

PERFORMANCE AUDIT REPORT

Pennsylvania Department of Health

July 2016



Commonwealth of Pennsylvania
Department of the Auditor General

Eugene A. DePasquale • Auditor General

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EUGENE A. DEPASQUALE
AUDITOR GENERAL

July 25, 2016

The Honorable Tom Wolf
Governor
Commonwealth of Pennsylvania
Harrisburg, PA 17120

Dear Governor Wolf:

Enclosed is our performance audit of the Department of Health (DoH) and its mission of regulating long-term care facilities, more commonly known as nursing homes. The Secretary of Health, Dr. Murphy, requested that my department conduct this audit, so I want to commend Dr. Murphy for her leadership in proactively seeking our recommendations. Going forward, this leadership will be crucial, because we have identified areas where DoH needs to improve its operations.

Briefly, our audit objectives included a review of DoH's policies and procedures related to how the department ensured nursing homes provided adequate resident quality of life/care, how the department responded to complaints, and how consistently the department imposed sanctions. Our audit covered the period January 1, 2014, through October 31, 2015, with updates as necessary through the report's release. Our audit was conducted under authority of Section 402 of the Fiscal Code, and in accordance with generally accepted government auditing standards, as issued by the Comptroller General of the United States. 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 conclusions based on our audit objectives.

Our audit identifies 13 findings and offers 23 recommendations for improvement. Our findings are categorized into three main issue areas, which mirror the above noted audit objectives. Most in need of immediate improvement by the department are the issues we discuss in *Issue Area One*. We found that residents' quality of life/care may be directly impacted by a nursing home's ability to provide sufficient direct nursing care. Pennsylvania regulations governing nursing homes require that nursing homes provide at least 2.7 hours of direct nursing care, per resident, per day. We found DoH lacked the requisite policies and procedures to guide its staff to ensure that nursing homes met this regulatory requirement.

Owing to this lack of procedural standardization, when we reviewed a selection of DoH completed nursing home staffing-level reviews, we found practices varied among field offices. For example, data was frequently self-reported by the facility with little to no supporting documentation obtained to verify the claimed figures. Of greater concern, we found instances where nursing homes failed to meet the state's minimum standard, yet because DoH used an informal practice of averaging time over a week, the deficiency was not cited. Additionally, we found that despite DoH possessing

regulatory authority, which allows it to order an increase to a nursing home's nurse-staffing levels, DoH has never used that authority.

Our research also indicated that the state's minimum standard of 2.7 hours of direct nursing care, per resident, per day, might be too low. Pennsylvania set this threshold in 1999, and given the evolution of clinical services provided by nursing homes, this requirement may need to be revised. DoH should review this policy area with the General Assembly and other health facility stakeholders.

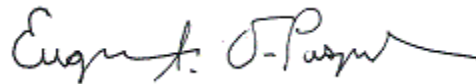
With regard to *Issue Area Two*, which deals with complaints, we found that during most of the audit period, DoH followed an unwise policy that rejected complaints from anonymous sources. This policy likely compromised DoH's ability to adequately receive and investigate complaints. Further, we found that cuts to DoH's complement caused it to revise certain other complaint-handling policies and procedures, which in turn influenced DoH's ability to correctly prioritize and respond to complaints it received. In other areas, we found that documentation practices could be improved, as could how DoH communicates certain aspects of its investigation results with complainants.

In *Issue Area Three*, which reviews sanctions, we found DoH exercises considerable administrative discretion, preferring to "educate" facilities first, rather than pursuing civil fines. Nonetheless, in cases where it did pursue fines, we found that decision-making was well documented. However, when the department did not take action—but could have done so because of the severity of the cited deficiency—we found DoH did not document its decision-making, which made it difficult to measure consistency.

The department has had an opportunity to review and comment on the audit report, and we have included their response in the report. Overall, the department concurs with the findings and is beginning to implement many of the recommendations.

Finally, I would like to note that while our audit critically assesses DoH's performance in some areas, we do not question the dedication of DoH's employees to their mission of protecting nursing home residents. It is this dedication, along with our recommendations, that will further DoH's mission and help to improve quality measures within Pennsylvania-based nursing homes. We will follow up at the appropriate time to determine whether and to what extent all recommendations have been implemented.

Sincerely,

A handwritten signature in black ink, appearing to read "Eugene A. DePasquale". The signature is fluid and cursive, with a long horizontal stroke at the end.

Eugene A. DePasquale
Auditor General

PA Department of Health



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Executive Summary

Why we did this audit...

- ✓ Approximately 80,000 Pennsylvanians currently reside in long-term care facilities, commonly known as nursing homes. These facilities provide all aspects of care to residents, including nourishment, comfort and safety, medical and nursing care, and assistance with activities of daily living. While the number of nursing homes in Pennsylvania has remained relatively stagnant—around 700 facilities—as Pennsylvania’s population continues to age, and subsequently becomes more frail and in need of long-term care services, demand for these facilities is likely to increase. Another concern: By some standards, nursing home quality in Pennsylvania is declining.
- ✓ The Department of Health (DoH) has an important regulatory responsibility to oversee Pennsylvania-based nursing homes. DoH’s responsibility includes ensuring that nursing homes meet federal and state regulatory standards and ensuring that complaints about nursing homes are investigated and resolved. We conducted a series of performance audits in the late 1990s that found troubling conditions with how DoH meet this responsibility.
- ✓ More recently, DoH has received renewed criticisms regarding its effectiveness in overseeing nursing homes. In response to these criticisms—and in light of our previous audit work reviewing DoH’s performance in overseeing nursing homes—the Secretary of Health requested us to conduct a new performance audit. Citing a concern for Pennsylvania’s nursing home residents and their families, Auditor General DePasquale commenced this independent assessment of DoH’s performance.

Our performance audit presents 13 findings, which are focused on three issue areas 1) resident quality of life/care, 2) complaint processing, and 3) sanctions. We also address the status of prior audit recommendations from audits we conducted in the late 1990s and 2000 (see pages 55 to 61). In total, we offer 23 recommendations to improve how the Department of Health (DoH) regulates Pennsylvania’s nursing homes. DoH management provided outstanding cooperation and assistance during the audit, and we thank them for their commitment to improve operations.

We discussed our results with DoH representatives, and their entire response to our report is included on page 64. In summary, DoH acknowledged the issues and findings we presented in this performance audit, and management will be starting a corrective action plan to implement our recommendations.

Before reviewing our results, it is important to understand that DoH’s role in overseeing nursing homes is a shared federal-state responsibility, with specific duties performed by each. At the federal level, the Centers for Medicare and Medicaid Services (CMS), develops quality standards, which nursing homes must meet to participate in the Medicare and Medicaid programs. At the state level, under agreement with CMS, DoH acts as a “state survey agency” for CMS and assesses whether nursing homes meet CMS’ standards, thereby allowing nursing homes to participate in the Medicare and Medicaid programs. At the state level, DoH also conducts concurrent licensing surveys (inspections), which ensures nursing homes are meeting state regulatory standards.

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Issue Area 1 – DoH’s nursing home staffing-level reviews require improvement. (pages 9 to 26)

✓ **Pennsylvania requires nursing homes to provide at least 2.7 hours of direct care, per resident, per day. DoH needs to improve how it ensures facilities meet this requirement.**

We found that nursing home residents’ quality of life and quality of care, can be directly impacted by the staffing levels within the residents’ respective nursing homes. For example, if a facility lacks sufficient staff to care for its residents, then poor resident outcomes will likely occur. Debate continues as to what appropriate staffing levels should be, but in Pennsylvania, state regulations require nursing homes to provide at least 2.7 hours of direct nursing care, per

resident, per day.

In our reviews of how DoH ensured that this standard was met, we found DoH lacked policies and procedures for how its staff were to conduct these important reviews; consequently, staffing-level reviews were conducted inconsistently. An example: in four instances where facilities were found to be non-compliant with the state’s regulation, only one was cited. In fact, during our audit period, DoH only cited facilities 13 times for failure to meet the state standard, out of more than 7,200 surveys (inspections) conducted. Another issue we found: DoH averaged facility staffing levels over a week, instead of holding facilities to the per day requirement. Further, DoH has the ability to require facilities to increase staffing levels, but during the audit period, it never required a facility to do so, despite finding numerous instances of poor quality of care at some facilities.

Other areas addressed in this issue area include, a need for better information sharing with the Department of Labor and Industry regarding mandated overtime complaints emanating from staff employed at nursing homes, and a call for a review of Pennsylvania’s regulations covering minimum staffing levels to see if the minimum staffing standard should be increased.

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Issue Area 2 – Complaint-handling policies and procedures require improvement. (pages 27 to 43)

- ✓ **DoH responded to complaints it received, but some recent revisions to its policies and procedures impacted how DoH received complaints, how it prioritized complaints, and how timely surveyors were in responding to complaints on-site.**

We found that recent revisions to DoH’s policies and procedures may have compromised DoH’s ability to receive, respond, and resolve complaints adequately. For example, for most of the audit period, DoH rejected complaints it received from anonymous sources. As a result, this decision compromised DoH’s ability to receive—and subsequently investigate—all complaint

allegations. DoH has wisely rescinded this policy, and since doing so, complaints have increased by 63 percent.

Other modifications made to DoH’s policies and procedures, included a change in timeliness criteria to complete complaint investigations from 14 calendar days to 21 business days. While this latter modification is permissible under CMS guidelines, the downside is that the longer it takes DoH to complete a complaint investigation, the longer a deficient practice may go undetected. Similarly, we found that DoH simplified its complaint prioritization and response criteria, using just two categories instead of the CMS-suggested four categories. Again, while permissible under CMS guidelines, the downside is that DoH may not be as timely as it should be in responding to complaints that are more serious.

Finally, we reviewed a selection of 90 complaint investigations and found that DoH surveyors need to better document their actions in resolving complaints to ensure sufficiency of the investigation, and in reviewing communications between DoH and complainants, we found that while DoH ensured that complainants received investigation results, in 20 percent of the letters we reviewed improvement was needed to ensure that DoH met CMS requirements.

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Issue Area 3 – DoH needs to improve how it documents actions when deciding not to issue penalties, but could have done so. (pages 44 to 54)

✓ **DoH did a good job of documenting its decisions and actions when it decided to issue civil monetary penalties; however, when it did not issue penalties—and could have done so—DoH did not document its decision-making for not doing so. As a result, measuring consistency is difficult.**

We found that under federal and state guidelines, DoH has considerable discretion in pursuing sanctions against facilities that fail to meet regulatory standards. DoH can terminate licenses, issue provisional licenses, and/or order civil monetary penalties (fines). DoH prefers to “educate” rather than solely fine facilities for non-compliance with federal and state regulations.

Under its state licensing authority, DoH has not pursued many civil monetary penalties, just

\$172,350 during the audit period. However, using CMS’ federal authority, Pennsylvania-based nursing homes were fined more than \$2 million in civil monetary penalties. Under federal guidelines, DoH can recommend civil monetary penalties to CMS, but CMS makes the final decision to impose a fine. We believe the General Assembly should revisit Pennsylvania’s current penalty structure, because in our review of selected other states, Pennsylvania had the lowest maximum penalty amounts allowed among the states that permitted civil monetary penalties. We also reviewed a selection of cases where DoH issued sanctions and found that DoH adhered to its policies and procedures. In particular, DoH conducted comparative analysis to ensure that the sanction being proposed was consistent with previous DoH actions. However, when DoH did not issue a sanction—but could have done so because of the severity of the cited deficiency—DoH did not document its decision-making for not taking action. As a result, it was difficult to ensure that the same level of consistency is being applied from district to district. Finally, we tested the reasonableness of DoH’s scope and severity rankings for certain deficiencies where we thought a higher ranking might have been warranted, and by extension, a sanction imposed. After DoH provided certain clinical clarifications and provided us with additional documentation, we were able to concur with DoH’s conclusions in these cases.

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PA Department of Health**Introduction
and
Background**

In the late 1990s, the Department of the Auditor General conducted several performance audits that highlighted issues with the Department of Health's (DoH)¹ oversight of nursing homes² (see *Prior Audit Findings* section). These audits prompted a number of regulatory changes and helped bring about much needed improvement to how DoH oversees nursing homes.

Despite these improvements, recent media reports have raised new concerns about DoH and its effectiveness in overseeing nursing homes and responding to complaints. In response to these criticisms, DoH requested that we conduct a performance audit to provide an independent assessment of DoH's mission with respect to nursing homes.³

Citing a concern for Pennsylvania's nursing home residents and their families, the Auditor General agreed to DoH's request for an audit. Our Department's performance audit has three objectives (see also *Appendix A – Objectives, Scope, and Methodology*), which are as follows:

1. Determine the adequacy by which DoH ensures that nursing homes meet acceptable living conditions for its residents, including a good balance of quality of life and quality of care.
2. Determine the adequacy by which DoH receives, responds, and timely resolves complaints involving nursing homes.
3. Determine whether DoH is consistently imposing sanctions on nursing homes in accordance with appropriate laws and regulations.

¹ Throughout this report, we refer to the Department of Health as the department, or DoH. When using these terms, we are referring to the collective staff who are involved, either directly or indirectly, with a responsibility to regulate nursing homes.

² For example, the following article from April 22, 1998: <http://www.prnewswire.com/news-releases/pennsylvania-auditor-general-casey--residents-still-in-jeopardy-audit-raises-alarming-new-concerns-about-nursing-home-complaint-system-77563012.html>.

³ DoH has also convened a panel of nursing home experts to help it identify any necessary regulatory changes that need to occur. The panel's recommendations are expected to be released during the summer of 2016.

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We conducted our work under the authority of Section 402 of the Fiscal Code⁴ and in accordance with applicable *Government Auditing Standards* as issued by the Comptroller General of the United States.⁵

In the sections that follow, we provide background information about nursing homes and how DoH regulates these facilities—including the unique balance between state licensing and federal certification.

What are nursing homes and why are these facilities important to Pennsylvania?

DoH is responsible for licensing, certifying, and monitoring the delivery of healthcare at numerous institutions. Specific to this audit, DoH is responsible for licensing and certifying more than 700 *long-term care facilities*, commonly referred to as nursing homes.⁶ Approximately 80,000 Pennsylvanians receive healthcare services in nursing homes.

Individuals who reside in nursing homes are fully dependent on the facility operator to provide their care. These residents are often (but not always) of advanced age, frail, or of poor mental and/or physical health. The residents depend on the facility operator for their health and wellbeing which includes health services, comfort/security, food, medicine, and assistance with aspects of their daily living (bathing, dressing, eating) while at the facility. Residents may be at the facility for weeks, months, or even years. The circumstances leading up to a resident's need for long-term care can be traumatic for the resident and his/her family. Consequently, it is imperative that a resident feel safe, secure, and receive the necessary attention—not just for the resident's well-being, but the well-being of the resident's family as well.

Nationally, Pennsylvania ranks fifth in the number of nursing homes, and fourth in the number of nursing home residents.⁷ While the number of nursing homes currently in operation has been on the decline, in the future it is likely that there will be an increasing need

⁴ 72 P.S. § 402.

⁵ *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

⁶ According to the Health Care Facilities Act, 35 P.S. § 448.802a (Act 48 of 1979), a nursing home is a type of “long-term care nursing facility.” The exact definition of which is “a facility that provides either skilled or intermediate nursing care or both levels of care to two or more patients, who are unrelated to the licensee, for a period exceeding 24 hours.”

⁷ Centers for Medicare and Medicaid, *Nursing Home Data Compendium*, 2015 Edition.

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for nursing homes as population demographics shift and the “baby boomer” generation reaches advanced age. Consider the facts that follow:⁸

- § Pennsylvania’s oldest baby boomers turned 65 in 2011. Today, more than 2.2 million Pennsylvanians are 65 or older.
- § An estimated 70 percent of the people currently turning 65 will require long-term care in their lifetime, and they will receive care for an average of three years.
- § By 2030, Pennsylvania’s 60-and-older age group is expected to be 29 percent of the population—or approximately 4 million people. In this same year, the population of residents age 85 and older will exceed 400,000 residents.

It is clear that it will increasingly become necessary to ensure the care and well-being of our most fragile citizens. Further, as demand for these long-term care services increases, the quality of care provided at those facilities will continue to be an ongoing concern for residents, residents’ families, the public at large, and policymakers.⁹

How are nursing homes regulated?

State licensing and federal certification

Nursing homes are regulated through a shared state-federal responsibility. At the state level, DoH licenses nursing homes, which ensures that the facilities are constructed, maintained, and operated in accordance with state-prescribed regulatory standards.¹⁰ At the federal level, DoH certifies that Pennsylvania-based nursing homes meet the standards necessary for participation in Medicare and Medicaid. In

⁸ Pennsylvania Health Care Association, *Long-Term Care Trends and Statistics*, accessed at www.phca.org, March 7, 2016.

⁹ California State Auditor, Audit Report 2014-111, California Department of Public Health, October 2014, p. 9.

¹⁰ 35 P.S. § 448.801a *et seq.* of the Health Care Facilities Act (Act 48 of 1979) provides for licensing of health care facilities. 28 Pa. Code § 211.1 *et seq.* provides for program standards for long-term care nursing facilities as outlined in the *Pennsylvania Code*.

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this latter capacity, the Centers for Medicare and Medicaid Services (CMS) contracts with DoH to act as its agent.¹¹ A facility cannot be certified if it does not also meet DoH licensure requirements. As of October 31, 2015, DoH licenses and certifies 99 percent of all Pennsylvania-based nursing homes.¹²

Annual (inspections) surveys

DoH ensures that nursing homes are meeting state and federal standards through annual surveys (inspections).¹³ During the annual survey, a team of DoH surveyors conducts an unannounced review of the facility. The review typically lasts several days and involves direct observations of the facility, interviews of staff and residents, and review of patient care documentation to evaluate whether the nursing home met standards focusing on medical needs, quality of care, and quality of life issues.

Although state licensure and federal certification are conducted concurrently during a nursing home's annual survey, the actual survey process follows requirements outlined by CMS because DoH serves as the state survey agency for the federal government.¹⁴ As such, CMS monitors DoH performance by conducting its own reviews of DoH surveys of nursing homes.¹⁵

During a standard survey, teams of DoH employees evaluate compliance with quality standards.¹⁶ Based on the care provided to a sample of residents, the survey team determines whether the care and services provided met the assessed needs of the residents, and it

¹¹ The Centers for Medicare and Medicaid Services (CMS) is a federal agency under the Department of Health and Human Services. CMS defines quality standards that nursing homes must meet in order to be eligible for Medicare/Medicaid reimbursement for services that nursing homes provide to residents. See <https://www.cms.gov/>.

¹² As of May 20, 2016, three facilities do not participate in Medicare/Medicaid. As such, these facilities are licensed by DoH, but are not certified.

