A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Department of Health Services

Office of Long Term Care

December • 2002
REPORT NO. 02 – 13

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

The **Auditor General** is appointed by the Joint Legislative Audit Committee, a bipartisan committee composed of five senators and five representatives. Her mission is to provide independent and impartial information and specific recommendations to improve the operations of state and local government entities. To this end, she provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits of school districts, state agencies, and the programs they administer.

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

December 30, 2002

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Ms. Catherine R. Eden, Ph.D., Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Health Services, Division of Assurance and Licensure Services, Office of Long Term Care. This audit, conducted pursuant to Laws 2001, Chapter 143, §1 was carried out under the authority vested in the Auditor General by A.R.S. §41-1279.03 I am also transmitting with this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Department agrees with all of the findings and recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on December 31, 2002.

Sincerely,

Debbie Davenport
Auditor General

Enclosure

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FACT SHEET

Department of Health Services—Division of Assurance and Licensure Services
Office of Long Term Care

Services:

The Office of Long Term Care is one of five programs under the Department of Health Services Assurance and Licensure Services Division. The Office has the following responsibilities:

1. Performing regular inspections of licensed nursing homes;
2. Investigating complaints;
3. Initiating enforcement actions against facilities with deficiencies;
4. Assisting providers with understanding statutes, rules, regulations, and policies;
5. Providing the public with information on facilities; and
6. Oversight of Medicare/Medicaid-certified facilities through an agreement with the federal Centers for Medicare and Medicaid Services (CMS).

Facilities and Equipment:

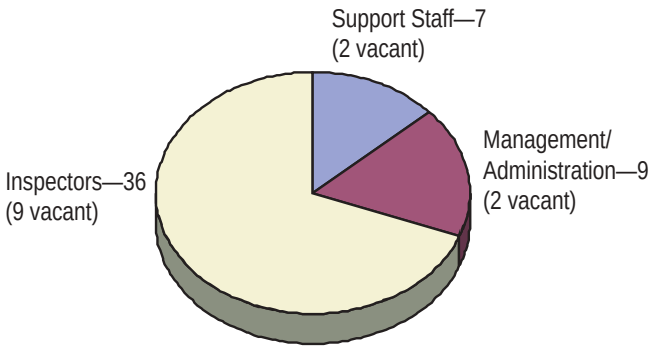
The Office leases space in two state-owned buildings at 1647 East Morton Street in Phoenix and 400 West Congress Street in Tucson. Its equipment includes typical office equipment such as furniture and computer equipment. In addition, the Office uses a satellite dish provided by CMS for mandated training broadcasts.

Mission:

The mission of the Office is to protect and promote the health and safety of residents in nursing care institutions and intermediate care facilities for the mentally retarded.

Program office staffing:

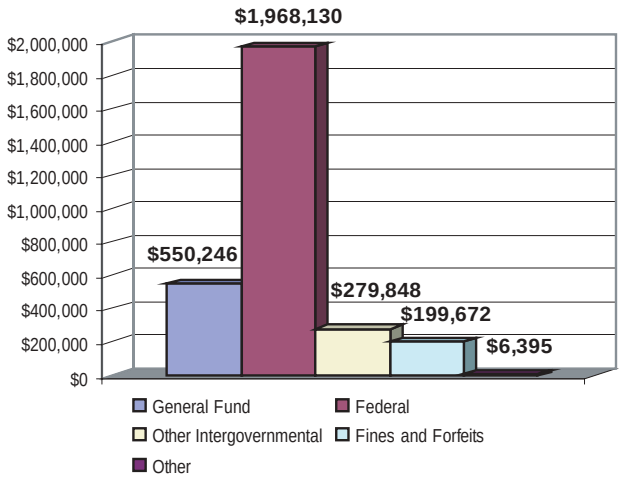
52 appropriated FTE (fiscal year 2003)



As of August 2002

Program office funding sources:

$3,004,291 (fiscal year 2002)



Goals:

The Office has established three goals separate from the Division's goals:

1. **Increase public information available to customers and stakeholders;**

2. **Improve timeliness of the inspecton and investigation process; and**

3. **Enhance the system of communicating internal changes and issues of concern to staff.**

In addition, according to division administrators, two of the Division's eight goals are particularly related to the Office's mission. These goals are:

1. **To perform inspections, complaint investigations, and license issuance within required time frames; and**

2. **To improve consumers' awareness of the Division as a source of information.**

Adequacy of performance measures:

For the first goal, the Division has established three performance measures to assess timeliness of inspections, complaint investigations, and license issuance. For example, it has developed a measure for the percentage of complaint investigations alleging actual harm that are not initiated within required deadlines and one for the overall percentage of late complaint investigations. However, the Office should also consider measures that would provide information on resources used, such as efficiency measures for the average number of staff hours for inspections and investigations.

The Division has developed one measure for the second goal, number of visits to the Division's Web site. The Office should consider establishing additional input, output, quality, and outcome measures to indicate how it intends to improve its public information function. For example, it could develop quality measures to assess both the completeness of information on its Web site, and consumer satisfaction with the information provided.

SUMMARY

The Office of the Auditor General has conducted a performance audit of the Department of Health Services, Division of Assurance and Licensure Services, Office of Long Term Care (the Office) to determine how effectively it regulates nursing care institutions. This audit, conducted pursuant to Laws 2001, Chapter 143, §1, was carried out under the authority vested in the Auditor General by A.R.S. §41-1279.03.

The Office, which licenses and regulates 139 Arizona nursing homes, is mandated to enforce nursing home quality-of-care regulations. Additionally, it certifies two tribal facilities and monitors the Arizona Pioneers' Home. Its responsibilities include conducting annual state licensure and Medicare certification inspections, investigating incidents reported by nursing homes and complaints received against nursing homes, providing technical assistance and education to nursing home staff, and providing information about nursing homes to the public. The Office is responsible for oversight of Medicare/Medicaid-certified facilities through an agreement with U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Additionally, the Office notifies homes of regulatory violations or deficiencies, obtains their corrective action plans, and issues sanctions against them as needed according to the scope and severity of their deficiencies.

Some investigation practices need improvement (see pages 9 through 13)

The Office needs to improve some of its practices regarding staff-related abuse- and neglect-related incidents reported by nursing homes and complaints reported by residents, families, and others. Problems are generally reported to the Office in two ways. First, the Office receives complaints from residents and their families, state agencies, and others. It receives over 700 such complaints each year. Second, nursing homes submit reports of incidents that range from minor incidents such as property loss to serious allegations of abuse.

Although the Office investigates all complaints and has recently eliminated its complaint investigation backlog, it does not investigate all incidents involving staff-related

abuse or neglect reported by nursing homes. Federal regulations require that all such incidents be investigated. Some of these reports involve issues as serious as those alleged in complaints from residents and families. Auditors reviewed files for 30 of the State's 139 homes and found the Office investigated only 20 out of 108 self-reported incidents of abuse and neglect at those 30 homes. At least 35 of the uninvestigated incidents involved staff. Limited staffing may preclude on-site investigation of all such incidents. However, in some cases the Office may be able to conduct investigations through telephone interviews and examination of documents provided by the home, including the home's internal investigation of the incident.

