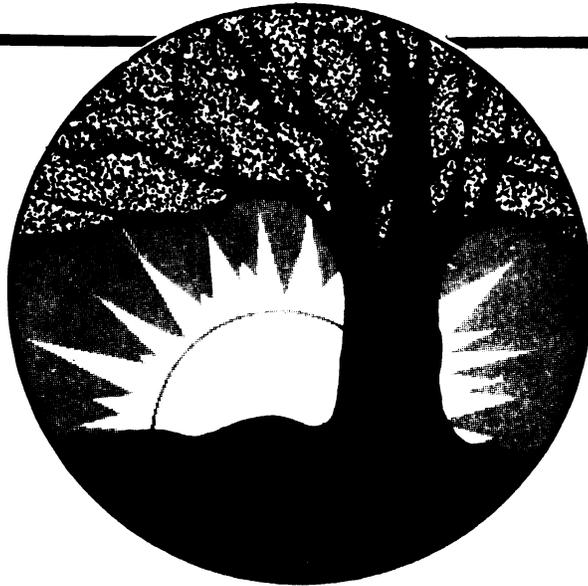


# PERFORMANCE AUDIT

Board for Licensing Health Care Facilities  
May 2008



John G. Morgan  
Comptroller of the Treasury



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**John G. Morgan**  
Comptroller

May 29, 2008

The Honorable Ron Ramsey  
Speaker of the Senate  
The Honorable Jimmy Naifeh  
Speaker of the House of Representatives  
The Honorable Thelma M. Harper, Chair  
Senate Committee on Government Operations  
The Honorable Mike Kernell, Chair  
House Committee on Government Operations  
and  
Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Board for Licensing Health Care Facilities. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the board should be continued, restructured, or terminated.

Sincerely,

John G. Morgan  
Comptroller of the Treasury

JGM/dlj  
07-085

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit  
**Board for Licensing Health Care Facilities**  
May 2008

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## AUDIT OBJECTIVES

The objectives of the audit were to determine the authority and responsibility mandated to the board and the Division of Health Care Facilities by the General Assembly; to assess compliance with the board's policies and procedures regarding the Abuse Registry; to determine the timeliness of complaint investigations and facility surveys; to examine waivers of board rules granted by the board; to determine whether the board is self-sufficient; to determine whether the board member positions are filled timely and whether the board has any vacant positions; to assess compliance with regulations for methadone clinics; to assess facility compliance with requirements for the installation of sprinkler systems; to examine monitoring processes for dialysis clinics; to assess the timeliness of surveys of Health Maintenance Organizations; to summarize Title VI and Civil Rights activities specific to the board and the Division of Health Care Facilities; and to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the board and the Division of Health Care Facilities.

## FINDINGS

### **The Abuse Registry Process Has Several Weaknesses That Highlight the Need for Clear Policies and Procedures, Increased Management Control and Monitoring of Compliance With Policies, and Improved Documentation**

Section 68-11-1001, *Tennessee Code Annotated*, requires the Department of Health to establish and maintain a registry containing the names of persons who have abused, neglected, or misappropriated the property of vulnerable individuals. Auditors identified several concerns regarding registry policies and procedures and the Division of Health Care Facilities' compliance with those policies, as well as concerns regarding the adequacy of documentation and management control. We

found that the division is not conducting all investigations of abuse allegations or related hearings timely, and in some cases documentation was insufficient for auditors or division management to determine compliance. We also found insufficient tracking of persons who have been removed from the registry and why they were removed. In addition, we found a lack of supervisory review and identified some instances in which incomplete or inaccurate information/documentation led to persons being removed from the registry (e.g., because notification of placement was not received) or inappropriately allowed some persons on the registry to continue working with vulnerable individuals (page 9).

**The Division of Health Care Facilities Is Not Investigating Complaints Timely, and a CMS Policy Change Is Contributing to the Problem**

The August 2003 performance audit of the board found that the Division of Health Care Facilities' investigations of complaints were not always timely. Auditors' review of 255 current complaint files revealed that conducting investigations within the priority time frames remains a problem, and that the problem has been worsened by a change in Centers for Medicare and Medicaid Services (CMS) policy regarding the reporting and investigation of facility self-reported incidents. Failure to investigate complaints in a timely manner jeopardizes patient safety and makes it more difficult to collect evidence associated with abuse and neglect cases (page 15).

**Licensed Health Care Facilities Are Not Required to Report on the Status of Waivers**

Section 68-11-209, *Tennessee Code Annotated*, grants the Board for Licensing Health Care Facilities the authority to waive the rules and regulations for any facility as long as the waiver does not have a detrimental effect on the health, safety, and welfare of the public. Between February 4, 2004, and May 7, 2007, 83 waiver requests came before the board and 77 (93%) were approved. The greatest percentage of waivers (31%) involved allowing a nursing home to operate without a nursing home administrator for a specific period of time. The board does not require facilities to report the status of rules and regulations waived. A board letter sent to facilities that have been granted a waiver includes a request that the facility notify the board in writing when there is a change in the waiver status. A board staff member also phones the facility near the date of waiver expiration, providing a reminder. However, there is no written policy describing this procedure or requiring the facility to notify the board, and there is no consequence if the facility fails to notify the board. Without a written policy that formalizes the monitoring process, requires facilities to report timely, and imposes penalties for not reporting, board members cannot be confident they have the most current information on waiver status (page 23).

**The Board for Licensing Health Care Facilities Has Not Met Its Statutory Requirement for Self-sufficiency**

Section 68-11-216(b)(2), *Tennessee Code Annotated*, states that the Board for Licensing Health Care Facilities should establish and collect fees sufficient to cover the costs of operating the board. For fiscal years 2003 through 2007, the board was not self-sufficient. The 2003 performance audit of the board found that the board was also not self-sufficient in fiscal year 2002. Effective July 1, 2005, the General Assembly authorized the board to set its own fees through rules, as necessary for the board to be self-sufficient. Prior to that time, license fees were increased only by legislative action. In April 2007, the board increased application and renewal fees from 25% to 50% (depending on the type of facility); however, despite the increase the board had more expenditures than revenues in fiscal year 2007 (page 25).

**Dialysis Technicians Are Weakly Regulated Because of an Absence of Minimum Requirements and Certification**

Chapter 1200-8-32-.04 of the rules for the Board of Licensing Health Care Facilities requires dialysis technicians to complete a training program administered by the employing facility. The trainee may provide patient care only under the immediate supervision of a registered nurse or assigned instructor, until the successful completion of a competency evaluation. Tennessee does not establish any minimum educational requirements or training durations, and the competency evaluation criteria are general and unspecified. Many states have adopted national certifications or minimum training and competencies as part of their requirements. In proposed rules, the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) advocates requiring dialysis technicians to have at least a high school diploma and complete at least three months experience following a facility's training program. CMS also proposes a training program that is specific to technicians who monitor the water treatment system. These changes are expected to go into effect in 2008 (page 27).

**The Division of Health Care Facilities and the Department of Commerce and Insurance Should Adopt the Required Interdepartmental Agreement Concerning Oversight of Health Maintenance Organizations, and Should Include in That Agreement Provisions Requiring That HMOs Submit Corrective Action Plans When Deficiencies Are Identified**

Section 56-32-215, *Tennessee Code Annotated*, requires the commissioners of the Department of Commerce and Insurance and the Department of Health to coordinate the regulation of Health Maintenance Organizations. In addition, the departments are required by law to develop an interdepartmental agreement to coordinate oversight of the HMOs. However, neither

department was able to provide us with a copy of such an agreement. The Division of Health Care Facilities, acting as the designee of the Commissioner of the Department of Health, has responsibility for the HMO surveys that determine the quality of health care services and are to be performed at least every three years. The division has surveyed six of the seven HMOs within the past three years. (Because one HMO was licensed in December 2006, the survey for it would not be due until December 2009.) Five of the six HMOs surveyed had findings requiring that they submit a Plan of Correction, but only one of the five had submitted a Plan of Correction. According to division staff, there are no penalties for failure to submit the plan (page 31).

**OBSERVATIONS AND COMMENTS**

The audit also discusses the following issues: board member vacancies, the Division of Health Care Facilities' oversight of methadone clinics, and facility compliance with sprinkler statutes (page 33).

**RESULTS OF OTHER AUDIT WORK**

The audit also discusses auditors' review of a sample of health care facilities statewide to determine if mandated survey time frames were met. For the 160 facilities reviewed, Division of Health Care Facilities surveyors had conducted the surveys (inspections) on time (page 38).

# Performance Audit Board for Licensing Health Care Facilities

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# **Performance Audit Board for Licensing Health Care Facilities**

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## **INTRODUCTION**

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### **PURPOSE AND AUTHORITY FOR THE AUDIT**

This performance audit of the Board for Licensing Health Care Facilities was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-229, the Board for Licensing Health Care Facilities is scheduled to terminate June 30, 2008. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the board and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the board should be continued, restructured, or terminated.

### **OBJECTIVES OF THE AUDIT**

The objectives of the audit were

1. to determine the authority and responsibility mandated to the board and the Division of Health Care Facilities by the General Assembly;
2. to assess compliance with the board's policies and procedures regarding the Abuse Registry;
3. to determine the timeliness of complaint investigations and facility surveys;
4. to examine waivers of board rules granted by the board;
5. to determine whether the board is self-sufficient;
6. to determine whether the board member positions are filled timely and whether the board has any vacant positions;
7. to assess compliance with regulations for methadone clinics;
8. to assess facility compliance with requirements for the installation of sprinkler systems;
9. to examine monitoring processes for dialysis clinics;
10. to assess the timeliness of surveys of Health Maintenance Organizations;
11. to summarize Title VI and Civil Rights activities specific to the board and the Division of Health Care Facilities; and

12. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the board and the Division of Health Care Facilities.

## **SCOPE AND METHODOLOGY OF THE AUDIT**

The activities and procedures of the board and the Division of Health Care Facilities were reviewed with a focus on procedures in effect at the time of fieldwork (June to September 2007). We conducted this performance audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Methods used included

1. reviews of applicable statutes and state and federal rules and regulations;
2. reviews of prior audit reports and documentation;
3. interviews with staff of the Board for Licensing Health Care Facilities, the Division of Health Care Facilities, and the Department of Health;
4. reviews of the board's and the division's files, reports, and information summaries;
5. a review of the Centers for Medicare and Medicaid Services 2006 Performance Review of the Division of Health Care Facilities;
6. reviews of the board's and the division's information systems used in licensing and complaint functions;
7. site visits, file reviews, and staff interviews at the division's regional offices; and
8. observation of nursing home and methadone clinic surveys.

## **ORGANIZATION AND RESPONSIBILITIES**

As stated in Section 68-11-202 et seq., *Tennessee Code Annotated*, the Board for Licensing Health Care Facilities has authority to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV supportive-living facilities, assisted-care living facilities, home-care organizations, residential hospices, birthing centers, prescribed child care centers, renal dialysis clinics, ambulatory surgical treatment centers, alcohol and drug treatment facilities, and outpatient diagnostic centers. See Appendix 2 for a list of licensed facilities by type and Appendix 3 for maps of facilities by location. Executive Order 44 transferred the licensing and regulation of Alcohol and Drug Treatment (A&D) Facilities to the Department of Mental Health and Developmental Disabilities and, effective January 1, 2008, the Division of Health Care Facilities will no longer license, survey, or investigate complaints for these facilities. In August 2007, there were 239 licensed Alcohol and Drug Treatment facilities. Chapter 373, 2007 Public Acts, amended *Tennessee Code Annotated*, Title 68, to require the Division of Health Care Facilities to regulate the practice of office-based surgeries across the state. Division management believes this will add more facilities to its survey and complaint investigation responsibilities than the 239 A&D facilities being transferred. See finding 2.

As part of its regulation authority, the board has the duty and power to adopt rules and regulations pertaining to the operation and management of any facilities required to be licensed (including adopting fire and life safety regulations and reviewing facilities for compliance with those regulations).

The board is required to meet at least twice a year and consists of 20 members who are appointed by the Governor to serve four-year terms:

- two medical doctors;
- one oral surgeon;
- one pharmacist;
- one registered nurse;
- two hospital administrators;
- one osteopath;
- three representatives of the nursing home industry;
- one architect;
- one operator of a home-care organization;
- one operator of a licensed residential home for the aged or a representative of the assisted-living industry;
- one representative of the drug and alcohol abuse service profession;
- two consumer members; and
- the Commissioner of Health, the Chair of the Tennessee Public Health Council, and the Executive Director of the Commission on Aging, all serving *ex officio*.

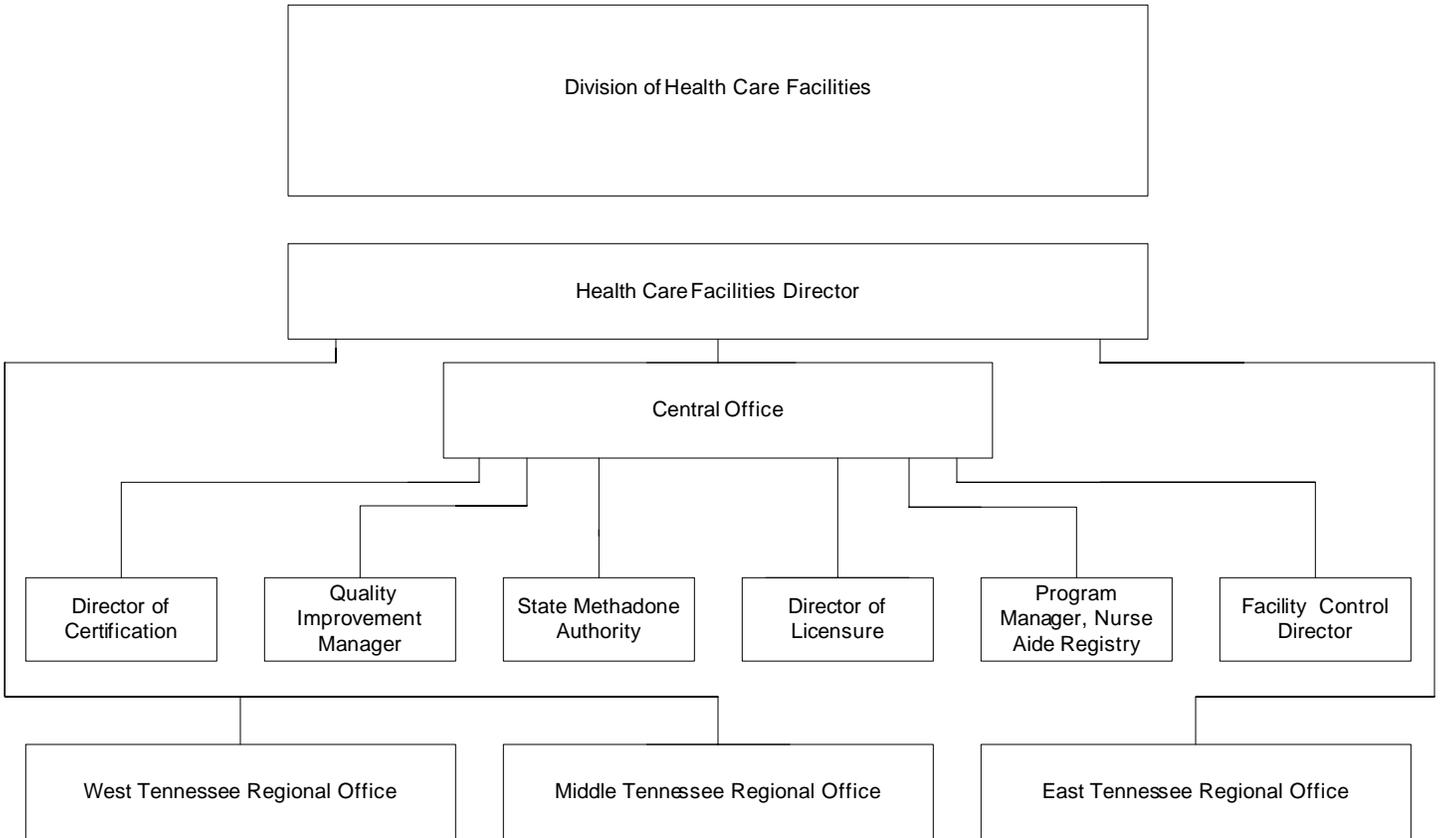
The Department of Health's Division of Health Care Facilities provides administrative support to the board. The division monitors the quality of health care facilities through investigation of complaints and the certification and licensure of health care facilities across the state. The division has regional offices in Jackson, Knoxville, and Nashville, and a central office in Nashville. All inspections (surveys) of health care facilities are conducted from the regional offices. See the organizational chart on page 4 and a map of the division's regions on page 5.

## **FUNDING**

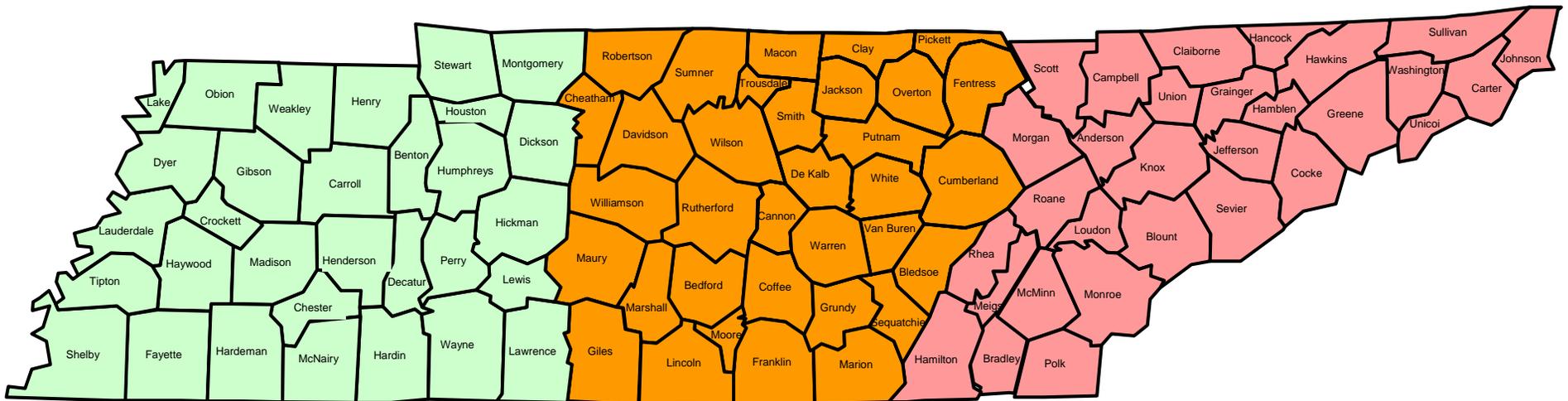
The Division of Health Care Facilities received \$11.8 million in fiscal year 2007. Expenditures totaled \$11.8 million.