¹³ CMS requires that facilities are surveyed not less than once every 15 months, and the statewide average for the surveys may not exceed 12 months between surveys. DoH conducts other types of surveys, including but not limited to, complaint investigation surveys and building surveys.

¹⁴ Federal regulations pertaining to nursing homes are outlined in Code of Federal Regulations (CFR), 42 C.F.R. § 483.1 *et seq.* CMS' *State Operations Manual* outlines the process and procedures that all state survey agencies, like DoH, use when conducting annual surveys. See <https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-part483/content-detail.html>.

¹⁵ In addition, CMS also conducts annual state performance reviews, which include an examination of the quality of state survey investigations and decision-making and the timeliness and quality of complaint investigations. We reviewed these CMS reports from 2013 and 2014 and found no problem areas.

¹⁶ Survey teams generally consist of a registered nurse, a dietician, and a social worker. Each member of the survey team has completed a CMS-mandated training program and passed a certification exam..

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measures resident outcomes, such as incidence of preventable sores, weight loss, and accidents.¹⁷

In areas where federal regulations may be unclear, state regulations may provide legal guidance. As discussed later in this audit report, one example where state regulations are stricter than federal regulations is mandated facility staffing requirements, which according to CMS are key components of measuring nursing home quality.

Complaint investigations and incident reporting

In addition to conducting annual licensure/certification surveys, DoH investigates complaints it receives about nursing homes. DoH accepts complaints through its web site, letters, telephone hotline, or even in person when it conducts surveys. Complainants may file complaints anonymously or request confidentiality when reporting their concerns.¹⁸

All complaints DoH receives about certified nursing homes are reported to CMS. Like annual surveys, CMS dictates how complaint investigations are to be conducted, and it mandates certain timeframes for response and reporting. As discussed herein, DoH has established detailed complaint handling policies and procedures. In responding to complaints, DoH conducts an “abbreviated survey” at the facility to investigate the merits of the allegations. Abbreviated surveys target a specific federal quality standard or state regulation. Surveyors interview staff and any witnesses, including the resident about whose care the complaint was filed and other residents with similar care needs, being careful to protect the identity of those involved. Complaint investigation plays an important role in DoH’s oversight of nursing homes because it allows DoH to review specific allegations that may directly impact resident care and/or quality of life between standard annual surveys.

Nursing homes are also required to self-report certain events, such as abuse, death by medication error, communicable diseases, or hospitalizations. Nursing homes report this data to DoH electronically

¹⁷ Before the survey begins, residents are pre-selected based on CMS’ Resident Level Quality Measure/Indicator Reports. Once the team has completed this initial review and the team has collected information to focus any identified concerns or potential issues, additional residents are included for review.

¹⁸ Historically DoH has accepted and investigated anonymous complaints; however, as discussed in Issue Area 2.1, DoH suspended this practice. On July 22, 2015, DoH rescinded its policy to begin accepting anonymous complaints.

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through DoH’s web portal. DoH reviews these self-reported incidents and may conduct abbreviated surveys, if necessary.

How are DoH-identified problems corrected?

Scope and severity

If DoH conducts a standard or abbreviated survey and finds that the facility is not operating in accordance with federal and/or state regulations, it will issue a “statement of deficiencies” to the facility. Deficiencies are classified into one of 12 categories, each designated with a different letter (A through L), according to the scope—the number of residents potentially affected—and severity—the potential for reoccurrence of harm to residents.¹⁹ “A” is the least severe deficiency, while “L” is the most severe—indicating widespread, immediate jeopardy to residents. The distinctions between these rankings are highlighted in the exhibit that follows:

Deficiency Ratings – “Scope and Severity” Matrix

Severity	Isolated	Pattern	Widespread
Potential for minimal harm	A	B	C
Potential for more than minimal harm	D	E	F
Actual harm	G	H	I
Immediate jeopardy	J	K	L

Source: Developed by Department of the Auditor General staff from information obtained from CMS and the Government Accountability Office.

For each deficiency, the facility must respond with a “plan of correction” (POC). The POC is mandatory, regardless of whether the facility agrees or disagrees with DoH’s findings. A POC, for purposes of licensure and certification, is not an admission of wrongdoing on the part of the facility. The POC is the means by which DoH monitors and ensures correction of deficiencies.

¹⁹ Only deficiencies that are related to federal quality standards receive scope and severity ratings. State-related deficiencies are not ranked according to scope and severity.

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As long as the facility submits a POC, the facility may continue to operate and receive Medicare and Medicaid payments while deficiencies are being corrected. DoH will conduct follow-up visits as necessary to ensure that all deficiencies have been corrected.

Sanctions

Because of the differences between licensure and certification, DoH can pursue various additional penalties against facilities. Under licensure, DoH can change a nursing home's licensing status to one of four stages of provisional licensure. Under provisional licensure, facilities receive surveys more frequently, and the facilities pay more for their state licenses. For serious or egregious deficiencies, DoH may also impose civil monetary penalties. Monies collected from penalties are used by DoH for the following purposes:

- § To provide payment to temporary management companies.
- § To maintain the operation of the health care facility pending correction of deficiencies or closure.
- § Relocation of residents to other licensed health care facilities.
- § To reimburse residents for misappropriated funds.

Facilities are offered an informal opportunity to dispute cited deficiencies. When a facility is successful in its appeal, the cited deficiency may be deleted or the scope and severity assessment for deficiency may be adjusted downward.

Under certification, DoH can also recommend to CMS that it pursue sanctions ranging from fines, a ban on new resident admissions, or even certification termination, meaning that the facility will lose its right to participate in Medicare or state Medicaid programs.

How is DoH organized?

The Department of Health (DoH) was created by Act 218 of 1905, and modified subsequently by the Administrative Code of 1929.²⁰ DoH's mission is to promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality health care for all Commonwealth citizens.

²⁰ 71 P.S. Part 1, Ch. 2, Art. XXI § 531 *et seq.* (Adm. Code § 2101 *et seq.*)

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Within DoH, nursing home regulation falls under the Division of Nursing Care Facilities (DNCF), which is within the Bureau of Facilities Licensure & Certification. The DNCF is divided into nine field offices and one central office located in Harrisburg.²¹

Complement information for DoH's DNCF is presented as follows:

**DNCF Complement, Filled and Vacant
as of September 16, 2015**

DNCF Staff by Field Office	Total	Filled	Vacant ^{a/}
Central Office	14	12	2
Lionville	14	12	2
Lehigh	14	13	1
Harrisburg	14	8	6
Norristown	27	23	4
Pittsburgh	27	22	5
Johnstown	12	11	1
Jackson	12	10	2
Williamsport	10	9	1
Scranton	15	14	1
Total	159	134	25

Note:

^{a/} Seven of these positions are actually filled with temporary annuitant employees, who can only work 95 days per calendar year.

Source: Developed by Department of the Auditor General staff from information obtained from DoH.

²¹ The Field Offices are Harrisburg, Jackson Center, Johnstown, Lehigh Valley/Bethlehem, Lionville/Exton, Norristown, Pittsburgh, Scranton, and Williamsport.

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Issue
Area

1

DoH's insufficient review of nurse staffing levels within long-term care facilities may be affecting residents' quality of care and quality of life.**Issue summary: Findings 1.1 — 1.6***At issue...*

Pennsylvania requires nursing homes to provide 2.7 hours of direct care to residents, per day. DoH needs to improve how it ensures facilities meet this requirement, and policy-makers should decide if the standard needs to be revised.

Adequate staffing to provide care for residents is one of the key factors affecting nursing home residents' quality of care and quality of life.²² While debate continues as to what constitutes adequate staffing levels for nursing homes, a logical conclusion is apparent—nursing homes that are better staffed with qualified and experienced nurses are generally able to provide better care and quality of life for its residents.

The Centers for Medicare and Medicaid Services (CMS)—the federal agency that largely guides how states are to oversee nursing homes—does not require a minimum number of nurse and nurse assistant hours per resident/day.²³ While CMS has not set specific minimum staffing requirements, it has conducted research that has identified staffing levels that are associated with a reduced risk for poor resident outcomes. That research recommended a daily minimum standard of 4.1 hours of total nursing time (registered nurses, licensed nurses, certified nurse assistants) per resident.²⁴

In 1999, Pennsylvania's DoH adopted regulations that specify minimum staffing requirements based on the number of residents at the facility. According to these regulations, each nursing home must provide a minimum of 2.7 hours of direct nursing care per resident, per day.²⁵ Other states also require certain mandated staffing

²² Mueller, Christine Ph.D, R.N., "Nursing Home Staffing Standards: Their Relationship to Nurse Staffing Levels," *The Gerontologist*, Volume 46, No. 1, 2006.

²³ Section 483.30 (Nursing Services) of Title 42, Part 483 pertaining to Requirements for States and Long Term Facilities of the *Code of Federal Regulations* provides that: certified nursing homes must have sufficient staff to provide nursing and related services to attain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. In terms of actual staffing requirements, federal regulations only require that nursing homes have an RN on duty at least 8 hours per day, 7 days per week. Further, nursing homes must have a director of nursing, who is an RN and serves on a full-time basis. See 42 C.F.R. § 483.30. Last Amended on October 28, 2005.

²⁴ Abt Associates for U.S. Centers for Medicare and Medicaid Services, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." Phase I and Phase II, July 2000 and December 2001.

²⁵ Section 211.12 (Nursing services) of Title 28, Chapter 211 pertaining to Program Standards for Long-Term Care Nursing Facilities of the *Pennsylvania Code*. See 28 Pa. Code § 211.12. Last Amended on July 24, 1999. Please

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requirements; however, there is great variance in these standards, and no state required the CMS-suggested 4.1 hours of direct nursing care as of May 5, 2016.²⁶

CMS collects staffing data and reports it on the federal government's "Nursing Home Compare" website, but that data is unreliable because it is self-reported by the facilities.²⁷ Prior to this audit, DoH lacked policies and procedures for how its surveyors²⁸ were to complete staffing level reviews; instead, informal practices were used that varied by field office.²⁹ As a result, we found that staffing level reviews were completed inconsistently.

In some cases, we also found that when DoH completed its staffing reviews, insufficient documentation was obtained to support the analysis, leaving us guessing as to how the facility complied with Pennsylvania's mandated regulatory staffing requirement. In other cases, we found facilities had failed to meet the state staffing requirement, yet DoH had not cited the facility.

In another related matter, DoH did not coordinate with the Pennsylvania Department of Labor and Industry (L&I) on matters linked to mandated overtime for nurses at nursing homes, although DoH management indicated it has recently started to do so.³⁰

We also found that nursing homes are rarely cited (under federal or state regulations) for having inadequate staffing levels. Of even greater concern was that we found DoH did not use its regulatory authority to require facilities to increase staffing levels.

Finally, given the obvious connections between nurse staffing and a facility being able to provide adequate quality of care and quality of life for residents, Pennsylvania should revisit its 17-year-old regulation on minimum staffing requirements.

note that the Department raised the minimum 24-hour staffing levels from 2.3 as it had been set by statement of policy, dated February 17, 1996, to a minimum of 2.7 hours effective July 24, 1999.

²⁶ According to CMS, no state requires 4.1 hours of direct nursing time, although some states like Florida approach it. Washington state will raise its standard to 3.4 on July 1, 2016, and intends to raise it to 4.1 hrs. of direct nursing time, if additional funding is identified.

²⁷ CMS updates this information on a quarterly basis. For CMS reporting purposes, DoH surveyors collect staffing data for a two-week period that immediately precedes the annual certification survey.

²⁸ Surveyors are specially trained investigators who respond to and resolve complaints about nursing homes, and conduct annual licensure and certification reviews. Refer to the *Introduction and Background* section for additional information.

²⁹ DoH has nine field offices. Refer to the *Introduction and Background* section for more information.

³⁰ We released an audit of L&I and this issue in April 2015.

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Finding 1.1

DOH lacked policies and procedures for its surveyors to follow when conducting staffing sufficiency reviews. CMS also provided little guidance to DoH on how to ensure facilities are adequately staffed.

As a requirement for participation in Medicare/Medicaid, a nursing home must ensure that it has sufficient staff to provide nursing and related services to attain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans.³¹ Pennsylvania's regulations are more specific, requiring that nursing homes must provide a daily minimum of 2.7 hours of direct resident care.³²

DoH conducts annual unannounced surveys (inspections) of all nursing homes (see *Introduction and Background* section for more information). These surveys serve the purposes of both federal certification and state licensure. Despite this dual purpose to the annual survey (i.e., review of federal/state regulatory compliance), DoH's actual procedures for conducting the annual survey follow guidance outlined by CMS.³³ Within CMS' framework, DoH survey teams conduct reviews of resident files, tour the facility, and interview staff and residents, looking for potential violations of federal and/or state regulations.

For certification purposes, CMS requires DoH to conduct minimal staffing level reviews, but only requires the review if problems are identified in other areas. CMS' *State Operations Manual*, states the following about sufficient staffing procedures during a regular survey (emphasis added):

§ This protocol is not required during the standard survey, unless it is triggered in the event of care concerns/problems which may be associated with sufficiency of nursing staff.

§ This protocol is to be used when:

³¹ 42 C.F.R. § 483.30(a).

³² 28 Pa. Code § 211.12(i).

³³ Surveys are conducted according to DoH policies and procedures, which are outlined in Appendix P of CMS' *State Operations Manual* and additional state requirements.

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- Quality of care problems have been identified, e.g., residents not receiving the care and services to prevent pressure sores, unintended dehydration, and to prevent declines in their condition as described in their comprehensive plans of care, such as bathing, dressing, grooming, transferring, ambulation, toileting, and eating; and
- Complaints have been received from residents, families or other resident representatives concerning services, e.g., care not being provided, call lights not being answered in a timely fashion, and residents not being assisted to eat.³⁴

CMS protocol provides little guidance as to how to conduct the review of staffing sufficiency. For example, CMS simply suggests cues such as asking residents about staff's response to call bells, or "if necessary, review nursing assistant assignments in relation to the care and/or services the resident requires to meet his/her needs."³⁵

Given that there is no federal minimum staffing requirement, it is not surprising that CMS requires DoH to do little to ensure facilities are adequately staffed. Conversely, given Pennsylvania's more stringent regulatory requirement for nurse staffing, DoH should have specific policies and procedures that were to be used in determining facility compliance with the regulatory requirement. However, we found that DoH lacked any policy related to how its surveyors were to check for compliance and instead simply left the matter up to the survey team to use general practices that had been in place for years (see Finding 1.2 that follows).

We noted this issue when we reviewed the process mapping³⁶ and related summary narrative for DoH's survey process. In reviewing these documents, we found that the survey process only required surveyors to obtain certain staffing-related information,³⁷ but nowhere did the process define where or when a facility staffing review was to

³⁴ This direction would include anonymous complaints. As discussed later in Issue Area 2, DoH rejected complaints from anonymous sources during much of our audit period.

³⁵ State Operations Manual, Appendix P – *Survey Protocol for Long-term Care, Investigative Protocols, Nursing Services Sufficient Staffing*.

³⁶ A process map is a detailed flow chart that shows the key steps involved in completing a process (e.g., the certification/licensure survey).

³⁷ As part of the certification survey process, CMS requires DoH to obtain information on facility staffing. However, this information is entirely self-reported by the facility and is not verified. The information is relayed to CMS who uses it in reporting information on the Nursing Home Compare web site.

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be completed. To DoH's credit, when informed of this oversight to its policies and procedures, it immediately created and adopted a policy. This new policy went into effect on April 4, 2016.³⁸

Finding 1.2**A lack of specific guidance by DOH on how and when to conduct facility-staffing reviews led to inconsistent reviews.**

To aid in our understanding of the nursing home survey process, DoH provided to us a detailed presentation explaining the various tasks that constitute the certification/licensure survey. As part of this presentation, DoH noted that under a category of "other tasks," the survey team conducted a three-week review of facility staffing to ensure that the facility met the regulatory 2.7-hour per day requirement. The three weeks selected for detailed review included the following:

1. The week of the survey.
2. One week prior to the survey.
3. One week from three months prior to the survey.

As stated in the previous finding, prior to the initiation of this audit, DoH lacked policies and procedures pertaining to facility staffing. In the absence of these policies and procedures, DoH had created an informal practice of reviewing staffing (using the above selected weeks) as necessary. Further, DoH developed a templated staffing worksheet to aid its surveyors in calculating facility compliance with the minimum 2.7-hour direct care-staffing ratio.

We were informed that the basis for selecting these three weeks was to give a varied perspective on facility staffing. For example, DoH informed us that although the actual date of the survey is unannounced, because state licensure runs for a 12-month period, and CMS requires certification to be completed within a 15-month window from the last survey, facilities are able to project when its next survey will occur. DoH further noted that while it had no direct evidence of such practices, it suspected that many facilities may increase staffing levels during the estimated survey window. In theory, by increasing

³⁸ Policy and Procedure Number DNCF 307 - *Determination of Sufficient Facility Staffing*. We did not review this policy for adequacy as it was outside the scope of our audit, and DoH indicated that it was continuing to revise the policy as our audit was progressing.

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staff levels the facility will appear more favorably during the certification/licensure survey. Therefore, to help counter-act this potentiality, DoH selects a week from a period three months prior to when it is on-site conducting the survey.

As part of our audit procedures, we shadowed a survey team as it was conducting an annual survey.³⁹ During the survey we watched as surveyors completed their review of facility staffing. Our observations, while not indicative of how DoH conducted every staffing level review, concerned us. In particular, we noted the following concerns:

1. The facility staff, and not the DoH surveyor, filled in the staffing hours and resident census on the DoH template used to verify compliance.
2. The facility provided insufficient documentation to support its assertions about staffing. The only documentation obtained were generic spreadsheets, which showed staff scheduled, but not the actual hours worked.
3. Administrative nurse time was included as direct resident care when calculating the facility's compliance with the 2.7 hours of direct resident care. Administrative nurses generally have other supervisory duties; thus, it is unlikely that all of their time would be devoted to direct resident care.⁴⁰

Due to the concerns we observed, we decided to review other annual relicensure/recertification surveys to determine whether similar issues were present. We selected 42 facilities from the approximately 700 nursing homes that were licensed/certified by DoH during our audit period (see *Appendix A – Objectives, Scope, and Methodology*). In selecting facilities for review, we ensured that we had at least four facilities from each of DoH's nine field offices. We selected facilities judgmentally based on factors such as the number and severity of deficiencies, number of complaints, and number of self-reported incidents to DoH.

After identifying facilities for our detailed review, we obtained and reviewed the "survey packets" for each facility's annual relicensure/recertification survey. The survey packet contains

³⁹ The survey we shadowed was actually a three-day survey; we were present for the final day.