In addition to not investigating self-reported incidents, the Office does not always consistently apply complaint priorities. When the Office receives a complaint, it assigns one of four priority levels for investigation based on the seriousness of the allegation. For example, priority 1 complaints involve immediate and serious threats to health and safety, and must be investigated within 2 days. Auditors found cases in which complaints alleging actual harm or neglect, which the Office should have classified as priority 2 and investigated within 10 days, were misclassified as priority 3, allowing 45 days to complete the investigation. This delayed those investigations for up to 35 days, which could have compromised nursing home residents' health and safety. CMS reviews of the Office have noted similar misclassifications. To help make consistent and appropriate priority assignments, the Office should develop detailed guidelines specific to the long-term care program for assigning priorities.

The Office should provide more public information (see pages 15 through 19)

The Office does not always provide the public with the information it needs to make informed decisions about the quality of care that nursing homes provide. Some public documents are misfiled in nonpublic files, which results in members of the public receiving incomplete information. Further, some documents in the public files have more material expunged than the law requires and are no longer meaningful. The Office has proposed a change in statute that would reduce its redaction requirements. Additionally, although the Office assigns a quality-of-care rating to each home, its explanation of what the rating means can be easily misunderstood. However, the Office has proposed rules to establish a new quality rating system to the Governor's Regulatory Review Council. Finally, the Office's limited staff resources and an inadequate complaint-tracking system have affected its ability to provide complete information over the telephone. Its new complaint-tracking system implemented in October 2002 should help staff provide more information by telephone.

The Office has made substantial changes to its Web site and is participating in a state-wide effort to improve information available for aging citizens. As it continues its

improvements, it may wish to consider models offered by other state Web sites that provide more comprehensive public information, such as comparisons between a home's performance and the state average. Further, some information is still not easily accessible through the Office's Internet site. For example, most specific information about homes is provided through a link to the CMS Web site, but state enforcement and other information, including quality rating, requires looking in a different place in the Office's own site. The Office should continue to improve the information it makes available and establish more user-friendly forms of access to this information.

The Office can use state sanctions more often (see pages 21 through 23)

The Office should make more use of state sanctions when it finds that nursing homes are deficient in meeting state standards. The Office has improved its inspection timeliness in the last 2 years, and it uses acceptable standards for inspections and consistently recommends sanctions to CMS when it finds violations of Medicare and Medicaid standards. However, the Office makes very limited use of some state sanctions, such as fines or license suspensions. Relying on federal penalties may reduce the Office's ability to ensure that facilities comply with standards because federal regulators do not always impose the recommended penalty. In 2001, CMS did not take any action against at least 5 nursing homes after the Office recommended penalties they believed should be implemented. In addition, the lengthy federal appeals process can delay penalties. Currently, two Arizona cases have unresolved federal appeals, and both are more than 2 years old. Some other states, such as Washington and Florida, impose state penalties more often than Arizona because they believe they can enforce these penalties more quickly than federal sanctions. The Office should make more frequent use of state sanctions in addition to recommending federal sanctions.

Other pertinent information (see pages 25 through 27)

Auditors gathered information about other states' licensing standards for nursing homes. Most states, including Arizona, supplement federal standards with some standards of their own. These additional standards usually relate to staffing levels, which several studies have linked to quality of care. Federal standards require nursing homes to provide "sufficient staff" for 24-hour service to residents and a registered nurse for 8 hours each day. A 2001 private research survey shows that 13 states have increased minimum staffing requirements over the federal standards and

33 states have minimum staffing requirements for nursing assistants and other direct-care nursing staff. In Arizona, administrative rules require the presence of at least one nurse to care for no more than 64 residents. Some states have gone further than Arizona, instituting additional requirements. However, nursing shortages and the financial condition of some nursing homes may make the imposition of higher staffing ratios impractical until those conditions change.

Besides adding more staffing requirements, some states have instituted more rigorous complaint investigation time frames than required by the federal standards to avoid delay in identifying serious problems. Arizona has not done so. However, the State has instituted requirements on some other matters not required by the federal standards, including fingerprinting checks for nursing home employees, and employee testing for tuberculosis.

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INTRODUCTION & BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Department of Health Services, Division of Assurance and Licensure Services, Office of Long Term Care (the Office) to determine how effectively it regulates nursing care institutions. This audit, conducted pursuant to Laws 2001, Chapter 143, §1, was carried out under the authority vested in the Auditor General by A.R.S. §41-1279.03.

Nursing care institutions are facilities that provide continuous nursing services to people who do not require hospital care or daily doctor's care.

The Office enforces quality-of-care regulations

The state and federal governments share responsibility for setting and enforcing nursing homes' quality care standards. All nursing homes operating in the State must be licensed and meet state quality standards. In addition, nursing homes desiring to participate in the Medicare and Medicaid health programs must be certified by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). One hundred thirty-five of the State's 139 licensed nursing homes are certified to participate in Medicare and/or Medicaid. The Office serves as the primary agency for enforcing both state and federal regulations through an agreement with CMS. The Office conducts complaint investigations and reviews of incidents that nursing homes are required to report, and takes a variety of steps to enforce regulations and ensure that corrective actions are taken. The Office's responsibilities also include technical assistance and education to nursing home staff and providing information.

Inspections—In Arizona, the Office enforces standards of care by inspecting the State's 139 nursing homes. In addition, it certifies two tribal facilities and monitors the Arizona Pioneers' Home. The Office inspects nursing homes between 9 and 15 months after the previous inspection.[1] Inspections are unannounced and usually take 4 to 5 days. Four of the State's nursing homes are not Medicare- or Medicaid-certified and, therefore, are not subject to federal certification requirements. However,

1 The 15-month maximum is pursuant to 42 C.F.R. §488.308, which also requires that the state-wide average interval for Medicare or Medicaid certification be no more than 12 months. The Office follows a similar time frame for nursing homes that are not Medicare- or Medicaid-certified.

they must meet all state licensing standards, which generally parallel those for federal certification. The Office determines if nursing homes are meeting state and federal regulatory standards in the following areas:

- **Quality of care**—ensuring residents' conditions improve to the extent possible or do not deteriorate beyond what should be expected given their ages and medical conditions;
- **Quality of life**—determining that facilities create and sustain an environment that respects each resident's humanity and individuality;
- **Resident rights**—providing residents with a dignified existence and self-determination, and ensuring adequate communication with and access to persons and services outside the facility;
- **Facility cleanliness**—providing a safe, clean, comfortable, and home-like environment; and
- **Hazard-free environment**—providing a physical environment that does not endanger residents' health.

Appendix A (see page a-iii) provides a complete list of the types of federal regulatory standards.

Investigation of complaints—The Office investigates complaints against nursing homes related to quality of life and quality of care, including allegations of abuse, dietary problems, denial of residents' rights, and staffing and environmental concerns. The Office receives complaints from residents and their families, state agencies, and others. The Office received over 700 complaints per year in fiscal years 2000, 2001, and 2002. Most complaints come from nursing home residents and their families, nursing home employees, former employees, and managers. The Office investigates all these complaints, and has recently eliminated a complaint investigation backlog. In addition, the Office receives some referred complaints from Adult Protective Services at the Department of Economic Security and the Arizona Health Care Cost Containment System (AHCCCS).

