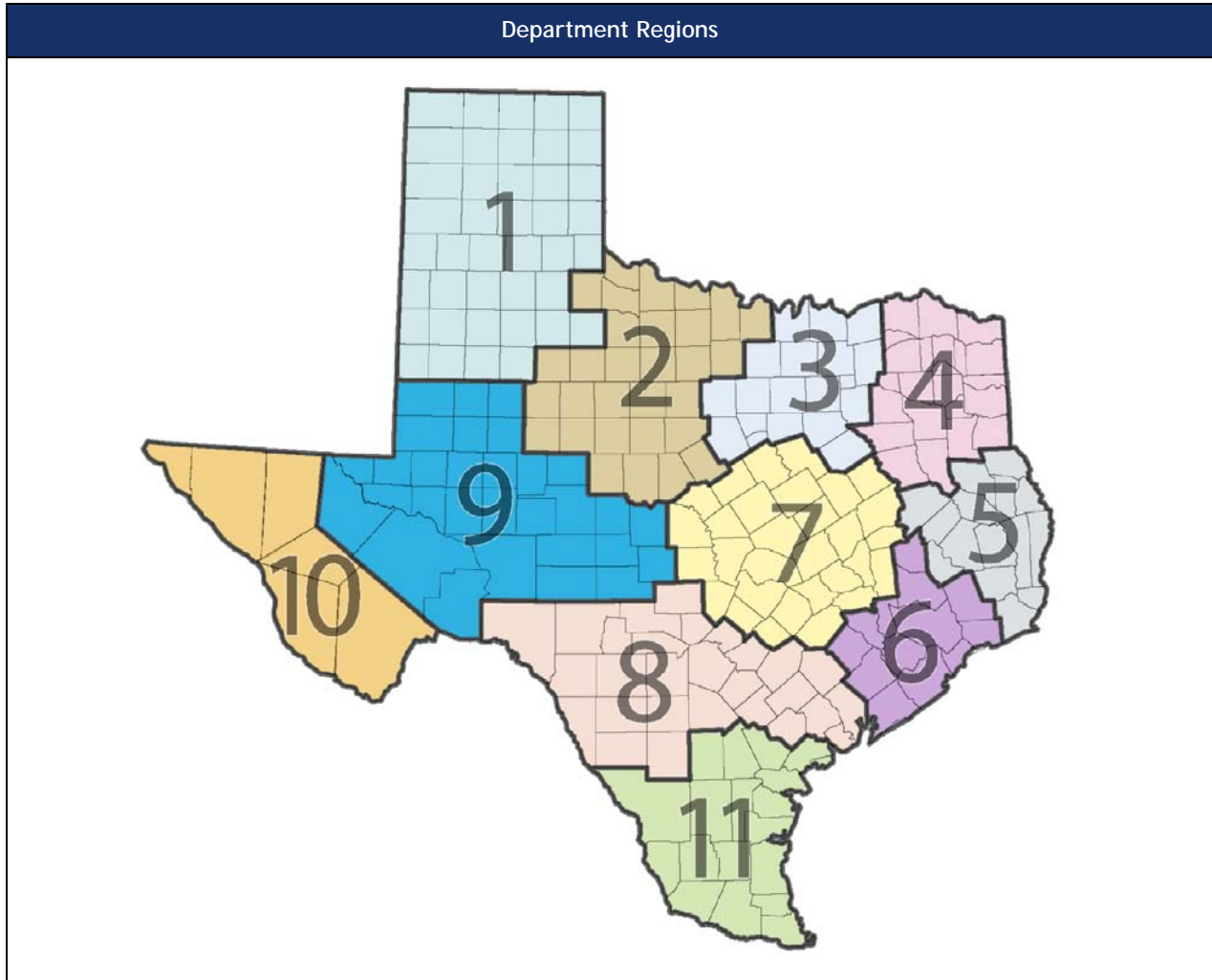
The following members of the State Auditor's staff performed the audit:

- Scott Boston, MPAff (Project Manager)
- Michael F. Boehme, CIA, PHR (Assistant Project Manager)
- Joe Fralin, MBA
- Sherry Sewell, CGAP
- Sonya Tao, CFE
- Dana Musgrave, MBA (Quality Control Reviewer)
- John Young, MPAff (Audit Manager)

Map of Department Regions

Figure 1 shows the locations of Department of Aging and Disability Services (Department) regions.