⁴⁰ DoH's newly adopted policy on determination of sufficient facility staffing (Policy and Procedure Number DNCF 307) states, "Direct care nursing does not include administrative nursing that are not providing hands-on care to residents. If they break from their administrative duties to provide hands-on care, then their time may be counted."

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supporting documentation obtained by the survey team when it conducted its survey (i.e., inspection). Where DoH had conducted more than one survey, we judgmentally selected a year's survey for review. Our results are presented in the table that follows:

DoH Determination of Sufficient Facility Staffing Levels

	Number	Percentage
Surveys reviewed	42	100
Staffing level review not completed ^{a/}	4	9.5
Staffing level review completed	38	90.5

Of the 38 staffing reviews completed ^{b/} :	Number	Percentage
Surveys with 3 weeks of staffing data	24	63.2
Surveys with 1 week of staffing data	14	36.8
Surveys with supporting documentation	17	44.7
Surveys without supporting documentation	21	55.3

Notes:

a/ DoH noted that for the 4 missing reviews the review may have been completed, but the documentation was destroyed after information was entered into DoH's survey tracking system.

b/ Tests of the staffing attributes are independent of each other. Staffing documents were reviewed to determine whether: 1) there were 3 weeks of staffing data, 2) documents were available to support staffing data, and 3) documents indicated the facility met a minimum of 2.7 hours of direct nursing care per resident per day.

Source: Developed by Department of the Auditor General staff from review of 42 DoH-conducted facility relicensure/recertification annual surveys.

Key points from our review⁴¹ revealed the following:

- § Ten percent (4 of 42) of the annual survey packets lacked any documentation showing that a review of the facility's staffing levels was conducted. DoH explained this anomaly by noting that an informal practice existed in two of its field offices whereby surveyors would enter the information into DoH's survey tracking system, but would then destroy the staffing sheets if no problem had been identified. However, even within these field offices we noted inconsistency, as some

⁴¹ Our results are based solely on our review of DoH files. Upon our initial review of DoH's files, documentation was missing for 11 (26 percent) of the staffing level reviews. After being notified about the missing documentation, DoH was later able to produce documentation for 7 of these 11 survey packets.

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sheets were present, yet apparently no staffing-level concerns had been identified.

- § In 14 of 38 completed reviews (37 percent), the surveyors reviewed only one week of staffing information, instead of the DoH recommended practice of reviewing three weeks.
- § In the 24 facility reviews that analyzed three weeks of staffing, only 12 of those (50 percent) also contained supporting documentation.
- § In more than half of the completed reviews (21 of 38), documentation to support the facility level staffing calculation was missing.

Perhaps most troubling from our review of DoH's analysis was that we found four instances (or 11 percent) where the facility was not in compliance with the required 2.7 hours of direct nursing care per resident per day, yet in only one of these instances was the facility cited.

DoH did not cite the facility in the other three instances because DoH used a practice of averaging time over the week instead of reviewing each day separately. Conversely, our review more accurately focused on each day within the week, because the regulation specifically states that direct care standard shall be provided for a 24-hour period.⁴²

An important point to remember is that we found 71 percent of the reviews were either missing from the file, lacked documentation, or had been completed in an incomplete manner. Consequently, the number of facilities that were actually non-compliant with the mandated direct care-staffing ratio could be higher.

Additionally, we reviewed the selected facility packets to identify any instances where residents and/or family members had made comments to the survey team about staffing, or other concerns attributable to quality of care/quality of life within the facility.⁴³ Of the 42 facility surveys we reviewed, we were able to identify 22 such instances—and yet in 13 of these instances (59 percent)—DoH did not conduct a

⁴² See 28 Pa. Code § 211.12(i).

⁴³ As discussed in the *Introduction and Background* section, the annual relicensure/recertification survey process follows prescribed tasks outlined by CMS. As part of these tasks, surveyors interview residents (individually and in a group setting), as well as family members, and inquire about any concerns they may have about the facility or care provided at the facility. These interviews are documented on CMS-required "Quality of Life Assessment" forms.

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thorough review⁴⁴ of the facility's staffing to ensure it complied with state regulations. We caution that our analysis is only as good as the documentation that was available to us in the survey packet; thus, the condition may be worse than what we found to be occurring. For example, if such concerns were relayed to surveyors, but those comments were never documented in the survey packet, we would not be aware of the occurrence.

DoH management acknowledged the errors in facility staffing reviews and conceded that there is inconsistency among DoH's field offices in how surveyors determine facility compliance with PA's nurse staffing regulations. DoH management believed such inconsistency was due to its lack of clear policy and procedures on the issue, and management was hopeful that its newly adopted policy and procedures would reiterate the importance of thorough and consistent reviews of facility staffing.

Finding 1.3**DoH rarely cites facilities for deficient facility staffing under federal or state regulations.**

Because of DoH's inconsistent practices when conducting facility-staffing reviews, we found that facilities were rarely cited for staffing-related deficiencies. As a result, DoH missed a key opportunity to take action to ensure facilities corrected a deficiency that contributed to residents' quality of care and quality of life. While this issue is problematic in itself, ultimately, the public is left poorly informed of what may be troubling and persistent conditions.

Few deficiencies cited related to federal staffing standard.

Deficiencies related to federal nursing home standards are referred to as "tags" and are numbered according to corresponding federal regulations. Related to the federal staffing standard listed above, if a facility was found to have insufficient staff to meet its residents' needs, the facility would be cited under tag F353, and a scope and severity rating would be assigned to the tag (see *Introduction and Background* discussion for more information on the survey process).

⁴⁴ By thorough review, we mean that the staffing level sheet was present, included a review of three weeks, and included documentation to support the review.

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To evaluate whether DoH's procedurally weak review of facility staffing could lead to an unexpectedly or unreasonably low number of violations related to staffing, we compared survey results for Pennsylvania-based nursing homes to survey results from other states. We obtained our information from CMS' "Nursing Home Compare" web site.⁴⁵ This federal web site contains all federal certification survey results for all US nursing homes that participate in Medicare/Medicaid. We obtained data files for the period August 25, 2010, through March 16, 2016.⁴⁶ We also obtained the most recently available information on the number of nursing homes in each state, as well as the number of residents residing in those facilities.⁴⁷ We included this latter information because we wanted to normalize the data for the potential for violations. For example, simply comparing each state's count of F353 deficiencies would not be as accurate without weighting that count in relation to the number of nursing homes in each state or its nursing home resident population (i.e., more nursing homes and more residents would increase the likelihood for violations).

The results of our analysis showed that despite Pennsylvania being a leader in the number of nursing homes and residents in nursing homes, very few facilities have been cited for federal deficiencies related to staffing. In fact, out of the 50 states, Pennsylvania ranked 42nd in terms of staffing-related tags per nursing home and 43rd in terms of staffing-related tags per resident.

One could argue that there are few deficiencies cited because those facilities met the federal standards. However, as we described in finding 1.2, our review of completed surveys found facility staffing information to be lacking and/or incomplete. Consequently, it could also be plausible that some facilities did not meet the standard and should have been cited. Simply put, only valid and reliable documentation will confirm either plausibility; however, the low

⁴⁵ <https://www.medicare.gov/nursinghomecompare/search.html>

⁴⁶ This period preceded and went beyond our audit scope; however, we believed it was necessary to expand the scope for this review in order to provide a more robust comparison to other states. During our audit period of January 1, 2014, through October 31, 2015, DoH conducted 7,235 surveys (which includes annual, follow-up, and complaint-related surveys) and cited facilities on 22 occasions for tag 353.

⁴⁷ We obtained this information from CMS' *2015 Nursing Home Compendium*, which was the most recent edition available. The Compendium contains figures and tables presenting data on all Medicare and Medicaid-certified nursing homes in the United States, as well as the residents in these nursing homes. CMS compiles its information from three primary sources: (1) CMS' database for survey and certification information, named Certification and Survey Provider Enhanced Reporting (CASPER); (2) United States population data from the United State Bureau of the Census; and (3) a set of clinical data collected on every resident of every Medicare- and Medicaid-certified nursing home in the country, the Minimum Data Set (MDS). Refer to Appendix A *Objective Scope, and Methodology* for additional information on data reliability.

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number of federal tags is an area that warrants further scrutiny by DoH.

Few deficiencies cited related to state-required minimum staffing standards.

Similarly, we reviewed state-related deficiencies related to Pennsylvania's nursing services regulations. As discussed earlier, Pennsylvania regulations require nursing homes to provide a minimum of 2.7 hours of direct nursing care per resident per day.⁴⁸

As part of our audit procedures, we obtained a listing of all surveys completed by DoH for the period January 1, 2014, through October 31, 2015. The file included all surveys, whether the survey was conducted as part of an annual relicensure/recertification or in response to a complaint. In total, 7,235 surveys were completed, which resulted in 10,070 deficiencies being cited.

DoH codes deficiencies related to nursing services as "LTCL 2020." We reviewed DoH's data for instances where facilities were cited using this code, and we found that during our audit period DoH made just 13 citations to facilities for having insufficient staff. Consequently, out of more than 7,200 facility surveys conducted by DoH, surveyors cited facilities for non-compliance with state staffing requirements just **0.2 percent** of the time.

The above analysis needs to be placed within the context of the most frequently cited deficiency, which was for facilities that failed to provide quality of care to its residents. For the same period, our review found that DoH used this tag 843 times, or approximately 12 percent of all the surveys conducted. Thus, on the one hand—12 percent of the time DoH cited facilities for failure to provide quality care to residents—yet on the other hand, DoH cited just 0.2 percent of the facilities for failure to meet state staffing standards. This anomaly suggests that either the state's minimum staffing standard is too low, and/or DoH may not be reviewing facility staffing appropriately.

⁴⁸ 28 Pa. Code § 211.12(i).

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Finding 1.4

Current regulations allow DoH to require nursing homes to increase staffing beyond 2.7 hours of direct care, but DoH has not used this authority.

As discussed elsewhere in this issue area, all Pennsylvania-licensed nursing homes must provide at least 2.7 hours of direct nursing care per day. However, it is important to remember that this standard is only the **minimum** standard and additional staffing beyond 2.7 hours of direct care may be necessary based on resident care needs. To that point, Pennsylvania's nursing home regulations give DoH the additional authority that follows:

The Department may require an increase in the number of nursing personnel from the minimum requirements if specific situations in the facility—including, but not limited to, the physical or mental condition of residents, quality of nursing care administered, the location of residents, the location of the nursing station and location of the facility—indicate the departures as necessary for the welfare, health and safety of the residents.⁴⁹

We asked DoH the frequency by which it has used the above authority during our audit period. DoH replied that it could not identify any instances where the authority granted under Section 211.12(l) of the DoH regulations to increase facility staffing was used. Consequently, despite DoH identifying 843 instances of poor resident care under federal regulatory standards—and even given the actual 13 instances where DoH *did* cite facilities for not meeting Pennsylvania's 2.7 hours of direct care standard—in not a single occurrence did DoH issue an order to a facility to increase its staffing levels. DoH stated that there was no particular reason as to why the department had not used its authority. DoH noted that outside of the information provided in the regulation, it had no internal directions as to the regulation's use or lack of use. Upon being made aware of the above occurrence, DoH management stated that it intends to review and begin utilizing its authority, as outlined in the regulation, in the future.

Based on the above facts, we believe DoH could do more to ensure facilities are adequately staffed to meet resident needs. Specifically, DoH should be looking beyond a particular cited deficiency to identify

⁴⁹ 28 Pa. Code § 211.12(l).

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factors that are *causing* the deficiency—and then if necessary—requiring the facility to add staffing to fix the issue.

Consider the facts that follow:

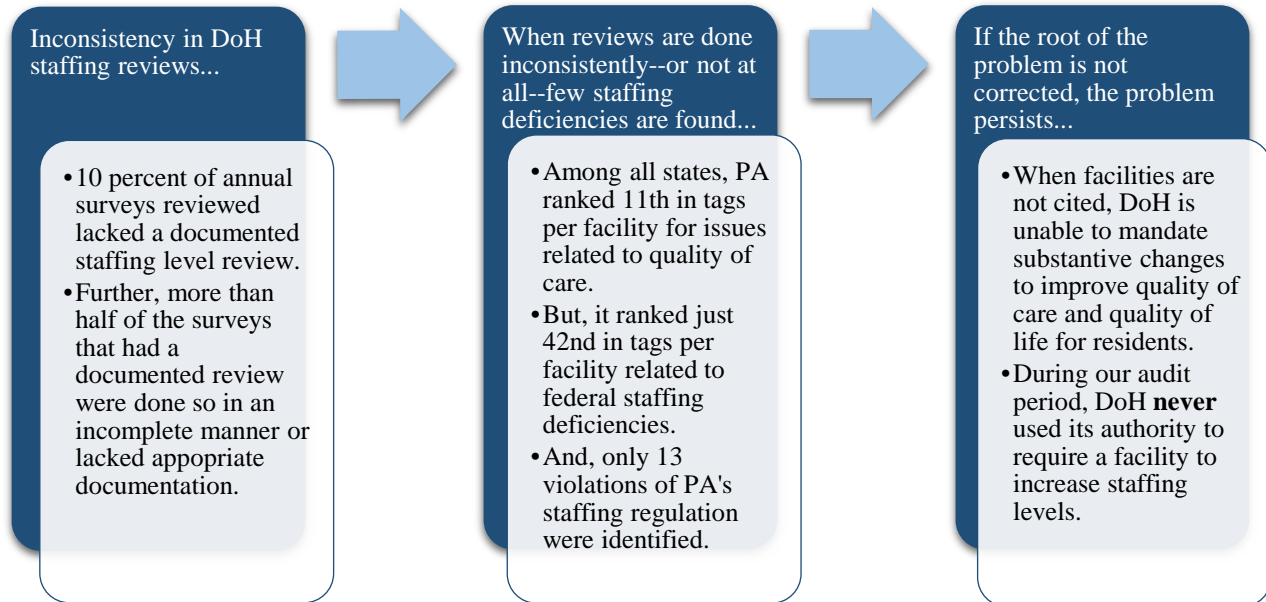
- § DoH is identifying deficient care practices, as nearly 12 percent of the facilities surveyed had a federal deficiency related to quality of resident care. By way of comparison to other states, for deficiencies related to quality of care, Pennsylvania ranks 21st in number of tags per nursing home residents, and 11th in number of tags per facility.⁵⁰
- § As suggested by CMS, it is widely accepted and understood that there is a strong correlation between quality of care and sufficient/adequate staffing.
- § Federal standards related to minimum staffing requirements are not as strict as Pennsylvania’s regulatory standards, which specify 2.7 hours of direct care per resident.

Consequently, because facilities are being cited at the federal level for failing to provide adequate care to residents, and further, because it is understood that quality of care and staffing are related—it seems logical that DoH would be finding instances of insufficient staffing. Moreover, in “closing the loop” and correcting those issues, DoH should then be requiring facilities to increase staffing at those facilities. However, we found the opposite to be the case. The exhibit that follows demonstrates the issue that challenges DoH on an on-going basis.

⁵⁰ Our analysis is based on unaudited information obtained from CMS’ *2015 Nursing Home Compendium*.

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DoH Needs to Improve Its Review of Nursing Home Staffing



Source: Developed by Department of the Auditor General staff.

For DoH, a systematic solution involves consistently reviewing nurse-staffing levels; citing facilities where there are violations; and where necessary, mandating increased nurse staffing when facilities have repeatedly been unable to provide quality of care to its residents. To date, DoH has not consistently delivered this emphasis and attention.

Finding 1.5

DoH did not coordinate with the Department of Labor and Industry to identify instances where staffing shortages may be occurring.

On April 21, 2015, we released a performance audit of the Department of Labor and Industry's (L&I) implementation of Act 102 of 2008, or the "Prohibition of Excessive Overtime in Healthcare Act."⁵¹ This law had important ramifications for healthcare workers—it prohibited their

⁵¹ The audit can be found in its entirety here:

<http://www.paauditor.gov/Media/Default/Reports/spe73272LaborAndIndustryAct102Audit042115.pdf>

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employers from routinely scheduling and requiring overtime. More specific to this audit, Act 102 of 2008 prohibits nursing homes from requiring its nursing staffing to work mandated overtime.⁵²

At that time, our audit found that L&I was unprepared to enforce the law; consequently, L&I failed to appropriately respond and resolve complaints about mandated overtime. Some of the complaints we reviewed during that audit were from nursing home employees.

As we began this current audit, an obvious connection seemed apparent—if L&I received complaints about a nursing facility that mandated overtime, then it is very likely that the facility may have a staffing-related issue for which DoH should be investigating a potential violation of the requirement for 2.7 hours of direct nursing care.⁵³

While DoH and L&I have no specific requirement to coordinate their efforts, as a means of improving government efficiency and effectiveness, such coordination should occur.

We inquired if DoH had coordinated its efforts in reviewing nurse-staffing levels with L&I. DoH representatives said they were aware of the law but did not coordinate with L&I on Act 102-related issues. Consequently, DoH did not use this potential warning sign of poor facility staffing as a means of proactively looking for violations at facilities it regulates.

To give DoH its due credit, when informed of this potential for collaboration, DoH management indicated that they immediately began a dialogue with L&I representatives to be better informed of mandated staffing violations at nursing homes.

Finding 1.6**Pennsylvania’s direct nursing care standard of 2.7 hours per resident may be too low and should be reconsidered.**

In 2001, CMS released research that found that staffing levels of 4.1 hours of nursing care per resident were “optimal” for reducing certain types of negative outcomes often associated with nursing home care

⁵² The Prohibition of Excessive Overtime in Health Care Act does allow mandated overtime for unforeseeable emergent circumstances and certain overtime exceptions. 43 P.S. §932.1 *et seq.*

⁵³ 28 Pa. Code § 211.12(i).

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(e.g., pressure sores, dehydration, and weight loss).⁵⁴ Since that time, debate continues on whether minimum staffing ratios lead to better outcomes. This debate continues largely because the methodologies used to measure quality of care/staffing are extremely complex and because CMS was only able to demonstrate the staffing level below which quality was threatened.⁵⁵

More recently, the state of Florida conducted research in which it studied the effects of Florida's nursing home minimum staffing ratios. The Florida Agency for Health Care Administration found that quality of care increased since it raised nurse-staffing standards.⁵⁶ Researchers noted the following:

Studies of nurse staffing have repeatedly demonstrated that quality of care is impacted by nurse staffing but the findings vary by the outcome measures used and by the way nurse staffing is measured. A recent review of the studies linking staffing and quality confirms that the strongest research suggests poor quality of care is linked to inadequate staffing levels but acknowledges that studies do not uniformly find increased nurse staffing always improves quality of care. Minimum staffing levels are needed before facilities can implement high quality resident outcomes, but the staff must be managed well with careful oversight if consistent quality outcomes are to be achieved.⁵⁷

Because of each state's subtleties and the overall lack of guidance from CMS, comparing nursing staffing requirements from state-to-state is complex. In fact, we found that thirteen states have no numerical ratio for nurse staffing, although some of these states

⁵⁴ Abt Associates for U.S. Centers for Medicare and Medicaid Services, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." Phase I and Phase II, July 2000 and December, 2001.