Receipt of incidents self-reported by nursing homes—In addition to complaints, the Office receives self-reports from nursing homes, which are required to submit reports of incidents ranging from minor issues such as property loss to potentially very serious issues such as abuse and neglect. Facilities may submit these reports by phone, but

Federal regulations require that states classify deficiencies into one of four categories according to severity:

Potential for Minimal Harm—with potential of no more than minimal harm to residents;

Potential for More Than Minimal Harm—when minimal harm, discomfort to residents, or the potential of actual harm to residents occurs;

Actual Harm—where residents' ability to reach their highest physical and mental well-being is compromised; or

Immediate Jeopardy—where residents are at immediate risk of serious injury or death.

then must subsequently send in a written report of the investigation they have conducted. Until recently, the Office did not count or track these incident reports, although, based on a random sample of facility files, auditors estimate there may be about 1,200 reports per year.[1]

Steps to ensure corrective action—The Office notifies nursing homes of regulatory violations, or deficiencies, identified during an inspection or complaint investigation. The Office classifies state and federal deficiencies according to the number of residents affected (scope) and the seriousness of the violation (severity). In most cases, including isolated deficiencies with the potential for minimal harm, a nursing home is required to submit a plan of correction to the Office identifying how it plans to correct the deficiencies and prevent future incidents.

The Office must determine the scope of deficiencies, i.e., whether they are **isolated**, constitute a **pattern**, or are **widespread**.

The Office conducts follow-up inspections at nursing homes with quality-of-care deficiencies, or any deficiencies that are not isolated or are more serious than having just the potential for minimal harm. If, during its follow-up inspection, the Office notes that the nursing home failed to correct its deficiencies, the Office and CMS have a variety of enforcement actions available to them. Specifically:

- **For minor deficiencies**—sanctions can include monitoring inspections to ensure compliance and state-directed in-service training;

- **For more serious deficiencies**—the Office may take action against a facility's license, such as issuance of a provisional license or, as a last resort, suspension or revocation. Moreover, it may impose financial penalties such as civil money penalties up to $500 per day or a moratorium on new admissions, which can have a significant financial impact on nursing homes. Additionally, CMS may deny Medicare and Medicaid payments for new admissions or all residents, and/or issue civil monetary penalties between $50 and $3,000 per day for these violations; and

- **For deficiencies that result in actual harm or place residents in immediate jeopardy**—the Office can suspend the facility's license, install a temporary manager, issue a provisional license, and impose civil money penalties up to $500 per day. In addition to state penalties, CMS may order temporary management or terminate Medicare or Medicaid certification. It also has the option of imposing civil money penalties of between $3,050 and $10,000 per day.

In fiscal year 2002, federal civil money penalties were imposed five times, and denial of payment for new admissions was imposed nine times. In addition, the Office installed a temporary manager two times. According to Department officials, few severe penalties were imposed because the number and seriousness of deficiencies decreased from 2001 to 2002, as the Office conducted more inspections to reduce its inspection backlog.

1 The estimate is based on multiplying 141, the number of nursing homes in Arizona, by 8.5, the median number of self-reports in the 30 randomly selected files.

Under some circumstances, the law requires mandatory penalties. For example, CMS must impose denial of payment for new admissions when a nursing home is not in substantial compliance with required standards within 3 months after being found out of compliance. Additionally, if a nursing home provides substandard care for three consecutive inspections, the Office must monitor the home in addition to denying payments for new admissions. Finally, if a nursing home places residents in immediate jeopardy, federal regulations require that the State and CMS impose at least one of the most severe sanctions.[1]

Organization, staffing, and budget

State General Fund provides only 18 percent of the Office's funding.

The Division of Assurance and Licensure Services is one of six divisions within the Arizona Department of Health Services. The Division contains five offices, including the Office, which regulates nursing homes. As of September 30, 2002, 52 full-time equivalent positions were assigned to the Office. Thirty-six of these positions were for surveyors who conduct nursing home inspections and complaint investigations. In fiscal year 2000, the Office received funding for 8 additional surveyor positions, which are included in the 36. The remaining employees comprise the Office's management and administrative staff.[2]

As illustrated in Table 1 on page 5, the Office received approximately $550,000 in fiscal year 2002 State General Fund appropriations. In addition, the Office received about $2 million from CMS to administer its nursing home Medicare and Medicaid certification inspection and investigation program.

Scope and methodology

This audit focused on the Office's regulation of nursing homes through its complaint and investigation practices, compilation and dissemination of public information, and its licensing and inspection processes.

This audit includes three findings and recommendations as follows:

- The Office should improve its practices for investigating self-reported incidents that involve nursing home staff and prioritizing complaints.
- The Office should continue to improve its filing practices and continue its efforts to enhance its Web site.; and

1 488 C.F.R. §488.410.

2 The Office also regulates intermediate care facilities for the mentally retarded (ICF/MR), which are not part of this audit.

Table 1

The Office of Long Term Care
Statements of Revenues, Expenditures, and Changes in Fund Balances
Years Ended June 30, 2000, 2001, and 2002
(Unaudited)

	2000	2001	2002
Revenues:			
Intergovernmental			
Federal Title XVIII and XIX	$1,812,042	$1,913,809	$1,968,130
Other	200,762	231,412	279,848
State General Fund appropriation	450,459	569,829	550,246
Fines and forfeits	21,158	216,330	199,672
Other	784	5,212	6,395
Total revenues	2,485,205	2,936,592	3,004,291
Expenditures:			
Personal services and employee-related	1,659,989	1,801,459	2,043,000
Professional and outside services [1]	161,784	174,292	155,122
Travel	151,283	149,398	135,934
Other operating	444,120	463,298	451,462
Equipment	51,226	127,385	12,461
Total expenditures	2,468,402	2,715,832	2,797,979
Excess of revenues over expenditures	16,803	220,760	206,312
Other uses:			
Operating transfers out		2,690	245
Remittances to the State General Fund	784	5,212	12,156
Total other uses	784	7,902	12,401
Excess of revenues over expenditures and other uses	16,019	212,858	193,911
Fund balance, beginning of year	206,302	222,321	435,179
Fund balance, end of year [2]	$ 222,321	$ 435,179	$ 629,090

[1] Includes $155,000 paid each year to the Arizona State Board of Nursing. The Department of Health Services contracts with the Board to meet certain federal requirements, such as preparing a register of nursing aides who have completed a Board-approved training program.

[2] Consists of unspent monies used to correct long-term care facility deficiencies related to residents' health and property. In accordance with A.R.S. §36-446.08, these monies were collected from long-term care facility administrators or managers for certain violations.

Source: Auditor General Staff analysis of financial information provided by the Arizona Department of Health Services for the years ended June 30, 2000, 2001, and 2002.

- The Office should increase its use of available state sanctions against deficient nursing homes to improve oversight and quality of care.

In addition, this report contains other pertinent information regarding states' nursing home staffing requirements and complaint investigation time frames.

Auditors used a variety of methods to conduct the audit: Interviewing Department management and staff about its nursing home inspections and investigations as well as its public information processes; and reviewing audit reports from Kansas, Michigan, Pennsylvania, and California, as well as from the U.S. General Accounting Office (GAO), regarding nursing home regulation, licensure, and oversight. In addition, the following specific methods were used:

- To assess whether the Office adequately addresses self-reported incidents and appropriately prioritizes all complaints, auditors accompanied investigators on a complaint investigation and observed their adherence to policies and procedures. Auditors also obtained the number of self-reported incidents and complaints from 30 randomly selected fiscal year 2002 facility files. Further, auditors reviewed the Office's complaint investigation and enforcement policies and procedures to assess the Office's efforts to comply with federal and state mandates;

Facility files contain nursing home information pertaining to state licensing and Medicare/Medicaid certification, both public and confidential.

