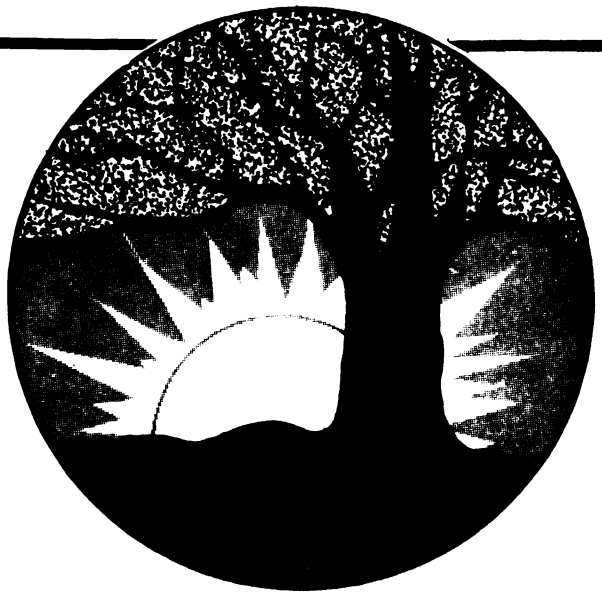
PERFORMANCE AUDIT

Board for Licensing Health Care Facilities
and
Division of Health Care Facilities
November 2011



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November 8, 2011

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Bo Watson, Chair
Senate Committee on Government Operations
The Honorable Jim Cobb, 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 and the Department of Health's Division of Health Care Facilities, which provides administrative support to the board. 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,

Arthur A. Hayes, Jr., CPA
Director

AAH/dlj
11-081

State of Tennessee

Audit Highlights

Comptroller of the Treasury | Division of State Audit

Performance Audit
Board for Licensing Health Care Facilities
Division of Health Care Facilities
November 2011

AUDIT OBJECTIVE

The objective of this audit was to determine the Division of Health Care Facilities' compliance with state and federal regulations for timely investigation and resolution of complaints. The Division of Health Care Facilities provides administrative support to the Board for Licensing Health Care Facilities, including information the board uses in making its regulatory decisions. In addition, we provided general information regarding the activities of the Board for Licensing Health Care Facilities.

FINDING

The Division of Health Care Facilities Has Not Investigated Complaints Timely; Some Concerns Have Been Addressed by Amending Statute and Implementing a Plan to Close a Backlog of Complaints, but Timeliness of Complaint Investigations Is an Ongoing Problem

Performance audits of the Board for Licensing Health Care Facilities and the Division of Health Care Facilities in August 2003 and May 2008 found that complaint investigations were not always timely. Division management focused on closing a backlog of approximately 2,800 complaints and worked with the General Assembly to amend state statute applicable to self-reported incidents. Auditor's review of 64 backlog complaints found that the number of days from the due date of the investigation to closure ranged from 312 to 1,490 days. Auditor's review of 28 current complaint files found that investigations were 12 to 399 days late. Management said the division's ability to investigate complaints timely has been hindered by surveyor position vacancies and turnover (page 11).

RESULTS OF OTHER AUDIT WORK

The audit also discusses references in statute to a terminated entity and board member vacancies for the Board for Licensing Health Care Facilities (page 22).

ISSUE FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider amending Sections 68-11-201(11) and 68-11-203(a)(1), *Tennessee Code Annotated*, to remove references to the Public Health Council (which was terminated in 2008) and its chair.

Performance Audit
Board for Licensing Health Care Facilities
Division of Health Care Facilities

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Performance Audit
Board for Licensing Health Care Facilities
Division of Health Care Facilities

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Board for Licensing Health Care Facilities and the Division of Health Care Facilities (which provides administrative support to the board) was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-233, the Board for Licensing Health Care Facilities is scheduled to terminate June 30, 2012. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the board and division 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.

OBJECTIVE OF THE AUDIT

The objective of this audit was to determine the Division of Health Care Facilities' compliance with state and federal regulations for timely investigation and resolution of complaints. The Division of Health Care Facilities provides administrative support to the Board for Licensing Health Care Facilities, including information the board uses in making its regulatory decisions. In addition, we provided general information regarding the activities of the Board for Licensing Health Care Facilities.