Revenues and expenditures for the Board for Licensing Health Care Facilities are included in the above totals. In fiscal year 2007, the board had revenues of \$2.3 million and expenditures of \$2.8 million. Board revenues are from state licensing fees, and expenditures are those costs specific to the board for state licensure activities. See finding 4.

**BOARD FOR LICENSING HEALTH CARE FACILITIES**  
**October 2007**  
**Organizational Chart**



Division of Health Care Facilities  
Regions  
September 2007



**West Tennessee Region**  
 Office in Jackson

**Middle Tennessee Region**  
 Office in Nashville

**East Tennessee Region**  
 Office in Knoxville

Source: Division of Health Care Facilities

## LICENSURE AND CERTIFICATION

The Division of Health Care Facilities is responsible for licensing health care facilities operating in Tennessee; for recommending to the federal government certification for facilities that have met the requirements to receive funding under the Medicare and Medicaid programs; and for conducting recertification surveys of facilities already federally certified. See Appendix 2 for facilities by type and region.

Licenses for health care facilities are issued on July 1 and expire on June 30 each year. State law requires that in order to be licensed, facilities must have a licensure inspection (survey) within 15 months of the last inspection to assess compliance with rules and regulations. Facilities that are accredited by a federally recognized accrediting health care organization (e.g., the Joint Commission on Accreditation of Healthcare Organizations and the Community Health Accreditation Program) are deemed to meet licensing needs. The division has promulgated rules for each facility type licensed by the state.

The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) delegate responsibility for determining whether facilities meet the requirements for participation in the medical assistance program (Medicare or Medicaid) to the state survey agencies (which for Tennessee is the Division of Health Care Facilities). Under its CMS responsibilities, the division is responsible for certification surveys of facilities. These surveys ascertain whether a provider/supplier meets applicable requirements for participation in the Medicare and/or Medicaid programs and evaluate performance and effectiveness in rendering a safe and acceptable quality of care. Surveyors use the requirements found in Title 42 of the Code of Federal Regulations to determine how a facility is

- preventing environmental hazards due to contagion, fire, contamination, or structural design and maintenance problems; and
- protecting health and safety through the efforts of its personnel.

A facility is considered certified by the state survey agency when the agency says the facility meets the Social Security Act's provider or supplier definitions and complies with standards required by federal regulations.

As part of its function as a state survey agency, the division has a toll-free telephone hotline to receive complaints and answer questions. The division also enters data from surveys and complaint investigations into CMS data systems. The division, as part of its federal certification duties, also certifies nurse aides, and maintains a nurse aide registry and an abuse registry.

The regional offices send teams of evaluators to facilities to investigate complaints and perform surveys. The team size varies depending on the experience levels of the facility evaluators assigned, the complexity of allegations within a complaint, the size of the facility, and the number of residents living at the facility. Most of the evaluators are licensed registered nurses in Tennessee. See table on page 38 for surveyors by regional offices.

In addition to licensing and certification responsibilities, the Division of Health Care Facilities monitors Health Maintenance Organizations to determine the quality of health care services, and supervises the Residential Homes for the Aged Quality Enabling Program and the Eden Alternative Grant Assistance Program for assisting residents of homes for the aged and nursing homes.

## **COMPLAINTS**

As part of its duties as a state survey agency for CMS and as the licensing agency for hospitals, the division is responsible for handling complaints. The division's central office has a complaint intake unit. Complaints originate with hotline calls, e-mail, mail, or are self reported by facilities via the Unusual Incident Reporting System (UIRS). See Appendix 4 for additional information on the complaint process.

The division's website provides instructions on when and how to file a complaint. Consumers can download a form and mail in their complaint or they can speak to a representative by dialing the unit's toll-free telephone number. The toll-free number is required to be posted in all health care facilities; it is also in public directories as well as the State Survey Agency website. Consumers are instructed that they have the right to file a complaint against a health care professional or a health care facility whenever they feel that the behavior or care is not acceptable. The complainant receives a letter acknowledging receipt of the complaint, and when an investigation is completed, a letter is sent detailing the outcome of the investigation.

The Centralized Complaint Intake Unit (CCIU) is located in the Division of Health Care Facilities' Central Office. CCIU staff review complaints, complete complaint intake, and assign priority codes based on the severity of the allegations. Complaint information is entered into a database—the Automated Complaint Tracking System (ACTS).

Based on the evidence obtained during the regional office's investigation of the allegation, the surveyor will determine whether or not the complaint is substantiated and what (if any) deficiencies should be cited. If a complaint is substantiated, facilities are given an opportunity to correct the associated deficiencies. If the deficiencies are not corrected upon the surveyor's return visit, state and federal civil monetary penalties as well as facility termination and suspension options may be pursued. See Appendix 5 for the federal penalty matrix which is used by the state survey agencies to determine the amount of federal civil monetary penalties based on the facility's level of noncompliance and the severity of the problems found.

### **Centralized Complaint Intake Unit Process**

- Complaint comes into CCIU.
- Priority determined and complaint entered in computer system.
- Regional Office investigates and enters results.
- If complaint substantiated and
  - Abuse is supported; the regional office sends information to the Program Manager of the Nurse Aide Registry.

- Deficiencies are supported; the facility must correct the deficiencies and provide a Plan of Correction. Surveyors review the facility again. If corrections have not been made, penalties may be assessed.

CMS's *State Operations Manual*, Chapter 7, provides a scope and severity grid used to determine the seriousness of deficiencies for skilled nursing facilities (SNFs) and nursing facilities (NFs). The matrix provides assessment factors for determining the appropriate remedy. Facilities other than SNFs and NFs are subject to corrective plans of action and termination procedures for non-compliance with Medicare conditions. Federal Civil Monetary Penalties (CMPs) are only applied to nursing homes. State CMPs are applied to both assisted-care living facilities and nursing homes. See Appendix 5 for the CMS severity grid.

During summer 2007, the division imposed enforcement actions on many deficient health care facilities throughout the state.

### Health Care Facilities' Enforcement Actions June to August 2007

| Survey Start Date | Facility                                    | Action Taken         | Civil Monetary Penalties                  |
|-------------------|---|----------------------|---|
| August 9          | Adams Place Nursing Home                    | Suspended Admissions | State \$1,500<br>*Federal \$3,050 Per Day |
| August 21         | Beech Tree Manor Nursing Home               | Suspended Admissions | State \$1,500<br>*Federal \$6,175 Per Day |
| June 24           | Bells Nursing Home                          | Suspended Admissions | State \$1,500<br>*Federal \$3,050 Per Day |
| May 31            | Bordeaux Long-Term Care                     | Suspended Admissions | State \$1,500<br>*Federal \$3,050 Per Day |
| June 27           | The Cornelia House                          | Suspended Admissions | State \$7,500<br>*Federal \$6,200 Per Day |
| August 6          | Dyersburg Manor Nursing Home                | Suspended Admissions | State \$1,500<br>*Federal \$3,550 Per Day |
| August 20         | Gallaway Healthcare Center                  | Suspended Admissions | State \$1,500<br>*Federal \$5,650 Per Day |
| July 17           | Hermitage Health Center                     | Suspended Admissions | State \$1,500<br>*Federal \$3,550 Per Day |
| May 29            | Mitchell Manor                              | Suspended Admissions | State \$3,000<br>*Federal \$5,000 Per Day |
| June 18           | National Healthcare Corporation in Milan    | Suspended Admissions | State \$1,500<br>*Federal \$5,050 Per Day |
| August 6          | Ripley Healthcare and Rehabilitation Center | Suspended Admissions | State \$1,500<br>*Federal \$4,050         |
| June 3            | Tennessee Veterans Home                     | Suspended Admissions | State \$3,000<br>*Federal \$6,500 Per Day |
| August 2          | Sun Valley Home for the Aged                | Suspended Admissions | Enforcement Actions Not Completed**       |
| August 9          | Shelby Woods Residential Home               | Suspended Admissions | Enforcement Actions Not Completed         |

\* Recommended penalty

\*\* License suspended on 8-16-07.

Source: Department of Health news releases maintained on department website.

In 2006, over \$2 million in fines were imposed against nursing homes in Tennessee. Just one year later, that figure has increased to over \$8 million in civil monetary penalties.

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## FINDINGS AND RECOMMENDATIONS

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### **1. The Abuse Registry process has several weaknesses that highlight the need for clear policies and procedures, increased management control and monitoring of compliance with policies, and improved documentation**

#### **Finding**

Section 68-11-1001, *Tennessee Code Annotated*, requires the Department of Health to establish and maintain a registry containing the names of persons who have abused, neglected, or misappropriated the property of vulnerable individuals. The Abuse Registry is administered by the Division of Health Care Facilities and had 1,221 registrants in November 2007. The chart on page 10 details the various professions represented on the registry. The division has an investigative and administrative process for cases of alleged abuse prior to placing an individual on the registry. Placement on the registry can also be made by other state agencies, such as the Department of Finance and Administration's Division of Mental Retardation Services and the Tennessee Bureau of Investigation once they have completed their investigative and administrative processes.

Auditors identified several concerns regarding registry policies and procedures and the division's compliance with those policies, as well as concerns regarding the adequacy of documentation and management control. We found that the division is not conducting all investigations of abuse allegations or related hearings timely, and in some cases documentation was insufficient for auditors or division management to determine compliance. We also found insufficient tracking of persons who have been removed from the registry and why they were removed. In addition, we found a lack of supervisory review and identified some instances in which incomplete or inaccurate information/documentation led to persons being removed from the registry (e.g., because notification of placement was not received) or inappropriately allowed some persons on the registry to continue working with vulnerable individuals.

#### Conflicting Information Regarding Policies Currently in Effect

Management and staff of the Division of Health Care Facilities provided conflicting information about Abuse Registry policies currently in effect. At the start of auditors' fieldwork, staff provided us with Policies 206–Processing Complaints for State Abuse Registry, 228–Abuse Registry Placement, and 238–Abuse Registry Panel Review. (The policies are described below.) The Nurse Aide Program Manager, who is also responsible for the Abuse Registry, uses Policy 238. However, the Interim Director of the Division of Health Care Facilities, the Director of Licensure, and other staff said that Policy 238 was never implemented.

The different policies provided also raised questions about notification letters to alleged abusers. Policy 228 describes a notification letter to be sent from the Nurse Aide Program Manager describing the findings and the accused abuser's right to a hearing. However, Policy 206 states that Office of General Counsel staff will send a notification letter to the accused outlining allegations, with a right to appeal notice. Our file review found the notification letters described in Policy 228 in a majority of the files but no letters from the Office of General Counsel regarding appeals. It was not clear whether both policies are describing the same letter (although this seems likely). The Office of General Counsel staff who works with Health Care Facilities was not aware of the policy requiring that she send a notification letter.

**Professions Represented on Abuse Registry  
As of November 2007**

| Profession                  | Number on Abuse Registry |
|-----------------------------|--------------------------|
| Nurse Aide                  | 704                      |
| Unknown                     | 275                      |
| Developmental Technician    | 52                       |
| Residential Technician      | 23                       |
| Licensed Practical Nurse    | 22                       |
| Home Manager                | 20                       |
| Housekeeper                 | 19                       |
| Nurse Technician            | 19                       |
| Companion                   | 17                       |
| Nursing Home Employee       | 11                       |
| Support Specialist          | 11                       |
| Caretaker                   | 10                       |
| Psychiatric Tech            | 6                        |
| Community Living Specialist | 8                        |
| Registered Nurse            | 8                        |
| Janitor                     | 3                        |
| Locational Trainer          | 3                        |
| Van Driver                  | 3                        |
| Group Home Employee         | 2                        |
| Community Living Assistant  | 2                        |
| Orderly                     | 1                        |
| Maid                        | 1                        |
| Support Care Manager        | 1                        |
| <b>Grand Total</b>          | <b>1,221</b>             |

| Department Referrals                                       | Number on Abuse Registry |
|--|--------------------------|
| Department of Health                                       | 835                      |
| Division of Mental Retardation Services                    | 228                      |
| Tennessee Bureau of Investigation                          | 80                       |
| Department of Mental Health and Developmental Disabilities | 67                       |
| Department of Human Services                               | 11                       |
| <b>Grand Total</b>   | <b>1,221</b>             |

Source: Division of Health Care Facilities, Abuse Registry.

### Investigations of Abuse Allegations Not Always Timely

According to Division of Health Care Facilities Policy 206, the division is to timely investigate and report (through appropriate channels) all abuse complaints against professional or paraprofessional employees. When the Central Complaint Intake Unit (see page 7) receives an allegation of abuse, staff assign a priority code of Immediate Jeopardy requiring a surveyor to begin an on-site investigation of the allegation within two working days. The surveyor then has 20 days to complete the investigation. We reviewed a sample of 51 files of persons listed on the registry to determine if the investigation began in two days. Only 27 of the 51 files contained sufficient information to determine the start date of an investigation after the allegation was reported. We found that 20 (74%) of those 27 files had investigation start dates of later than the 2 days, one as late as 109 days.

If abuse is substantiated, the investigative file is submitted to the Nurse Aide Registry Program Manager in the Division of Health Care Facilities' central office. The Program Manager is responsible for the administration of the Abuse Registry, which includes scheduling reviews of substantiated cases with the Abuse Registry Panel. Cases that involve a licensed health care professional are referred to the appropriate health-related board (e.g., a case involving a nurse is referred to the Board of Nursing for action).

### Abuse Registry Panel and Concerns Regarding Hearing Timeliness and Documentation

Division of Health Care Facilities Policy 238 provides for a three-person Abuse Registry Panel to review completed investigations of individuals referred for Abuse Registry placement and to determine whether there is sufficient evidence to proceed with placement of an individual on the registry. The panel, which consists of the Nurse Aide Program Manager, the Director of Certification, and an attorney from the Department of Health's Office of General Counsel, convenes every other week, according to the Nurse Aide Program Manager. Minutes are not kept for the panel meetings. Instead, the Nurse Aide Program Manager prepares a list of substantiated cases received for the panel to consider. We reviewed these lists and found that they contain notations by each listed file of the date and the action determined by the panel, such as

- Proceed with Placement
- Closed for Insufficient Evidence
- Closed does not rise to Level of Abuse

- Contact regional office for additional information.

Policy 228 states that if the abuse case is substantiated by the panel, the alleged perpetrator is notified via certified mail of the intent to place him/her on the Abuse Registry and is given the opportunity to request a hearing. If the alleged perpetrator does not respond within 30 days, the individual is placed on the Abuse Registry. If the individual requests a hearing, it must take place within 120 days from the date of the request. Placement on the registry will be determined based upon the hearing results.

Our file review determined that 18 of the 51 files in the sample contained documentation of hearing requests from the alleged perpetrator, with 2 of those requests documented as being canceled by the accused. However, only three of the files contained sufficient documentation to determine when a hearing was held and if it was held timely. None of the three were heard within 120 days, with one being heard 232 days after the request—112 days later than the time specified in the division's policy. According to Office of General Counsel staff, the 120 days is not possible to comply with because Administrative Procedures law gives judges 90 days to rule on a case.

#### Concerns Regarding the Removal of Persons From the Abuse Registry

The Nursing Home Inspection Enforcement Activities Reports, prepared by the Department of Health, indicated that the following numbers of registrants were removed from the Abuse Registry: 3 in 2003, 4 in 2004, 4 in 2005, and 11 in 2006. Because of the potentially serious consequences of removing a person from the registry after it was determined that sufficient evidence existed to place that person on the registry, we requested a list of persons removed from the registry and the associated files (to determine the reasons for removal). The Nurse Aide Program Manager was, however, unable to provide a list of registrants removed. Based on interviews with the Nurse Aide Program Manager and Department of Health Information Systems staff, we found that there is no record or audit trail created when persons are removed from the registry. Through our file reviews, auditors found instances where registrants were being removed from the registry for reasons such as not receiving a notification letter of placement, the letter being sent to the wrong zip code, or the registrant requesting a hearing after placement onto the registry. In some cases, no reason was provided.

#### Concerns Regarding Management Control and Completeness and Accuracy of Information

The Nurse Aide Program Manager is responsible for the administration of the Abuse Registry (in addition to administration of the Nurse Aide Program), which includes reviewing investigative files, corresponding with the alleged perpetrators, preparing files for review by the Abuse Registry Panel, and placing registrants on and removing registrants off of the registry. Based on our review of the documentation and interviews with staff, the Division of Health Care Facilities and the Department of Health have no supervisory review to ensure that the actions of the Abuse Registry Panel are carried out in a timely manner, that listings are not duplicated, and that registrants are listed correctly with correct name spellings and social security numbers. The risk of errors because of a lack of segregation of duties and lack of management oversight leaves the division, the department, and the Program Manager open to potential questions regarding

placement on and removals from the registry. Errors could adversely affect reputations, careers, and the safety of vulnerable citizens.

