STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Department of Health Services
Office of Long Term Care

REPORT
HIGHLIGHTS
PERFORMANCE AUDIT

Subject

All nursing homes operating in the State must be licensed and meet state quality standards. Nursing homes that receive federal monies must also comply with federal certification standards. The Office of Long Term Care is responsible for enforcing both state and federal regulations of nursing homes. The Office conducts inspections, investigates complaints, and reviews incidents of abuse, neglect, and safety.

Our Conclusion

The Office should comply with federal regulations and investigate all nursing home staff-involved incidents of abuse and neglect. The Office should also provide the public more information about nursing homes. Finally, the Office should make greater use of available state sanctions to ensure more immediate compliance with state standards.

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Some Investigation Practices Need Improvement

Problems at nursing homes may be reported to the Office in two ways:

- **Complaints**—residents, family members, or others may file complaints. The Office receives about 700 complaints each year.
- **Incident Reports**—nursing homes are required to self-report incidents including safety issues, resident abuse, neglect, and injury.

The Office should investigate all staff-involved abuse and neglect incidents— Federal regulations require an investigation of all allegations of abuse or neglect involving nursing home staff. Although the Office investigates all of the complaints it receives, it does not investigate all incident reports alleging abuse or neglect that involve nursing home staff. We reviewed incident reports involving abuse or neglect from 30 randomly selected nursing homes for FY2002. In at least 35 incidents involving staff-related abuse and neglect, the files provided no evidence of any investigation by the Office.

Example of an uninvestigated incident report

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 nursing home fired the CNA for inappropriate conduct and poor service.

In recent years, the Office has suffered from a lack of investigators and inadequate software. Although the Office added eight investigators in 2001, it currently has nine vacant positions that it cannot fill due to a hiring freeze. This may affect its ability to investigate these incidents. However, the Office may be able to conduct some investigations through telephone interviews and examine documents submitted by the nursing homes. It has also implemented a new complaint-tracking system that will allow it to record and analyze the incident reports that it receives. The Office should also develop clear policies for the investigation of staff-involved abuse and neglect incidents.

Complaint prioritization inconsistent—The Office classifies complaints into four categories with a specified number of days within which an investigation must begin:

- **Priority 1**—Immediate threat to health and safety and has caused or may cause serious injury or harm (2 days)

- **Priority 2** —Actual harm or severe hazard, but not a serious threat to health and safety (10 days)
- **Priority 3** — No risk to health and safety (45 days)
- **Priority 4**—All others, including cases over which the Office has no jurisdiction (none)

The Office has not consistently prioritized complaints, sometimes misclassifying priority 2 complaints as priority 3. Therefore, these complaints were not investigated promptly, which could adversely affect resident health and safety. The Office has made staff changes in an effort to address this problem.

Example of a complaint misclassified as a priority 3

A resident who was left unattended on a patio suffered from heat exhaustion and required hospitalization.

Recommendations

The Office should:

- Investigate all self-reported incidents of abuse and neglect involving nursing home staff to comply with federal regulations and better protect resident health and safety
- Adopt detailed guidelines to ensure more consistent complaint prioritization

More Public Information Needed

The Office has information the public needs to make informed decisions about a nursing home's quality of care. However, the information the Office provides is sometimes incomplete or unclear.

Part of the problem is that the Office sometimes puts public information in confidential or nonpublic files.

The Office also makes investigation reports available to the public only after editing. However, the editing sometimes goes beyond what state or federal law requires and sometimes what is left makes no sense. For example:

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 Office is proposing a statutory change to help resolve this problem.

Also, the Office's nursing home quality ratings can be misunderstood. The Office provides three quality ratings; i.e., excellent, standard, or substandard, based on its inspection results. However, a nursing home's rating may not equate to the quality of care it gives. For example, an excellent rating means only that the nursing home met minimal standards in 90 percent of the categories. The Office has proposed rule changes to adopt a more meaningful rating system.

Telephone and Web site information need improvement—Office staff provide only limited information over the phone. Partly because of difficulty in accessing the information and limited resources, staff do not give callers information regarding:

- Complaints
- Inspection results

- Deficiencies
- Enforcement actions

If members of the public want this information, they must visit the Office's Phoenix or Tucson locations or its Web site. They may also contact the nursing home, which is required to make some of this information available for review. However, the Office has implemented a new complaint-tracking system that should make it easier to provide this information by phone. The Office should train staff on using this to respond to telephone inquiries.

The Office is participating in a state-wide effort to improve information availability for aging citizens. It has also recently improved its Web site, but some information is still not easily accessible. The public must follow several links to obtain information and what information is available at each link is unclear. Several other states' Web sites provide the public more information in an easier-to-read format. For example, Pennsylvania gives a nursing home's number of citations versus the state average or that of other nursing homes similar in size.

Recommendations

The Office should:

- Ensure that all public information is available to members of the public
- Provide adequate information over the phone
- Continue efforts to improve its Web site

Office Needs To Use State Sanctions More Often

The Office does a good job of conducting inspections on a timely basis and follows state and federal standards to evaluate quality of care. However, when violations are found, the Office often refers cases to the Centers for Medicare and Medicaid Services (CMS) to impose penalties rather than using available state sanctions.

The problems with referring cases to the federal government to impose sanctions are that:

- CMS sometimes does not act. CMS did not impose any penalty on at least 5 nursing homes after the Office recommended federal sanctions in 2001.
- The federal process allows appeals that are typically longer than the state appeals process. Two cases the Office referred to CMS have been under appeal for over 2 years.

Other states, such as Florida and Washington, use state penalties more extensively because they can enforce them more quickly.

Recommendations

The Office should:

- Make greater use of state sanctions in addition to federal penalties

Information on Licensing Standards

Some states, like Arizona, have adopted state licensing requirements that exceed federal certification standards.

Staffing—Many healthcare studies have found that staffing affects nursing homes' ability to provide quality care. In other words, quality-of-care problems emerge when nursing homes don't have enough staff.

Many states, including Arizona, have established staffing requirements beyond those required by the federal standards. Federal requirements state that nursing homes must provide "sufficient staff" for 24-hour service to residents and a registered nurse for 8 hours a day.

- Arizona prohibits a licensed nurse from providing care to more than 64 residents.
- Thirty-three states have minimum staffing requirements for nursing assistants, such as having at least 1 nursing assistant for every 20 residents.

Arizona has not adopted any specific minimum staffing standard for nursing assistants. However, nursing shortages and financial hardships at some nursing homes may make higher staffing ratios impractical until those conditions change.

Care regulations—In addition, some states have adopted care regulations beyond the federal regulations. For example, Arizona has added fingerprinting, training, and tuberculosis testing. Some states have also shortened the time to investigate priority 1 and 2 cases. Arizona follows the federal time frames for these investigations.

TO OBTAIN MORE INFORMATION

A copy of the full report can be obtained by calling
(602) 553-0333

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www.auditorgen.state.az.us

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