⁵⁵ CMS ratios included certified nurse assistants (CNA), licensed-practical nurses (LPN), and registered nurses (RN) only. The minimum number of hours per resident per day was 2.75 hours, while preferred minimums were 3.0 hours, and optimal minimums were 4.1 hours.

⁵⁶ Florida currently requires a total of 3.6 hours of direct care, including specific ratios between LPNs and RNs.

⁵⁷ A consortium of researchers from the University of South Florida's, Florida Policy Exchange Center on Aging and School of Aging Studies, Texas A&M's, University Health Science Center, and the University of Florida's, College of Public Health and Health professions conducted the research. Their results were presented in a report titled, *Preliminary Analyses on Outcomes of Increased Nurse Staffing Policies in Florida Nursing Homes: Staffing Levels, Quality and Costs [2002 – 2007]*, February 2009.

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require more licensed and/or registered nursing presence than federal requirements.⁵⁸

In a few states, like New Jersey, a complex formula is applied whereby varying additional time is added to the basic nursing staff-to-resident ratio for each resident who needs any of a number of nursing procedures.⁵⁹ These ratios may be more helpful in ensuring that facilities are adequately staffed as the staffing is keyed to each resident's acuity of care needs. However, verifying compliance with the standard can be especially onerous.

Whether Pennsylvania should increase the current minimum staffing regulation, or otherwise modify it, is a matter for policy makers. However, we believe that because 17 years have passed since the regulation was last reviewed—and given that significant changes have occurred and will continue to occur within Pennsylvania's population—a review of all regulations surrounding nursing homes is appropriate. Such a review will strengthen DoH's mission to ensure that nursing home residents' quality of care and quality of life are protected.

Issue Area Recommendations

We recommend that DoH:

1. Develop written policies and procedures to guide surveyors for the assessment of facility staffing-level reviews. The policy and procedures should include, but not be limited to, the following requirements:
 - a. A staffing-level review is always conducted for any relicensure/recertification survey.
 - b. The facility level staffing is reviewed for each 24-hour period and not merely a weekly average.
 - c. Use supporting documentation of actual hours worked and not hours scheduled for determining direct care hours.
 - d. Only count hours related to direct care.

⁵⁸ University of Minnesota, Long-term Care resource Center, Nursing Services – Staffing Ratios. Accessed at, <http://www.hpm.umn.edu/nhregsplus/NH%20Regs%20by%20Topic/Topic%20Nursing%20Services%20-%20Staffing%20Ratios.html> on November 6, 2015.

⁵⁹ Ibid.

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- e. At a minimum, three weeks are reviewed, and more weeks may be added, if necessary. The weeks should vary and not be consecutive.
 - f. Monitoring of staffing level reviews by management.
2. Retain all staffing level review documentation in the survey packets.
3. Conduct training for all surveyors on the importance of consistently conducting facility level staffing reviews, in accordance with DoH's new policy and procedures.
4. Conduct periodic quality assurance reviews of completed facility-staffing reviews to ensure that the staffing reviews comply with DoH's policy and procedures and are consistently applied.
5. Partner with other states to identify potential best practices for DoH to implement with regard to conducting facility staffing-level reviews.
6. Seek guidance and clarification from CMS on how best to cite facilities using federal staffing requirement criteria.
7. Cite facilities that fail to meet the state's 2.7 hours of direct care requirement on a 24-hour basis (not averaged over a week), and ensure the facility institutes a corrective action plan.
8. Exercise its authority to mandate additional direct care staffing (above 2.7 hours) where facilities fail to implement a successful corrective action plan related to staffing concerns, or if the facility continues to have other deficiencies related to quality of care.
9. Develop written policies and procedures for surveyors to determine when to mandate direct care staffing above the 2.7 hour requirement.
10. Develop a memorandum of understanding or other working agreement with the Pennsylvania Department of Labor and Industry, so that DoH is notified of potential issues related to mandated overtime complaints involving nursing homes.
11. Work with the General Assembly, the Governor, and nursing home stakeholders to reevaluate whether Pennsylvania's 2.7 daily hours of direct care ratio should be increased or otherwise amended in DoH regulations.

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Issue
Area

2

Poorly written revisions to DoH's policies and procedures may have compromised DoH's ability to receive, respond, and resolve complaints adequately.**Issue summary — Findings 2.1 through 2.4***At issue...*

During our audit period, DoH had detailed policies and procedures for how it received, responded, and resolved complaints. In some areas, these policies and procedures exceeded CMS guidelines that DoH was required to follow. However, DoH rejected anonymous complaints and it used broad definitions of when it initiated complaint investigations, which made it appear more timely than it really was. DoH also needs to improve the standard by which it documents its actions in complaint investigations.

Responding to complaint allegations involving nursing homes is one of Pennsylvania Department of Health's (DoH's) most critical responsibilities. Complaint investigations often identify instances where a facility is failing to provide care or services as required by federal and state regulations. DoH maintains detailed policies and procedures to guide its complaint handling activities; however, as discussed herein, some recent revisions may have compromised DoH's ability to address all complaints and provide timely responses.

During our audit period of January 1, 2014, through October 31, 2015, DoH accepted 4,062 complaints⁶⁰ for investigation, or an average of about six complaints per day.⁶¹ DoH received these complaints via phone, mail, and through its web site. Through most of the period, until July 2015, DoH rejected anonymous complaints. This decision compromised DoH's ability to receive and investigate all complaint allegations. DoH has since rescinded this policy—and as result—complaints received by DoH have increased by 63 percent.

Due to staffing reductions, DoH amended its complaint policy during our audit period to allow more time to investigate and close-out complaints. Specifically, DoH switched its timeliness criteria from 14 calendar days to 21 business days (an increase in days and which days were counted). By making this switch, surveyors had more than double the time to complete a complaint investigation. DoH was able to make this change because the federal Centers for Medicare and Medicaid Services (CMS) only requires timeliness for complaint initiation, not completion of the investigation.

⁶⁰ This figure does not include self-reported incidents, which DoH requires nursing homes to report through an online portal.

⁶¹ Complaints are composed of one or more allegations. Per CMS guidance complaints are counted based on how the allegation(s) is received. For example, if one person calls with ten allegations about one provider, this occurrence is counted as one complaint record. If six people call with the same allegation, this occurrence is counted as six complaints. If one letter is received with many allegations and is signed by 20 people, this occurrence is still counted as one complaint.

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CMS' guidelines regarding complaint investigations require DoH to prioritize complaints on intake and then assign an appropriate response based on that prioritization.⁶² CMS requires prioritization to follow one of four categories;⁶³ however, DoH only uses two categories—priority and general. DoH would be able to better allocate its increasingly scarce human resources to respond to higher priority complaints by prioritizing complaints on intake according to CMS' guidelines.

Finally, we also tested 90 complaints to determine the sufficiency of the investigation and the adequacy of communication with the complainant. We found that because surveyors typically only document the deficiencies that are found, as opposed to a complete record of the investigatory activities used to respond to the complaint, it is difficult to determine if a complaint was sufficiently investigated—even for DoH management. Consequently, DoH should revise its complaint investigation policies and procedures to document all actions taken to investigate a complaint to ensure the complaint is sufficiently investigated. We also found that while DoH did communicate with complainants, in 20 percent of the cases we reviewed, DoH failed to meet one or more of five performance categories.

Finding 2.1**DoH rejected complaints received from anonymous sources, which limited DoH's knowledge about possible nursing home violations.**

As a state survey agency for CMS, DoH is required to maintain detailed policies and procedures to guide its complaint-handling process.⁶⁴ We reviewed these policies and procedures, and we reviewed the process by which DoH received complaints. We noted that for most of our audit period of January 1, 2014, through October 31, 2015, DoH followed an internal policy that required it to reject complaints from anonymous sources. However, due to concerns that complaints were not being communicated to DoH because of

⁶² CMS guidance is outlined in Chapter 5 of the *State Operations Manual*.

⁶³ CMS also has four additional prioritization categories for off-site reviews.

⁶⁴ DoH's complaint handling policy and procedures are embodied within several policy and procedure documents. The primary documents are: (1) DNCF 702, Central Office Complaint Processing, which covers how complaints are received and entered into its tracking system; and, (2) DNCF 701, Complaint Investigation, which covers how complaints are prioritized, resolved, and reported.

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complainants' fear of retribution by the nursing facility, DoH changed its policy in July 2015.

DoH representatives stated that prior to July 2012 anonymous complaints were routinely accepted and investigated; however, around that time, and based on direction from the previous administration, a decision was made to reject complaints received from anonymous sources. In response to this decision, DoH's complaint policy was revised to state that complainants could remain confidential, but contact information must be provided in order for DoH to accept and act on the complaint.

However, DoH's policy was not in line with CMS' *State Operations Manual* which requires "In some instances, the complainant may request anonymity."⁶⁵ Further, CMS requires that DoH must ensure "the privacy and anonymity of every complainant."⁶⁶

DoH's policy to reject anonymous complaints likely had serious and unintended consequences for DoH and the public at large. By denying anonymous complaints, DoH denied itself awareness of potentially harmful conditions that existed in the very facilities it was responsible for regulating. Additionally, some of these complainants were likely from residents and/or nursing home employees that had vitally important information about significant violations, but who also feared retaliation either from caregivers or from their employer for doing so.

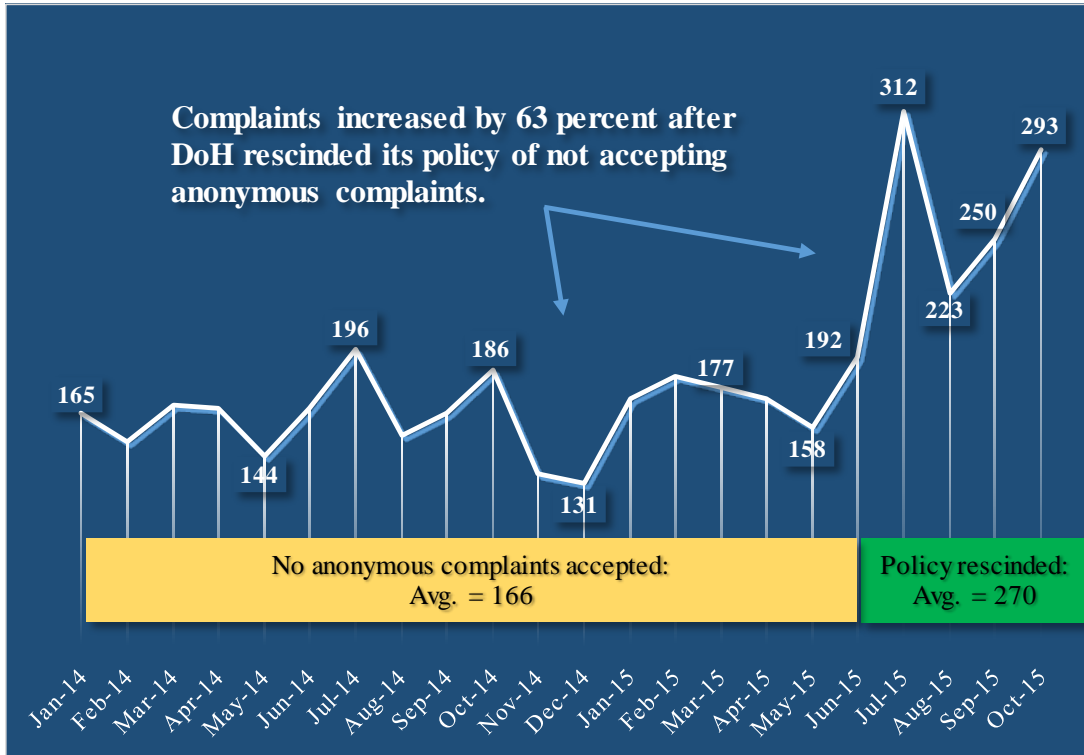
Since reversing its policy in July 2015, DoH immediately had a significant increase in the number of complaints it received. As shown in the exhibit that follows, prior to DoH's reversal it averaged 166 complaints per month. However, after its policy reversal in July 2015, complaints increased by 63 percent to an average of 270 per month. DoH management noted that other factors may have also contributed to this increase, including but not limited to, additional public outreach conducted by the Secretary of Health, and modifications to DoH's web site, which made it easier to file complaints electronically.

⁶⁵ See *State Operations Manual*, Chapter 5, Section 5010, "General Intake Process." Effective March 17, 2006.

⁶⁶ *Ibid.*

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Total Complaints Received by DoH



Source: Developed by Department of the Auditor General staff from information received by DoH.

We believe DoH’s decision to reverse its policy decision and again accept anonymous complaints was appropriate. DoH should continue on this path in order to protect residents and to ensure facilities comply with federal and state regulations.

Finding 2.2

Due to staffing reductions, DoH has extended the timeframe for completing complaint investigations.

As shown in the table below, DoH’s Division of Nursing Care Facilities (DNCF) has witnessed a 12 percent reduction in its filled complement. As of June 30, 2012, which was also the period when DoH decided to reject anonymous complaints, DNCF had 152 filled full-time positions. As of September 16, 2015, near the end of our audit period, DNCF’s complement had dropped to 134 filled full-time

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positions. As a means of easing this strain on DNCF’s complement, DoH has also increased its use of annuitants.⁶⁷

DoH’s DNCF Complement

	As of:	Total	Filled	Vacant
12 percent reduction in staffing.	June 30, 2012	164	152 ^{a/}	12
	December 31, 2013	161	142	19
	September 16, 2015	159	134 ^{b/}	25

Notes:

^{a/} In addition to the 152 full-time positions, DoH utilized two temporary annuitants.

^{b/} In addition to the 134 full-time positions, DoH utilized seven temporary annuitants.

Source: Developed by Department of the Auditor General staff from information provided by DoH.

Because of reductions in DoH’s complement, DoH management revised its complaint handling policy because it could not meet processing requirements contained therein. Specifically, DoH could not meet timeliness requirements for when complaint investigations must be completed.

Consequently, in July 2015, DoH revised its complaint-handling policy to require complaint investigations to be completed within 21 business days. Before this revision, the policy required complaint investigations to be completed within 14 calendar days (i.e., weekends and holidays were counted in the timeliness standard).

By way of example, under DoH’s old policy, if DoH received a complaint on July 1, the investigation needed to be completed by July 15. Under the current (revised) policy, a complaint received on July 1 would not require an investigation to be completed until August 2—an increase of over two weeks, and a more than doubling of the previous completion timeframe.

Prior to adopting the revised policy, DoH management stated that they tested the revised timeframes from October 2014, through July 2015. DoH management said they were unable to identify any negative results to nursing home residents during this timeframe; thus, it adopted the policy formally on July 22, 2015.

⁶⁷ Annuitants are former employees who have retired and are receiving a retirement annuity from the PA State Employees Retirement System (SERS). Annuitants are paid an hourly wage and may not work more than 95 days per year.

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While DoH management may not have identified any negative results in its review, we disagree with the logic behind their conclusion for this reason: the longer an investigation takes to complete, the longer a deficient practice could go uncorrected. By association, the longer a deficiency goes uncorrected, the more likely it is that residents could be harmed from that deficient practice.


We reviewed DoH's timeliness, both before and after the July 22, 2015, policy revision. We noted that while DoH was able to improve its compliance rate by switching to its new policy, the obvious downside was that it took longer to complete investigations. Consider the following:

- § Under the former requirement to complete investigations within 14 calendar days, 80 out of 1,478 investigations failed to meet the policy requirement—equating to a five percent noncompliance rate. The timeframe for the completion of the 80 investigations not in compliance ranged from 15 to 40 days late.
- § Under the revised 21-business day threshold, just 13 investigations failed to meet the requirement, out of 2,584 total investigations—equating to a 0.5 percent noncompliance rate. The timeframe for the completion of the 13 investigations not in compliance; however, ranged from 22 to 51 days late—a significant increase in days to complete investigations.

It should be noted that DoH has the ability to adjust its timeliness threshold for when it must complete an investigation, because CMS provides no specific guidance on the issue. However, as discussed further in the finding that follows, CMS guidance on timeliness is focused on when an investigation is initiated, not when it is completed.

Finding 2.3

DoH complaint prioritization policy differs from CMS requirements; thus, DoH may not be as timely as it should be in responding to certain complaints.



CMS specifies the general parameters by which complaints involving nursing homes are to be received, responded to, and ultimately resolved.⁶⁸ These parameters outline two key aspects as follows:

⁶⁸ CMS outlines these parameters in Chapter 5 of the *State Operations Manual*.

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- 1) **Prioritization.** Complaints are prioritized on intake (i.e., categorized according to the severity of the complaint's allegations).
- 2) **Response.** Based on the prioritization assigned to the complaint, an appropriate and timely response is made (i.e., complaints that are prioritized more severely are responded to first).

Within these parameters, CMS allows state survey agencies to have flexibility, so long as the state's policies agree with or are more stringent than CMS requirements. DoH used this flexibility in how it prioritized complaints it received. As discussed below, DoH attempted to simplify its complaint prioritization procedures to ensure residents were not in immediate jeopardy—a noteworthy goal—but the downside to this approach was that, because DoH did not use CMS' prioritization categories, it may have incorrectly coded complaints and not met CMS timeliness requirements to be on-site to investigate the complaint.

With respect to complaint investigation prioritization and response, a summary comparison between CMS requirements and DoH's complaint investigation policy follows (emphasis added):

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**Complaint Investigation Comparison
CMS and DoH**

<i>CMS State Operations Manual</i>	Prioritization categories:^{a/}	Immediate Jeopardy (IJ)	Non-IJ (High)	Non-IJ (Medium)	Non-IJ (Low)
	Required response timeline:	Must initiate an <u>onsite survey</u> within <u>2 working days</u> of receipt.	Must initiate an <u>onsite survey</u> within <u>10 working days</u> of prioritization.	No timeframe specified, but an onsite survey must be scheduled.	Must investigate during the next onsite survey.
<i>DoH Complaint Investigation Policy</i>	Prioritization categories:	Priority	General		
	Required response timeline:	Immediate on-site response.	All complaint investigations must be <u>initiated</u> within <u>2 business days</u> .		

Note:

^{a/} CMS includes four additional prioritization categories: administrative review/offsite investigation; referral—immediate; referral—other; and no action necessary. No onsite investigation is required for these prioritizations.

Source: Developed by Department of the Auditor General staff from review of CMS State Operations Manual, Chapter 5 – Complaint Procedures and DoH Complaint Investigation Policy, DNCF – 701.