Completeness and accuracy of Abuse Registry information is vital because, pursuant to Section 68-11-1006, *Tennessee Code Annotated*, entities licensed by a state agency must, prior to hiring an employee or using a volunteer, determine whether the prospective employee or volunteer is listed on the Abuse Registry. In addition, there are specific statutory requirements that child care agencies (Sections 37-5-511 and 71-3-507), adult day care centers (Section 71-2-403), and the Department of Education, State Board of Education, and local education agencies (Section 49-10-608) check the registry before hiring an employee or using a volunteer. Our review, however, raised concerns about the completeness and accuracy of information on the registry. There were some instances where persons on the Abuse Registry were still working with vulnerable individuals. For example, a Certified Nurse Aide (CNA) was placed on the registry under a nickname (Bobby) with the same social security number and later became an LPN under his legal name (Robert), even though the social security number was the same. Another individual was placed on the registry and after placement received a CNA license. This individual's social security number was listed correctly on the registry, but her name was misspelled. This individual was subsequently removed from the Abuse Registry after stating that required notification was never received. While reviewing the division's website, auditors found that some persons with hyphenated last names (or more than one last name) are only accessible if the full last name is given. If persons are not listed correctly on the registry, vulnerable individuals can be placed at risk, given that nicknames and misspellings have afforded some persons listed on the registry the opportunity to continue working with vulnerable individuals.

#### Related Internal Audit Report

The Department of Health's Division of Internal Audit issued a report in October 2007 regarding the Abuse Registry. The report included five findings:

- There is disparity in the placement of licensed and unlicensed individuals
- Individuals were removed from the Abuse Registry with no record of reason
- A backlog of files has not been resolved
- No written policy exists for the retention of investigation files
- Investigation files were not complete and supportive of substantiated complaints

The Division of State Audit coordinated audit efforts with Internal Audit in an attempt to minimize duplication of effort. Internal Audit's findings are consistent with concerns raised by the Division of State Audit.

## **Recommendation**

Division of Health Care Facilities management should review policies and procedures and revise them as necessary to ensure that policies address all major actions related to placement on and removal from the Abuse Registry; responsibility for the actions is clearly assigned; and any time frames set are consistent with other federal and state requirements and laws. Management should then ensure that updated policies are communicated to all relevant staff.

Management should ensure there is supervisory review of Abuse Registry actions to monitor the timeliness of abuse investigations and hearings and to ensure that all required actions are taken and adequately documented in the files. Management should ensure that all persons recommended for placement on the registry are placed timely and listed with complete and correct information (including any nicknames as well as full legal name) so that those individuals can be identified if they subsequently seek employment in a facility that cares for vulnerable individuals. Removals of persons from the registry should be tracked and fully documented, and management should ensure that the reasons for removal are fully explained and meet the criteria for removal.

Division of Health Care Facilities management should review the statutory provisions for other Tennessee registries (particularly sex offender registration statutes) to identify changes that could be made to strengthen and improve the Abuse Registry legislation, for example, adding specific authority for updating the registry, requiring registrants to provide complete name and all aliases as well as any name changes, and adding penalties if registrants fail to provide complete, accurate, and up-to-date information. Department of Health management should then propose to the General Assembly appropriate legislative changes.

## **Management's Comment**

We concur with the audit findings. The Division of Health Care Facilities (HCF) has worked in conjunction with the Bureau of Health Licensure and Regulation and the Office of General Counsel to review, significantly revise, and combine all the individual policies into one policy that addresses all major activities related to placement on and removal from, the Abuse Registry. Responsibilities for registry action(s) are assigned and clearly documented with time frames consistent with state and federal requirements and laws.

Management will oversee supervisory review of Abuse Registry actions including monitoring the timeliness of investigations and hearings. This supervisory review will also ensure that all persons recommended for placement on the registry are placed timely, with complete and correct information, to readily facilitate the identification of an individual seeking subsequent employment in a facility that cares for vulnerable individuals. A new computer program, currently under development, will have the capability to address all monikers and aliases of persons placed on the registry.

Changes have been made to the current computer system to address removal from the registry. A code has been added to the system to reflect “Removed” rather than deleting the file. The notes in the system will reflect the date that the removal occurred and details regarding the request for removal. Each removal is tracked, explained, and fully documented, and only those meeting the requirement(s) for removal are removed.

The HCF Abuse Registry Manager will review the statutory provisions for other Tennessee registries to identify changes that could be made to strengthen and improve the Abuse Registry law. If statutory changes are determined to be necessary to improve this process, consideration will be given to proposing such changes in the next legislative session.

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## **2. The Division of Health Care Facilities is not investigating complaints timely, and a CMS policy change is contributing to the problem**

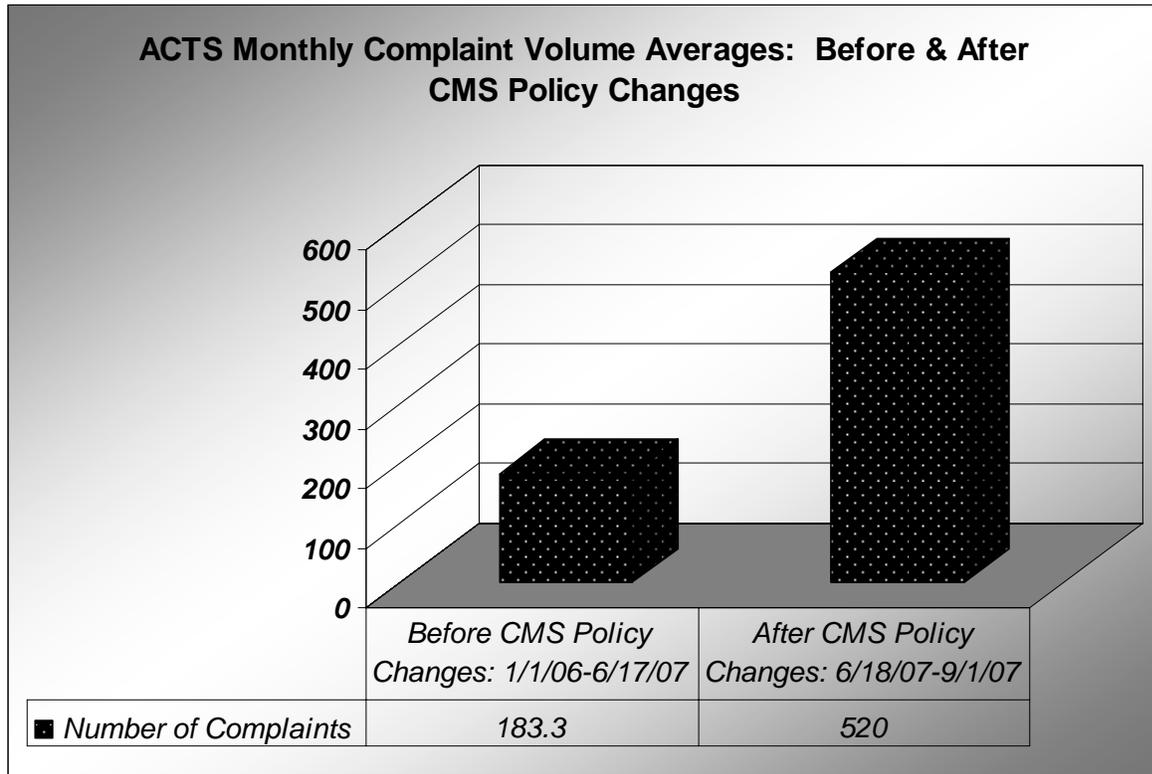
### **Finding**

The August 2003 performance audit of the board found that the Division of Health Care Facilities’ investigations of complaints were not always timely. Auditors’ review of 255 current complaint files revealed that conducting investigations within the priority time frames remains a problem, and that the problem has been worsened by a change in Centers for Medicare and Medicaid Services (CMS) policy.

Using complaint files reviewed from all regions of the state and data from the CMS Aspen Complaint Tracking System (ACTS), we were able to assess the division’s investigative timeliness. We conducted file reviews and reviewed ACTS-generated complaint files for two separate time periods—(1) January 1, 2006, to June 30, 2007, and (2) July 1, 2007, to September 1, 2007—for the three regional offices. These time frames were used to measure the effect of a change in policy regarding the reporting and investigation of facility self-reported incidents. Prior to June 18, 2007, self-reported incidents involving abuse, neglect, misappropriation, and injuries of unknown origin were the only types of self-reported events entered in ACTS. As of June 18, 2007, CMS initiated a policy change instructing the Division of Health Care Facilities’ Central Office to investigate all unusual incidents violating federal levels of participation.

Adjustments to the handling of these self-reported events (i.e., CMS requiring a wider scope of self-reported incidents to be entered into the ACTS system) dramatically increased the number of complaints that need investigating. Complaint volume changes can be seen on the following page.

## ACTS Complaint/Incident Volume by Week Reports\*



\*The increased volume has created a backlog of complaints. Because of the backlog, only Immediate Jeopardy and Non-Immediate Jeopardy High complaints are entered into the ACTS system immediately. Less serious complaints are set aside for later entry into ACTS. Thus, the total complaint volume is higher than the ACTS Investigation Log volume.

The division is required to investigate complaints in accordance with CMS guidelines. The division's policies match those established by CMS and include investigative time frames for other facilities not defined by CMS.

### CMS Complaint Investigation Guidelines

| Priority                      | Investigation Time Frame   |
|-------------------------------|--|
| Immediate Jeopardy            | Investigate within 2 working days  |
| Non-Immediate Jeopardy High   | Investigate within 10 working days<br>(nursing homes only)   |
| Non-Immediate Jeopardy Medium | For nursing homes—no specific time frame, but onsite survey should be scheduled<br>For deemed providers/suppliers* or non-deemed providers, other than nursing homes—investigate within 45 calendar days |

\*Deemed providers are those providers which have been accredited by a private accrediting body resulting in Medicare and Medicaid participation in lieu of the state survey.

Source: *State Operations Manual*, Chapter 5.

CMS requires that 100% of all Immediate Jeopardy complaints be investigated within the two-day time frame and that 95% of all Non-Immediate Jeopardy High complaints (nursing homes only) be investigated within the 10-day time frame.

**Division of Health Care Facilities  
Prioritization of Long-Term Care (LTC) and Non-Long-Term Care**

|   | Immediate Jeopardy (IJ) | Non-IJ High       | Non-IJ Medium |
|---|-------------------------|-------------------|---------------|
| Non-LTC (Deemed providers* or non-deemed providers, other than nursing homes) | 2 days                  | No set time frame | 45 days       |
| LTC (Nursing Homes)   | 2 days                  | 10 days           | 430 days      |
| State-Only Licensed Facilities  | 2 days                  | No set time frame | 360 days      |

\*Deemed Providers are those providers which have been accredited by a private accrediting body resulting in Medicare and Medicaid participation in lieu of the state survey.

Source: *State Operations Manual*, Chapter 5, and *HCF Administrative Policies and Procedures*.

File Reviews

January 1, 2006–June 30, 2007 (Before CMS Policy Changes). From a total of 1,659 complaints received, auditors reviewed a sample of 70 files for each of the three regions from January 1, 2006, to June 30, 2007—a total of 210 files. (See Table 1.) The data showed that 2% of total complaints were investigated late. This allowed the Division of Health Care Facilities to meet its own budget performance measure goal of conducting 90% of all investigations timely and CMS’s requirement that 95% of all Non-Immediate Jeopardy High investigations be conducted timely (3% were investigated late).

However, by conducting 3% of all Immediate Jeopardy investigations late, the division failed to meet CMS’s required Immediate Jeopardy complaint investigation rate of 100%.

**Table 1**  
**Regional Office Complaint File Review**  
**January 1, 2006, Through June 30, 2007 (Before CMS Policy Changes)**

| Priority                      | Investigation Time Frame(s)                          | Number of Complaints All Regions | Number of Complaints Investigated Late | Percent of Complaints Investigated Late by Priority | Percent of Total Complaints Investigated Late |
|-------------------------------|--|----------------------------------|--|---|---|
| Immediate Jeopardy            | 2 working days                                       | 58                               | 2                                      | 3%  | NA  |
| Non-Immediate Jeopardy High   | 10 working days                                      | 91                               | 3                                      | 3%  | NA  |
| Non-Immediate Jeopardy Medium | 45 working days/430 calendar days/360 calendar days* | 61                               | 0                                      | 0   | NA  |
| Totals                        |  | 210                              | 5                                      | NA  | 2%  |

NA – Percent calculation is not applicable for this column heading.

\*See page 17 for specific time frame breakdown.

Investigations for all of the 210 complaints reviewed had been completed, and surveyors found that 39% of those complaints were substantiated.

July 1, 2007–September 1, 2007 (After CMS Policy Changes). For July 1, 2007, to September 1, 2007, auditors reviewed 45 complaint files—15 from each of the three regions. (See Table 2.) The file review found that 36% of complaint investigations were late. Immediate Jeopardy complaints were investigated late 33% of the time, and Non-Immediate Jeopardy High complaints were investigated late 58% of the time. For this time frame, HCF failed to meet both of CMS’s complaint investigation requirements as well as its own performance goals.

**Table 2**  
**Regional Office Complaint File Review**  
**For July 1, 2007, to September 1, 2007 (After CMS Policy Changes)**

| Priority                      | Investigation Time Frame(s)                          | Number of Complaints All Regions | Number of Complaints Investigated Late | Percent of Complaints Investigated Late by Priority | Percent of Total Complaints Investigated Late |
|-------------------------------|--|----------------------------------|--|---|---|
| Immediate Jeopardy            | 2 working days                                       | 24                               | 8                                      | 33%   | NA  |
| Non-Immediate Jeopardy High   | 10 working days                                      | 12                               | 7                                      | 58%   | NA  |
| Non-Immediate Jeopardy Medium | 45 working days/430 calendar days/360 calendar days* | 9                                | 1                                      | 11%   | NA  |
| Totals                        |  | 45                               | 16                                     | NA  | 36%   |

NA – Percent calculation is not applicable for this column heading.

\*See page 17 for specific time frame breakdown.

Investigations had been completed for 73% of the 45 complaints reviewed, and surveyors found that 42% of the complaints with completed investigations were substantiated.

CMS Review for the Period October 1, 2005, Through September 30, 2006

In its Fiscal Year 2006 Performance Review, CMS cited the Division of Health Care Facilities for not meeting complaint and incident investigation time frame requirements. According to Division of Health Care Facilities staff, CMS instructed staff during a June 2007 conference call that telephone contact could not be used as a means to satisfy investigation timeline requirements. As opposed to making an on-site visit within the designated time frame, as required by CMS, in some cases surveyors had been merely calling facilities in order to meet CMS guidelines, and not going to the facilities in person.

In the 210 complaint files reviewed for the period January 1, 2006, to June 30, 2007, auditors found 17 instances where telephone calls were used to satisfy investigation timelines. For the 45 complaint files reviewed for the time period July 1, 2007, to September 1, 2007, however, auditors found only one instance of telephone contact being used in place of the required on-site visit. The reduced incidence of misused telephone contact demonstrates the Division of Health Care Facilities' increased compliance with CMS directives.

Review of Data From the ASPEN Complaint Tracking System (ACTS)

The Division of Health Care Facilities has a Central Complaint Intake Unit (see page 7) and uses CMS's ASPEN Complaint Tracking System (ACTS) to record and track investigations. Auditors used ACTS-generated complaint data to evaluate management's assertion of an increased complaint volume (see page 16), as well as to examine the full extent of late complaint investigations.

Tables 3 and 4 demonstrate the significant difference in complaint investigation performance for the two time periods auditors reviewed. For the 18-month period reviewed that was largely prior to the June 18, 2007, policy change, only 3% of total complaints had investigation start dates that were late. However, for the two-month period reviewed after the policy change, 28% of total complaints had start dates that were late.

**Table 3**  
**ACTS Complaint/Incident Investigation Log**  
**All Regional Offices**  
**January 1, 2006, Through June 30, 2007\***

| Priority                      | Investigation Time Frame(s)                               | Number of Complaints All Regions | Number of Complaints Investigated Late | Percent of Complaints Investigated Late by Priority | Percent of Total Complaints Investigated Late |
|-------------------------------|---|----------------------------------|--|---|---|
| Immediate Jeopardy            | 2 working days  | 487                              | 17                                     | 3%  | NA  |
| Non-Immediate Jeopardy High   | 10 working days   | 744                              | 27                                     | 4%  | NA  |
| Non-Immediate Jeopardy Medium | 45 working days/430 calendar days/<br>360 calendar days** | 428                              | 3                                      | 1%  | NA  |
| Totals                        |   | 1,659                            | 47                                     | NA  | 3%  |

NA – Percent calculation is not applicable for this column heading.

\*Table includes two weeks of complaints taken after the policy change. This slightly under-represents the impact of the change by including complaints attributed to the modification. The differences between the tables would be even more pronounced had the two weeks of complaints been excluded from the data.

\*\*See page 17 for specific time frame breakdown.

**Table 4**  
**ACTS Complaint/Incident Investigation Log**  
**All Regional Offices**  
**July 1, 2007 through September 1, 2007**

| Priority                      | Investigation Time Frame(s)                           | Number of Complaints All Regions | Number of Complaints Investigated Late | Percent of Complaints Investigated Late by Priority | Percent of Total Complaints Investigated Late |
|-------------------------------|---|----------------------------------|--|---|---|
| Immediate Jeopardy            | 2 working days  | 177                              | 46                                     | 26%   | NA  |
| Non-Immediate Jeopardy High   | 10 working days                                       | 260                              | 146                                    | 56%   | NA  |
| Non-Immediate Jeopardy Medium | 45 working days/430 calendar days/360 calendar days** | 306                              | 16                                     | 5%  | NA  |
| Totals                        |   | 743                              | 208                                    | NA  | 28%   |

NA – Percent calculation is not applicable for this column heading.

\*44% of the most serious complaints—IJ and Non-IJ High Complaints—were late.

\*\* See page 17 for specific time frame breakdown.