SCOPE AND METHODOLOGY OF THE AUDIT

The activities of the Board for Licensing Health Care Facilities and the Division of Health Care Facilities were reviewed for the period January 2009 through September 2011. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Methods used included

1. review of applicable statutes and state and federal rules and regulations;

2. review 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 Centers for Medicare and Medicaid Services;
4. review of the board's and the division's files, reports, and information summaries;
5. review of Centers for Medicare and Medicaid Services 2008, 2009, and 2010 Performance Reviews of the Division of Health Care Facilities;
6. review of the division's information system data used in complaint functions; and
7. file reviews and staff interviews at the division's regional offices.

STATUTORY RESPONSIBILITIES AND ORGANIZATION

As stated in Section 68-11-202 et seq., *Tennessee Code Annotated*, the Board for Licensing Health Care Facilities is authorized 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, outpatient diagnostic centers, and adult care homes. As part of its authority, the board reviews health care facilities for compliance with rules and regulations pertaining to fire and life safety code regulations.

The board consists of 18 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;
- two consumer members; and
- the Commissioner of the Department of Health and the Executive Director of the Commission on Aging and Disability, who serve *ex officio*.

Sections 68-11-201(11) and 68-11-203(a)(1), *Tennessee Code Annotated*, still refer to the Public Health Council and its chair as an ex-officio member of the Board for Licensing Health Care Facilities. However, Chapter 951 of the Public Acts of 2008 terminated the Public Health Council effective July 1, 2008. See Other Audit Work (page 22) for our recommendation for amending statute.

Statute requires the board to meet at least twice a year. The board met this requirement for calendar years 2009, 2010, and 2011 (see Table 1). The board has two vacancies—the osteopath member and the architect member.

Table 1
Board for Licensing Health Care Facilities
Number of Meetings by Calendar Year

	2009	2010	2011*
Board Meetings	3	3	2
Rulemaking and Subcommittee Meetings	0	4	2

*As of August 1, 2011

The board reviewed and voted on facility changes of ownership, ratified license applications, reviewed and approved rule waivers, and heard and voted on consent orders. The board also held an emergency rule-making hearing for Adult Care Homes, which were authorized by the 2008 Long-Term Care Community Choices Act. Other topics considered by the board were Nurse Aide Program reports and board self-sufficiency updates.

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 a central office in Nashville, a regional office in Jackson, and a regional office in Knoxville. Both regional offices supervise staff in a satellite office in Nashville. All inspections (surveys) and complaint investigations 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. See Table 2 for a list of facilities by type and region.

FUNDING

In the *State of Tennessee's Budget for Fiscal Year 2011-2012*, the Division of Health Care Facilities' revenues and expenditures are budgeted at $17 million. Revenues and expenditures for the Board for Licensing Health Care Facilities are included in the above totals. The board is required to be self-sufficient, and it met that requirement for fiscal year 2010, with board revenues of approximately $2.3 million and expenditures of $1.9 million. Final fiscal year 2011 revenues and expenditures were not available as of September 2011.