- To assess the Office's compilation and dissemination of public information, auditors reviewed seven facility files; examined Web sites from Arizona and six other states; interviewed an attorney who frequently uses facility files; interviewed division staff and management; reviewed a study on federal and state nursing facility Web sites[1]; and reviewed a 2000 Pennsylvania audit report;[2]

- To assess the Office's use of state sanctions, auditors observed a license and certification inspection, and reviewed calendar year 2000 and 2001 sanctions from five inspection case files to identify the types of nursing home violations and department sanctions. Additionally, auditors reviewed the Office's sanction log sheets from 1999 through 2001 to determine the frequency with which the Office recommends sanctions and how often CMS approves the recommendations. Finally, auditors conducted interviews with officials from five other states and CMS staff to gain their perspectives[3]; and

- To develop information on other states' nursing home licensing standards, auditors reviewed CMS quality indicators and its report to Congress on the appro-

1 Charlene Harrington, Ph.D.; Eric Collier, B.S.N.; Janis O'Meara, M.P.A.; and Martin Kitchener, Ph.D.; University of California, San Francisco. Lisa Payne Simon, M.P.H., California HealthCare Foundation; John F. Schnelle, Ph.D. Borun Center for Gerontology Research, UCLA; *Just What the Consumer Needs? Federal and State Nursing Facility Web Sites,* June 2002.

2 *A Follow-up Performance Audit of Nursing Home Oversight in Pennsylvania*, October 2000.

3 States contacted were California, Florida, Oregon, South Carolina, and Washington, which were identified as having the best practices.

priateness of minimum nursing home staffing ratios, the CMS State Operations Manual, the October 2000 Pennsylvania follow-up performance audit of nursing home oversight, a Kaiser Family Foundation staffing study[1], and GAO reports on the need for stronger complaint and enforcement practices and the inadequacy of complaint investigation processes.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the director of the Department of Health Services, and the management and staff of the Division of Assurance and Licensure Services and its Office of Long Term Care, for their cooperation and assistance throughout the audit.

1 Charlene Harrington. *Nursing Home Staffing Standards in State Statutes and Regulations*. A survey for the Henry J. Kaiser Family Foundation, April 2001.

FINDING 1

Some investigation practices need improvement

To ensure that residents receive adequate quality of care, the Office should improve its practices related to abuse and neglect incidents reported by nursing homes and complaints reported by residents and their families. Although it investigates all complaints it receives, the Office does not investigate all incidents reported by nursing homes alleging abuse and neglect when staff may be involved. Federal regulations require that all such incidents be investigated. Additionally, the Office does not consistently prioritize complaints. In some cases, complaints alleging actual harm were misclassified, delaying the Office's investigation. The Office should investigate all self-reported incidents of abuse and neglect involving nursing home staff and develop detailed guidelines for complaint prioritization.

Self-reported incidents not always investigated

Although the Office protects the health and safety of nursing home residents by investigating complaints from residents and their family members, it does not always investigate incidents reported by nursing homes that involve abuse and neglect by nursing home staff. Additionally, until recently, the Office did not track or log the number of self-reported incidents received. The Office should investigate all of these staff-related abuse and neglect incidents, as required by federal regulations and similar to practices in other states, and take corrective action to ensure hazards to resident health and safety are eliminated. However, the Office's investigative response may be limited by staff vacancies, which cannot be filled due to a hiring freeze. Finally, the Office recently acquired a new complaint-tracking system it can use to track these incidents.

Uninvestigated incidents can lead to abuse or neglect of residents.

Not all incidents are investigated—The Office does not investigate all incidents of abuse and neglect reported by nursing homes. Nursing homes are required by law to report any such incidents to the Office within 5 days. Facilities initially phone in details of the incident and subsequently send in a written investigation

report. Federal regulations require that states investigate allegations of resident neglect and abuse when there is oral or written evidence to believe that staff providing resident services could be involved in such incidents.[1]

Despite the importance of investigating abuse and neglect incidents involving nursing home staff, a review of records from 30 randomly selected nursing homes found no evidence that the Office had investigated several incidents reported by those homes. In at least 35 incidents alleging resident neglect or abuse and involving staff, the Office had no record of conducting any investigation. For example:

- A family member voiced concern to facility administration about a staff Certified Nursing Assistant (CNA) who was gruff and uncaring toward residents in the dining room and would not provide assistance when asked. The CNA was seen forcefully shaking a resident's wheelchair to wake her and then pushing her into bed. The incident report indicates that nursing home employees were aware of the CNA's previous inappropriate behavior. However, only after the resident's family threatened action and demanded the CNA's termination did the nursing home fire the CNA for inappropriate conduct and poor service. The Office did not conduct any further review to determine, for instance, whether a lack of CNA training or supervision led to this incidence.

The Office should investigate all staff-related abuse and neglect incidents—To address serious self-reported incidents adequately and to comply with federal regulations, the Office should investigate all staff-related abuse and neglect incidents received from self-reports and take appropriate action to ensure the nursing homes correct deficiencies. Although limited staffing may preclude on-site investigation of all such incidents, the Office may be able to conduct some investigations without making on-site visits, based on the severity of the incident and history of the nursing home in preventing abuse and neglect. For example, the Office may be able to conduct some investigations through telephone interviews with nursing home staff and examination of documents provided by the home. In some cases, the Office may be able to limit its efforts by thoroughly examining the nursing home's internal investigation of the incident, assessing its completeness and credibility, and documenting its conclusion that an Office investigation would only duplicate the home's own efforts. However, according to a CMS official, self-reported allegations of staff-related abuse and neglect will usually require investigation by the Office itself.

Once current staff and resource limitations have eased, the Office should consider following practices used in two other states, where officials reported they do more in response to self-reports. The Office currently has 9 vacant surveyor positions it cannot fill due to a hiring freeze, affecting its ability to initiate any new efforts. However, an official from the state of Washington, cited for many best practices by CMS staff, reported that its investigation rate for self-reports, including abuse incidents that do not involve nursing home staff, is 60 percent or more. Additionally, California's policy

[1] 42 CFR 488.335.

is to conduct an on-site investigation within 24 hours of receiving any self-report that indicates abuse, neglect, or resident harm. When the Office has returned to full staffing in the future, it should consider adopting similar policies regarding investigation of abuse and neglect incidents.

Software and a lack of clear policies have limited past investigation response—In addition to staff limitations, inadequate software and a lack of clear policies have contributed to the Office's inadequate investigation practices. Because the Office's complaint-tracking system did not allow data entry of self-reported incidents, investigators could not use it to identify nursing homes with repeat incidents that might help them determine the extent of investigation needed when a new incident is reported. Homes report a wide variety of incidents in addition to the staff-related abuse and neglect incidents that require investigation. In auditors' review of 30 facilities' files, one home had 50 self-reported incidents, and another had 46. While these high numbers could suggest the homes were more conscientious about reporting incidents to the Office, they might also indicate recurring problems that should be addressed. In October 2002, the Office implemented a new complaint-tracking system provided by CMS, and has begun to record self-reported incidents as well.

The Office lacks written policies instructing staff to investigate self-reported abuse and neglect incidents involving nursing home staff. It needs to modify its complaint policy to formalize and clarify the policy for handling self-reported incidents, including the requirement to investigate every self-report that involves staff abuse or neglect.

Complaint prioritization inconsistent

In addition to not investigating some incidents reported by nursing homes, the Office does not consistently prioritize all complaints received from residents, their families, and others. In some instances, complaints alleging actual harm were misclassified, resulting in investigation delays. The Office should provide investigators with clear guidelines to follow, addressing situations unique to the Office, to alleviate this problem.