For the period January 1, 2006, through June 30, 2007, the Division of Health Care Facilities did not meet the CMS standard that 100% of all Immediate Jeopardy complaints be investigated within two days (3% of Immediate Jeopardy complaints were investigated late). The division also did not meet this standard for the July 1, 2007, to September 1, 2007 period, during which 26% of Immediate Jeopardy complaints were investigated late. During that two-month period, the division also failed to meet the CMS standard that 95% of Non-IJ High nursing home complaints be investigated within ten days (56% of Non-Immediate Jeopardy High complaints were investigated late). In addition, the division did not meet the Board for Licensing Health Care Facilities’ goal (listed in its Budget Performance Measures) of having 90% of all complaints investigated timely (28% of total complaints were investigated late).

Conclusion and Other Challenges Affecting Compliance

Failure to investigate complaints in a timely manner jeopardizes patient safety and makes it more difficult to collect evidence associated with abuse and neglect cases. Complaints often involve physical evidence (bruises, scratches, etc.) and eyewitnesses that necessitate a timely response in order to accurately evaluate and/or substantiate the complaint. For some types of complaints, the jeopardy may be widespread, and delayed action could put multiple patients at risk. In addition to jeopardizing patient welfare, the Division of Health Care Facilities can also incur monetary penalties for failing to meet CMS requirements. Alabama was recently fined \$298,000 for not completing health care facility surveys within the required time period.

In addition to the challenges resulting from CMS's more stringent directives, internal changes at the division also pose increased challenges for staff to comply with CMS investigation time frames. Executive Order 44 transfers the Bureau of Alcohol and Drug Abuse Services from the Department of Health to the Department of Mental Health and Developmental Disabilities effective January 1, 2008. However, it is unlikely that removing those responsibilities from surveyors will free up more surveyors for complaint investigations. Offsetting the Alcohol and Drug Abuse Services changes is Chapter 373, Public Acts of 2007, which amended Title 63, Chapter 6, and Title 68, Chapter 11, *Tennessee Code Annotated*, relative to the practice of medicine. This legislation requires the board to regulate the practice of office-based surgeries across the state. It is unknown how many facilities that this will add; but the Division of Health Care Facilities will be responsible for conducting surveys and complaint investigations at the newly regulated facilities. Division management expressed confidence in meeting the survey time frames (see page 38), but is concerned that the division will not be able to meet the complaint time frames or the CMS performance measures.

Staffing for surveys and complaint investigations also presents challenges. Health Care Facilities operates a Regional Office in each of the state's three territorial divisions. From the cities of Jackson, Nashville, and Knoxville, surveyors travel to health-care facility destinations within their assigned areas to conduct surveys and complaint investigations. As shown in the maps on pages 47-59, surveyors are responsible for a considerable number of facilities within their regions. The volume of health care facilities and the distances between them present logistical difficulties for conducting surveys and investigations in an efficient and timely manner.

### **Recommendation**

The Division of Health Care Facilities should investigate complaints (particularly Immediate Jeopardy and Non-Immediate Jeopardy High complaints) timely and in accordance with CMS guidelines. Division of Health Care Facilities management should review staffing levels and allocations, complaint workload, complaint investigation procedures, and procedures for tracking and overseeing the complaint process to identify any areas where procedures could be improved or streamlined, or workload reallocated, to handle the increased complaint volume and ensure timely and appropriate complaint handling and resolution. Efforts should be made to reduce the existing backlog of complaints and to enter all complaints into ACTS as they are received.

### **Management's Comment**

We concur with the audit findings. Health Care Facilities (HCF) should investigate complaints (Immediate Jeopardy and Non-Immediate Jeopardy High) timely and in accordance with CMS guidelines.

As noted in the audit report, CMS, on June 18, 2007, instituted a policy change that required investigation of all unusual incidents (UIRS) violating federal levels of participation. During the subsequent two and one-half month period (June 18, 2007–September 1, 2007) the complaints requiring timely investigation increased 184% above the prior period (January 1

2006–June 17, 2007). An unfortunate, unintended impact of this CMS policy change was that our percentage of late complaint investigations in all priority categories increased.

HCF has requested a budget appropriation to add a minimum of three additional surveyors to each regional office for a total of nine additional surveyors to handle the increased complaint volume. We believe this added staff will ensure timely and appropriate complaint handling and resolution and eliminate the backlog of complaints. Until such time as funding is appropriated to HCF for the requested increase in surveyors, we will work diligently and as efficiently as possible within the existing staffing pattern to investigate complaints timely but it is anticipated that we will continue to experience high percentages of late complaint investigations. It is our hope that the current workload on the current workforce will not result in a higher attrition rate.

### 3. Licensed health care facilities are not required to report on the status of waivers

#### Finding

Section 68-11-209, *Tennessee Code Annotated*, grants the Board for Licensing Health Care Facilities the authority to waive the rules and regulations for any facility as long as the waiver does not have a detrimental effect on the health, safety, and welfare of the public. Between February 4, 2004, and May 7, 2007, 83 waiver requests came before the board and 77 (93%) were approved. (See Table 5.) The greatest percentage of waivers (31%, or 24 of 77 granted) involved allowing a nursing home to operate without a nursing home administrator for a specific period of time. (See page 24 for additional explanation.) Table 6 lists the types of waivers granted by rule type.

**Table 5**  
**Number of Waivers Acted on by Board for Licensing Health Care Facilities**  
**By Type of Action**  
**February 2004 Through May 2007**

|                 | 2004 | 2005 | 2006 | 2007 | Total |
|-----------------|------|------|------|------|-------|
| Granted         | 16   | 23   | 30   | 8    | 77    |
| Denied          |      | 1    | 2    | 1    | 4     |
| Dismissed       | 1    |      |      |      | 1     |
| No action taken |      | 1    |      |      | 1     |
|                 | 17   | 25   | 32   | 9    | 83    |

Source: Board meeting documentation and minutes.

**Table 6**  
**Waivers Granted by Rule Type Waived**  
**February 2004 Through May 2007**

| Description of Rule Waived | 2004      | 2005      | 2006      | 2007     | Total     |
|----------------------------|-----------|-----------|-----------|----------|-----------|
| Nursing Home Administrator | 9         | 5         | 6         | 4        | 24        |
| Health Related (1)         | 2         | 0         | 0         | 0        | 2         |
| License Related (2)        | 3         | 9         | 20        | 3        | 35        |
| Fire Safety Related (3)    | 1         | 3         | 1         | 0        | 5         |
| Other (4)                  | 1         | 6         | 3         | 1        | 11        |
| <b>Total</b>               | <b>16</b> | <b>23</b> | <b>30</b> | <b>8</b> | <b>77</b> |

Examples of waivers granted:

- (1) Waived rule requiring specific amount of medication maintained at facility/waived fixed medical gas piping at facility.
- (2) Placed license on inactive status/allowed facility to become satellite of another facility or move from being satellite to being free-standing licensee/placed some beds in abeyance.
- (3) Allowed extension of time to install sprinkler system.
- (4) Allowed facility to share some services (e.g., laundry, food services) with other facility/allowed facility to operate without Director of Nursing until new director can be hired/waived rule requiring awake attendant on the premises at all times.

Source: Board meeting documentation and minutes.

Based on a review of waiver documentation, we found that the board approves waivers of the requirement for a licensed nursing home administrator for 60, 90, or 180 days. In reality, however, the period without the licensed nursing home administrator is longer. When a nursing home does not have a licensed administrator because of illness, resignation, or termination, etc., Rule 1200-8-6-.04 requires the facility to report that fact to the board within 24 hours. The facility then has seven days to file a request for a waiver of the rule, and the board considers the request at its next meeting, which may be as far away as 90 days. For example, in March 2004, a nursing home facility terminated the administrator, notified the board, and filed a waiver request. The board heard the request at its May 2004 meeting, approving a waiver for 90 days. The nursing home was actually without an administrator from March 2004 until the expiration of the waiver in August 2004, for a total of 129 days.

The board does not require facilities to report the status of rules and regulations waived. A board letter sent to facilities that have been granted a waiver includes a request that the facility notify the board in writing when there is a change in the waiver status. A board staff member also phones the facility near the date of waiver expiration, providing a reminder. However, there is no written policy describing this procedure or requiring the facility to notify the board, and there is no consequence if the facility fails to notify the board. Without a written policy that formalizes the monitoring process, requires facilities to report timely, and imposes penalties for not reporting, the board cannot be confident it has the most current information on waiver status.

Section 68-11-210, *Tennessee Code Annotated*, requires that all health care facilities be inspected within 15 months of the last inspection. This appears to be the only method by which the board would discover that a facility had not conformed to the waiver requirements, unless a

surveyor was investigating a complaint at the facility and found that the facility was operating without a licensed administrator. For example, pursuant to Rule 1200-8-6-.04, after the unexpected loss of a nursing home's administrator, the board may authorize an individual to be responsible for the facility for up to 30 days. At the end of that period, the facility must have a "temporary administrator" who is licensed and approved by the Board of Examiners for Nursing Home Administrators (BENHA). This license is granted temporarily for a period of no longer than six months. If the facility does not have a fully licensed Tennessee nursing home administrator, then (a) the facility could be subject to regulatory discipline by the board, and (b) the individual who is serving as the "administrator" could be subject to disciplinary action by BENHA for unlicensed practice. Requiring a facility to update the board at the onset of a waiver change could help ensure a facility is not violating a waiver requirement.

### **Recommendation**

The division should develop and implement rules that require facilities to notify the board of changes in the waiver status and should impose penalties if the facility fails to notify. These requirements would help ensure the board has the most current information on waiver status, allowing for improved waiver monitoring and tracking. Division management should also develop formal procedures regarding waiver monitoring and tracking.

### **Management's Comment**

We concur with the audit findings. At the May 7 and 8, 2008, Board meeting, the Director of Licensure, in conjunction with the Office of General Counsel, will submit to the Board for Licensing Health Care Facilities for review and approval a written policy detailing the waiver monitoring and tracking process. The Director will also present recommendations for a revision to Rule 1200-8-6-.04, that will:

- require facilities to report to the board staff the status of rules and regulations previously waived (e.g., to ensure a facility is not violating a waiver requirement), and
- recommend penalties for waiver violations.

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#### **4. The Board for Licensing Health Care Facilities has not met its statutory requirement for self-sufficiency**

### **Finding**

Section 68-11-216(b)(2), *Tennessee Code Annotated*, states that the Board for Licensing Health Care Facilities should establish and collect fees sufficient to cover the costs of operating the board. On or before December 31 of each year, the Commissioner of the Department of Health is to report to the Government Operations Committee of each house and the Tennessee

Code Commission, if the board did not, during the fiscal year, collect fees in an amount sufficient to pay the costs of operating the board. If the board fails to collect sufficient fees to pay the costs of operating the board for a period of two consecutive fiscal years, the board shall be reviewed by the joint evaluation committees and shall be subject to a revised termination date of June 30 of the fiscal year immediately following the second consecutive fiscal year during which the board operated at a deficit.

For fiscal years 2003 through 2007, the board was not self-sufficient. (See Table 7.) The 2003 performance audit of the board found that the board was also not self-sufficient in fiscal year 2002. (In 2000, the General Assembly passed legislation stating the legislature’s intent that the board be self-sufficient, effective for fiscal year 2002.)

**Table 7**  
**Board for Licensing Health Care Facilities**  
**Fees and Expenditures\***  
**Fiscal Years Ending June 30, 2003, Through 2007**

|                       | 2003        | 2004        | 2005        | 2006        | 2007        |
|-----------------------|-------------|-------------|-------------|-------------|-------------|
| <b>Fees</b>           | \$1,620,407 | \$1,717,571 | \$1,726,191 | \$1,795,390 | \$2,341,648 |
| <b>Expenditures</b>   | 1,796,425   | 1,922,789   | 2,366,341   | 2,560,841   | 2,781,898   |
| <b>Ending Balance</b> | (\$176,018) | (\$205,218) | (\$640,150) | (\$765,451) | (\$440,250) |

\*These revenues and expenditures do not include the Division of Health Care Facilities federal revenues and related expenses in administering the federal certification program.

Source: State of Tennessee Accounting and Reporting System.

April 2007 Licensing Fee Increases

Board revenues are generated from application and license-renewal fees. Effective July 1, 2005, the General Assembly authorized the board to set its own fees through rules, as necessary for the board to be self-sufficient. Prior to that time, license fees were increased only by legislative action.

In April 2007, the board increased application and renewal fees from 25% to 50% (depending on the type of facility); however, despite the increase the board had more expenditures than revenues in fiscal year 2007.

Department of Health management notified the Joint Government Operations Committee in January 2007 and the Department of Finance and Administration in November 2006 certifying that the board was not self-sufficient in fiscal year 2006. The Joint Government Operations Committee was notified in October 2007 that the board was not self-sufficient in fiscal year 2007.

**Recommendation**

Board members and Division of Health Care Facilities staff should review the board’s revenues and expenditures and determine actions to be taken to achieve self-sufficiency.

## Management's Comment

We concur with the audit findings. As soon as practicable, staff will present a fiscal report to the Board and ask the Board to consider raising its fees appropriately to achieve and sustain self-sufficiency.

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### **5. Dialysis technicians are weakly regulated because of an absence of minimum requirements and certification**

#### **Finding**

There are no federal requirements for dialysis technicians under current CMS End Stage Renal Disease (ESRD) conditions of coverage. This is consistent with CMS's long history of respecting state oversight of health professionals. Subsequently, states have engaged in a variety of approaches to regulate dialysis technicians that have included certification, competency testing, and minimum qualification requirements.

The Department of Health establishes standards for dialysis clinics which are outlined in Chapter 1200-8-32-.04 of the rules for the Board of Licensing Health Care Facilities. (The board is given the authority to license and regulate dialysis clinics in Section 68-11-202, *Tennessee Code Annotated*.) Dialysis technicians are required to complete a training program administered by the employing facility, as defined in Chapter 1200-8-32-.04. The trainee may provide patient care only under the immediate supervision of a registered nurse or assigned instructor, until the successful completion of a competency evaluation. All training programs for dialysis technicians must include the following minimum components:

**Training Program Requirements  
Per the Standards for Dialysis Clinics  
Board for Licensing Health Care Facilities Rules**

|    |   |
|----|---|
| 1  | Introduction to dialysis therapies to include history and major issues  |
| 2  | Principles of hemodialysis  |
| 3  | Understanding the individual with kidney failure  |
| 4  | Dialysis procedures   |
| 5  | Hemodialysis devices  |
| 6  | Water treatment following current AAMI guidelines   |
| 7  | Reprocessing, utilizing current AAMI guidelines if the facility practices reuse   |
| 8  | Patient teaching  |
| 9  | Infection control and safety - (a) Universal precautions, aseptic technique, specimen handling and (b) Risk to employees of blood and chemical exposure   |
| 10 | Principles of Quality Improvement and role of the technician or nurse in QI activities  |
| 11 | Principles of peritoneal dialysis to include – (a) Peritoneal dialysis delivery systems; (b) Symptoms of peritonitis; and (c) Other complications of peritoneal dialysis  |
| 12 | If a dialysis technician is to cannulate or administer normal saline or lidocaine during initiation or termination of dialysis, the following must be included:<br>(1) Access to the circulation to include (a) fistula creation, development, needle placement, and prevention of complications; (b) grafts, materials used, creation, needle placement, and prevention of complications; and (c) symptoms to report<br>(2) Safe administration of medications including (a) identifying the right patient; (b) assuring the right medication; (c) measuring the right dose; (d) ascertaining the right route; (e) checking the right time for administration; (f) reasons for administration; (g) potential complications; (h) administration limits; and (i) information to report and record. |

In the Federal Register/Vol. 70, No. 23/Friday, February 4, 2005/Proposed Rules, CMS advocates requiring dialysis technicians to have at least a high school diploma and complete at least three months experience following a facility’s training program. CMS also proposes a training program that is specific to technicians who monitor the water treatment system. These changes are expected to go into effect in 2008.

Facilities are given both the responsibility and discretion to adhere to the requirements for dialysis technician training programs as defined in Chapter 1200-8-32-.04. Tennessee does not establish any minimum educational requirements or training durations, and the competency evaluation criteria are general and unspecified. Many states have adopted national certifications or minimum training and competencies as part of their requirements. Table 8 below lists a cross section of states and their dialysis technician requirements.

**Table 8  
Dialysis Technician Requirements by State**

| State            | Certification Requirement (1) | Educational Requirement (2) | Specific Training Requirement (3) |
|------------------|-------------------------------|-----------------------------|-----------------------------------|
| Arizona          | Yes                           | Yes                         | -                                 |
| California       | Yes                           | Yes                         | Yes                               |
| Colorado         | Yes                           | -                           | Yes                               |
| Connecticut      | Yes                           | Yes                         | -                                 |
| Georgia          | -                             | -                           | Yes                               |
| Kentucky         | -                             | -                           | Yes                               |
| New Mexico       | -                             | Yes                         | Yes                               |
| Mississippi      | Yes                           | Yes                         | Yes                               |
| Ohio             | Yes                           | Yes                         | Yes                               |
| Oregon           | Yes                           | Yes                         | Yes                               |
| South Dakota     | -                             | Yes                         | Yes                               |
| <b>Tennessee</b> | -                             | -                           | -                                 |
| Texas            | Yes                           | Yes                         | Yes                               |
| Utah             | -                             | -                           | Yes                               |
| Virginia         | Yes                           | -                           | -                                 |
| West Virginia    | Yes                           | Yes                         | Yes                               |

Source: Federal Register and State Rules and Regulations.

Notes:

- (1) For states requiring hemodialysis technicians to obtain certification through a national organization—such as the Certified Clinical Hemodialysis Technician offered by the Nephrology Nursing Certification Commission (NNCC); Certified Hemodialysis Technician offered by the Board of Nephrology Examiners Nursing and Technology (BONENT); and Certified Nephrology Technologist offered by the Nephrology Certification Organization (NNCO)—applicants are required to meet the minimum educational threshold of having a high school diploma or GED. Thus, if educational requirements are not specifically referenced in state statutes/regulations, but a national certification requirement is, then educational minimums are indirectly required.
- (2) “Educational Requirements” refer to obtaining a minimum of a high school diploma or GED.
- (3) “Specific Training Requirements” refer to minimum training lengths and/or curriculum, adopted department-wide training, continuing education requirements, or that the governing board has approved the particular training program.