At first glance, DoH’s policy appears to be more stringent and straightforward: complaints are either *Priority*, requiring immediate onsite responses, or *General*, requiring that investigations must be initiated within two business days. Conversely, CMS uses four categories, with decreasing timeliness requirements for response based on the complainant’s prioritization coding.

DoH asserts that its timeframes for investigating either a *Priority* or *General* complaint exceeds CMS time frames. With regard to *Priority* complaints, we agree—DoH’s complaint policy is more rigorous. However, as discussed further below, with respect to *General* complaints, we believe DoH’s policy is misaligned with CMS guidelines due to DoH’s broad definition for how it defines a complaint investigation initiation.

For example, DoH’s complaint investigation policy defines initiation to include any of the following six actions, only one of which is actually being on-site:

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1. Telephone contact with the complainant or other information source for purposes other than obtaining the initial complaint.
2. Telephone contact with the facility for the purpose of securing information.
3. Telephone contact with the field office supervisor for additional information.
4. Review of facility files, including Pennsylvania Automated Complaint Tracking System (PACTS).
5. On-site investigation.
6. Referral to any other agency.

Referring to the previous table, under CMS guidance, a complaint coded as “Non-Immediate Jeopardy (IJ)-High” requires an on-site survey within 10 working days. Moreover, and as clearly defined by CMS, “The initiation of these types of investigations is generally defined as the SA [state agency] beginning an onsite survey.” [Emphasis added.] By way of comparison, under DoH’s policy, that same type of complaint would be coded as *General* and would require an investigation to be initiated within two business days.⁶⁹

This divergence from CMS protocols is an important distinction because, as shown above, under DoH policy, initiation does not necessarily mean that the surveyor was actually on-site, the surveyor may have just made a phone call or reviewed electronic files. Consequently, the net effect is that DoH surveyors may not be as timely getting to the facility to actually begin investigating the complaint allegations as it may appear.

Test results showed differences between “initiating” a complaint investigation and actually being on-site.

We obtained from DoH a data file of all complaints for the period January 1, 2014, through October 31, 2015. During this period, DoH received and responded to 4,062 complaints. Our analysis of the data showed that for 99 percent of these complaints, DoH surveyors initiated an investigation in less than two days, which met DoH’s policy requirements. However, initiation was interpreted to mean per DoH’s policy, as outlined above, and not necessarily when the surveyor went on-site, which is the actual CMS requirement.

⁶⁹ As discussed previously, DoH revised this policy during the middle of our audit period. Prior to this revision, complaint investigations were to be initiated within two calendar days.

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To test the potential distinction between complaint initiation and when the surveyor actually was on-site, we judgmentally selected 90 complaints for detailed review.⁷⁰ We then reviewed the complaint's case notes and related documentation to identify the dates when the surveyor actually visited the facility and investigated the complaint allegation(s), as opposed to when DoH said it initiated the complaint investigation.

It is important to repeat that because DoH does not use CMS complaint prioritization coding, it is impossible to know if DoH's response met CMS timeliness guidelines. In our selection, we found that there were no *Priority* complaints, so none of those complaints would have required an immediate response by DoH.⁷¹

Knowing that none of the complaints had been prioritized as *Priority* (or an "immediate jeopardy" prioritization under CMS definitions), we checked to see how many of the complaints met CMS' next most severe category, "Non-Immediate Jeopardy-High." As shown on the previous exhibit, this complaint prioritization requires an on-site survey within 10 working days. We found that 69 (or 77 percent) of the 90 complaints met this 10-day, on-site requirement. Consequently, because DoH met that 10-day requirement, then by default it would have also met any other lower ranked prioritization categories that could have been assigned to these complaints. In other words, because DoH had a surveyor on-site within 10-days, then it also met the timeliness requirements had the complaint been prioritized as "non-immediate jeopardy-medium" or "non-immediate jeopardy-low."

Our review for the remaining 21 complaints revealed the following:

- § Four complaints (4 percent) were resolved through a file review and not an on-site review.
- § 17 complaints (19 percent) took more than 10 working days for DOH surveyors to initiate an on-site survey.

While the above are examples of potential non-compliance, we reiterate that because DoH did not code these complaints according to CMS guidelines, and instead used its coding of *General*, we cannot determine if the response timeliness met CMS requirements. For

⁷⁰ Complaints may contain one or more allegations.

⁷¹ In fact, out of the 4,062 complaints received by DoH during our audit period, only 23 complaints (or .6 percent) of the total were coded as *Priority*.

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example, excluding the four complaints where DoH did not initiate an on-site review, if DoH had prioritized the other complaints as “non-immediate jeopardy-medium,” then no timeframes were applicable and DoH would have complied with CMS timeliness requirements.

Accordingly, while on the surface, DoH appears to be initiating complaint investigations in a timely manner, it may not actually be on-site within the timeframes required by CMS guidelines. We contend that DoH would be able to ensure compliance more accurately by prioritizing its complaints on intake according to CMS guidelines.

Furthermore, by prioritizing all complaints as *General*, DoH is not effectively maximizing its resources. For example, higher priority complaints should require a quicker response to ensure residents are protected from harm, before lower priority complaints that are less critical. Yet, by categorizing all complaints as *General*, DoH may end up in some cases “over-prioritizing” complaints, while in other cases, it may “under-prioritize” complaints.

The above issue also highlighted a concern we had with how DoH reports complaint priority to CMS.⁷² When we asked DoH how it converts its prioritization to the CMS-required categories, DoH stated that it uses a “crosswalk” to match to the categories. However, we found that this crosswalk is actually done *after* the complaint has already been investigated, and not on intake as it should be. In other words, DoH first waits until the complaint has been investigated, reviews the number of days it took to respond to the complaint, and only then assigns the complaint a matching CMS prioritization code based on those days.

For example, if DoH determined that a complaint took more than 10 days to investigate, then DoH would report to CMS that the complaint was a “Non-Immediate Jeopardy-Medium” prioritization. In reality, that complaint may have actually been a “Non-Immediate Jeopardy-High” prioritization, which necessitated a 10-day or less onsite investigation from DoH.

By following this after-the-fact prioritization practice, DoH is virtually assured of meeting CMS’ timeframes. While this practice may make DoH look good in CMS’ perspective, it negates the ability to measure DoH’s compliance with CMS requirements accurately.

⁷² Under CMS requirements, complaints received by a state survey agency must be reported to CMS using CMS’ complaint prioritization categories.

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Finding 2.4**Based on our review of selected complaints, DoH could improve how it communicates with complainants, and how it documents actions taken to resolve complaints.**

DoH tracks complaints through the Pennsylvania Automated Complaint Tracking System (PACTS). DoH surveyors also use the system to document their actions as they investigate and resolve complaint allegations. Using the same 90 complaints as discussed in Finding 2.3, we reviewed the adequacy by which DoH responded to complaints it received.⁷³

In conducting our test work, DoH provided us with information from PACTS, including complaint intake information and the responding surveyor's investigation notes. DoH also provided us with copies of any correspondence between DoH and the complainant and between DoH and the facility about the complaint. Finally, DoH provided us with a form required by CMS called the *CMS-2567* form. This form is used to document the complaint investigation, the results of DoH's investigation, and any resulting deficiencies.

In reviewing complaints, we focused on two areas: 1) did DoH sufficiently investigate the complaint, and 2) how well did DoH communicate its findings?

Sufficiency of complaint investigation

While the timeliness of complaint investigations is important, how DoH surveyors responded to the complaints is of greater concern. To that end, we reviewed each of the 90 complaints in our selection to determine if DoH sufficiently investigated the complaint, including whether the investigation generally conformed to guidance provided by CMS.⁷⁴

⁷³ For the period January 1, 2014, through October 31, 2015, DoH received 482 complaints related to these 42 facilities. In selecting complaints for review, we focused on complaints that contained allegations involving quality of care or services. The 90 complaints we selected for review, included 336 separate allegations. DoH investigated each of these allegations and found 69 of the allegations to be substantiated, meaning that the surveyor was able to document the concern. Substantiating a complaint; however, does not necessarily mean that the facility was cited for a deficiency as the issue may not pertain to a state or federal regulation.

⁷⁴ Sections 5300 through 5300.5 of CMS' *State Operations Manual* outline general tasks that guide a complaint investigation. These tasks include, off site preparation, entrance conference, information gathering, information analysis, and exit.

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In reviewing complaints for sufficiency, we reviewed investigation summary notes prepared by the surveyor and approved by his/her supervisor. We used this documentation to make conclusions about whether the surveyor performed important tasks to investigate the complaint allegations sufficiently, including but not limited to, the following:⁷⁵

- § Were patient files, and/or other facility records, reviewed?
- § If necessary, were residents interviewed?
- § If necessary, were applicable staff interviewed?
- § Were surveyor observations related to the allegation made and documented?
- § Was applicable supporting documentation (e.g., facility policies and procedures) reviewed at the facility?

Using the above guidelines, and applying our own judgment to our review of surveyor investigation notes, we found that of our 90 selected complaints, seven did not appear to be sufficiently investigated by DoH. Because our review relied heavily on the adequacy of surveyor documentation notes, we asked DoH to respond to detailed questions about those seven complaints and to provide supporting documentation to support the actions/conclusions made by the surveyor.

Based on DoH's responses, it appears that these seven complaints (or eight percent) in question were sufficiently investigated; however, DoH's actions were not adequately documented. Therefore, we were unable to validate and conclude that the investigations were indeed sufficient. DoH concurred that poor documentation is an issue because it makes it difficult for DoH management to ascertain that a thorough investigation was conducted.

DoH stated that documentation issues stem from CMS survey rules, which require that surveyors document information that supports a deficient practice. CMS does not require that surveyors document every step in the investigation. Further, DoH noted that it would be nearly impossible to document every piece of an investigation that did not support a deficient practice.

We disagree with DoH's reasoning. All actions taken to investigate a complaint should be documented regardless of whether (or not) a

⁷⁵ See CMS, *State Operations Manual*, Section 5300.3 – Task 5: Information Gathering. CMS does not outline specific investigation procedures. CMS states, “The order and manner in which information is gathered depends on the type of complaint that is being investigated.”

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deficient practice is found. Without adequate documentation, DoH management cannot be assured that all investigations were conducted sufficiently.

In fact, one of the seven complaints that we questioned due to inadequate documentation highlighted to us an example of management being unable to determine if a sufficient investigation was completed.

According to the complaint documentation, the complainant, who was an employee of the facility, alleged that a resident had fallen out of bed and then was returned to bed (apparently without an appropriate injury assessment).⁷⁶ Approximately 30 minutes later, when a supervisor arrived, the resident went into cardiac arrest. Further, according to the complainant, none of the staff knew what to do about the resident's condition, and when staff went to retrieve the automated external defibrillator (AED)⁷⁷ it was not working and parts were missing. The resident later died.

A DoH surveyor investigated the complaint allegation during the facility's annual relicensure/recertification survey and found it to be unsubstantiated. Based on our review of documentation that DoH could provide, we could not determine that the investigation included actions such as determining the following:

- § Whether staff had been trained in using AEDs?
- § Whether AEDs had been checked to ensure that they were properly equipped?
- § Whether the facility's AEDs were functional?
- § Did a resident die as a result of the facility not providing appropriate lifesaving care?
- § Was a resident not properly assessed after a fall?
- § Were other lifesaving means used to help the resident?
- § Why were staff, who work with critically ill patients, not better prepared?

⁷⁶ This complaint also underscores the point made in Finding 2.1 about anonymous complaints. Prior to July 2015, DoH flatly rejected anonymous complaints. This complaint was received on October 28, 2015. Based on our review, we found the complaint allegations to be highly credible and worthy of an immediate on-site investigation. Had this complaint been received prior to DoH's policy reversal; however, DoH may have summarily dismissed the complaint.

⁷⁷ According to the American Heart Association, an automated external defibrillator (AED) is a lightweight, portable device that delivers an electric shock through the chest to the heart. The shock can stop an irregular heart rhythm and allow a normal rhythm to resume following sudden cardiac arrest. Sudden cardiac arrest is an abrupt loss of heart function. If it is not treated within minutes, it quickly leads to death. Accessed from the American Heart Association, "Answers by Heart", at www.heart.org, May 23, 2016.

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§ If lifesaving equipment is not working, and/or staff are not trained, are the residents at that facility in immediate jeopardy?

From DoH management perspective—due to the practice of only documenting deficiencies—because there was no documentation to indicate a deficient practice, then the complaint was sufficiently investigated and the results were valid. Our concern; however, is that the absence of documentation should not be a basis to conclude that everything was done correctly to investigate the complainants’ allegations. From our perspective, there were still unanswered and potentially serious issues.

Consequently, we contacted DoH because we were concerned that residents may have been (or were in) immediate jeopardy. After our inquiry and due to the seriousness of the allegations, a DoH supervisor returned to the facility and obtained additional documentation to support the original surveyor’s conclusion that this complaint allegation was unsubstantiated.

DoH agreed that this case highlighted that improvements were needed in how surveyors document their actions. Going forward, DoH management noted it has reviewed with surveyors the importance of documentation, so that the Department can ascertain that a thorough investigation has been completed for all nursing home complaint investigation.

DoH’s practice likely also contributed to errors noted in our review of communications with complainants, in that DoH was not sufficiently communicating to complainants the procedures used to investigate the complainant as discussed in the following section. Without this information, complainants and others who review DoH’s investigatory results are left wondering if their concerns were taken seriously.

Complaint finding communications

Per CMS guidance, after a complaint is investigated, a written report of the investigation findings must be prepared and provided to the complainant.⁷⁸ CMS outlines general parameters for what to include in the report, including, but not limited to, the following:

⁷⁸ CMS, *State Operations Manual, Chapter 5 – Complaint Procedures*, Section 5080, Investigation Findings and Reports; Section 5080.1, Report to the Complainant.

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- § Identify DoH as the appropriate regulatory authority.
- § Provide a summary of the investigation methods used.
- § Provide dates of when the investigation was conducted.
- § Provide a summary of the finding.
- § Identify appropriate follow-up action that will be taken, if necessary.

We reviewed DoH's performance in the above categories as part of testing the 90 complaints discussed above. While DoH should be commended for ensuring that every complainant received a communication from DoH, we found that improvement is needed in how DoH communicates its results. Specifically, we identified 17 instances out of a possible 83 occurrences (or 20 percent) where DoH did not meet at least one of the requirements. The other seven complaints we reviewed were from anonymous sources and/or the complainant did not want written communication from DoH; consequently, DoH could not provide a written response in these situations.

Most often (10/83 or 12 percent), we found that DoH did not provide a summary of the investigation methods it used. While this occurrence is not a glaring oversight, failure to provide this information can leave complainants wondering exactly what DoH *did* do to answer their concerns. This issue can be particularly troubling when the complainant's allegations were found to be unsubstantiated, as the complainant may be left feeling that their concerns were simply dismissed.

Also, in reviewing DoH correspondence, we found one occurrence in which DoH indicated differing outcomes about the complaint allegations. In this occurrence, a complainant filed a complaint with DoH that involved five allegations. DoH investigated all five allegations and two of the allegations were substantiated. However, neither of these two substantiated allegations resulted in a deficiency citation. According to the DoH surveyor's notes, one substantiated allegation could not be tied to a specific deficient practice. The surveyor noted that the remaining substantiated allegation was related to a previously cited deficiency for which the facility was currently in the process of correcting.⁷⁹

DoH adequately explained the above occurrences in its letter to the complainant. However, the letter sent to the facility administrator

⁷⁹ After a facility is cited for a deficiency, it is given an opportunity to correct the deficiency through a plan of correction. During this time, the facility is not cited for repeat offenses that may occur.

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stated, “The findings of this survey revealed that no evidence of deficient practice had been identified.” While this statement is true for one of the allegations, it was not true for the second allegation as a deficient practice *was* identified, but the facility could not be cited as it was in the process of correcting the deficiency. In our opinion, this statement was misleading, and DoH should have instead informed the facility that the allegation was substantiated, but because of the facility’s corrective action status, it would not be further cited.

Issue Area Recommendations

We recommend that DoH:

1. Continue to accept complaints from anonymous sources.
2. Replace complement positions that were lost in the DNCF to the extent that budgetary constraints permit.
3. Strive to complete complaint investigations within DoH’s previous complaint-handling policy of 14 calendar days as additional staffing permits.
4. Revise its complaint intake prioritization policies and procedures to be in alignment with CMS guidance.
5. Report complaint priority to CMS based on complaint intake and not based on the length of the investigation.
6. Document all actions taken to investigate a complaint regardless of whether (or not) a deficient practice is found.
7. Ensure that communications with complainants regarding complaint investigations are clear and accurately reflect the actions taken by the surveyor to investigate the complaint. Further, when applicable, ensure that complainant communications meet all requirements outlined by CMS.

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Issue
Area

3

DoH has considerable discretion in pursuing sanctions against facilities that fail to meet regulatory standards, but rarely imposes penalties under state rules.**Issue Summary — Findings 3.1 through 3.3***At issue...*

When DoH orders sanctions, we found staff documented their actions and ensured necessary approvals were obtained. However, when staff could have imposed sanctions—but decided not to do so—decision-making was not documented. DoH prefers to “educate” rather than solely fine facilities for non-compliance. The Commonwealth’s sanction structure has not been revised in 36 years—updates to the law should be considered.

When nursing homes fail to meet either state or federal standards, DoH may impose sanctions for the deficiencies.⁸⁰ According to DoH policy, DoH imposes sanctions on nursing care facilities that are found to be in less than substantial compliance with the provisions of 28 Pa Code, Long Term Care Facilities Licensure regulations and the Code of Federal Regulations.

DoH’s authority to impose state sanctions is outlined in the Health Care Facilities Act of 1979, P.L. 130, No. 48, which permits DoH to impose civil monetary penalties of up to \$500 for each day the cited deficiency continues. In addition, DoH can impose “provisional licensure” status on nursing homes as well as other remedy options.⁸¹

During the 22 months of our audit period, DoH issued just \$172,350 in civil monetary fines.⁸² By way of comparison, in Pennsylvania the median nursing home cost is \$113,150 for one resident for one year.⁸³ In comparing Pennsylvania to states we reviewed, Pennsylvania had the lowest maximum penalty amounts allowed among the states that permitted civil monetary penalties. We believe the General Assembly should revisit Pennsylvania’s current penalty structure.

At the federal level, DoH makes recommendations to CMS for the imposition of civil monetary fines. These fines are substantially larger than state fines. In fact, CMS issued over \$2 million in civil monetary fines to Pennsylvania-based nursing homes during our audit period.⁸⁴ However, the actual imposition of federal civil monetary penalties is

⁸⁰ DoH considers the citing of a deficiency as the first step of a sanction or remedy.