BOARD FOR LICENSING HEALTH CARE FACILITIES
October 2011
Organizational Chart

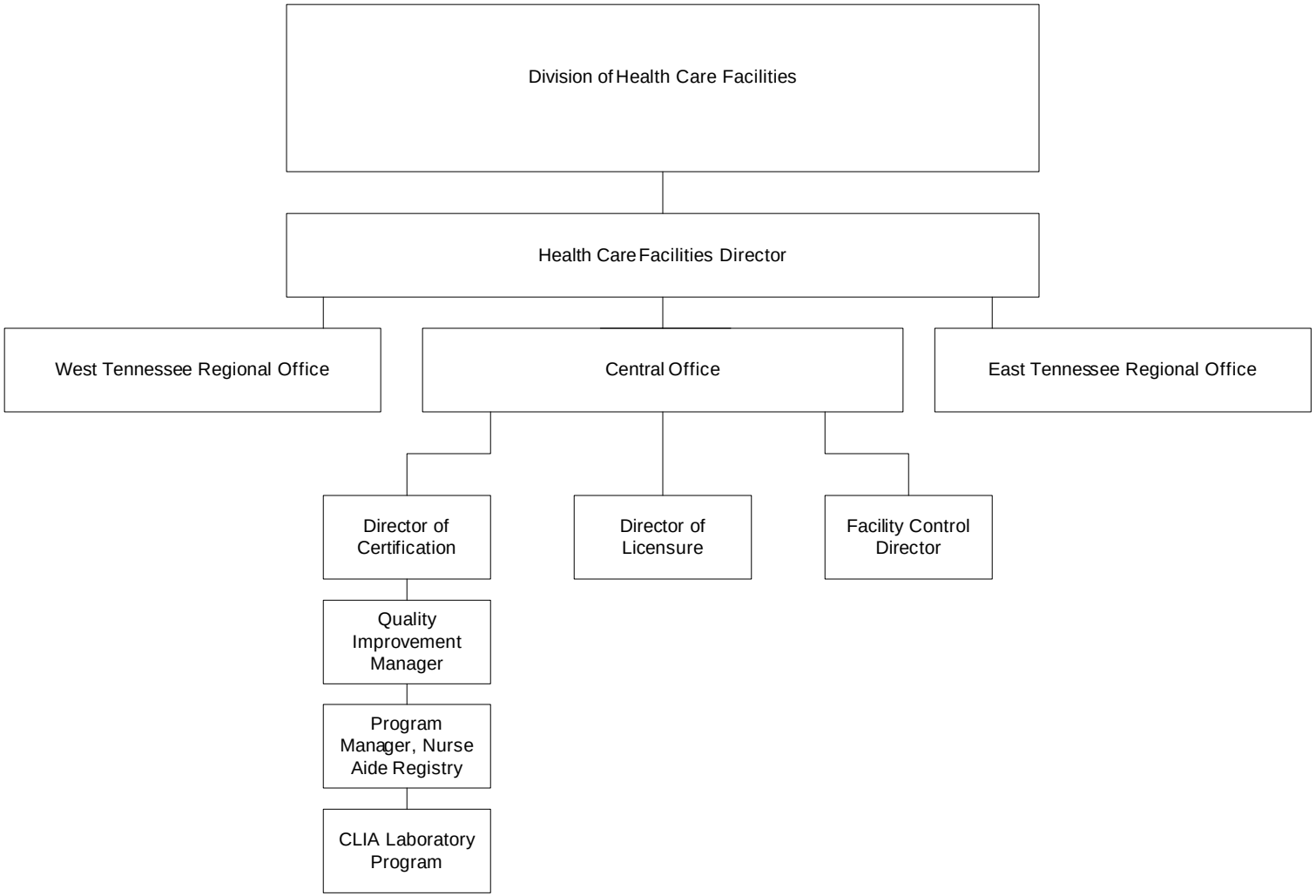
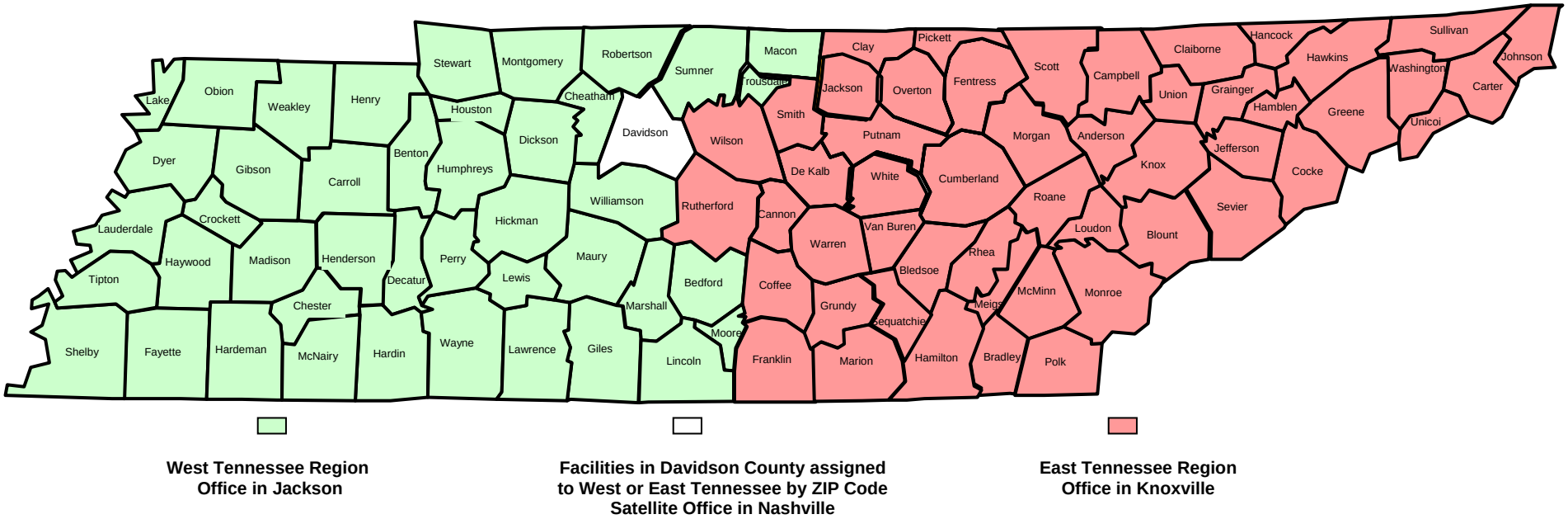