Figure 1

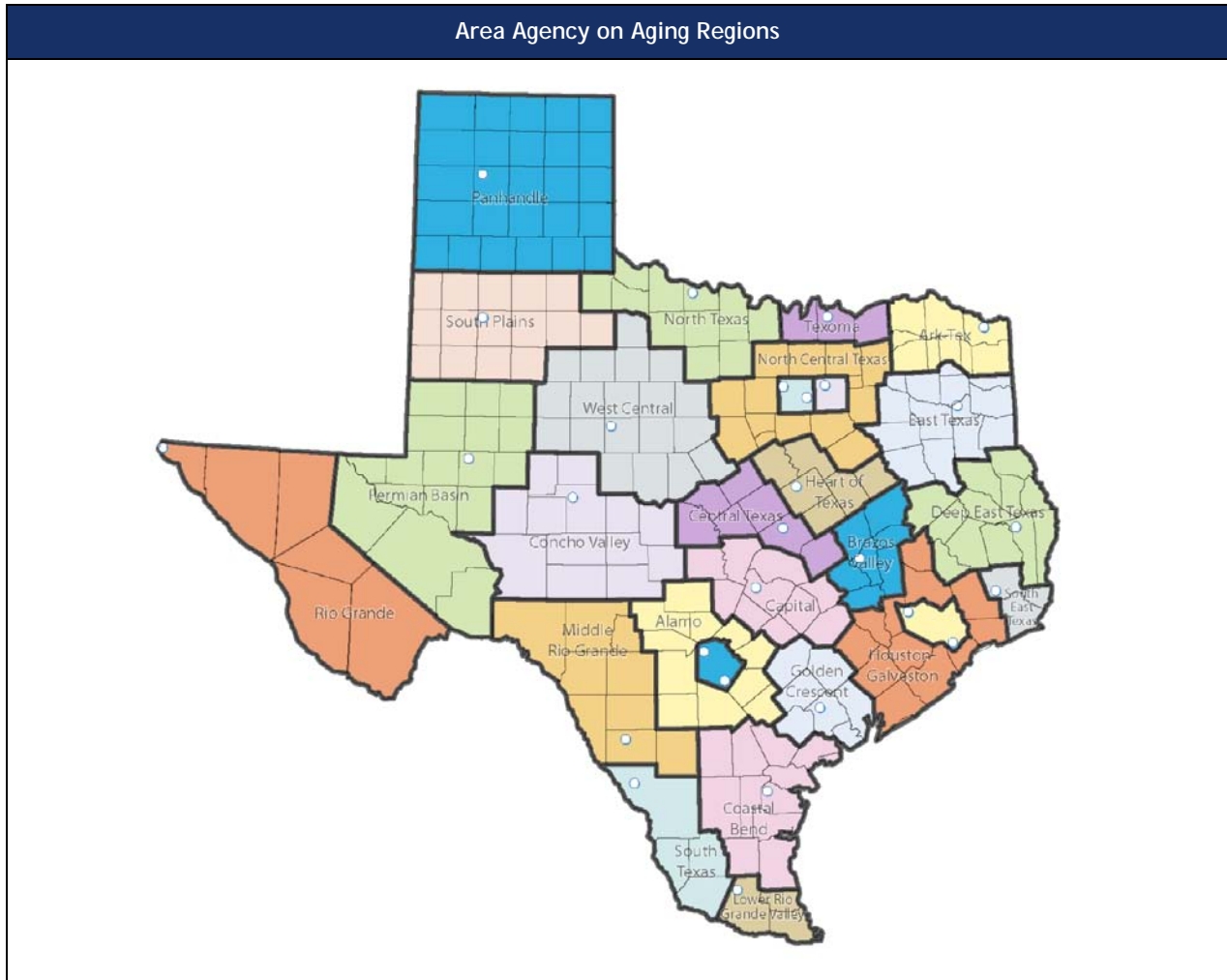


Source: The Department.