⁸¹ There are four progressive stages of provisional licensure (I-IV), with provisional IV being the highest level of non-compliance. A facility remains in provisional license status for as long as it is out of compliance. However, once a facility meets regulatory compliance it is returned to full licensure status. Generally, it would take two years for a facility to reach Provisional License IV status.

⁸² DoH issued a total of 32 civil monetary fines, 11 in 2014 and 21 in 2015.

⁸³ Cost estimates are based on a private room. Nationally, the median annual cost for a private room in a nursing home is \$91,250. See Pennsylvania Health Care Association, “Long-Term Care Trends and Statistics,” accessed at www.phca.org.

⁸⁴ CMS issued a total of 47 civil monetary fines, 26 in 2014 and 21 in 2015.

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solely at CMS' discretion, not DoH's. CMS has granted DoH the authority to mandate "directed in-service training"—which is a federal sanction—to correct deficient conditions in nursing homes. For less serious deficiencies, DoH prefers to pursue this option rather than civil monetary penalties, which explains the lower state fines issued during the audit period

DoH possesses considerable professional and administrative discretion in how and when it imposes a sanction against a nursing home. Generally, DoH imposes sanctions when it finds that a deficiency resulted in "actual harm" to a resident or residents. We tested DoH's adherence to its policies and procedures when it imposed a sanction, and we found DoH appropriately followed those policies and procedures.

In seven selected cases, we tested the reasonableness of DoH's discretion when it chose *not* to impose a sanction. Our results found that DoH failed to document its decision-making process when it chose not to impose a sanction. Without documentation, we could not determine the reasonableness of DoH's decision to not issue sanctions in these seven cases. Proper documentation is necessary to allow management to ensure that the decision to not impose a sanction was appropriate and consistent with practices across DoH regions.

Finally, we tested the reasonableness of DoH's scope and severity rankings for certain deficiencies where we thought a higher ranking might have been warranted—and by extension—a sanction imposed. After DoH provided certain clinical clarifications and provided us with additional documentation, we were able to concur with DoH's conclusions in these cases.

Finding 3.1

DoH has issued very few monetary fines, and state fine amounts are lower than amounts in other states we reviewed.

DoH has several options available to it when facilities fail to meet regulatory standards. Pennsylvania's Health Care Facilities Act (HCFA)⁸⁵ provides DoH the authority to assess a fine – a "civil monetary penalty" (CMP) of up to \$500 for each deficiency and for

⁸⁵ 35 P.S. §§ 448.101 – 448.904 at §448.817

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each day the deficiency continues.⁸⁶ DoH may also issue provisional licenses, which carry higher licensing fees and require additional surveys (inspections) by DoH. Ultimately, in the most egregious cases, DoH may use its most severe sanction, license revocation, to close the facility.⁸⁷

DoH has an internal policy⁸⁸ for the imposition of sanctions, including decision-making guidelines for CMPs to supplement its staff's professional judgement. Under the guidelines, the \$500-per-deficiency level is for violations that have a direct impact on resident health and safety, such as for a death that was avoidable. Repeat deficiencies of a serious nature, such as failing to meet residents' needs for incontinence care, may be assessed at between \$100 and \$500 per deficiency for every day that each deficiency continues.

For violations of federal regulations, DoH recommends federal CMPs, but CMS has the final say in whether to impose the fine and in what amount. Federal CMPs are complex but may be issued on a "per day" or "per instance" level.⁸⁹ Dollar amounts vary depending on the circumstances but are substantially more than state fines. A per day federal CMP can range from \$50 to \$5,050 per day. A per instance federal CMP can range from \$1,200 to \$5,500. However, both of these amounts can be increased over the base amounts, if aggravating circumstances are present.⁹⁰

CMS may also deny the facility Medicare reimbursements for services it provided to residents.⁹¹ CMS does allow DoH to impose "directed in-service training" without obtaining its prior approval. According to DoH management, directed in-service training is generally more effective than a fine. To that point, DoH management noted the following:

The facility must pay an outside consultant to educate their staff regarding the deficient practice. We feel that

⁸⁶ According to DoH, Section 817 of the Health Care Facilities Act of 1979 (HCFA), permits DoH to assess a civil penalty "of up to \$500 for each deficiency for each day that each deficiency continues." Thus, the HCFA, like the federal rules, permits DoH to impose a per instance or per day civil penalty.

⁸⁷ As discussed later, under the Health Care Facilities Act of 1979, DoH can impose temporary management or ban new admissions.

⁸⁸ DDCF-401 Imposition of Sanctions for Noncompliance – Nursing Homes (Civil Money Penalties and Provisional Licenses)

⁸⁹ To help calculate federal CMPs, CMS requires state survey agencies to use its Civil Money Penalty Analytic Tool. DoH has incorporated this tool into the policy and procedures it uses when ordering federal sanctions.

⁹⁰ These conditions include, repeat deficiencies, historical non-compliance, substandard quality of care, and culpability (e.g., neglect, indifference, and disregard for resident care).

⁹¹ CMS actions are based on DoH's recommendations.

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education is very important and generally is effective when attempting to fix deficient practice, and [staff training] benefits the residents more than a fine.

While we understand DoH's preference for in-service training over civil monetary penalties, we note that during our audit period, just 30 directed in-service trainings were ordered; yet, 9,189 federal deficiencies were cited for Pennsylvania-based nursing facilities.

During our audit period (January 1, 2014, through October 31, 2015) DoH issued \$172,350 in state civil monetary fines. There was a significant increase in monetary sanctions in 2015. In fact, in the first 10 months of 2015, there was a 91 percent increase in the number of fines issued, which equaled a 78 percent increase in the dollar amount of fines issued compared to all of 2014.⁹² Still, this amount is minimal compared to the \$2,063,941 in federal fines that were issued during the same period.⁹³

In explaining this difference, DoH management said the agency historically has chosen not to impose a per-day state monetary penalty in addition to the federal sanction due to the likely significant financial burden of the federal sanction. DoH management reiterated that its goal when imposing a civil penalty is to identify and sanction deficient practices without jeopardizing the facility's ability to improve resident care, comfort and safety.

Pennsylvania's civil monetary penalty levels should be reviewed.

We agree that some states do not impose state-level monetary penalties for non-compliance; however, as we found from our research, some states also have significantly higher state penalties than Pennsylvania. As shown in the exhibit below, we compared Pennsylvania's CMPs to select other states and found that Pennsylvania's maximum fines were the lowest of those states selected for review.⁹⁴

⁹² DoH issued 11 state civil monetary fines totaling \$62,000 during 2014. For the period January 1, 2015, through October 31, 2015, DoH issued 21 fines totaling \$110,350.

⁹³ CMS issued 26 civil monetary fines in 2014 totaling \$1,525,651. For the period January 1, 2015, through October 31, 2015, CMS issued 21 fines totaling \$538,290. DoH noted that CMS fines generally take longer to process than state fines, so additional federal fines may have been issued that are not yet reflected in the 2015 totals.

⁹⁴ Selected states have the largest numbers of nursing homes and nursing home residents nationally, and/or border Pennsylvania.

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PA Civil Monetary Penalties Compared to Select Other States

State	Maximum state CMP	Circumstances
Pennsylvania	\$500 per day	
New York	\$10,000	Repeat violation within 12 months and serious physical harm or death
California	\$100,000	Violation was a direct, proximate cause of death
New Jersey	\$5,000 per day	n/a
Maryland	\$10,000 per day	On-going pattern, serious and immediate threat
Florida	\$15,000, may be doubled	Serious injury, harm, impairment, or death
Texas	\$10,000 per day State law also provides for administrative penalties.	n/a
Ohio	No state-only penalties. Only recommends CMPs to CMS.	n/a
Illinois	\$25,000, may be doubled.	A violation of the same provision 3 or more times in the previous 12 months or willful misstatements of fact.

Source: Developed by Department of the Auditor General staff from review of selected other state statutes and regulations.

Our research also found that some states' laws codify tiers into their CMPs. For example, California fines range from \$100 to \$1,000 for Class B, \$2,000 to \$20,000 for Class A and \$25,000 to \$100,000 for Class AA. The citation class and amount of the fine depend upon the significance and severity of the substantiated violation.

In yet another example, Florida, for the most serious, or class I, violations of law, CMPs range from \$10,000 for an isolated deficiency, to \$12,500 for a patterned deficiency, and \$15,000 for a widespread deficiency. The fine amount is doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection.

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Not only do some other states have higher CMPs than Pennsylvania, many assess those fines more frequently. During 2014 and 2015, DoH assessed 32 CMPs totaling \$172,350. During the same period, New York assessed 38 CMPs totaling \$398,000. Further, in just the fourth quarter of 2015 alone, Illinois fined nursing homes 48 times totaling \$441,400.

DoH management reiterated to us that civil monetary penalties are merely one type of sanction to bring about regulatory compliance. In explaining these distinctions, DoH management said that DoH exercises its administrative discretion using the facts of the particular situation, and similar prior situations, to make the final determination.

We agree that DoH has administrative discretion in determining sanctions. However, DoH has no administrative discretion as to the actual imposition of federal civil monetary penalties.

Finding 3.2**DoH adhered to its policies and procedures when ordering sanctions against nursing homes.**

The decision to pursue a sanction against a nursing home begins in the field after the survey team identifies and documents a deficient practice. If the team agrees that sanctions are warranted, it prepares an “initial alert” and prepares an adverse action document for processing through DoH’s central office.

After these documents are prepared, the central office continues processing the sanction by reviewing it for consistency and comparing the proposed action to cases where DoH took similar action. Prior to recommending sanctions, each level of review is to consider the following:

- § Most current deficiency report (CMS-2567).
- § Threat or potential threat to resident health and safety.
- § The number of residents at risk or affected by the noncompliance.
- § The facility’s plan of correction.
- § Similar survey findings where sanctions were imposed.
- § Repeat noncompliance in the same or similar regulatory categories.

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After all factors have been considered, an order is prepared which the director signs and sends via certified mail to the nursing home facility's administrator and the facility owner.⁹⁵ A facility has 30 days to appeal the sanction. Appeals are reviewed and either approved or denied by the Commonwealth's Health Policy Board.

During our audit period, DoH issued 47 state sanctions. These sanctions included both civil monetary penalties and/or provisional licenses. Among our selection of 42 nursing homes, DoH ordered 10 sanctions to six of the 42 nursing homes in our selection.⁹⁶ We tested all ten of these sanctions for compliance with DoH's internal policy, including appropriate approvals. As a means of checking the timeliness by which DoH was issuing sanctions, we calculated the number of days from when DoH completed the initial survey to when it issued the sanction order. We also checked to see if DoH had conducted an appropriate on-site follow-up survey for the previously cited deficiencies.

From our review, we noted the following:

- § ***DoH appears to be following its sanction policy.*** All ten sanctions complied with DoH's sanction policy, including a detailed description of the facts surrounding the case, all required supervisory reviews were present, and appropriate comparative examples were documented to justify DoH's decision to make a sanction.
- § ***Sanctions were generally processed in a timely manner.*** DoH's goal is to issue orders within 35 days of the survey's exit date. We found in our selection that the average number of days was 34 days; however, DoH exceeded its 35-day goal in four of the 10 sanction processes we reviewed. The longest sanction processing timeframe was 39 days (exceeding the practice by 4 days), while the shortest was 28 days (bettering the practice by 7 days).
- § ***DoH conducted follow-up surveys.*** After a deficiency is cited, the facility must complete a "Plan of Correction" to bring itself back into regulatory compliance. The deficiencies that were

⁹⁵ The review process includes approvals from the respective DoH field office supervisor, central office program personnel, the assistant director, director, and DoH's legal office.

⁹⁶ Refer to Appendix A – *Objectives, Scope, and Methodology* for more information on our selection of 42 nursing homes.

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sanctioned in our review involved:⁹⁷ failure to provide care/services for the highest well-being (5); failure to maintain an area free of accident hazards (5); failure to provide treatment to prevent pressure ulcers (2); and failure to provide services in accordance with a care plan (1). In all instances, DoH conducted on-site follow-up surveys to ensure deficiencies had been corrected.

Finding 3.3**When DoH chooses not to sanction a facility for a deficient practice, it does not document its decision-making, even when resident harm has occurred.**

Deficiencies (also referred to as “tags”) are ranked on an alphabetical matrix (A-L) that factors scope (i.e., the prevalence of residents impacted) and the severity (i.e., the harm caused to residents).⁹⁸ Not all deficiencies cited by DoH result in a sanction. There are six scope and severity rankings where federal sanctions may apply: G, H, I, J, K, and L.

A deficiency that is ranked at “G” means that the deficient practice was isolated to the fewest residents, staff, or occurrences, and which caused actual harm to the resident’s ability to achieve his/her highest functional status, but which did not constitute immediate jeopardy.⁹⁹ Deficiencies ranked as a J, K, or L are the most serious deficiencies, meaning that resident(s) were in immediate jeopardy of harm.

During our audit period, DoH reported 9,189 federal deficiencies at nursing homes.¹⁰⁰ Of these deficiencies, 259 (or approximately 3 percent of the total) were ranked at G or higher.¹⁰¹ Knowing that DoH issued only 47 state sanctions during our audit period, as discussed in the sections that follow, we tested DoH’s data to see why more sanctions had not been ordered in these cases.

⁹⁷ Some facilities had multiple deficiencies for which it was sanctioned. The numbers in parenthesis are the numbers of the applicable type of sanction.

⁹⁸ Refer to the *Introduction and Background* section for more information on this topic.

⁹⁹ H or I ranked deficiencies would mean that more residents, staff, or occurrences were impacted.

¹⁰⁰ This number does not include deficiencies of state regulations, which do not receive a scope and severity rating.

¹⁰¹ When we refer to a deficiency as being ranked higher, we mean that the deficiency falls higher on the alphabetical scope and severity matrix (i.e., H, I, J, K, or L) and was therefore a more pervasive or harmful deficiency.

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Lack of documentation for sanctions not imposed.

From our previously selected 42 test facilities, we identified 24 tags that were ranked at G and for which DoH did not issue a sanction for the deficiency. We selected seven of these 24 tags for detailed testing¹⁰² and requested documentation to substantiate DoH's decisions. However, DoH did not provide this documentation, acknowledging that it does not document its decision-making when it chooses not to sanction facilities. Going forward, DoH management stated that they will review their policy and consider how to add such documentation to its current processes.

While DoH management did provide after-the-fact explanations to our inquiries as to why sanctions were not issued for the seven deficiencies we selected, we could not validate these explanations.

Maintaining documentation to support management decisions is a critical element of effective program administration. In particular, having this information allows central office personnel to ensure that decision making (when not issuing sanctions) is done appropriately, as well as consistently, across DoH field offices.

Test results of cases where sanctions could have been applied if DoH had ranked the deficiency higher.

We also tested DoH's ranking of certain deficiencies to determine if it was "under-ranking" the scope and severity of deficiencies, and therefore, failing to consider sanctions. To accomplish this test, we focused on facilities that had been cited for deficiencies related to the care and/or prevention of pressure sores.¹⁰³ We focused on this particular standard because pressure sores should be preventable, and if a resident developed sores (or the already present sores worsened) while a resident of the facility, that may be a clear indication of actual harm to a resident—and by extension—a situation where DoH could have issued a sanction.

Federal regulations require that a resident who enters without pressure sores does not develop sores unless the individual's clinical condition

¹⁰² These seven tags applied to four distinct facilities. Our selection process was haphazard.

¹⁰³ Pressure sores, also known as pressure ulcers, or bed sores, result from remaining in one position for extended periods. Over time, blood flow is reduced to the skin and the skin begins to breakdown from the pressure. Pressure sores can be slow to heal and can become infected, which can cause complications to already frail patients.

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demonstrates that they were unavoidable.¹⁰⁴ Further, a resident having pressure sores must receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.¹⁰⁵ Deficiencies related to this standard fall under tag F314.

The 42 nursing homes in our selection had 21 F314 tags, which were ranked at a level “D,” and one deficiency that was ranked at “E.” On the federal scope and severity matrix, these rankings meant that “no actual harm” occurred to the resident(s).

We reviewed the “statement of deficiencies (CMS 2567)” for each of these 21 cases, and then using our judgment, we selected seven “D” level tags and the one “E” level deficiency for further review. In selecting these cases, our judgment included identifying cases where we believe the circumstances of the case may have warranted a higher severity ranking.

We then asked DoH to provide documentation to explain why the selected tags did not have a higher severity ratings. In its response, DoH provided detailed explanations of each finding, along with references to the CMS guidance on Deficiency Categorization¹⁰⁶, and a copy of a recent mandatory training program DoH conducted for its surveyors. Based on this information as well as additional information requested and received, we believe that DoH was reasonably justified not ranking the deficiencies more severely.

Issue Area Recommendations

We recommend that DoH:

1. Work with the General Assembly to amend the Health Care Facilities Act of 1979 to provide more stringent civil monetary penalties.
2. Update its policies and procedures related to sanctions, to include a requirement that decision-making, including supervisory review, is documented when survey teams decide not to impose sanctions but

¹⁰⁴ CMS, *State Operations Manual, Appendix PP Guidance to Surveyors for Long-Term Care Facilities* §483.25(c) Pressure Sores.

¹⁰⁵ Ibid.

¹⁰⁶ CMS, *State Operations Manual, Appendix P, Survey Protocol for Long-Term Care Facilities*.

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could have done so when a deficiency is cited which caused actual harm (scope/severity ranked G or above).

3. Document how all sanctions-related decisions are made, including the levels of supervisory and managerial review and approval.

PA Department of Health**Update to
Prior Audit
Findings****Introduction**

This audit is our fourth performance audit of the Department of Health (DoH) and its regulation of nursing homes. Our first audit was nearly 20 years ago, and since that time significant improvements have occurred. Our initial audit found such alarming conditions that we took the unique action of initiating an immediate follow-up audit to ensure DoH was working on our recommendations to safeguard nursing home residents.

Our follow-up audit report found that DoH's late responses to complaints and its inability to track trends in poor performance were statewide, systemic problems that demanded action from the governor and legislature. The state responded with an investment of \$1.4 million in additional staff, training, and technology.

Two years later, in October 2000, we returned and found DoH had made significant improvements in handling complaints, though the agency had not implemented all of our recommendations.

Listed below are the highlights of our previous audits as they pertain to our current audit objectives. Overall, DoH has implemented our most significant audit recommendations. The matter of developing a "nursing home report card" continues to be an unresolved issue, although we note the federal government has taken some action on this matter through its "nursing home compare" initiative.

***The Oversight of Nursing Home Care in Pennsylvania:
Residents in Jeopardy, March 1998.***

Our first performance audit covered the period July 1, 1993, through September 30, 1997. Our auditors found conditions as follows:

- § In one of the eight DoH field offices, investigators responded late nearly 70 percent of the time to "immediate jeopardy" complaints.
- § DoH had no system to receive and record complaints after normal business hours.