Tennessee ranked last in the nation in the fistula-first rate (a CMS initiative). Fistulas are created by surgically joining a vein and an artery in the forearm to provide access for dialysis. Fistulas are more durable and are associated with lower infection, hospitalization, and death rates. The Department of Health and Human Services’ Healthy People 2010 includes increasing fistulas in dialysis patients as one of its objectives.

Adding insight into the overall condition of the Tennessee renal community, the Board for Licensing Health Care Facilities cited serious deficiencies at the Memphis University Dialysis Center and suspended the facility’s license earlier this year. The cumulative effect of these factors, which include state regulation comparisons, proposed federal requirements, poor CMS initiative performance, and the closing of a dialysis clinic, compels the board to consider actions that would more closely regulate dialysis technicians and improve the quality of care for end-stage renal disease patients.

Division of Health Care Facilities staff agree that state dialysis regulations should be updated and that there needs to be a certification process. There are, however, a multitude of state regulatory approaches and a lack of consensus regarding certification, licensing, and their relationship with improved patient outcomes. For example, the Colorado Department of Regulatory Agencies Office of Policy, Research, and Regulatory Reform produced a 2006 Sunrise Review that explicitly argued against licensing, certifying, or otherwise regulating dialysis technicians. The Colorado report cited and agreed with CMS's rationale which included:

- (1) There is no consensus within the hemodialysis community regarding the efficacy of technician certification to provide improved patient outcomes and care.
- (2) There is no one generally-accepted national certification test available to the profession.
- (3) A certification (or licensure) requirement would necessitate additional costs for transportation, lodging, fees, and preparatory materials associated with an examination.

Alternately, a 2005 Sunrise Report by the West Virginia Performance Evaluation and Research Division argued that it was in the best interest of the state to establish a certification and credentialing process. The legislative auditor's rationale included increased protection for the patient and the technician, and competency assurance through testing and training standards. States' varied positions on this topic are evidenced through their regulatory differences regarding dialysis technicians.

### **Recommendation**

Pending the outcome of the new federal requirements scheduled for release in 2008, the Division of Health Care Facilities should begin developing a certification and standardized training process to better regulate dialysis technicians. Minimum education and training requirements for dialysis technicians should be considered. The division may wish to consult the National State Auditors Association's *Best Practices in Carrying Out a State Regulatory Program* for guidance in standard setting, the certification process, and identifying people to be regulated.

### **Management's Comment**

We concur in part with the audit findings. Although we agree that the Dialysis Technicians should be subject to competency requirements, we are not certain, at this time, whether the Department has the statutory authority to undertake such a regulatory program. We will consult with our Office of General Counsel for clarification. However, until such legal clarification is obtained, we will immediately establish the development of a Dialysis Tech Advisory Committee. The Committee will be charged with:

- Identifying minimum educational requirements of candidates.

- Drafting minimum training program requirements and training duration.
- Determining competency requirements.
- Determining continuing education requirements.

Upon presentation of a final report from the Committee and a positive legal interpretation from our General Counsel, the Board will initiate development of regulations incorporating the Committee findings on the certification of Dialysis Technicians. The initial phase will only address patient care.

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**6. The Division of Health Care Facilities and the Department of Commerce and Insurance should adopt the required interdepartmental agreement concerning oversight of Health Maintenance Organizations, and should include in that agreement provisions requiring that HMOs submit corrective action plans when deficiencies are identified**

**Finding**

Section 56-32-215, *Tennessee Code Annotated*, requires the commissioners of the Departments of Commerce and Insurance and Health to coordinate the regulation of Health Maintenance Organizations. While the Department of Commerce and Insurance is responsible for financial reviews of the HMOs and/or their providers, the Department of Health is responsible for determining whether the HMO has the capability to provide health care services efficiently, effectively and economically, through surveying the HMOs. In addition, the departments are required by law to develop an interdepartmental agreement to coordinate oversight of the HMOs. However, neither department was able to provide us with a copy of such an agreement.

The Division of Health Care Facilities, acting as the designee of the Commissioner of the Department of Health, has responsibility for the HMO surveys that determine the quality of health care services. The law requires the surveys to be performed at least every three years.

We obtained and reviewed the most recent surveys of the seven licensed HMOs. See Table 9. The division has surveyed six of the seven HMOs within the past three years. (Because one HMO was licensed in December 2006, the survey for it would not be due until no later than December 2009.) However, the division could not provide any surveys prior to the most recent survey, so we could not determine whether the HMOs were surveyed within the prior three-year period. Five of the six HMOs surveyed had findings requiring that they submit a Plan of Correction but only one of the five had submitted a Plan of Correction. According to division staff, there are no penalties for failure to submit the plan.

**Table 9**  
**Health Maintenance Organization Survey Dates**  
**Surveys Completed As of October 31, 2007**

| <b>Health Maintenance Organization</b>    | <b>Most Recent Survey Date</b>   | <b>Plan of Correction Submitted</b>                           |
|---|----------------------------------|---|
| Aetna US Healthcare, Inc.                 | 2/14/2007                        | No  |
| Bluegrass Family Health Inc.              | Initially Licensed<br>12/31/2006 | N/A   |
| Cariten Health Plan, Inc.                 | 12/31/2004                       | No Plan of Correction needed because<br>no deficiencies cited |
| Cigna Healthcare of<br>Tennessee, Inc.    | 7/30/2005                        | No  |
| Healthspring, Inc.                        | 10/30/2006                       | Yes   |
| United Healthcare Plan of<br>River Valley | 8/18/2005                        | No  |
| United Healthcare of<br>Tennessee, Inc.   | 3/18/2005                        | No  |

Source: Department of Commerce and Insurance and Health Care Facilities Division.

### **Recommendation**

The Division of Health Care Facilities and the Department of Commerce and Insurance should promptly adopt an interdepartmental agreement concerning oversight of Health Maintenance Organizations as required by Section 56-32-215(a), *Tennessee Code Annotated*. The agreement should include provisions requiring the HMOs to submit Plans of Correction when applicable. The Division of Health Care Facilities should maintain HMO survey files to ensure that surveys are conducted timely.

### **Management's Comment**

We concur with the audit findings. Within the next 180 days Health Care Facilities (HCF) will work with the Department of Commerce and Insurance to develop an interdepartmental agreement to coordinate oversight of HMOs. In this agreement we will propose that Commerce and Insurance would provide financial review of the HMOs and their providers, and that HCF would determine the HMO's capability of providing quality health care services. The agreement will include provisions requiring the HMOs to submit Plans of Correction, when applicable, with specified time frames and recommended penalties for failure to do so. HCF will maintain HMO survey files in a singular location (file cabinet) and ensure that surveys are conducted timely.

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## OBSERVATIONS AND COMMENTS

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The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the board and on the citizens of Tennessee.

### BOARD MEMBER VACANCIES

Section 68-11-203, *Tennessee Code Annotated*, requires that the Board for Licensing Health Care Facilities consist of 20 members. Board members are appointed by the Governor and serve a four-year term. If a vacancy occurs in the board for any reason other than the expiration of term, the appointment shall be for the unexpired term. Vacancies shall be filled from the same classification as was represented by the outgoing member. In the August 2003 performance audit, we reported that one board member's position—the consumer representative—had remained vacant for 28 months.

As of October 2007, the board had a vacancy for an architect representative. The term for this representative began May 1, 2007, but the architect representative whose term expired in May 2007 is continuing to serve until a new member is appointed.

Auditors reviewed board member timelines to determine if any positions were continuously vacant. Thirteen of the 18 membership changes we reviewed were timely (one month or less from expiration to appointment). The five other vacancies ranged from 4 months to 20 months. The 20-month vacancy was for the Oral Surgeon appointment, which became vacant in February 2003 and was not filled until September 29, 2004. When positions are allowed to remain vacant, the board is deprived of another perspective in its decision making.

Appointments should be made in a timely manner to ensure the board is compliant with statute. The Board for Licensing Health Care Facilities' staff should work with the Governor's Office to ensure that the Governor has sufficient notice of upcoming vacancies and any other additional information his office might need to make timely appointments.

### METHADONE CLINICS

Methadone clinics provide a combination of medical, mental health, and social services for treating opiate dependent clients. Treatment services consist of three treatment modalities: 30-day detoxification treatment, a 180-day long-term detoxification program, and a narcotic-replacement maintenance treatment program. Clients are admitted based upon client requests and admission criteria defined in the state and federal rules, as medically appropriate.

Oversight by Division of Health Care Facilities

The Division of Health Care Facilities currently licenses nine methadone clinics.

**Licensed Methadone Clinics  
August 2007**

| <b>Name</b>   | <b>Location</b> | <b>Accreditation</b> | <b>Year of Original Licensure</b> |
|---|-----------------|----------------------|-----------------------------------|
| ADC Recovery and Counseling Center                  | Memphis         | CARF                 | 2003                              |
| DRD Knoxville Medical Clinic                        | Knoxville       | JCAHO                | 1994                              |
| DRD Knoxville Medical Clinic Central                | Knoxville       | JCAHO                | 2004                              |
| Jackson Professional Associates                     | Jackson         | CARF                 | 1994                              |
| Memphis Center for Research and Addiction Treatment | Memphis         | CARF                 | 2001                              |
| Middle Tennessee Treatment Center                   | Nashville       | CARF                 | 1997                              |
| Raleigh Professional Associates                     | Memphis         | CARF                 | 1994                              |
| Solutions of Savannah                               | Savannah        | CARF                 | 2006                              |
| Volunteer Treatment Center Inc.                     | Chattanooga     | CARF                 | 1994                              |

Source: Division of Health Care Facilities.

CARF - Commission on Accreditation of Rehabilitation Facilities.

JCAHO - Joint Commission on Accreditation of Healthcare Organizations.

The division employs a pharmacist who serves as the State Methadone Authority (SMA) and monitors the methadone clinics. The SMA's responsibilities include overseeing licensure, investigating complaints, and surveying all methadone clinics. He also supervises the maintenance of the Central Registry (a patient-specific report that tracks patients' medication dosage and enrollment). The SMA prepares an annual report for the Director of Health Care Facilities that presents averaged, summarized data about the treatment facilities. See Appendix 6 for calendar year 2004, 2005, and 2006 data. In preparing the report, the SMA compiles self-reported statistics of pertinent patient information (e.g., enrollments, drop outs, etc.) from the treatment facilities. Although this information is unaudited, if the numbers appear out of the norm the SMA stated that he will call the facilities to be sure they have not made an error.

Certificate of Need Process for Any Proposed New Treatment Facility

Section 68-11-1607, *Tennessee Code Annotated*, directs the process for applying for a new methadone clinic. Within ten days of the filing of an application for a methadone clinic with the Tennessee Health Services and Development agency, the applicant is required to send a notice to the county mayor of the county where the facility is proposed and also to the state representative and senator representing that district. If the facility will be located within a municipality, the mayor of that city must also be notified. The Health Services and Development Agency (HSDA) is responsible for receiving, processing, and hearing any application. In order to establish a new facility, the HSDA must issue a Certificate of Need. Then the facility would apply for licensure through the Division of Health Care Facilities, file with accrediting bodies for accreditation, provide Health Care Facilities' Engineering staff blueprints for approval, develop

policies and procedures, and hire personnel. Health Care Facilities will then survey the facility before it opens, to validate that policies and procedures meet state and federal standards.

### Facility Surveys and Complaint Investigations

We reviewed survey and complaint data for the methadone clinics. According to Section 68-11-210(a)(1), *Tennessee Code Annotated*, every facility should be inspected within 15 months of the date of the last inspection. Most of the surveys were conducted timely; however two surveys were conducted late—four months and seven months late, respectively. According to the State Methadone Authority (SMA), the surveys were late because he had the wrong due date on his calendar.

Our review of complaints found that 79% (15 of 19) of the complaints were found to be unsubstantiated, 11% (2 of 19) were substantiated. Two complaints lacked any survey information so we asked the SMA about those two complaints. He stated that he did not have a record of receiving one of the complaints, but that the other complaint had been investigated; however, he did not provide the results of that complaint investigation. For those complaints for which we reviewed the data, the complaint investigations were conducted timely overall; however, in three instances investigations were conducted late (the three complaints ranged from three days to nearly two months late).

### Change for Oversight of Methadone Clinics

Executive Order 44, dated February 23, 2007, transferred licensing and regulation of alcohol and drug abuse facilities from the Department of Health to the Department of Mental Health and Developmental Disabilities, effective July 1, 2007. This includes transfer of responsibility for the methadone clinics. During our field work, the Division of Health Care Facilities management stated that the transfer had been delayed until January 1, 2008.

## **FACILITY COMPLIANCE WITH SPRINKLER STATUTES**

Section 68-11-258, *Tennessee Code Annotated*, requires that the Board for Licensing Health Care Facilities post on the state's website all licensed nursing homes, residential homes for the aged, and assisted-care living facilities, and indicate whether each facility has a fire suppression sprinkler system throughout the facility or a smoke detector or alarm in each patient room. To comply with this statute, the board posts on its website, updated monthly, a list of facilities that are not compliant. This list notes that "facilities not appearing on this list are fully sprinklered." As of November 2007, 11 facilities were listed as being without full sprinkler systems. See Table 10.

**Table 10  
Facilities Without Sprinkler Systems  
November 2007**

|    | <b>Region</b> | <b>Type</b>                     | <b>Name</b>                            | <b>Location</b> | <b>Comments</b>                                   |
|----|---------------|---------------------------------|--|-----------------|---|
| 1  | East          | Nursing Home                    | Brookhaven Manor                       | Kingsport       | Only Canopies Not Sprinklered                     |
| 2  | East          | Residential Home for the Aged   | Standifer Gap Home for the Elderly     | Chattanooga     | Facility Vacant and Under Construction            |
| 3  | Middle        | Residential Home for the Aged   | Haven of Rest 1                        | Tracy City      | Inadequate Water Supply Extension Granted         |
| 4  | Middle        | Residential Home for the Aged   | Haven of Rest Homes, Inc. #2           | Tracy City      | Inadequate Water Supply Extension Granted         |
| 5  | Middle        | Residential Home for the Aged   | Pineview Boarding Home for the Aged #3 | Hartsville      | Installation Due Date 7/24/08                     |
| 6  | Middle        | Residential Home of the Aged    | Wellington Place of Brentwood          | Brentwood       | Installation Due Date 4/6/08                      |
| 7  | Middle        | Assisted Care Living Facilities | Cedar Hills Retirement Center          | Cookeville      | Canopy not sprinklered, granted waiver to 2008    |
| 8  | West          | Nursing Home                    | Bailey Park Community Living Center    | Humboldt        | CN0704-032 for Replacement Facility Approved 8/07 |
| 9  | West          | Nursing Home                    | Hardin Home                            | Savannah        | Submitted new plans and extension request         |
| 10 | West          | Residential Home for the Aged   | Harlan Morris Retirement Home          | Trenton         | Completed, waiting plans review and inspection    |
| 11 | West          | Residential Home for the Aged   | Metro Community Care Home, Inc.        | Memphis         | Installation Due Date 10/25/08                    |

\*Source: Division of Health Care Facilities.

According to division staff, following the passage of sprinkler-related legislation (codified as Sections 68-11-235 through 237, *Tennessee Code Annotated*) in 2004, the Division of Health Care Facilities used the following process to identify licensed nursing homes, residential homes for the aged, and assisted-care living facilities that would have to install sprinkler systems:

- Each regional office compiled a list of all licensed facilities.
- Surveyors and/or fire safety inspectors from the three regional offices identified the facilities on the list that were already sprinklered or partially sprinklered. They used the Approval for Facility Licensure or Occupancy form. This form is completed by the fire safety inspector (after inspecting the facility) and approved by the regional office administrator and the Division of Health Care Facilities Licensure Manager prior to a facility being occupied.
- For those facilities not sprinklered or partially sprinklered, fire safety staff measured the square footage of the facility not sprinklered.
- The results of this inventory of facilities were sent of the central office, which used it to compile the original list of all facilities not in compliance.

Once the non-compliant facilities have installed a sprinkler system and been issued occupancy approval, they are removed from this non-compliant list. Once the Fire Safety supervisors in the regional offices determine a facility is “fully sprinklered,” occupancy forms are completed and sent to the Central Office where they are entered into the Regulatory Board System (RBS). Newly sprinklered facilities will be removed from the division’s website in the month following inspection approval.

Using one of the division’s original lists of noncompliant facilities, which included 938 facilities, we chose a sample of 64 Assisted Care Living Facilities, Nursing Homes, and Residential Homes for the Aged, and used RBS to locate the occupancy form to confirm that those facilities were now in compliance. The system for imaging and storing documentation related to licensed facilities is cumbersome. Documentation is stored by date rather than by a title that might help identify what is imaged. We found either occupancy forms for facilities or a letter from the Licensing Manager stating the facility was sprinklered and approved for occupancy for 21 of the facilities. The division’s Engineering Section was able to provide us with those forms for 5 of the facilities. We then asked the central office staff for the remaining documentation. They were able to provide the Life Safety Code inspection and the resulting form in which existing sprinkler systems are mentioned for 54 of the facilities. Documentation provided was produced from ASPEN as well as the Engineering Computer system. Using these multiple sources, we were able to obtain documentation for all 64 facilities, with documentation from more than one source for some facilities.

The Division of Health Care Facilities should improve the process and procedure for organizing and maintaining information documenting that facilities have met the requirements for sprinkler systems, so that proof of compliance is readily available when needed by division staff or requested by members of the public. Because the division posts a list of non-compliant

facilities rather than a list of all licensed facilities with respective sprinkler information, it is possible that all facilities may not be fully accounted for by this method.