Map of Area Agency on Aging Regions

Figure 2 shows the locations of Area Agency on Aging regions.

Figure 2



Source: The Department of Aging and Disability Services.

Most Common Nursing Facility Complaint Intake Reasons

Table 2 shows the top 10 most frequent nursing facility complaint intake reasons in fiscal year 2010.

Table 2

Top 10 Most Frequent Nursing Facility Complaint Intake Reasons Fiscal Year 2010		
Rank	Category	Description
1	Neglect	Failure to provide services, treatment, or care that causes or could cause mental or physical injury, or harm, or death to the resident. (Ranked number 1 in fiscal year 2009.)
2	Resident Rights/Client Protections	Failure to ensure that residents have autonomy and choice, as far as possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. (Ranked number 2 in fiscal year 2009.)
3	Activities of Daily Living	Failure to provide necessary care and services to maintain or prevent deterioration in a resident's ability to bathe, dress, groom, transfer, ambulate, and toilet unless the deterioration was unavoidable; or, failure to provide residents who are dependent on staff to meet their activities of daily living all the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. (Ranked number 3 in fiscal year 2009.)
4	Quality of Care	Failure to provide services that improve (or at least maintain) a resident's overall physical and mental condition as indicated by the resident's comprehensive assessment. (Ranked number 4 in fiscal year 2009.)
5	Quality of Life	Failure to care for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's dignity and self-determination about aspects of his or her life in the facility that are significant to the resident. (Ranked number 5 in fiscal year 2009.)
6	Environment	Failure to provide a safe, clean, comfortable, and homelike environment with everything in proper working order. (Tied for number 6 in fiscal year 2009.)
7	Medications	Failure to ensure that residents' medications are administered in the correct dosage as prescribed by the physician; or failure to ensure a resident's drug regimen is free from drugs used in excessive dose or duration, without adequate monitoring, without adequate indications for their use, in the presence of adverse consequences that indicate the dose should be reduced or discontinued. (Tied for number 7 in fiscal year 2009.)
8	Sufficient Staff	Failure to provide sufficient qualified and trained staff to care for residents to enable them to reach their highest practicable physical, mental, and psychosocial well-being. (Ranked number 8 in fiscal year 2009.)
9	Administration	Failure to ensure responsible supervision and management of the facility to ensure the health and safety of residents, compliance with policies and procedures, and compliance with applicable state and federal regulations. (Ranked number 10 in fiscal year 2009.)
10	Pressure Sores	Failure to prevent pressure sores from developing on residents, or to provide sufficient care to heal pressure sores that a resident may already have on admission. (Ranked number 9 in fiscal year 2009.)

Source: The Department of Aging and Disability Services' *Regulatory Services Annual Report (FY2010)*.

Actions the Department Took Against Nursing Facilities in Fiscal Year 2010

Table 3 presents actions the Department of Aging and Disability Services (Department) took against nursing facilities by region in fiscal year 2010.