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§ At least three of DoH's field offices had no written procedures to address complaints of a life-threatening nature.

We also reported that in cases where its investigators found deficiencies at nursing homes, DoH was not aggressively imposing sanctions. In fact, the number of sanctions consistently decreased during the three years ended December 31, 1996, while the number of nursing homes was steadily increasing. Further, the consistency of DoH's sanction procedures could not be determined because the decision-making process was not documented.

Our March 1998 nursing home performance audit report also included our initial call for a consumer guide, or report card, to provide Pennsylvanians with easy-to-understand information necessary for them to make decisions about placement of their loved ones in nursing homes.

Residents Still in Jeopardy, April 1998.

Given the gravity of our initial findings, we conducted a follow-up audit to investigate whether DoH was taking corrective actions to ensure that quality care was being provided to nursing home residents.

Ultimately, our follow-up procedures further underscored the major issues raised in the initial audit: DoH was still late in investigating complaints and its oversight did not provide nursing home residents the protections they needed.

As a result of information from our audits and a concurrent state Office of Comptroller Operation's audit, the governor and legislature increased DoH's budget by \$1.4 million to enhance its use of technology, to provide additional training for complaint investigators, and to increase the number of investigative staff.

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

A third performance audit of DoH's oversight of nursing homes, released on October 6, 2000, found the investments and renewed

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commitment by the agency had paid dividends. By the time that audit was released, we found that DoH had made significant improvements in its system of responding to complaints and had implemented many of our recommendations from the prior audits, including the following:

- § Improved complaint intake procedures.
- § DoH was much timelier in opening complaint investigations, and it was “on site” more frequently than it had been in 1998.
- § A complaint tracking system was created that enabled timely reviews and analyses to identify poor performing nursing homes, showed trends in complaints and provided comparisons of facilities.
- § In February 1998, about a month before we released our first audit findings, DoH implemented a new policy for the imposition and administration of sanctions.

Accordingly, our 2000 performance audit report centered on four areas as follows:

1. DoH’s complaint system.
2. Sanctions.
3. Intergovernmental cooperation.
4. Nursing home report cards.

Our 2000 audit report included few specific recommendations, but rather made conclusions about DoH’s performance. As discussed in the sections below, we found that DoH continued to improve in some of these areas, but in other areas, improvement was still needed.

Current Status of Previously Identified Issues

Complaints

Prior status. In 2000, we concluded that DoH had substantially improved its complaint investigation procedures, including improvement in how it received and investigated complaints, and that it was much timelier in responding to complaints on-site.

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Current status. Our current report found that while DoH responds to complaints it receives, improvements are needed (see *Issue Area Two*). We noted the following issues:

- Ø ***Anonymous complaints rejected.*** DoH rejected complaints from anonymous sources. This action likely compromised DoH's ability to receive and investigate all complaint allegations. DoH has since rescinded this policy, and now accepts anonymous complaints.
- Ø ***Complaint timeliness.*** We also found that DoH had broad definitions for when it initiated complaint investigations, which made it look as if its performance was timelier than it actually was.
- Ø ***Complaint prioritization.*** Although we previously found that DoH had simplified its complaint prioritization categories to include just "Priority" and "General" complaint types, the downside of this simplification was that when DoH reports complaint data to CMS, it recodes the prioritization *after* the complaint has been investigated, instead of on intake. We recommend DoH use CMS' prioritization categories on complaint intake.
- Ø ***Communication and documentation improvements needed.*** We found that DoH could improve its communications with complainants. More importantly, we found that DoH needs to improve how it documents complaint investigation results, so that management and outside reviewers are able to clearly understand what actions were taken to ensure complaints were investigated and resolved appropriately.

Sanctions

Prior status. Our 2000 report concluded that DoH issued sanctions inconsistently (and in some cases not at all). On a positive note, DoH did adhere to its new sanction policy when it decided to pursue sanctions, including civil monetary penalties.

Current status. DoH continues to have considerable administrative discretion in how it decides to pursue sanctions. For example, while federal and state remedies are available, DoH

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has a preference for “educating” facilities rather than issuing fines. During our current audit, we again reviewed DoH sanctions against nursing homes and found improvement in how it ensures consistency when issuing civil monetary penalties. Specifically, when DoH pursues sanctions, DoH uses an “adverse action” worksheet in which it cites examples of previous sanctions as criteria for its decision-making.

Our audit also uncovered new concerns including the following (see *Issue Area Three*):

- Ø ***State penalties lower than federal penalties.*** During our audit period, we found that there were very few state civil monetary civil penalties issued (\$172,350), compared to federal fines levied (\$2,063,941). This occurrence is due to the lower financial penalties outlined within the Commonwealth’s Health Care Facilities Act of 1979. We recommend that DoH work with the General Assembly to amend this law to increase the penalties that DoH can pursue under state law.
- Ø ***Not all decision-making is documented.*** We found that DoH did a good job in documenting its actions when it chose to pursue sanctions, but when it did not pursue sanctions, but it could have done so because of the severity of the deficiency, DoH did not document its decision making. This omission makes it difficult for DoH management to perform quality assurance reviews to ensure that actions **not** to pursue a sanction are done so appropriately and consistently.

Intergovernmental cooperation

Prior status. Our 2000 audit concluded that DoH and the Department of Aging shared information in instances where appropriate, but there was little documentation to record those instances.

Current status. Coordination between the Department of Aging and DoH was not an objective of our current audit. Nonetheless, we did reach out to the Department of Aging’s director for the long-term care

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ombudsmen program¹⁰⁷; however, because of the newness of the director to her position, she was unable to comment about interagency cooperation with DoH during the audit period. In our reviews of nursing homes annual surveys, we noted that DoH included documentation of when it contacted Aging's local long term care ombudsman, and the ombudsmen were invited to meet with the survey team about any concerns they may have about certain residents or the facility itself. These concerns were documented on DoH's "presurvey planning worksheet."

Regarding interagency cooperation, we found DoH could improve by working with the Department of Labor and Industry (L&I) on complaints L&I receives about mandated overtime at nursing homes.¹⁰⁸ DoH representatives said they were aware of the law but did not coordinate with L&I on these issues (see *Finding 1.5*). Consequently, DoH did not use this potential warning sign of poor facility staffing as a means of proactively looking for violations at facilities it regulates. To give DoH its due credit, when informed of this potential for collaboration, DoH management indicated that they immediately began a dialogue with L&I representatives to be better informed of mandated staffing violations at nursing homes.

Nursing home report cards

Prior status. Our 2000 audit report included a call for DoH to develop a comprehensive, user-friendly nursing home "report card" to help consumers make informed choices about nursing home care. Our report noted that DoH had made important information available on its website, including:

- § Nursing home state inspection reports.
- § Links to federal websites that provide nursing home comparisons and measures of quality.
- § Staffing ratios.
- § A directory of Pennsylvania nursing homes.

¹⁰⁷ Pennsylvania Ombudsmen are federally mandated to advocate and give voice to older consumers of long-term care services, whether delivered in the community or a facility-based setting.

¹⁰⁸ 43 P.S. 932.1 - 932.6 *et seq.* (Act 102 of 2008), the "Prohibition of Excessive Overtime in Healthcare Act" prohibits health care employers from routinely scheduling and requiring overtime. More specific to this audit, Act 102 of 2008 prohibits nursing homes from requiring its nursing staffing to work mandated overtime.

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Current status. Despite the progress, we found in our current audit that information DoH presents may be difficult for some users to find, is overly technical, and users will be on their own when attempting to put the information together in a way that makes it meaningful to their decision-making process.

Over the years following our last audit, DoH has broadened the information available on its website. More of the 29 items we originally recommended for a nursing home report card are now present. However, other items, such as a clear identification of the owner, administrator, and management company, are not readily apparent.

Since our last audit, CMS has created a 5-star rating system where consumers are able to compare nursing homes. A key feature of the system is that it provides a measure for overall ratings and for useful categories, such as staffing and quality. However, as we reported in *Issue Area 1*, the staffing information is entirely self-reported, and as such, may not be reliable. CMS has also instituted a “Nursing Home Compare” web site,¹⁰⁹ which offers a broader set of comparative information about nursing homes, although this information only pertains to facilities that participate in Medicare/Medicaid.

DoH has greatly improved the amount of information it presents on its web site and now provides helpful information for consumers who may need a nursing home. For example, users can search for facilities within a specified area of their zip code and then compare the results by the cited deficiencies.¹¹⁰ While these improvements are helpful, we believe DoH could better organize the data into meaningful rating categories, like a report card. Further, if DoH developed a “digital dashboard”¹¹¹ it would then be able to present consumers with improved search options that would allow them to pinpoint specific areas of interest. DoH indicated that it is interested in pursuing these options, but to date it has been limited by budgetary constraints.

¹⁰⁹ www.medicare.gov/nursinghomecompare

¹¹⁰ Initially when we tried to use this feature, we found search results to be inaccurate. For example, on July 5, 2016, when querying the system for facilities within the Harrisburg area, our search query returned facilities located in Pittsburgh. DoH management explained this error as likely being caused from web links that were incorrectly directed to an old computer server. DoH has since corrected those links.

¹¹¹ A digital dashboard is an executive information system available for computers that offers a set of customizable windows and data portals. It allows users to filter and customize the presentation of large amounts of data specific to their interests or tasks. See also, <http://www.businessdictionary.com/definition/digitaldashboard>.

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Recommendations



We recommend that DoH:

1. Update its web site to supplement data available on CMS's nursing home compare web site.
2. Organize and benchmark nursing home performance into a report card that would allow consumers to evaluate Pennsylvania-based nursing home performance.

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Agency Response and Auditor Conclusion



Prior to this audit report's release, we provided a draft copy of our audit report to DOH for its review. On the following pages, we present DOH's response to that draft report in its entirety. Our conclusion follows DOH's response.

PA Department of Health



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

July 11, 2016

The Honorable Eugene DePasquale
Auditor General
Commonwealth of Pennsylvania
Department of Auditor General
Finance Building, Room 229
Harrisburg, PA 17120

**RE: Performance Audit – Department of Health Regulation of
Nursing Care Facilities**

Dear Auditor General DePasquale,

Thank you for the opportunity to review the audit report. As you know, in addition to the audit, the Pennsylvania Department of Health (PADOH) has taken several steps to improve regulatory oversight of long term care facilities. They include:

- Convening a panel of national and state experts on nursing home quality. The taskforce will be completing their report later this summer.
- Initiating the receipt of anonymous complaints.
- Increasing the number of staff responsible for investigating nursing home complaints.
- Installing a new telephone system for complaint intake with multiple lines to increase caller access to a person rather than voice mail.
- Relocating the nursing home complaint intake form to be immediately visible and directly accessible from the department's home page.
- Increasing enforcement of regulatory sanctions. For example, the department issued more than twice the number of provisional licenses (19) in 2015 than were issued in 2014 (9). Likewise, the number of civil monetary penalties issued increased by 191% in 2015 (32) over 2014 (11). Current year trends indicate that the numbers of 2016 actions will meet or exceed 2015 numbers.
- Soliciting feedback on current nursing home regulations from all long term care facilities.

Overall, we believe the recommendations in the draft report are sound and provide useful guidance and support for current and future quality improvement activities.

We offer the following comments to the draft report for your consideration.

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Issue Area 1: PADOH's failure to sufficiently review nurse staffing levels within long-term care facilities may be affecting residents' quality of care and quality of life.

Current state licensure regulations establish a minimum requirement that each nursing home resident receive 2.7 hours of direct nursing care per day. PADOH acknowledges inconsistent practice with regard to surveyor evaluation of facility compliance with this regulation, as noted in [Finding 1.1](#). Effective April 4, 2016, PADOH established and implemented a policy for assessment of facility nurse staffing consistent with the recommendation offered in this report.

[Finding 1.2](#) notes four instances in which facilities were not in compliance with the staffing standards, but were not cited for this deficiency. PADOH's review of these cases found that the lack of citation was due to the use of a projection method for calculating nursing care hours, rather than actual staffing numbers, which is no longer permitted by PADOH policy. The department concurs with the audit finding that one such facility should have been cited but was not.

[Finding 1.3](#) notes that facilities were cited for non-compliance with staffing requirements in only 0.2% of surveys. This rate is calculated using all surveys during the audit period as the denominator. The PADOH suggests that this conclusion is not valid because the total number of surveys (denominator) includes many in which examination of staffing hours would not be appropriate or required. For example, a survey in response to a complaint about water temperature would provide no reason for a surveyor to calculate staffing hours. The PADOH further offers clarification that the absence of a citation for inadequate staffing does not mean that the facility was not cited for failure to provide adequate care.

The PADOH accepts all recommendations offered regarding this issue, and either has already initiated actions to comply or will do so.

Issue Area 2: Poorly written revisions to PADOH's policies and procedures may have compromised the department's ability to receive, respond to, and resolve complaints adequately.

[Finding 2.1](#) notes that the PADOH's former policy of not permitting anonymous complaints limited the ability to know about and adequately respond to potential nursing home violations. In actual practice, PADOH did not reject all complaints if a complainant refused to provide his/her name. If, during the intake process, the complainant made statements suggesting a deficient practice, but did not want to be personally identified, the complaint was processed using a different name. As noted in the report, the reversal of this policy to once again permit anonymous complaints was one of several factors that PADOH believes to have contributed to the 63% increase in nursing home complaints over the past year.

[Findings 2.2 and 2.3](#) address timeline guidelines for initiating and completing a complaint investigation and the related matter of prioritization of complaints which dictates the urgency for addressing each complaint. From the PADOH's perspective, initiation of a complaint is not synonymous with being on site at the facility; rather PADOH considers initiation of the complaint to include the very important preliminary steps that are critical for conducting a

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thorough investigation. These are the data and information gathering specific to the complaint, review of facility history and current files, and communications with other involved agencies. After reviewing the 17 cases cited by the audit report for taking more than 10 working days for initiation of an on-site survey. The PADOH confirms that 15 of the cases were actually onsite, of which nine exceeded the 10 business day timeframe, and all of these met the CMS priority code of "Non-IJ Medium" which CMS defines as "No timeframe specified but an onsite survey must be scheduled."

Finding 2.4 notes instances of the PADOH's failure to meet one or more of the CMS performance categories for communications with complainants. Although CMS considers these five categories as guidance but not requirements for measuring the adequacy of communications, the department will continue to use these categories for reference in our current process for reviewing and improving the clarity and detail of our standard communications related to complaints and survey findings.

Finding 2.4 also points out that survey documentation addresses findings of deficiencies, but does not document survey findings when there are no deficiencies. The PADOH conducts surveys according to a process required by CMS, using surveyors who are trained in survey techniques by CMS and meet CMS certification requirements. Survey staff and supervisors are accountable for appropriate conduct of all surveys, based on CMS survey protocol, including findings of "no deficiency." The PADOH will further discuss this audit finding with CMS.

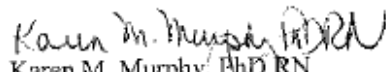
The department will take all recommendations offered in this section under consideration to assure that the complaint investigation process is as thorough, timely and effective as possible. We have been accepting anonymous complaints for a year and intend to continue this policy, and we will complete current revisions to communications to assure that they are written with sufficient detail to clearly explain the complaint investigation process and to support the conclusion that a complaint was either substantiated or unsubstantiated.

Issue Area 3: PADOH has considerable discretion in pursuing sanctions against facilities that fail to meet regulatory standards, but rarely imposes penalties under state rules.

The PADOH concurs with all three findings and will determine the most effective way to enact the recommendations offered for this issue area.

In closing, I want to express my sincere thanks for the time and effort you and your staff invested in responding to my audit request. The Department of Health views the audit findings and recommendations as valuable and important to our efforts to ensure that we use best practices in regulating nursing care facilities, ultimately to promote the highest quality in care and services for nursing home residents.

Sincerely,


Karen M. Murphy, PhD RN
Secretary of Health

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Auditor Conclusion to the Department of Health's Response

Overall, the department concurs with the findings and recommendations, and we are pleased that the department has already started to initiate many of our recommendations. In this regard, the department's management should be commended for proactively taking action to correct the issues we have identified. Nonetheless, the department's response raises two issues that require further commentary from us:

Finding 1.3

DoH notes that our comparison of staffing-related cited deficiencies to the total number of surveys completed is not valid because not all surveys would have required a staffing level review. In our estimation, DoH's reasoning falls short for this reason: regardless of the basis for a DoH survey, a surveyor is still reviewing some aspect of the nursing home's operations—and while doing so—that surveyor may very well witness and document other deficiencies. The logic behind DoH's argument underscores the point we raise in the finding, which is that DoH needs to be looking at nursing home compliance more systematically and not just myopically addressing complaint issues as they “pop-up.”

For instance, using DoH's example that “a complaint about water temperature would provide no reason for a surveyor to calculate staffing hours,” we would hope that while investigating that specific complaint, DoH's surveyors would not just ignore other conditions occurring at the facility. For example, perhaps the surveyor observes that call bells are repeatedly ignored, or that staffing information has not been appropriately posted, or maybe the complaint of water temperature is really the result of staff not being able to tend to the residents' needs (i.e., because it lacks the staff). All of these occurrences are events that should necessitate DoH taking a closer look at the staffing conditions to see if there is an underlying problem. DoH has the authority to conduct these staffing-level reviews anytime, and it should begin to do so more frequently and consistently.

DoH acknowledges it lacked policies and procedures addressing staffing-level reviews, which caused such reviews to be conducted inconsistently (when they were conducted). Consequently, DoH does not know the number of times a review *should* have been completed, but was not. In the end, we conclude that our analysis is correct for presenting a contextual reference for the lack of appropriately completed facility staffing-level reviews.

Finding 2.2 and 2.3

DoH reiterates its perspective that initiating a complaint response is not the same as being on-site at the facility—that there are preliminary steps needed to conduct a thorough investigation before a surveyor is on-site. As we discussed in the finding, there are “definitional” matters at play with

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this issue. In summary, we do not dispute that DoH's preliminary steps are necessary; however, we do dispute DoH claiming that this activity is equivalent to starting an on-site investigation. Only actually being at the facility (when required) should qualify as initiating an on-site survey. This point is clearly defined by CMS: "the initiation of these type of investigations is generally defined as the state agency beginning an on-site survey."