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## RESULTS OF OTHER AUDIT WORK

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### SURVEYS OF FACILITIES

The Division of Health Care Facilities has a central office in Nashville and three regional offices located in Jackson, Nashville, and Knoxville. The regional offices' staff includes 83 surveyors responsible for conducting surveys (inspections). See Table 11 for surveyors by regional offices. Teams of three to four surveyors periodically inspect each facility to ensure that it meets applicable state licensing and federal certification requirements. (Requirements for certification are established by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services.) The size of the survey team varies depending on the experience of the surveyors, the complexity of allegations within a complaint, the size of the facility, and the number of residents living at the facility. Most division surveyors are registered nurses.

**Table 11**  
**Division of Health Care Facilities**  
**Regional Offices**

| Regional Office                  | Number of Surveyors | Number of Counties | Number of Facilities |
|----------------------------------|---------------------|--------------------|----------------------|
| East Tennessee Regional Office   | 29                  | 30                 | 730                  |
| Middle Tennessee Regional Office | 26                  | 34                 | 679                  |
| West Tennessee Regional Office   | 28                  | 31                 | 636                  |
| Totals                           | 83                  | 95                 | 2045                 |

At each regional office, a regional administrator is responsible for surveyors, survey assignments, fire safety inspections and coordination with the central office. See organizational chart on page 4. The regional office administrators prioritize the survey and complaint workload for the surveyors in their offices. State and federal regulations require surveys to be completed not later than 15 months after the previous survey. When a facility is accredited by a federally recognized accrediting health care organization, CMS and Tennessee law permit the division to accept the accreditation in lieu of an annual licensure survey. Accreditations from the Joint Commission on Accreditation of Healthcare Organizations, Community Health Accreditation Program, and Commission for Accreditation of Rehabilitation Facilities are accepted. Division policy requires that, even if accredited, a facility must be surveyed every three years. When accreditation status is accepted in lieu of a survey, the facility survey records contain a statement that the accreditation was used.

Surveyors complete their work, and the regional supervisors review and approve it. Automated Survey Processing Environment (ASPEN), a database that CMS developed and maintains, is used to track the progress of the survey function. Regional offices enter survey data into ASPEN.

We selected a sample of facilities in each of the three regions and reviewed the most recent surveys to determine if the time frames mandated were met. We used source documents in the survey reports (packages) as evidence and did not rely on the information in the ASPEN system. However, we did find that for the dates of the surveys, the date in the ASPEN system matched the date in the source documents. For the 160 facilities reviewed, we found that the surveys were conducted on time.

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## RECOMMENDATIONS

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### ADMINISTRATIVE

The Board for Licensing Health Care Facilities and the Division of Health Care Facilities should address the following areas to improve the efficiency and effectiveness of their operations.

1. Division of Health Care Facilities management should review policies and procedures and revise them as necessary to ensure that policies address all major actions related to placement on and removal from the Abuse Registry; responsibility for the actions is clearly assigned; and any time frames set are consistent with other federal and state requirements and laws. Management should then ensure that updated policies are communicated to all relevant staff.
2. Management should ensure there is supervisory review of Abuse Registry actions to monitor the timeliness of abuse investigations and hearings and to ensure that all required actions are taken and adequately documented in the files. Management should ensure that all persons recommended for placement on the registry are placed timely and listed with complete and correct information (including any nicknames as well as full legal name) so that those individuals can be identified if they subsequently seek employment in a facility that cares for vulnerable individuals. Removals of persons from the registry should be tracked and fully documented, and management should ensure that the reasons for removal are fully explained and meet the criteria for removal.
3. Division of Health Care Facilities management should review the statutory provisions for other Tennessee registries (particularly sex offender registration statutes) to identify changes that could be made to strengthen and improve the Abuse Registry legislation; for example, adding specific authority for updating the registry, requiring registrants to provide complete name and all aliases as well as any name changes, and adding penalties if registrants fail to provide complete, accurate, and up-to-date information. Department of Health management should then propose to the General Assembly appropriate legislative changes.
4. The Division of Health Care Facilities should investigate complaints (particularly Immediate Jeopardy and Non-Immediate Jeopardy High complaints) timely and in accordance with Centers for Medicare and Medicaid Services guidelines. Division of Health Care Facilities management should review staffing levels and allocations, complaint workload, complaint investigation procedures, and procedures for tracking and overseeing the complaint process, to identify any areas where procedures could be improved or streamlined, or workload reallocated, to handle the increased complaint volume and ensure timely and appropriate complaint handling and resolution. Efforts should be made to reduce the existing backlog of complaints and

- to enter all complaints into the ASPEN Complaint Tracking System as they are received.
5. The division should develop and implement rules that require facilities to notify the board of changes in the waiver status and should impose penalties if the facility fails to notify. These requirements would help ensure the board has the most current information on waiver status, allowing for improved waiver monitoring and tracking. Division management should also develop formal procedures regarding waiver monitoring and tracking.
  6. Board members and Division of Health Care Facilities staff should review the board's revenues and expenditures and determine actions to be taken to achieve self-sufficiency.
  7. Pending the outcome of the new federal requirements scheduled for release in 2008, the Division of Health Care Facilities should begin developing a certification and standardized training process to better regulate dialysis technicians. Minimum education and training requirements for dialysis technicians should be considered. The division may wish to consult the National State Auditors Association's *Best Practices in Carrying Out a State Regulatory Program* for guidance in standard setting, the certification process, and identifying people to be regulated.
  8. The Division of Health Care Facilities and the Department of Commerce and Insurance should promptly adopt an interdepartmental agreement concerning oversight of Health Maintenance Organizations (HMOs) as required by Section 56-32-215(a), *Tennessee Code Annotated*. The agreement should include provisions requiring the HMOs to submit Plans of Correction when applicable. The Division of Health Care Facilities should maintain HMO survey files to ensure that surveys are conducted timely.

## **Appendix 1 Title VI Information**

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discrimination against participants or clients based on race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning (1) federal financial assistance received by the Board for Licensing Health Care Facilities and the Health Care Facilities Division and (2) their efforts to comply with Title VI requirements internally and to monitor Title VI compliance in licensed facilities. The results of the information gathered are summarized below.

### Federal Funding and Department of Health Title VI Plan

For fiscal year 2007, the division received federal financial assistance of \$9.5 million. Neither the board nor the division prepare a Title VI plan or report directly to a state or federal agency concerning Title VI. Instead, both use the Department of Health's (DOH) *Title VI Compliance Plan and Implementation Manual*. We reviewed the Department of Health's 2007-08 plan for issues related to the board and the division. The plan's stated goal is to fulfill the provisions of Title VI of the Civil Rights Act of 1964. DOH has a Title VI Coordinating Committee and the Title VI Coordinator for the Division of Health Care Facilities is a member. The committee has prioritized the following Title VI objectives for 2007-2008:

- implementing a comprehensive Title VI Compliance Plan for use in the Department of Health's efforts to ensure that all persons receive services and benefits in a non-discriminatory manner,
- training for new hires and sub-recipients,
- informing the public through statewide collaborative workshops,
- assuring compliance in the Pre and Post Awards process through a Contract Administrative Tracking System and,
- investigating complaints in a timely and efficient manner.

Division of Health Care Facilities staff receive Title VI training and materials during orientation and instructions on the complaint process.

### Facility Compliance Monitoring

The division's Title VI Coordinator also serves as the Civil Rights Compliance Officer. The division monitors health facilities receiving federal funds for compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Section 504 of the Rehabilitation Act of 1973 is a federal law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the act apply to organizations that receive financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (DHHS). The act defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.

Section 68-11-901, *Tennessee Code Annotated*, establishes rights for nursing home residents. Those rights include

- privacy during treatment and personal care
- visits in private
- communication by telephone with any person they so choose
- mail delivery
- use of personal clothing and possessions
- choice of personal physician.

The division's goal in monitoring civil rights compliance is to improve access to health care facilities and to assess discriminatory practices and behavior based on race, color, and national origin in facilities licensed by the board. The division is responsible for disseminating information to health care facilities, conducting on-site reviews, interpreting state and federal regulations for staff and the public, preparing periodic investigative reports, and maintaining a complaint resolution system. If, during an on-site review or complaint investigation, a facility is found noncompliant with Title VI, the board and the department have several enforcement mechanisms available.

Section 68-1-113(c), *Tennessee Code Annotated*, allows the board to deny, suspend, or revoke a license issued to a health care facility, as the result of a Title VI violation. In addition to any such action by the board, Section 68-1-113(d) allows the Commissioner of Health to impose a civil penalty in an amount not to exceed \$5,000 for such a violation. Department of Health Rule 1200- 24-3-.03 specifies three penalty levels:

- Type I penalties range from \$3,500 to \$5,000 and may be assessed when a health care facility engages in discrimination which negatively impacts the health, safety, and welfare of multiple minority patients. For example, denying people admission to the facility; transferring multiple patients from one room to another; and clustering patients on the basis of race, color, and national origin meet these criteria.
- Type II penalties, ranging from \$1,500 to \$3,500, may be assessed if the health care facility engages in discrimination which impacts a single minority patient, and the facility refuses to correct the violation. For instance, denying admission to a single individual; assigning a room or transferring a single individual; or denying an individual the opportunity to participate on a planning or advisory board based on race, color, and national origin, or providing segregated services are Type II violations.
- Type III penalties, ranging from \$500 to \$1,500, may be assessed for civil rights violations that do not directly involve a specific individual. These include failures to (1) submit an acceptable plan of correction when required; (2) maintain and make available all data necessary to determine the facility's compliance with Title VI; (3) notify referral sources and the minority community that services are provided in a

nondiscriminatory manner; (4) display compliance statements; and (5) include a nondiscriminatory statement in all vendor contracts and brochures and other information distributed to the public.

According to the Division of Health Care Facilities Title VI Coordinator, the division has not found any civil rights deficiencies during surveys conducted since the 2003 performance audit.

Breakdown of Board Members and Division Staff by Gender and Ethnicity

As of July 2007, the Board for Licensing Health Care Facilities had 20 members. See table below.

**Board for Licensing Health Care Facilities Members  
By Gender and Ethnicity  
July 2007**

|                   | Gender     |            | Ethnicity |            |           |           |            |           |
|-------------------|------------|------------|-----------|------------|-----------|-----------|------------|-----------|
|                   | Male       | Female     | Asian     | Black      | Hispanic  | Indian    | White      | Other     |
| <b>Total</b>      | <b>13</b>  | <b>7</b>   | <b>0</b>  | <b>5</b>   | <b>0</b>  | <b>0</b>  | <b>15</b>  | <b>0</b>  |
| <b>Percentage</b> | <b>65%</b> | <b>35%</b> | <b>0%</b> | <b>25%</b> | <b>0%</b> | <b>0%</b> | <b>75%</b> | <b>0%</b> |

Note: Includes Ex-Officio Members.

As of October 2007, the Division of Health Care Facilities had 161 filled positions. See table below.

**Division of Health Care Facilities Staff  
By Title, Gender, and Ethnicity  
October 2007**

| Position Title                       | Gender |        | Ethnicity |       |          |        |       |       |
|--------------------------------------|--------|--------|-----------|-------|----------|--------|-------|-------|
|                                      | Male   | Female | Asian     | Black | Hispanic | Indian | White | Other |
| Administrative Assistant 1           | 0      | 12     | 0         | 4     | 0        | 0      | 8     | 0     |
| Administrative Secretary             | 0      | 5      | 0         | 0     | 0        | 0      | 5     | 0     |
| Administrative Services Assistant 2  | 0      | 5      | 0         | 2     | 0        | 0      | 3     | 0     |
| Administrative Services Assistant 3  | 0      | 5      | 0         | 3     | 0        | 0      | 2     | 0     |
| Administrative Services Assistant 4  | 1      | 3      | 0         | 0     | 0        | 0      | 4     | 0     |
| Attorney 3                           | 0      | 1      | 0         | 0     | 0        | 0      | 1     | 0     |
| Clerk 3                              | 0      | 1      | 0         | 0     | 0        | 0      | 1     | 0     |
| Database Administrator 3             | 1      | 0      | 0         | 0     | 0        | 0      | 1     | 0     |
| Dietetics Consultant                 | 0      | 3      | 0         | 0     | 0        | 0      | 3     | 0     |
| Facilities Construction Director     | 1      | 0      | 0         | 0     | 0        | 0      | 1     | 0     |
| Facilities Construction Specialist 3 | 4      | 0      | 1         | 0     | 0        | 0      | 3     | 0     |
| Fire Safety Specialist 1             | 7      | 1      | 0         | 1     | 1        | 0      | 6     | 0     |
| Fire Safety Specialist 2             | 1      | 2      | 0         | 0     | 0        | 0      | 3     | 0     |
| Fire Safety Supervisor               | 1      | 0      | 0         | 1     | 0        | 0      | 0     | 0     |
| Health Facilities Program Manager 1  | 0      | 3      | 0         | 1     | 0        | 0      | 2     | 0     |

| Position Title                            | Gender    |            | Ethnicity |           |          |          |            |          |
|---|-----------|------------|-----------|-----------|----------|----------|------------|----------|
|   | Male      | Female     | Asian     | Black     | Hispanic | Indian   | White      | Other    |
| Health Facilities Survey Director         | 1         | 0          | 0         | 1         | 0        | 0        | 0          | 0        |
| Health Facility Survey Manager            | 2         | 1          | 0         | 1         | 0        | 0        | 2          | 0        |
| Health Facilities Surveyor                | 2         | 0          | 0         | 0         | 0        | 0        | 2          | 0        |
| Information Resource Support Specialist 3 | 2         | 1          | 0         | 1         | 0        | 0        | 2          | 0        |
| Information Resource Support Specialist 4 | 1         | 0          | 0         | 0         | 0        | 0        | 1          | 0        |
| Information Resource Support Specialist 5 | 0         | 1          | 0         | 0         | 0        | 0        | 1          | 0        |
| Licensing Technician                      | 0         | 2          | 0         | 1         | 0        | 0        | 1          | 0        |
| Medical Social Worker                     | 0         | 2          | 0         | 0         | 0        | 0        | 2          | 0        |
| Medical Technologist Consultant 1         | 1         | 2          | 0         | 1         | 0        | 0        | 2          | 0        |
| Medical Technologist Consultant 2         | 0         | 3          | 0         | 0         | 0        | 0        | 3          | 0        |
| Pharmacist 2                              | 1         | 1          | 0         | 0         | 0        | 0        | 2          | 0        |
| Public Health Nursing Consultant 1        | 4         | 58         | 0         | 3         | 0        | 0        | 59         | 0        |
| Public Health Nursing Consultant 2        | 0         | 11         | 0         | 1         | 0        | 0        | 10         | 0        |
| Public Health Nursing Consultant Manager  | 1         | 4          | 0         | 0         | 0        | 0        | 5          | 0        |
| Program Analyst 4                         | 1         | 0          | 0         | 0         | 0        | 0        | 1          | 0        |
| Secretary                                 | 0         | 1          | 0         | 0         | 0        | 0        | 1          | 0        |
| Statistical Analyst 4                     | 0         | 1          | 1         | 0         | 0        | 0        | 0          | 0        |
| <b>Total</b>                              | <b>32</b> | <b>129</b> | <b>2</b>  | <b>21</b> | <b>1</b> | <b>0</b> | <b>137</b> | <b>0</b> |

**Appendix 2  
Facilities by Type and Region  
September 2007**

| Facility Type                    | Region     |            |            | Total       |
|----------------------------------|------------|------------|------------|-------------|
|                                  | East       | Middle     | West       |             |
| Alcohol and Drug Facility* (1)   | 80         | 78         | 81         | 239         |
| Ambulatory Surgical Treatment**  | 57         | 60         | 47         | 164         |
| Assisted Care Living Facility*   | 75         | 80         | 50         | 205         |
| Birthing Center*                 | 2          | 0          | 1          | 3           |
| End Stage Renal Disease Center** | 39         | 40         | 48         | 127         |
| Home Health Agencies**           | 55         | 53         | 49         | 157         |
| Home Medical Equipment**         | 117        | 101        | 95         | 313         |
| Hospice**                        | 21         | 18         | 20         | 59          |
| Hospitals**                      | 51         | 47         | 44         | 142         |
| Nursing Homes**                  | 117        | 105        | 110        | 332         |
| Outpatient Diagnostic Center*    | 10         | 18         | 4          | 32          |
| Professional Support Services**  | 63         | 39         | 44         | 146         |
| Residential Homes for the Aged*  | 41         | 39         | 43         | 123         |
| Residential Hospice**            | 2          | 1          | 0          | 3           |
| <b>Totals</b>                    | <b>730</b> | <b>679</b> | <b>636</b> | <b>2045</b> |

Source: Division of Health Care Facilities.

\*Licensed

\*\*Licensed and certified

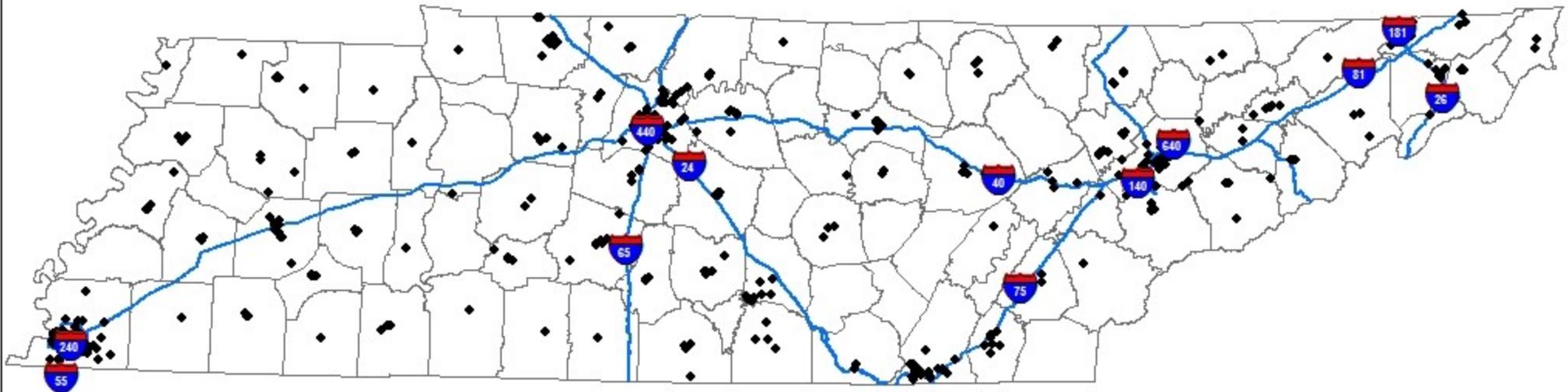
- (1) Executive Order No. 44 dated 2/23/2007 transferred responsibility for licensing and monitoring Alcohol and Drug facilities to the Department of Mental Health and Development Disabilities (MHDD) as of July 1, 2007. During our audit field work, the Division of Health Care Facilities and MHDD agreed on a transfer effective 1/1/2008.