The Office sets complaint priorities—To satisfy its complaint-handling responsibilities, the Office's complaint team receives and classifies complaints about nursing homes into four priorities, each of which has a specified number of days within which an investigation must begin (see Table 2, page 12). Categories 1 and 2 are the highest priorities, with investigation time frames that match federal requirements. They include incidents such as when an individual is intimidated and/or threatened, physically abused, sustains a fracture from a fall caused by inadequate supervision or neglect, dies unexpectedly or without explanation, or is injured due to inappropriate use

of restraints or inadequate staffing. The State also defines category 3 incidents, which are those that do not compromise resident health or safety, and category 4 incidents, which are all other incidents, such as those outside the Office's jurisdiction that are referred to other agencies.

Priorities not always assigned consistently—The Office does not uniformly prioritize complaints with similar issues, which can adversely affect resident health and safety. A CMS 2001 performance review for Arizona's Long Term Care program examined 18 complaints and found 9 that involved actual harm (priority 2), but were misclassified as priority 3 and, therefore, were not investigated promptly. Additionally, in a review of 30 randomly selected facility files, auditors found similarly misclassified complaints. The 30 files contained 119 complaints, 34 of which were classified as priority 3. At least five of these complaints met the definition for priority 2 because they involved potential risks to residents' health and safety. For example:

- A resident was left unattended on the patio and appeared to be ill when staff later found him. He was found to be suffering from heat exhaustion and was sent to the hospital for evaluation. The resident's guardian alleged that the facility, by failing to monitor this resident, caused the problem.

Table 2 Complaints Received by Priority
Year Ended June 30, 2002

Priority	Definition of Priority	Number of Complaints[1]	Investigation Time Frame
1	Immediate and serious threat to health and safety has caused or may cause serious injury, harm, impairment, or death	10	Within 2 working days (federal requirement)
2	Actual harm that does not rise to level of immediate and serious threat, or where severe hazards to health and safety may exist	398	Within 10 working days (federal requirement)
3	Risk to health and safety is not an issue	294	Within 45 working days (state guideline)
4	Does not meet the definitions for priorities 1 to 3. For example, the complaint is not in the Office's jurisdiction	24	None

[1] Auditor General staff determined the number of complaints by analyzing information provided by the Office of Long Term Care from its Complaint Tracking System FY2002 database.

Source: Arizona Department of Health Services, Division of Assurance and Licensure Services, *Complaint Process*.

- A resident with diabetes, kidney problems needing dialysis, and Alzheimer's disease was wheelchair bound and unable to self-propel or feed herself. The family voiced its concerns about her weight loss and three separate falls that occurred. Four days after they expressed their concerns to the nursing home, the resident went into a diabetic coma, was hospitalized, and died of respiratory arrest. The family alleged that the facility failed to prevent falls, did not assess the resident's condition when her blood sugar was abnormal, and failed to feed her knowing she needed total assistance with her meals.

Lack of detailed guidelines may hamper prioritization—The Office's inconsistent prioritization of complaints may stem from its lack of specialized guidelines to help its investigators apply existing policies. The Office uses DHS, Division of Assurance and Licensure Services policies that describe complaint procedures for all programs within the Division, but do not address situations unique to the Office. These policies define each complaint priority but the Office may need to develop more detailed supplementary guidelines to promote consistent priority assignment among investigators. For example, the guidelines could provide examples illustrating how to apply the policies in situations the Office may encounter. During the audit, the Office made staff changes in an effort to address the problem with prioritization.

Improperly categorizing complaints can adversely affect residents' health.

Recommendations

1. To better protect the health and safety of nursing home residents and to comply with federal regulations, the Division of Assurance and Licensure Services should:

    - Revise its complaint policy to clarify and formalize the policy for handling self-reported incidents; and

    - Investigate all self-reported abuse and neglect incidents involving nursing home staff, and document its conclusions regarding the credibility and completeness of the home's internal investigation if it relies on that investigation to help it reach its own conclusions.

2. To help ensure more consistent practices for assigning complaint priorities, the Office should develop detailed guidelines specific to the long-term care program to supplement and explain existing policies for assigning complaint priorities.

FINDING 2

The Office should provide more public information

The Office needs to improve the way it compiles and disseminates information to the public. To evaluate nursing homes adequately, nursing home residents and their families need quality-of-care information. However, the Office's public files do not always include all public information and the information that is available is not always understandable. The Office should continue its efforts to improve the information it provides to the public over the telephone and on its Web site.

Information needed for decisions

In addition to the cost and service information they obtain from nursing homes, residents and families need information regarding nursing homes' quality of care in order to make informed decisions. For example, they may be interested in deficiencies identified at inspections as important quality indicators. Further, they might judge the level of resident and family dissatisfaction with a nursing home by the numbers and types of complaints it receives. Moreover, the public can determine the severity with which the Office views violations through reviewing its enforcement actions.

Some information incomplete or unclear

The Office's current system for filing and providing information does not allow the public access to information that is adequate, understandable, and meaningful for making decisions about nursing homes. In its filing system, some documents that should be available to the public are placed in nonpublic files. In addition, some documents that are made available have so much information expunged that they are no longer understandable or meaningful. The Office has submitted a proposed statutory change to help alleviate this problem. Finally, the ratings the Office provides about

Public information provides insights into nursing home quality.

nursing home quality are not explained well, although proposed changes in the rating system should help make them clearer.

Some public documents not in public files—The Office keeps information on each nursing home in four separate files: Public, Confidential, Medicare/Medicaid, and Inspectors' Documents. Generally, only the public file is made available for public inspection. However, information that should be available to the public is sometimes placed only in the other files. The Office does not have complete and clear policies explaining what documents belong in each of the four files.

Placing public information only in nonpublic files makes it very difficult for residents and families to obtain useful information. For example, the Office does not place federal enforcement information in the public files. Further, although the Office does have a policy that calls for Statements of Deficiencies and Plans of Corrections to be in the public files, auditors found cases where these documents were only in other files. As a result, public file reviews can leave residents and families with incomplete and inaccurate impressions of nursing home quality of care.

Incomplete public files inhibit residents and families from making informed decisions.

Office documents not always understandable—Documents the Office makes available to the public are not always decipherable. A copy of the investigation report is available in the public file, but it is often severely edited so it lacks essential information such as dates and the nature of the incident. Sometimes the Office expunges information in these reports beyond what state or federal law requires. Such practices can make it difficult—or impossible in some cases—for residents and families to evaluate a facility by reviewing public files. For instance, one investigation report that had been heavily edited for the public file stated the following facts:

> "On (deleted), (name of CNA), CNA was observed to (deleted) Resident (deleted) to (deleted) by having (deleted). The (deleted) CNA, (deleted) is (deleted). This was reported to the administrator, DNS and social worker this morning, (deleted). The administrator counseled the observing/reporting CNA (deleted) to report incidents immediately. The facility will fax the completed report. The facility will notify the ombudsman, APS, the physician, the family, and the Arizona State Board of Nursing."
>
> "Staff failed to report alleged CNA (deleted) to Administration for six days."

The Office has submitted a proposed statutory change that would conform state statutes to federal laws. Currently, A.R.S. §36-404 mandates redacting all medical information, which may contribute to staff uncertainty over what they should not redact and leave in the public record. The proposal submitted to the

Governor on December 2, 2002, would require eliminating personally identifiable information but not other information. Whether or not the statute is changed, the Office needs to better train its staff on editing documents in compliance with state and federal patient privacy laws without removing information that should remain available to the public.