Table 3

Nursing Facility Actions by Region for Fiscal Year 2010													
Type	Action	Region											Totals
		01	02	03	04	05	06	07	08	09	10	11	
Administrative Penalties ^a	Imposed	2	1	4	5	3	14	0	11	0	0	0	40
	Assessed	0	0	2	4	0	8	0	1	0	0	1	16
Injunctive/Other Relief and Civil Penalties ^b	Referred	0	0	0	0	0	0	0	0	0	0	0	0
Amelioration of Violations	Approved	0	0	1	1	1	1	0	3	0	0	0	7
	Denied	0	0	0	0	0	1	0	0	0	0	0	1
Trusteeships	Ordered	0	0	1	0	0	0	0	0	0	0	0	1
Closures Under Trusteeship	Accomplished	0	0	1	0	0	0	0	0	0	0	0	1
Emergency Suspension and Closing Orders	Ordered	0	0	0	0	0	0	0	0	0	0	0	0
Suspensions of Admission	Ordered	0	0	0	0	0	0	0	0	0	0	0	0
Denials of License ^c	Proposed	1	1	1	0	2	1	3	1	0	0	0	10
	Denied	0	1	2	0	1	0	1	0	0	0	0	5
Revocations of License ^d	Proposed	1	0	1	0	0	0	0	0	0	0	0	2
	Revoked	0	0	1	0	0	0	0	0	0	0	0	1
Civil Money Penalties ^e	Imposed	8	24	59	41	3	23	40	14	16	7	14	249
	Assessed	2	7	38	8	1	1	6	6	4	3	2	78

^a Assessed administrative penalties can include final actions on penalties imposed in a previous fiscal year.

^b The Department refers injunctive/other relief and civil penalties to the Office of the Attorney General.

^c The Department may propose to deny renewal of a license for many reasons. However, if a nursing facility has been cited for one or more violations of the licensing rules and those violations have not been determined to have been corrected by the date the nursing facility's license is due for renewal, the Department may propose to deny the application. If the nursing facility subsequently corrects the violation(s), the Department may withdraw its proposal to deny the application for license renewal. Denied actions may also include final actions on cases proposed in a previous fiscal year.

^d Revoked actions may include final actions on cases proposed in a previous fiscal year.

^e Assessed civil money penalties can include final actions on penalties imposed in a previous fiscal year.

Source: The Department's *Regulatory Services Annual Report (FY2010)*, page 153.

Actions the Department Can Take for Deficiencies Identified at Nursing Facilities

Table 4 presents the various actions the Department of Aging and Disability Services (Department) can take for deficiencies identified at nursing facilities.

Table 4

Actions the Department Can Take for Deficiencies Identified at Nursing Facilities		
Category	Conditions That Must be Present	Actions
1	<p>Select at least one action from category 1 when there:</p> <ul style="list-style-type: none"> ▪ Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy. or ▪ Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy. 	<ul style="list-style-type: none"> ▪ Directed plan of correction. ▪ State monitoring. ▪ Directed in-service training.
2	<p>Select at least one action from category 2 when there are:</p> <ul style="list-style-type: none"> ▪ Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy. or ▪ One or more deficiencies (regardless of scope) that constitute actual harm that is not immediate jeopardy. 	<ul style="list-style-type: none"> ▪ Denial of payment for all new Medicare and/or Medicaid admissions. ▪ Denial of payment for all Medicare and/or Medicaid residents, imposed by the regional office. ▪ Civil money penalties of \$50-\$3,000 per day of noncompliance. ▪ Civil money penalties of \$1,000-\$10,000 per instance of noncompliance.
3	<p>Termination or temporary management, or both, must be selected when there are one or more deficiencies that constitute immediate jeopardy to resident health or safety. A civil money penalty of \$3,050-\$10,000 per day or a civil money penalty of \$1,000-\$10,000 per instance may be imposed in addition to the remedies of termination and/or temporary management. Temporary management is also an option when there are widespread deficiencies constituting actual harm that is not immediate jeopardy.</p>	<ul style="list-style-type: none"> ▪ Temporary management. ▪ Termination. ▪ Civil money penalties of \$3,050-\$10,000 per day of noncompliance optional, in addition to the remedies of termination and/or temporary management. ▪ Civil money penalties of \$1,000-\$10,000 per instance of noncompliance optional.

Source: The U.S. Centers for Medicare and Medicaid Services' *State Operations Manual*.

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The Honorable Harvey Hilderbran, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Mr. Thomas Suehs, Executive Commissioner

Department of Aging and Disability Services

Mr. Chris Traylor, Commissioner



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