**Appendix 3**  
**Maps of Facilities by Location**  
**November 2007**

Note: This appendix does not include maps for birthing centers or residential hospice facilities. According to the Department of Health's facility directory on its website, there are only three licensed birthing centers in the state: one in Knoxville, one in Madisonville, and one in Waynesboro. There are only three licensed residential hospice facilities in the state: one in Bristol, one in Knoxville, and one in Nashville.

# Alcohol & Drug Treatment Facility Locations

## State of Tennessee



### Legend

- ◆ Alcohol & Drug Treatment Facility
- Interstate Highway
- County Boundary

48

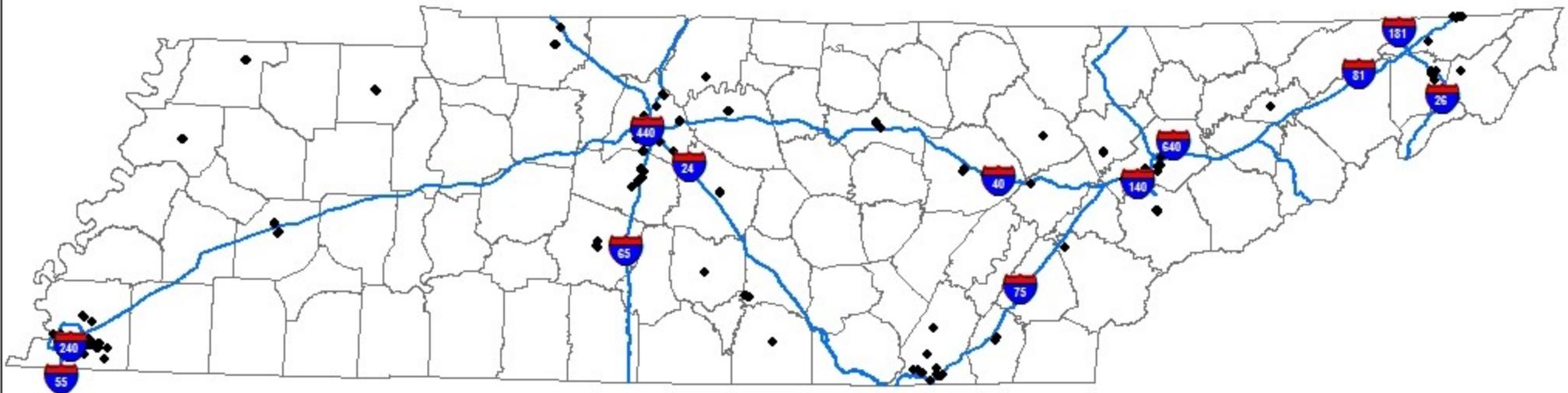
Facility location data provided by the Tennessee Department of Health,  
Bureau of Licensing and Regulation.



Herrington  
OIR GIS Services  
11/05/2007

# Ambulatory Surgical Treatment Facility Locations

## State of Tennessee



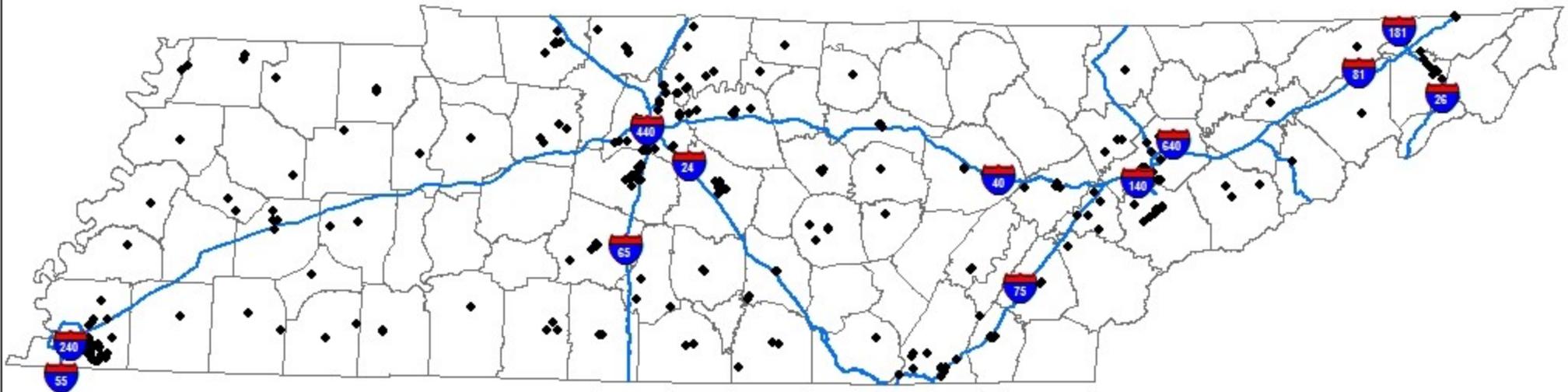
### Legend

- Ambulatory Surgical Treatment
- Interstate Highway
- County Boundary



# Assisted Care Living Facility Locations

## State of Tennessee



### Legend

- ◆ Assisted Care Living Facility
- Interstate Highway
- County Boundary

50

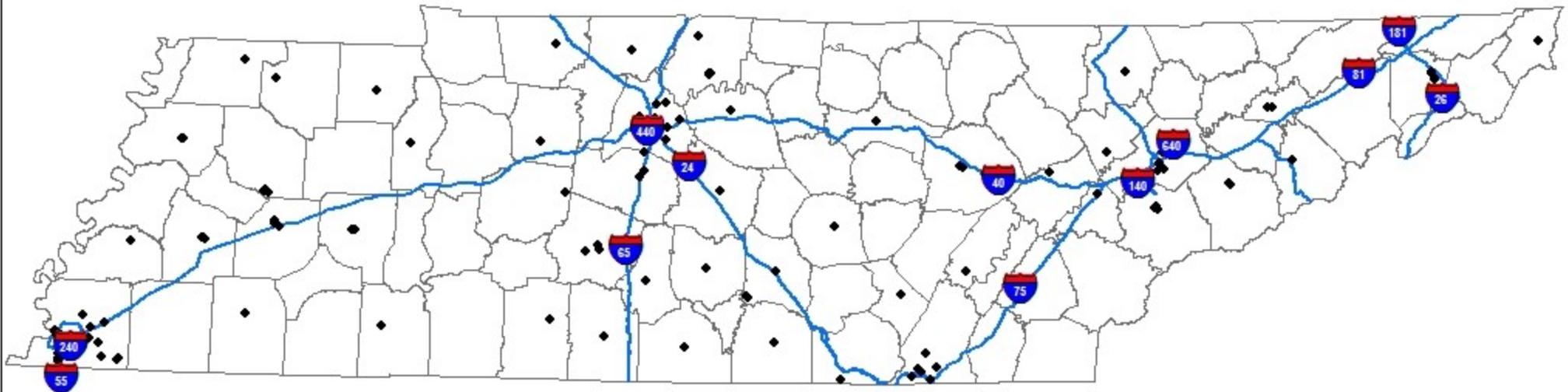
Facility location data provided by the Tennessee Department of Health,  
Bureau of Licensing and Regulation.



Herrington  
OIR GIS Services  
11/05/2007

# End State Renal Disease Center Locations

## State of Tennessee



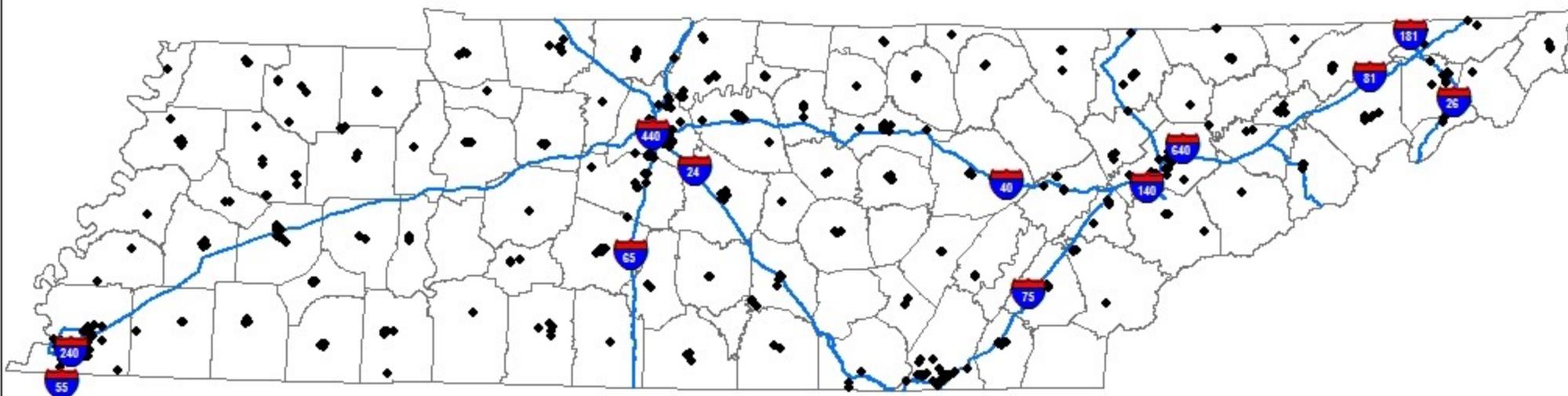
### Legend

- ◆ End State Renal Disease Center
- Interstate Highway
- County Boundary



# Home Health Agency Locations

## State of Tennessee



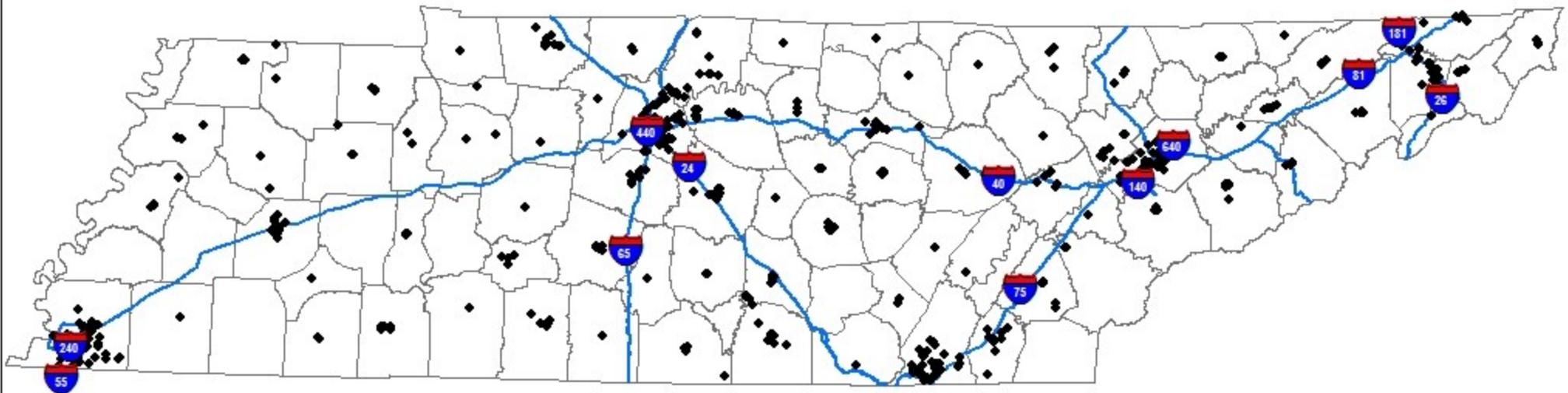
### Legend

- ◆ Home Health Agency
- Interstate Highway
- County Boundary



# Home Medical Equipment Facility Locations

## State of Tennessee



### Legend

- ◆ Home Medical Equipment Facility
- Interstate Highway
- County Boundary

53

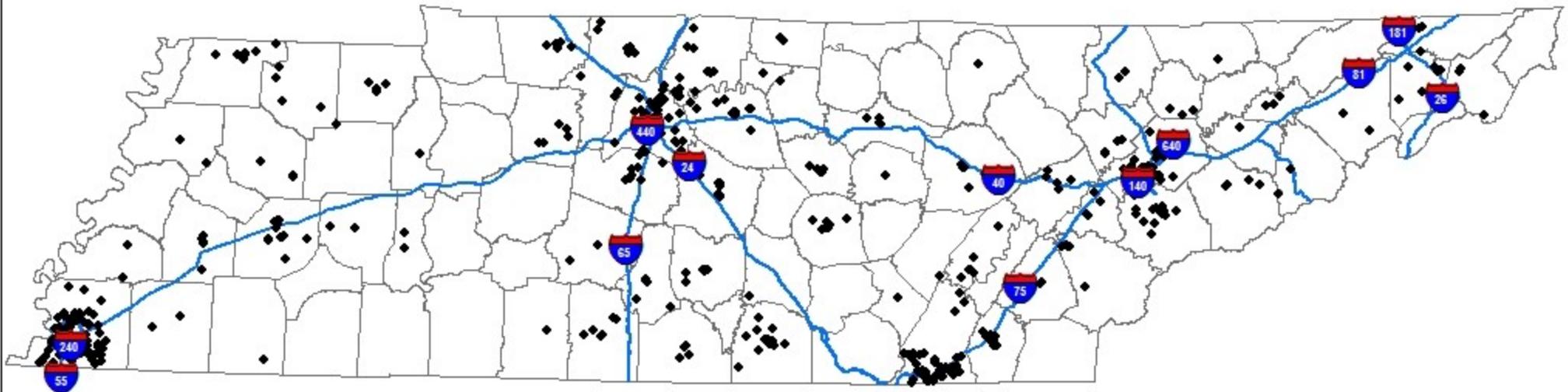
Facility location data provided by the Tennessee Department of Health,  
Bureau of Licensing and Regulation.



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OIR GIS Services  
11/05/2007

# Homes for the Aged Locations

## State of Tennessee



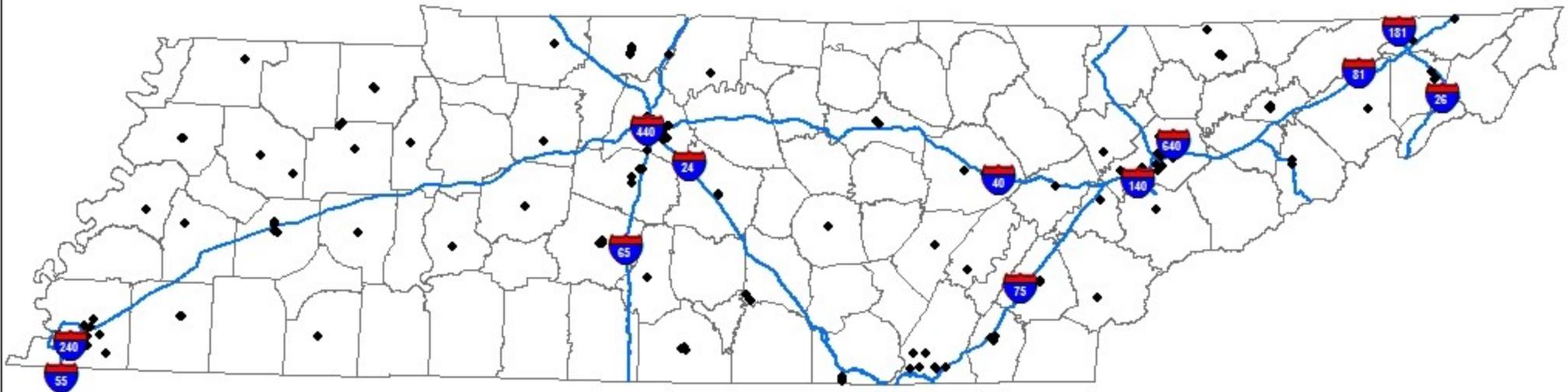
### Legend

- ◆ Home for the Aged
- Interstate Highway
- County Boundary



# Hospice Facility Locations

## State of Tennessee



### Legend

- ◆ Hospice
- Interstate Highway
- County Boundary

55

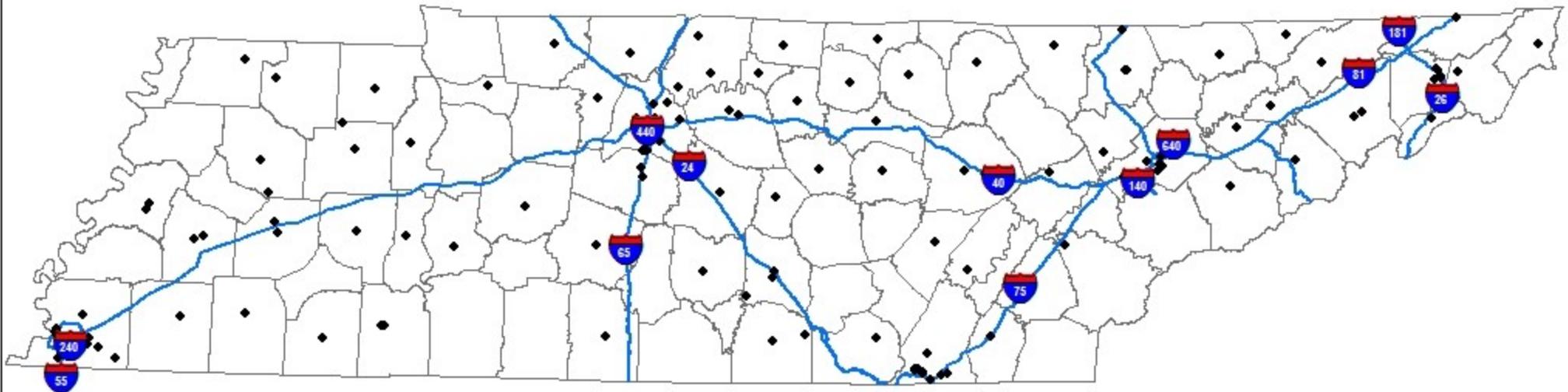
Facility location data provided by the Tennessee Department of Health,  
Bureau of Licensing and Regulation.