Additionally, with respect to DoH's review of the cases we selected and its assertion that all cases met the CMS priority code of Non-IJ medium, and thus, no specific timeframe was necessary, we again reiterate our position about after-the-fact complaint prioritization. DoH's process of waiting to see how long it takes to complete an investigation—and then assigning a prioritization which matches that time—does little to effectively gauge compliance with CMS timelines. The purpose of proper complaint prioritization is to triage complaints; thereby, those that are the most serious are responded to in the timeliest manner. As it stands now, better than 99 percent of the time, DoH prioritizes complaints as "general," which forces DoH to meet self-imposed deadlines that may not otherwise be necessary. Consequently, on the one hand, DoH's goal of trying to exceed CMS response timeframes *is* noteworthy—however, on the opposite hand—DoH has struggled to meet these self-imposed deadlines, so it has resorted to less than noteworthy modifications to its policies and procedures, such as rejecting complaints from anonymous sources and manipulating the number of days to complete investigations.

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Appendix A

Objectives, Scope, and Methodology

The Department of the Auditor General conducted this special performance audit in order to provide an independent assessment of the Pennsylvania Department of Health (DoH) and its regulatory oversight of nursing homes.

We conducted this audit in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.¹¹² 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.

Objectives

Our audit objectives were as follows:

1. Determine the adequacy by which the DoH ensures that nursing homes meet acceptable living conditions for its residents, including a good balance of quality of life and quality of care. *[Issue Area One.]*
2. Determine the adequacy by which DoH receives, responds, and timely resolves complaints involving nursing homes. *[Issue Area Two.]*
3. Determine whether DoH is consistently imposing sanctions on nursing homes in accordance with appropriate laws and regulations. *[Issue Area Three.]*

Scope

Unless otherwise stated, our audit covered the period January 1, 2014, through October 31, 2015, with updates as necessary through the report's release.

¹¹² *Government Auditing Standards*, December 2011 revision, issued by the Comptroller General of the United States, United States Government Accountability Office, Washington D.C.

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DoH management is responsible for establishing and maintaining effective internal controls to provide reasonable assurance that the department is in compliance with applicable laws, regulations, contracts, grant agreements, and administrative policies and procedures.

In conducting our audit, we obtained an understanding of relevant internal controls, including any information systems controls, if necessary, and that we considered to be significant within the context of our audit objectives.

For those internal controls that we determined to be significant within the context of our audit objectives, we also assessed the effectiveness of the design and implementation of those controls as discussed in the methodology section that follows. Any deficiencies in internal controls that were identified during the conduct of our audit—and determined to be significant within the context of our audit objectives—are included in this report.

Methodology

To address our audit objectives, we performed audit procedures as follows:

- Conducted interviews of DoH management and staff responsible for administering areas related to our audit objectives.
- Obtained complement information for DoH's Division of Nursing Care Facilities.
- Obtained and reviewed documents from the Centers for Medicare and Medicaid Services (CMS) that compared and reviewed DoH's performance in conducting annual recertification surveys. Our review included 47 Federal Oversight and Support Surveys (FOSS), and 8 Comparative Reports.
- Interviewed representatives from the CMS to discuss their reviews of DoH performance in overseeing nursing homes.

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- Obtained and reviewed applicable state laws and regulations to determine DoH's responsibilities as related to our audit objectives, including specific provisions from the following:
 - Ø Health Care Facilities Act of 1979.
 - Ø The Pennsylvania Code – Title 28 – Health and Safety.

- Obtained and reviewed federal laws and regulations administered by CMS for provisions related to our audit objectives, including specific provisions from the following:
 - Ø Social Security Act – Title XVIII – Health Insurance For The Aged and Disabled.
 - Ø Title XIX – Grants to States for Medical Assistance Programs.
 - Ø Affordable Health Care for America Act.
 - Ø State Operations Manual Appendix P, Survey Protocol for Long Term Care Facilities.
 - Ø State Operations Manual Appendix PP, Guidance to Surveyors for Long Term Care Facilities.
 - Ø State Operations Manual, Chapter 7, Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities.
 - Ø State Operations Manual, Chapter 5, Complaint Procedures.

- Obtained and reviewed DoH policies and procedures for responding to and resolving complaints, imposing sanctions, and ensuring that nursing homes provide a good balance of quality of life and quality of care for its residents, including the following:
 - Ø DNCF-401, Imposition of Sanctions for Noncompliance-Nursing Homes (Civil Money Penalties and Provisional Licenses).
 - Ø DNCF-701, Complaint Investigation.
 - Ø DNCF-307, Determination of Sufficient Facility Staffing.
 - Ø DNCF-411, Licensure and Recertification Processing.
 - Ø DNCF-412, Health and Life Safety Revisit Processing Procedure.
 - Ø DNCF-702, Central Office Complaint Processing.
 - Ø DNCF-707, Quality Assurance - Complainants.

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- Obtained and reviewed DoH’s process mapping and summary descriptions related to complaint-handling, annual surveys, and sanctions.
- Conducted research on Pennsylvania’s population demographics and future trends in nursing home demand.
- Contacted the Department of Aging’s director for the long-term care ombudsman program regarding interagency cooperation with DoH during the audit period.
- Conducted research on appropriate nurse staffing levels in nursing homes, and the impact these levels have on nursing home resident outcomes.
- Researched the imposition of Civil Monetary Penalties (CMPs) and other sanctions in selected states, as well as the frequency by which the CMPs were imposed. Our research involved the review of respective state laws and regulations, as well as interviews of relevant state staff, as necessary. We selected eight states for comparison. Our judgment for selecting these states included four states that border Pennsylvania and four other states with a high number of nursing homes/residents. States selected were as follows:
 - Ø New York
 - Ø New Jersey
 - Ø Maryland
 - Ø Ohio
 - Ø Florida
 - Ø Texas
 - Ø California
 - Ø Illinois
- Attended a “Survey Process Overview” training presented by DoH staff.
- Observed a DoH pre-survey planning meeting conducted by DoH field surveyors and supervisors in preparation for an annual nursing home relicensure/recertification survey.
- Observed a DoH survey team as it conducted an annual nursing home relicensure/recertification survey. The survey was a three-day survey; we were present for the final day.

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Observations from this review included, but were not limited to, DoH procedures used to review and calculate the facility level staffing reviews; a survey team meeting to decide facility violations, as well as the scope and severity of those violations; and a complaint investigation.

- Toured two Pennsylvania nursing homes, one located in DoH's Harrisburg region and one in DoH's Lionville region. Our visits were unannounced to the facility and involved observations of the facilities' operations, as well as interviews with administration about DoH's performance. At each facility, we toured housing, resident common areas, and grounds.
 - Ø Made inquiries about DoH's collaboration efforts with the Department of Labor and Industry regarding mandated staffing violations at nursing homes.
 - Ø Reviewed DoH's web site to evaluate the information DoH posts regarding helpful information for consumers and others.
- Researched and reviewed other states' mandated nursing home staffing ratios and compared them to Pennsylvania's mandated staffing ratio. Our information was initially obtained from the University of Minnesota's, Long-Term Care Resource Center, but was not the sole basis for our analysis. Information obtained from this source was used as background information for starting our research. Where necessary, we then conducted follow-up research with selected states that had higher rates than Pennsylvania's mandated staffing ratio.
- Obtained and reviewed a data file containing all complaints (4,062) received and responded to by DoH during the audit period (see section that follows on *Data Reliability*). We reviewed this file to determine the timeliness of DoH's response to complaints, as well as how quickly DoH completed the investigation.
- Conducted comparative state analysis using data sourced from CMS' *2015 Nursing Home Compendium* and CMS' *Nursing Home Compare* web site. We did not audit information extracted from these sources; consequentially, the data is of undetermined reliability. However, because the data is

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compiled by CMS, which is the best-known and reputable source for information about nursing homes that receive Medicaid/Medicare funding, the data presented no limitations for purposes of our analysis (and this engagement).

In using the data, we compared and ranked states by the following:

- Ø Number of nursing home facilities.
 - Ø Number of nursing home residents (census).
 - Ø Number of 0353 tags (a code for a federal deficiency related to nursing services).
 - Ø Number of 0353 tags per nursing home facility.
 - Ø Number of 0353 tags per capita.
- Selected 42 facilities from 711 nursing homes that were licensed/certified by DoH during the audit period (see section that follows on *Data Reliability*). In selecting these facilities, we selected at least four facilities from each of DoH's nine district offices. We selected facilities judgmentally based on factors such as the number and severity of deficiencies, number of complaints, and number of self-reported incidents to DoH. Because we used judgment in selecting these facilities, our results cannot be projected to a broader population of facilities. However, we determined that the selection of these facilities was appropriate for our audit objectives and that these facilities would generate valid and reliable evidence to support our work.
 - Using the 42 selected facilities as a basis for testing and review, we also did the following to address objective one:
 - Ø Obtained and reviewed all "survey packets" prepared by surveyors from our initial selection of 42 nursing homes to determine if the packets contained the proper supervisory approvals.
 - Ø We evaluated DoH's process for conducting facility staffing level reviews, and identified instances where residents of nursing homes and/or family members had made comments to the survey team about staffing, or other concerns related to quality of care/quality of life within the facility. Our source for this information included, but was not limited to, the "quality of life assessment" forms used by surveyors during the annual survey.

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- Ø Conducted follow-up interviews with DoH management regarding missing or incomplete facility staffing-level reviews.
- Using the 42 selected facilities as a basis for testing and review, we also did the following to address objective two:
 - Ø Using our judgment, we selected 90 nursing home complaints for detailed review. DoH received a total of 482 complaints related to the 42 selected nursing homes during the audit period. In selecting 90 complaints for further review, our judgment included factors such as the scope and severity of any cited deficiencies resulting from the complaint, and any complaint allegations that may have impacted resident quality of life/quality of care. Because we used judgment in our selection of complaints, the results cannot be generalized to the entire population of complaints.
 - Ø We reviewed the 90 complaints for required supervisory approvals, adequacy of communication with complainants, and to determine if complaints were sufficiently investigated in accordance with DoH policies and procedures.
 - Ø Conducted follow-up inquiries with DoH management for seven of the 90 complaints where insufficient documentation existed about the investigation outcome.
- Using the 42 selected facilities as a basis for testing and review, we also did the following to address objective three:
 - Ø Identified and reviewed all sanctions (10) from our selection of 42 nursing homes to determine if fines were processed timely, imposed in accordance with DoH's policies and procedures, and if follow-up surveys were conducted.
 - Ø Identified 24 deficiencies (tags) from our initial selection of 42 nursing homes that were ranked at a "G" level (indicating harm to a resident) and for which DoH did not issue a sanction for the deficiency. We haphazardly selected seven tags of 24 tags, and reviewed the documentation supporting the seven tags to evaluate DoH's

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decision not to cite the facility even though the deficiency was ranked at a level indicating resident harm had occurred.

- Ø Identified 22 F314 tags (deficiency related to pressure sores) from our selection of 42 nursing homes. We focused on the F314 tag because pressure sores should be preventable; consequently, if a resident developed sores while at a facility, that may be a clear indication of actual harm to a resident. We judgmentally selected eight cases (seven “D” level tags and one “E” level tag) from the 22 F314 tags. Our judgment in selecting these cases for review was based on our understanding of the circumstances surrounding the case, which was obtained from the CMS 2567 report – *Statement of Deficiency*. We tested DoH’s ranking decisions for the eight tags to determine if it was possibly “under-ranking” the scope and severity of deficiencies, and therefore, failing to consider sanctions.

Data Reliability

In performing this audit, we obtained several data files extracted from information systems maintained by DoH. *Government Auditing Standards* requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support our findings, conclusions, or recommendations. The assessment of the sufficiency and appropriateness of computer-processed information includes considerations regarding the completeness and accuracy of the data for the intended purposes.

Electronic data that we obtained from DoH, and which was used in this audit report, included data about licensed/certified nursing homes, completed surveys (inspections), complaints, and sanctions. We used this data to select case examples for further testing and in making conclusions about DoH’s performance in overseeing nursing homes. It is important to note that any statistics presented in our findings are based on the best information (data) available at the time of our audit procedures.

In response to our requests, DoH supplied us with several data files in an electronic spreadsheet format. These data files originated from DoH’s Survey Agency Information System (SAIS), which serves as the infrastructure for all nursing home survey and certification

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activities (which includes activities related to complaints and sanctions). SAIS covers all health care providers regulated by DoH. The system is built around the federal ASPEN (Automated Survey Processing Environment) program. Many of the core functions of each SAIS module work in conjunction with the ASPEN program, which is maintained by CMS.

To assess the completeness and accuracy of SAIS data provided to us, we conducted additional audit procedures as follows:

- Verified record counts to other available data sources to ensure that the data included all Pennsylvania-based nursing homes.
- Verified that all nursing homes listed in the data received at least one annual relicensure/recertification survey and verified with DoH that the facilities that did not meet this criterion either were closed or were not CMS-certified.
- Traced a selection of data to source documents and vice-versa, where available.
- Compared DoH's survey data to survey data presented on DoH's web site.
- Interviewed DoH officials with knowledge about the data, and specifically the processes used for data entry and/or input.
- Obtained an understanding of DoH's information technology environment, which included a general overview of selected information technology controls.
- For any data provided to us, obtained relevant field descriptions and record control totals.
- Obtained a "management representation letter" from DoH confirming that all electronic data provided to us met the following conditions:
 - Ø There were no alterations or falsification of electronic-data records.
 - Ø No electronic records were removed or discarded.

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Ø The electronic data was accurate and complete and is a duplicate of the data from which it was extracted.

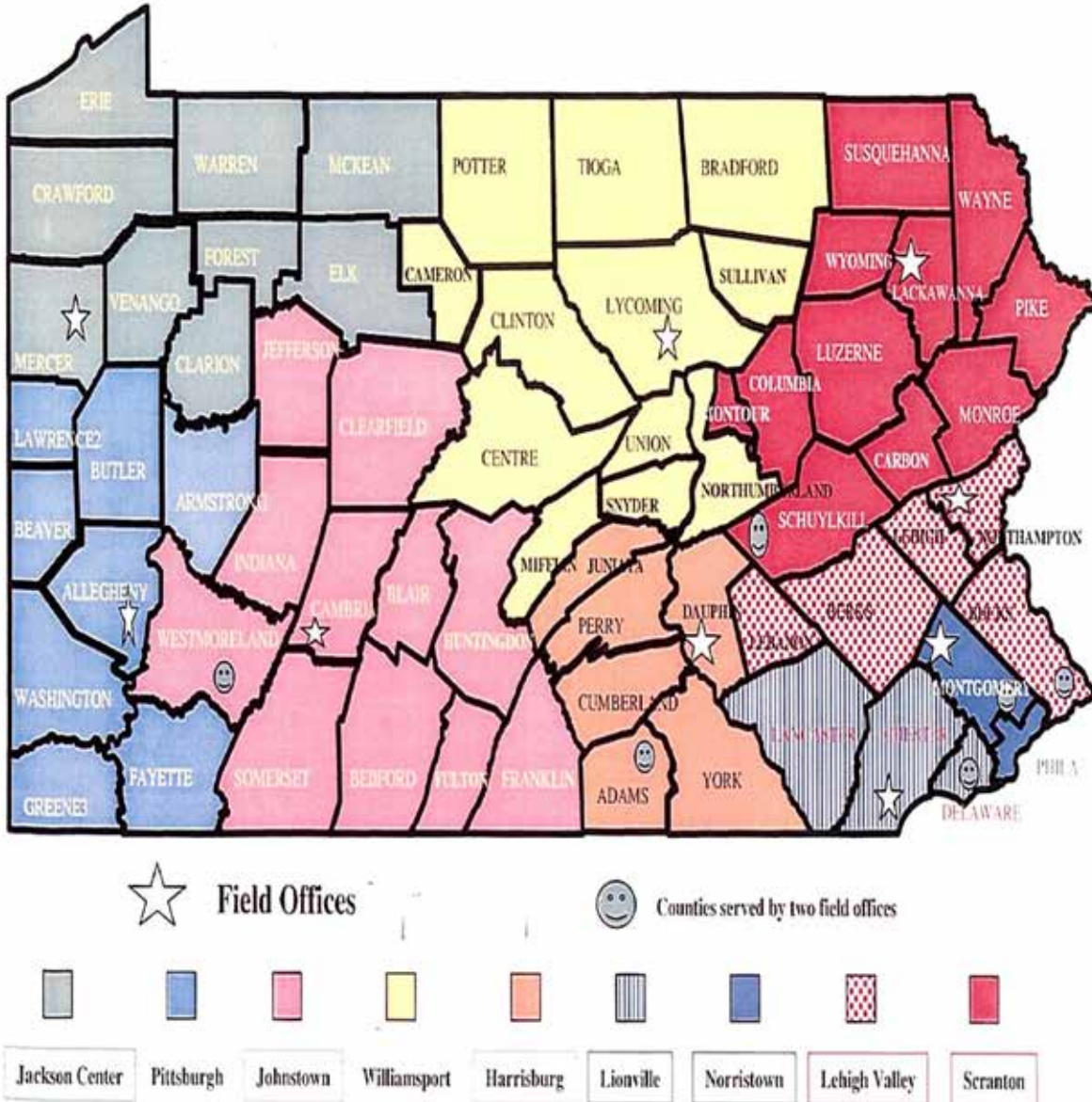
Based on the above, we found no limitations with using the data for our intended purposes. In accordance with *Government Auditing Standards*, we concluded that DoH's computer-processed data was sufficiently reliable for the purposes of this engagement.

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Appendix B

DoH Field Office Coverage

DNCF FIELD OFFICES AND COUNTIES



Source: Department of Health, Division of Nursing Care Facilities.

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Appendix C**Distribution List**

Upon its release, this report was distributed to the following Commonwealth officials:

The Honorable Tom Wolf
Governor

The Honorable Randy Albright
Secretary of the Budget
Office of the Budget

The Honorable Timothy Reese
State Treasurer
Treasury Department

The Honorable Karen Murphy
Secretary
PA Department of Health

The Honorable Christine Filipovich
Deputy Secretary for Quality Assurance
PA Department of Health

The Honorable Kathleen G. Kane
Attorney General
Office of the Attorney General

The Honorable Sharon Minnich
Secretary of Administration
Office of Administration

The Honorable Patricia Vance
Republican Chair
Senate Public Health and Welfare
Committee

The Honorable Shirley Kitchen
Democratic Chair
Senate Public Health and Welfare
Committee

The Honorable Matthew Baker
Republican Chair
House Health Committee

The Honorable Florindo Fabrizio
Democratic Chair
House Health Committee

The Honorable Tarah Toohill
Republican Chair
House Subcommittee on Health Facilities

The Honorable Michael Schlossberg
Democratic Chair
House Subcommittee on Health Facilities

Ms. Mary Spila
Collections/Cataloging
State Library of Pennsylvania

Mr. Brian Lyman, CPA
Director, Bureau of Audits
Office of Comptroller Operations

This report is a matter of public record and is available online at www.PaAuditor.gov. Media questions about the report can be directed to the Pennsylvania Department of the Auditor General, Office of Communications, 229 Finance Building, Harrisburg, PA 17120; via email to: news@PaAuditor.gov.

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