Ratings information can be difficult to understand.

Rating system classifications can be misunderstood—In addition to not always providing information the public should have, some information the Office provides can be easily misunderstood. For example, the Office's quality ratings do not present a clear understanding of a nursing home's quality of care. The Office inspects each nursing home and gives one of three performance quality ratings defined in the Administrative Rules: excellent, standard, or substandard, based on a 40-point quality rating score. A nursing home's rating may not equate to the quality of care it gives. For example, an excellent quality rating shows only that the nursing home met minimal standards in at least 90 percent of the measured categories, but a member of the public might believe it means the nursing home offers excellent quality of care. To improve the usefulness of its quality ratings, the Office has developed a revised rating system, with four possible ratings, based on a point system that relies more on quality of care instead of on meeting minimum standards. It submitted rules outlining its new system to the Governor's Regulatory Review Council on November 15, 2002.

The Office should continue improving telephone and Web site information

Public information over the telephone is limited.

The Office should continue to enhance its methods of disseminating public information over the telephone and on the Internet. Currently, the public cannot obtain some important public information via the telephone or Internet. Other states provide public information in a more concise, understandable format, such as by giving nursing homes report cards or performance ratings, which make it easier to identify nursing homes that provide quality care. To make information more readily accessible to the public, the Office should provide staff with telephone protocols and training, and build on its Web site improvements.

Information not easily accessible by telephone—Office staff provide only limited information over the telephone. For example, residents and families calling the Office can receive nursing homes' names, addresses, telephone numbers, and quality ratings. However, they must visit the Office's Phoenix or Tucson locations to obtain information regarding complaints, inspection results, deficiencies, or enforcement actions against a nursing home. Alternatively, much of this information is available from links through the Office's Web site, or by visitiing the nursing home itself, which is required to make information about deficiencies arising from inspections or complaint investigations available for review.

Limited staff resources and its former inadequate complaint-tracking system have affected the Office's ability to provide complete information over the telephone. Too much staff time would be required to locate information in the Office's files in response to telephone inquiries. However, the Office implemented a new CMS complaint-tracking system as of October 1, 2002. This should enable its staff to quickly look up the number, nature, and disposition of complaints. The Office should ensure its staff are trained to use the new system in order to provide publicly available information over the telephone.

The Office should continue efforts to expand and simplify Web site information—The Office has made recent improvements to its Web site, although some information is still not easily accessible. In recent months, the Office has implemented substantial changes, such as adding state enforcement actions and altering the design to make site navigation easier. It has also established a committee to recommend further Web site improvements and has sought input from division staff. The Office is also participating in a state-wide effort to improve information availability for aging citizens. This effort also involves the Department of Economic Security and AHCCCS and is expected to result in improved Web site information at all three agencies. The Division should continue its efforts to improve its Web site. For example, Web site users must follow several links to obtain information, and it is not always clear what information is available at each link. For example, most specific information about homes is provided through a link to the CMS Web site, but state enforcements and other information, including quality rating, is found only on the Office's Web site. The Office has submitted a budget decision package requesting resources for Web site improvements. As resources become available, the Office should continue to add public information to its Web site and provide more descriptive links to aid the public in accessing available information.

Other states' Web sites are more user-friendly.

Auditors identified a number of other states' Web sites that provide public information in a concise, understandable format. The Pennsylvania Department of Health's Web site was particularly comprehensive and easy to use. It posts several items that can help potential residents and their families make informed decisions. The Web site provides a list of facilities that have dedicated Alzheimer's units or are part of a larger continuing-care facility. In addition, for each nursing home in the state, it provides the number of licensed beds, the number that are Medicare- and/or Medicaid-certified, and the number of citations received in each of ten categories, and compares the home's performance against the state average and homes of similar size. Finally, it reproduces Statement of Deficiencies and Plan of Correction forms, provides a detailed narrative explanation of the incident resulting in the deficiency finding, and posts the Code of Federal Regulations and Pennsylvania Administrative Code citations violated by the nursing home. The Office could consider using Pennsylvania's Web site as a model as it continues its efforts to improve its own.

Recommendations

1. The Office should ensure that all public information, including meaningful information about complaints and sanctions, is available to members of the public who review nursing home files in person at the Office, by:

   a. Revising its policies and procedures regarding what documents should be placed in the public file; and

   b. Providing training to staff on the new policies.

2. The Legislature should consider revising A.R.S. §36-404 to conform state statutes to federal laws regarding the redacting of information.

3. To provide adequate information to members of the public over the telephone, the Office should train staff how to use the new CMS complaint-tracking system to access the number, nature, and disposition of complaints in order to respond to telephone inquiries.

4. The Office should continue its efforts to improve its Web site by adding public information not currently included and providing more descriptive links to information.

FINDING 3

The Office can use state sanctions more often

Although the Office performs some aspects of its quality assurance well, it should use available state sanctions more often against noncompliant nursing homes. The Office, which is responsible for ensuring quality of care in nursing homes, does a good job of conducting inspections on a timely basis, following acceptable standards to evaluate care, and using standard CMS guidelines on citing facilities. However, the Office does not always use the state sanctions available to it, choosing instead to request the federal government to impose penalties. Using state sanctions offers an opportunity to encourage facilities' more immediate compliance, in part because federal sanctions can go through an extended appeals process.

The Office performs some inspection aspects well

The Office performs some areas of its state and federal inspections well. The Office has improved its inspection timeliness in the last 2 years, and it uses acceptable standards for inspections and consistently recommends sanctions for violations.

- According to office administrators, in fiscal year 2000, inspector shortages contributed to an average of 15 months between inspections, although federal standards require a 12-month average. An Office report shows that as of January 2000, at least 1 home went 23 months between inspections. After the Office hired eight additional inspectors, the state-wide average for number of months between inspections decreased to 13.2 months in fiscal year 2001, and 11.3 months in fiscal year 2002.

The Office conducts timely inspections that meet federal and state requirements.

- The Office uses state and federal standards to evaluate quality of care. For example, inspectors assess homes for problems, such as lack of treatment for pressure sores, the presence of accident hazards, and the existence of significant medication errors.

- The Office's manager review process helps ensure that it recommends sanctions using consistent criteria. Managers review inspection results and propose sanctions based on written guidelines.

The Office could make more use of state sanctions

While the Office consistently proposes sanctions against nursing homes that are out of compliance with federal and state law, in most cases, it recommends that the federal government impose penalties rather than assessing state sanctions. As a result, some facilities may avoid sanctions, either because CMS elects not to impose a federal sanction, or because nursing homes use the federal appeals process to postpone the penalty. Other states have made greater use of their own penalties and shorter appeals processes.

The Office underutilizes state sanctions.

The Office usually recommends noncompliant facilities for possible federal sanctions—While there are several state penalties available to the Office, it usually only recommends federal sanctions. The Office has a variety of state penalties that differ according to the violation's seriousness, including requiring that all staff receive training, levying fines, suspending or revoking licenses, and issuing provisional licenses that are conditional on the facility maintaining compliance with federal and state requirements. For the 32 violations since 1999 that involved actual harm or immediate jeopardy to residents, the Office issued provisional licenses three times and entered into one stipulated agreement with a nursing home in which temporary management was installed.

Rather than sanctioning noncompliant facilities itself, in most cases, the Office recommends that CMS impose federal penalties. For example, if a facility does not correct problems found at an inspection or incurs a serious violation regarding health and safety, the Office will recommend that CMS assess the facility a penalty such as a fine or denial of federal payments for new residents. When imposed, some of these federal sanctions are severe. For example, a denial of payment for new admissions can have a serious financial impact on a nursing home. However, where appropriate, the Office should make greater use of state sanctions in addition to federal sanctions.