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# Hospital Locations

## State of Tennessee



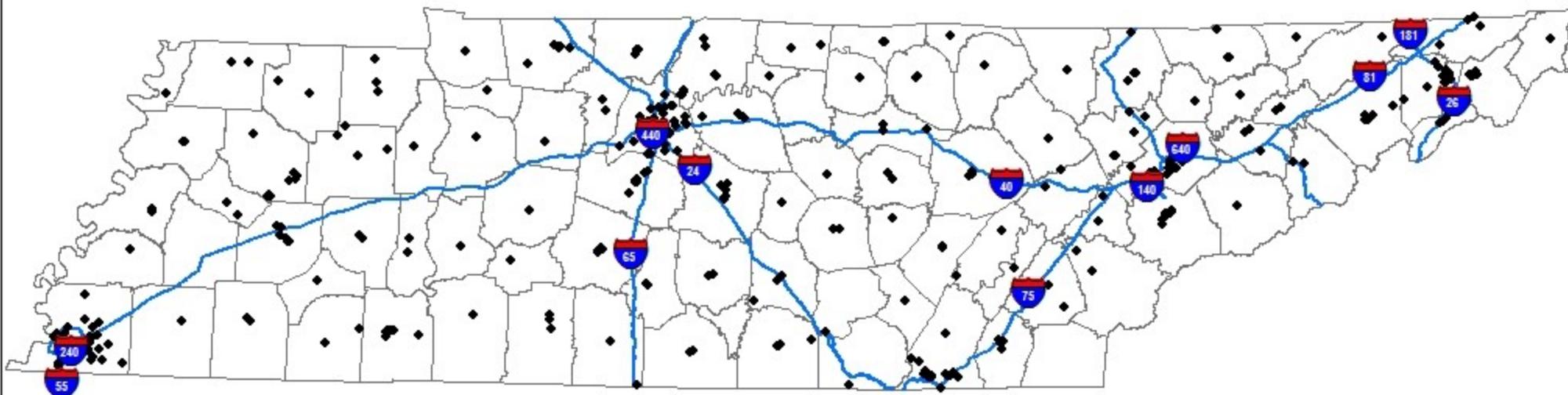
### Legend

- ◆ Hospital
- Interstate Highway
- County Boundary



# Nursing Home Locations

## State of Tennessee



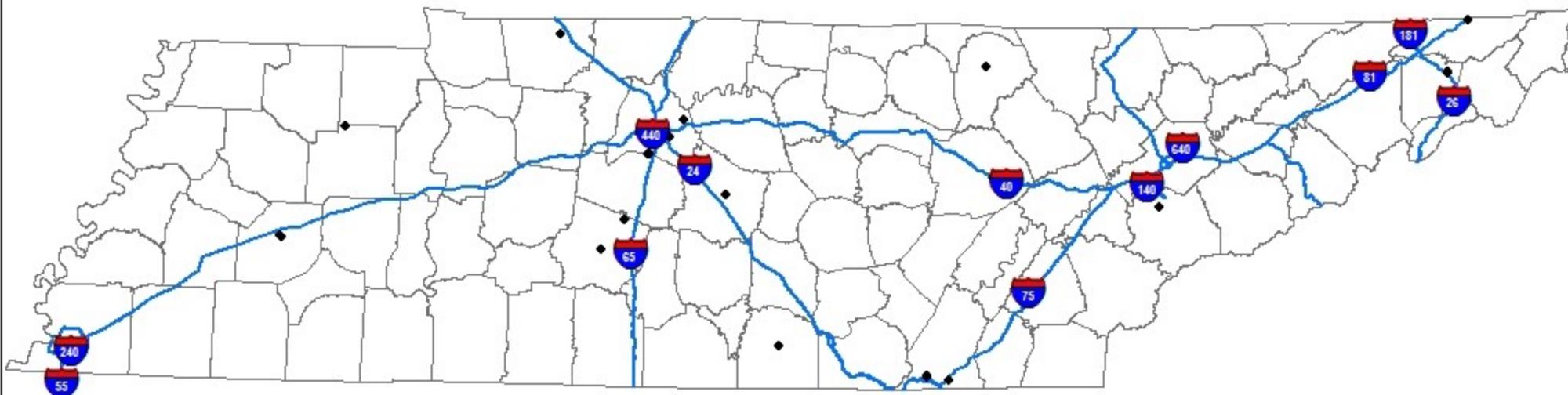
### Legend

- ◆ Nursing Home
- Interstate Highway
- County Boundary



# Outpatient Diagnostic Center Locations

## State of Tennessee



### Legend

- ◆ Outpatient Diagnostic Center
- Interstate Highway
- County Boundary

58

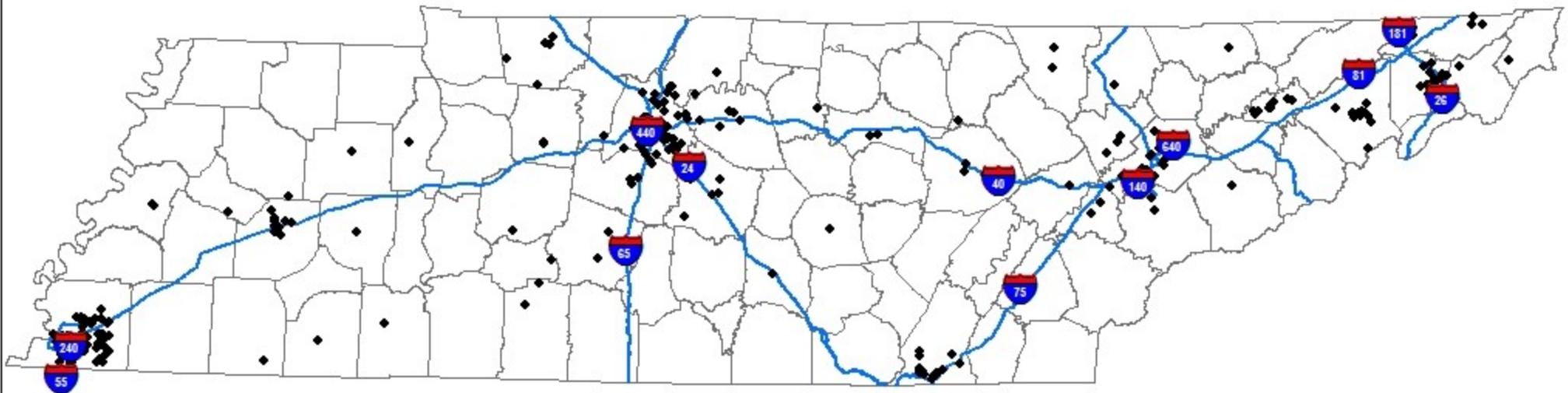
Facility location data provided by the Tennessee Department of Health,  
Bureau of Licensing and Regulation.



Herrington  
OIR GIS Services  
11/05/2007

# Professional Support Service Facility Locations

## State of Tennessee

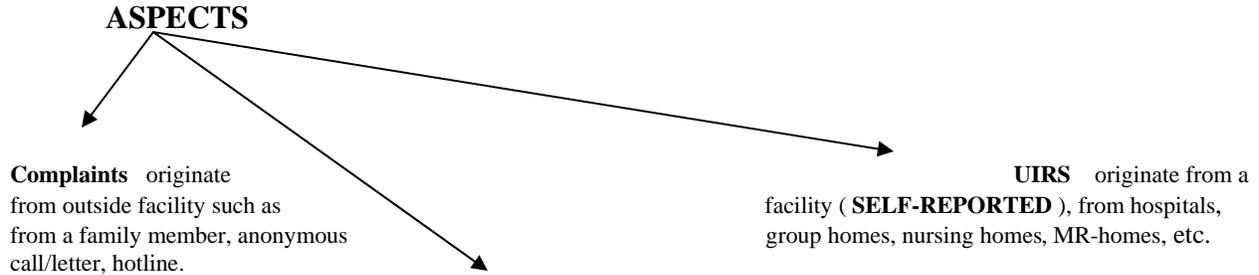


### Legend

- ◆ Professional Support Service Facility
- Interstate Highway
- County Boundary



## Appendix 4 Complaint Process



**UIRS (Unusual Incident Reporting System) or COMPLAINTS may contain abuse allegations**

State = **Licensure**  
Federal = **Certification**

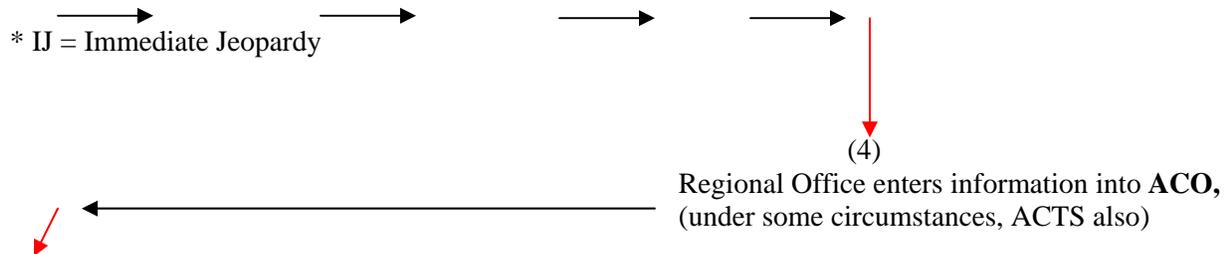
### Two Aspen Systems

**ACTS** = Federal formal complaints system, used to track investigations. Staff can choose State or Federal category depending on severity (more serious= Federal). Staff also must obtain permission from CMS to investigate certain entities. UIRS entered in as of June 18, 2007.

**ACO** = Aspen Central Office—State surveyors log in survey information (~12 months) into ACO. - Regional Offices log all of their data into ACO. (Tennessee Veterans Home deficiencies discovered this way.)

### Centralized Complaint Intake Unit (CCIU) Process

(1) Complaint comes into CCIU (2) Priority determined & put into ACTS (IJ, Non-IJ) (3) Regional Office investigates



(5) If Investigation is substantiated...A) If Abuse is substantiated...CCIU sends info to Abuse Registry Manager for individual to be entered into Abuse Registry. A hearing is offered. The end result—person ends up on registry or does not.

(B) If deficiencies are found, the facility is given time to correct and surveyors go back in about a month to check. Next comes the penalty phase (No Opportunity to Correct). Depending on how the information was logged in and the outcome of the surveyor's assessment, the penalties will be State or Federal.

\*Abuse can be alleged from a complaint, UIRS, Department of Human Services, etc. Everything starts as a type of complaint. It is prioritized, investigated, is substantiated or not, and individuals are sent to the abuse registry or penalties are assessed against the facilities.

Source: Discussion with staff of Centralized Complaint Intake Unit on July 3, 2007.

**Appendix 5**  
**Assessment Factors Used to Determine the Severity and Scope of Deficiencies**  
**at Skilled Nursing Facilities**

| Level of Severity | Description of Severity   | Level of Scope |          |            |
|-------------------|---|----------------|----------|------------|
|                   |   | Isolated       | Pattern  | Widespread |
| 4                 | Immediate jeopardy to resident health or safety   | <b>J</b>       | <b>K</b> | <b>L</b>   |
| 3                 | Actual harm that is not immediate   | <b>G</b>       | <b>H</b> | <b>I</b>   |
| 2                 | No actual harm with potential for more than minimal harm that is not immediate jeopardy | <b>D</b>       | <b>E</b> | <b>F</b>   |
| 1                 | No actual harm with potential for minimal harm  | <b>A</b>       | <b>B</b> | <b>C</b>   |

**Required Federal Enforcement Actions**

|  |   |
|--|---|
|  | State may appoint a temporary management company to operate the facility, or may terminate its Medicare/Medicaid provider agreement. State may also impose civil monetary penalties of up to \$10,000 per day or per instance of noncompliance. |
|  | Facility may lose some or all Medicare/Medicaid payments, and/or be assessed civil monetary penalties of up to \$3,000 per day or \$10,000 per instance of noncompliance.   |
|  | State may develop plan of corrective action for the facility, appoint a monitor to oversee corrective action taken, or require facility staff to attend training.   |
|  | Skilled nursing facility is in substantial compliance with federal requirements.  |

Source: Centers for Medicare and Medicaid Services' *State Operations Manual*, Chapter 7—Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities.

Note: In addition to the required enforcement actions, each facility that has a deficiency labeled with the letters “B” through “L” must submit an acceptable plan of correction. For a deficiency labeled with a letter “A”, no plan of correction is required.

**Appendix 6  
Methadone Clinics  
Outcome/Performance Data  
2004-2006**

| <b>Statewide Totals</b>                         | <b>2004</b> | <b>2005</b> | <b>2006</b> |
|---|-------------|-------------|-------------|
| New Admissions                                  | 1,701       | 2,400       | 2,442       |
| Readmissions                                    | 288         | 451         | 563         |
| Transfer from another Clinic                    | 430         | 189         | 278         |
| Total Admissions                                | 2,419       | 3,040       | 3,283       |
| Number of Patients in Program at Year End       | 2,631       | 4,001       | 4,526       |
| Total Program Capacity                          | 4,085       | 11,445      | 6,380       |
| Number of names on waiting list                 | 0           | 132         | 205         |
| Total slots available at year end               | 1,454       | 6,654       | 1,654       |
|   |             |             |             |
| <b>Illicit Behavior Following Admission</b>     | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Criminal Arrests                                | 4%          | 3%          | 3%          |
| Positive Urine Drug Screen after 30 days        | 41%         | 43%         | 37%         |
| Alcohol Use                                     | 7%          | 7%          | 6%          |
|   |             |             |             |
|   |             |             |             |
| <b>Gender Percentage</b>                        | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Male  | 41%         | 41%         | 59%         |
| Female  | 59%         | 59%         | 41%         |
| <b>Patient Satisfaction</b>                     | 91%         | 87%         | 93%         |
|   |             |             |             |
| <b>Discharges</b>                               | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Excessive Absences                              | 47%         | 38%         | 40%         |
| Illicit Substance Use                           | 7%          | 7%          | 11%         |
| Administrative Detox                            | 11%         | 10%         | 9%          |
| Non-Compliance                                  | 5%          | 12%         | 13%         |
| Transfers                                       | 23%         | 26%         | 19%         |
| Incarceration                                   | 13%         | 2%          | 2%          |
| Medical Reasons (including death)               | 2%          | 2%          | 3%          |
| Completed Treatment                             | 3%          | 3%          | 5%          |
|   |             |             |             |
| <b>Patients Receiving Out-of-State Services</b> | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Mental Health                                   | 21%         | 21%         | 21%         |
| Medical for other reasons                       | 39%         | 21%         | 28%         |
| Other substance abuse services                  | 10%         | 4%          | 6%          |
| Counseling (12 step, etc)                       | 15%         | 15%         | 10%         |
|   |             |             |             |
| <b>Out of State Patients</b>                    | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Alabama   | 9           | 20          | 21          |

|  |             |             |             |
|--|-------------|-------------|-------------|
| Arkansas                                   | 23          | 52          | 37          |
| Georgia                                    | 53          | 50          | 80          |
| Indiana                                    |             | 6           | 7           |
| Kentucky                                   | 27          | 47          | 103         |
| Louisiana                                  |             | 15          | 4           |
| Mississippi                                | 115         | 135         | 222         |
| North Carolina                             | 1           | 3           | 4           |
| Virginia                                   | 19          | 12          | 9           |
| Other                                      |             |             | 7           |
|  |             |             |             |
| <b>Drug of Choice at Time of Admission</b> | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Dilaudid                                   | 17%         | 17%         | 12%         |
| Oxycodone/Hydrocodone                      | 37%         | 23%         | 34%         |
| OxyContin                                  | 50%         | 45%         | 40%         |
| Heroin                                     | 18%         | 13%         | 10%         |
| Morphine/Codeine                           | 16%         | 7%          | 12%         |
| Demerol                                    | 0%          | 0%          | 4%          |
| Cocaine                                    | 6%          | 4%          | 9%          |
| Benzodiazepines                            | 2%          | 3%          | 9%          |
| THC  | 2%          | 3%          | 10%         |
| Other                                      | 2%          | 4%          | 6%          |
|  |             |             |             |
| <b>Disease Positive Upon Admission</b>     | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Hepatitis B                                | 2%          | 0.4%        | 6%          |
| Hepatitis C                                | 24%         | 11.8%       | 11%         |
| TB   | 1%          | 0.5%        | 0%          |
| Pregnant                                   | 1%          | 0.7%        | 2%          |
| HIV  | 0%          | 0%          | 0%          |
|  |             |             |             |
| <b>Employment</b>                          | <b>2004</b> | <b>2005</b> | <b>2006</b> |
| Percentage Employed at Admission           | 52%         | 49%         | 56%         |
| Percentage Currently Employed              | 64%         | 62%         | 65%         |
| Disabled                                   | 11%         | 9%          | 7%          |
| Homemakers                                 | 8%          | 7%          | 6%          |
| Students                                   | 7%          | 5%          | 4%          |
| Retired                                    | 2%          | 2%          | 1%          |
| Unemployed                                 | 10%         | 15%         | 16%         |
| Other                                      | 1%          | 1%          | 6%          |

Source: Division of Health Care Facilities State Methadone Authority.