Deficient nursing homes may avoid penalties.

Some facilities may avoid penalties due to the State's reliance on federal enforcement—The Office's reliance on recommending federal penalties means that some facilities the Office believes should receive sanctions may in fact avoid penalties altogether, or at least delay them for a long time. One reason is that CMS does not always impose the recommended penalty. In 2001, CMS did not take action against at least five nursing homes after the Office recommended penalties instead of imposing any state sanctions. When CMS does not act, the facility is usually only required to ensure that its staff take in-service training. Even if CMS agrees with an office recommendation and imposes a civil fine, nursing homes may

be able to postpone the action for a considerable period if they choose to appeal. Under CMS procedures, nursing homes do not have to pay this penalty until they exhaust appeals, which can take years. Currently, two Arizona cases are under appeal in the federal system, and both are more than 2 years old. Federal appeals generally take longer than the state appeals process. Department officials report that only two nursing homes have appealed federal sanctions since 1995.

Other states make stronger use of penalties—Some states use state penalties more extensively. For example, according to Washington state officials, its Department of Social and Health Services often uses state civil fines because it believes it can enforce them more quickly than CMS can enforce its penalties. Further, Washington uses state sanctions more than federal penalties. It usually fines noncompliant nursing homes that demonstrated actual harm to residents, and may suspend new admissions to facilities for other serious violations. Similarly, Florida's office can set a moratorium on new admissions as one of its penalties, and it now imposes mandatory fines for serious care or injury violations in addition to recommending federal sanctions to CMS.

Recommendation

1. To provide greater opportunity to ensure that nursing homes comply with regulations, the Office should make greater use of state sanctions, where appropriate, in addition to recommending the home for federal sanctions.

OTHER PERTINENT INFORMATION

During the audit, auditors developed information about other states' nursing home licensing standards. Some states, including Arizona, have standards that exceed federal certification standards. Most commonly, these standards involve staffing requirements that are more specific than the federal standard. However, currently nursing shortages and nursing homes' financial hardship could make such requirements impractical. Some states have adopted licensure requirements that exceed federal standards to a greater degree than Arizona's. Unlike Arizona, some states also have more rigorous complaint inspection deadlines than those called for under federal standards.

Some states have additional staffing standards

Because research has shown that staffing levels affect quality of care, many states have adopted additional staffing regulations beyond the federal standards. Several healthcare studies have shown that there is a relationship between staffing and quality of care. Most states, including Arizona, have adopted at least some staffing requirements that exceed federal requirements. The additional requirements vary from state to state, with some states adopting more requirements than Arizona.

Healthcare studies have linked staffing with improving nursing home care—Many healthcare studies have found that staffing affects nursing homes' ability to provide quality care. For example, two studies in 2000 reported that staffing was a systematic factor affecting care, and that healthcare professionals have viewed the federal staffing requirement as inadequate and recommended higher staffing levels for patients with greater care needs.[1,2] Additionally, researchers for a 2001 CMS report to Congress observed 17 nursing care facilities and reported that quality-of-care problems emerged when inadequate numbers of staff were available.[3] Finally, a GAO report of selected states found that nursing homes providing more nursing-care hours per resident were less likely to have repeated serious problems.[4]

1 *A Follow-up Performance Audit of Nursing Home Oversight in Pennsylvania*, October 2000.

2 "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States": *The Gerontologist, 2000.*

3 *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*. CMS Report to Congress, Phase II Final, 2001.

4 Nursing Homes: Quality of Care More Related to Staffing than Spending. Report to Special Committee on Aging and Committee on Finance, U.S. Senate, June 2002. GAO-02-431R.

Nursing shortage may hinder ability to meet minimum staffing ratios—An important consideration in evaluating the feasibility of minimum staffing ratios is whether an adequate workforce exists to allow nursing homes to meet higher required levels. In a 2000 report to Congress, CMS reported that a nursing shortage existed and that there were reasons to believe the shortage would increase over time. For example, enrollments in nursing schools have decreased in recent years and the population is aging at a rate that is expected to increase the demand for nursing services in nursing homes and other healthcare facilities. CMS estimated that the implementation of maximum quality standards would result in 97 percent of nursing homes failing to meet one or more of the standards. It may be difficult for the State to establish minimum staffing ratios under current conditions. Additionally, according to DHS officials, the financial conditions of some nursing homes could prevent them from meeting higher staffing ratios even if nurses were available to fill the positions.

States have established additional staffing requirements for licensure—Despite the difficulty of enforcing minimum staffing requirements, some states, including California and Florida, have developed and enforce staffing requirements that go beyond the federal standards. Federal certification requirements state that nursing homes must provide "sufficient staff" for service to residents and a registered nurse for 8 hours each day. Some states have established requirements that are more specific—for example, requiring nursing homes to increase the number of minimum staffing hours for registered nurses, or developing specific staffing hour requirements for licensed practical nurses and nursing assistants.

- Several states, including Arizona, have implemented overall minimum staffing requirements that go beyond the federal standards or clarify what "sufficient staff" means in the State. According to a 2001 survey 13 states have done so since 1999.[1] For example, Florida's staffing regulations require homes to have at least one licensed nurse for every 40 residents. Florida issues both state and federal citations to nursing homes that fail to meet staffing requirements, according to one Florida official. Arizona's regulations prohibit a licensed nurse from providing care to more than 64 residents. In California, nursing homes with more than 100 beds must have a registered nurse on duty 24 hours a day, compared with the federal standard of 8 hours a day.

- Thirty-three states have specific staffing requirements for nursing assistants and other direct care nursing staff, that is, staff providing actual care to residents such as bathing, giving medications, and observing residents. For example, Florida's statutes require homes to have at least one nursing assistant for every 20 residents. Arizona has not adopted any specific minimum staffing standards for nursing assistants.

1 Charlene Harrington. *Nursing Home Staffing Standards in State Statutes and Regulations*. A survey for the Henry J. Kaiser Family Foundation, April 2001.

States have developed additional care regulations

In addition to staffing regulations, Arizona and other states have developed other care-related regulations. Arizona's additional requirements relate to fingerprinting of all staff providing care, and tuberculosis testing for all employees.

Some states have developed regulations to shorten the time frames for complaint response. CMS requires that states investigate a priority 1 complaint, in which immediate jeopardy is alleged, within 2 working days and a priority 2 complaint, or allegation of actual harm, within 10 working days. Because failure to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions, some states strengthen the federal requirements by shortening the time frame for investigation.[1] For example, according to a 1999 GAO report, nursing home regulatory agencies in Louisiana, Kansas, and Michigan must investigate immediate jeopardy situations within 24 hours.[2] Further, Pennsylvania categorizes all complaints as "priority" or "general." It initiates priority complaint investigations onsite within 24 hours and general complaint investigations within 2 calendar days. Arizona has not adopted shorter time frames for investigation, but uses the same time frames as CMS for investigating priority 1 and 2 complaints.

1 *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*. U.S. General Accounting Office. Report to the Chairman and Ranking Minority Member, Special Committee on Aging, U.S. Senate. GAO/HEHS-99-80, March 1999.

2 Scanlon, William J. *Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care*. U.S. General Accounting Office. Testimony before the Senate Special Committee on Aging. GAO/T-HEHS-99-89, March 1999.

APPENDIX

Appendix 1 Federal Quality-of-Care Regulations for Nursing Homes

The facility must provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.

Facility will prevent pressure sores if none exist on admission and provide treatment if sores are present.

Facility must provide each resident with sufficient fluid intake to maintain proper hydration/health.

Facility must see residents receive treatment such as injections, parenteral and enteral fluids, colostomy, tracheostomy care, respiratory care, foot care, and prostheses.

Facility must ensure it is free of medication error rates of 5 percent or greater.

Facility must ensure residents are free of any significant medication errors.

Resident's abilities in activities of daily living do not diminish unless unavoidable due to clinical condition. Includes resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech and language.

Resident's regimen must be free from unnecessary drugs.

Resident environment remains as free from accident hazards as is possible.

Resident receives adequate supervision and assistance devices to prevent accidents.

Resident maintains acceptable body weight and protein levels.

Resident receives a therapeutic diet when there is a nutritional problem present.

Resident who is incontinent receives appropriate treatment and services.

Resident with limited range of motion receives appropriate treatment and services.

Resident with mental or psychosocial adjustment difficulty receives appropriate treatment/services to correct assessed problem.

Resident who could previously eat alone is not fed by tube unless unavoidable due to clinical condition.

Resident does not show a pattern of decreased interaction unless unavoidable due to clinical condition.

Resident will have no catheter unless necessary because of clinical condition.

Resident who is fed by tube receives necessary treatment/services.

Resident will have no reduction in range of motion unless unavoidable due to clinical condition.

Residents who have not used antipsychotic drugs are not given these drugs unless the therapy is necessary to treat specific condition as diagnosed/documented in clinical record.

Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions in effort to discontinue drugs.

Source: Centers for Medicare and Medicaid Services, *State Operations Manual*, Guidance to Surveyors, Appendix P.

AGENCY RESPONSE

Arizona Department of Health Services

Office of the Director

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JANE DEE HULL, GOVERNOR
CATHERINE R. EDEN, DIRECTOR

December 26, 2002

Debra K. Davenport
Auditor General
2910 N. 44th Street
Phoenix, Arizona 85008

Dear Ms. Davenport:

Thank you for an opportunity to respond to your audit of the Department of Health Services' Office of Long Term Care ("Office"). We agree with all of the report's findings. In addition, we agree to implement all of its recommendations, where applicable.

We are pleased that the report highlights many of the Office's accomplishments. The report notes that inspection timeliness has improved over the past two years, and that inspections are now performed within federal standards. The report also recognizes that the Office investigates all of the complaints it receives. The Department takes great pride in these accomplishments, given that our workload has steadily increased over the last two years. Indeed, the average number of facility beds regulated per surveyor has increased from 634 in June 2000 to 854 in November 2002.

With regard to the specific recommendations made in your audit, the response contained in the attached document is provided

Thank you for this opportunity to respond to your office's report. We appreciate the professionalism and responsiveness demonstrated by you and your staff throughout this audit.

Sincerely,

Catherine R. Eden
Director

Attachment

Arizona Department of Health Services
Response to Recommendations Contained in the
Office of the Auditor General Performance Audit of the Office of Long Term Care

Recommendation:

To better protect the health and safety of nursing home residents and to comply with federal regulations, the Division of Assurance and Licensure Services should:

- *Revise its complaint policy to clarify and formalize the policy for reporting self reported incidents.*

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: In recent months the Division of Assurance and Licensure Services (Division) has worked hard to update many of its Policies and Procedures related to the licensure and complaint investigation processes. We will ensure that these Policies and Procedures continue to be refined, and carried down to the Office level.

- *Investigate all self-reported abuse and neglect incidents involving nursing home staff, and document its conclusions regarding the credibility and completeness of the home's internal investigation if it relies on that investigation to help it reach its own conclusions.*

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: We agree with the report's assertion that the Office should investigate all self-reported incidents of abuse or neglect involving nursing home staff. We believe that *we already do conduct such investigations*, oftentimes over the phone, as the report suggests is appropriate. However, we believe that we need to do a better job of documenting such investigations.

Recommendation:

To help ensure more consistent practices for assigning complaint priorities, the Office should develop detailed guidelines specific to the long-term care program to supplement and explain existing policies for assigning complaint priorities.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: Guidelines specific to the Office that supplement and explain Division Policies and Procedures developed and updated in recent months will be will be developed and implemented.

Recommendation:

The Office should ensure that all public information, including meaningful information about complaints and sanctions, is available to members of the public who review nursing home files in person at the Office, by

- *Revising its policies and procedures regarding what documents should be placed in the public file; and*

- *Providing training to staff on the new policies.*

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: Policies and Procedures specific to information to be included in public files will continue to be developed and updated in accordance with existing State and Federal Requirements. As these Policies and Procedures are developed and updated, training will be provided to staff.

Recommendation:

The Legislature should consider revising A.R.S. §36-404 to conform state statutes to federal laws regarding the redaction of information.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: We fully support the report's recommendation that the Legislature consider changing redaction requirements for nursing home information. The Department has proposed legislation to make such changes to statute, allowing us to better provide needed consumer information.

Recommendation:

To provide adequate information to members of the public over the telephone, the Office should train staff how to use the new CMS complaint-tracking system to access the number, nature, and disposition of complaints in order to respond to telephone inquiries.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: Training has already been initiated to assist staff in utilizing the CMS complaint-tracking system. This training will be continued to ensure that staff can use the software to provide needed telephonic information to the public.

Recommendation:

The Office should continue its efforts to improve its Web site by adding public information not currently included and providing more descriptive links to information.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: We are grateful that the report recognizes recent improvements made to our Web site. State enforcement information is now available on the site, and a link provides easy access to federal enforcement information found on the Centers for Medicare and Medicaid Services Web site, allowing consumers access to the information they need to make informed decisions when choosing a nursing home. We will continue to make improvements to our Web site, as the report suggests. We have recently proposed a budget decision package that would allow us to make further Web site improvements.

Recommendation:

To provide greater opportunity to ensure that nursing homes comply with regulations, the Office should make greater use of state sanctions, where appropriate, in addition to recommending the home for federal sanctions.

Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Comment: We agree that the Office should use state sanctions as an enforcement tool. However, it is important to note that while civil money penalties are often considered to be the primary sanction available there are a number of other remedies that are also available, and statutes do not require the imposition of such penalties. (See A.R.S. § 36-431.01). Capping facilities' ability to enroll Medicare clients is a powerful enforcement tool, since it has a significant impact on facilities' bottom lines. In addition, federal fines are quite significant, oftentimes mirroring state civil money penalties. Thus, the imposition of state civil money penalties in addition to federal penalties can amount to "overkill." The Office is continually balancing the need to appropriately enforce existing regulations against the knowledge that many facilities are financially fragile.

Performance Audit Division reports issued within the last 12 months

01-21	Board of Nursing
01-22	Department of Public Safety—Criminal Investigations Division
01-23	Department of Building and Fire Safety
01-24	Arizona Veterans' Service Advisory Commission
01-25	Department of Corrections—Arizona Correctional Industries
01-26	Department of Corrections—Sunset Factors
01-27	Board of Regents
01-28	Department of Public Safety—Criminal Information Services Bureau, Access Integrity Unit, and Fingerprint Identification Bureau
01-29	Department of Public Safety—Sunset Factors
01-30	Family Builders Program
01-31	Perinatal Substance Abuse Pilot Program
01-32	Homeless Youth Intervention Program
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