Exhibit 1

Division of Health Care Facilities
Regions
September 2011



West Tennessee Region
Office in Jackson

Facilities in Davidson County assigned
to West or East Tennessee by ZIP Code
Satellite Office in Nashville

East Tennessee Region
Office in Knoxville

Source: Division of Health Care Facilities.

Table 2
Facilities by Type and Region
September 2011

Facility Type	Region		
	East	West	Total
Adult Care Home*	0	0	0
Ambulatory Surgical Treatment**	85	79	164
Assisted Care Living Facility*	123	111	234
Birthing Center*	3	1	4
End Stage Renal Disease Center**	67	98	165
Home Health Agency**	89	70	159
Home Medical Equipment**	153	141	294
Hospice**	30	29	59
HIV Supportive Living*	0	0	0
Hospital**	70	63	133
Nursing Home**	167	156	323
Outpatient Diagnostic Center*	17	16	33
Prescribed Childcare Center*	0	0	0
Professional Support Services*	64	57	121
Residential Home for the Aged*	40	52	92
Residential Hospice**	4	2	6
Totals	912	875	1787

Source: Division of Health Care Facilities.
*Licensed
**Licensed and Certified

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 meeting the requirements to receive Medicare and Medicaid funding; and for conducting recertification surveys of facilities already federally certified.

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 board 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 delegates responsibility for determining whether facilities meet the requirements for participation in the medical assistance program (Medicare or Medicaid) to state survey agencies

which, for Tennessee, is the Division of Health Care Facilities. This is referred to as the certification process.

In addition to licensing and certification responsibilities, the Division of Health Care Facilities is responsible for the Nurse Aide Program, the abuse registry, the Eden Alternative Grant Assistance Program, reviewing engineering and architectural plans for all new facilities and major renovations to existing facilities, and ensuring quality of health of Health Maintenance Organizations for the Department of Commerce and Insurance.

COMPLAINT INTAKE AND RESOLUTION

As part of its function as a state survey agency, the division receives and investigates complaints. According to the Centers for Medicare and Medicaid Services (CMS) *State Operations Manual*, the objectives of a complaint management system are protective oversight, prevention, and promotion of efficiency and quality within the health delivery system. Protective oversight includes investigating immediately complaints that pose an immediate threat to the health, safety, or welfare of individuals. Prevention includes identifying less serious complaints and averting their escalation into more serious situations. The promotion of efficiency and quality means looking for Medicare/Medicaid fraud, reviewing complaints against individual licensed practitioners, and resolving billing issues. Complaints/incidents not directly related to federal requirements are forwarded to the appropriate agencies for follow-up and investigation.

The Centralized Complaint Intake Unit (CCIU) is located in the Division of Health Care Facilities' Central Office in Nashville. Complaints originate with hotline calls, e-mail, mail, or are self-reported by facilities. The division's toll-free complaint hotline number is posted in healthcare facilities, on the division's website, and in local public telephone directories. The division's website provides instructions for filing complaints and directions for completing and mailing a complaint form. Instructions are also available for using the toll-free telephone number and providing complaint details to complaint intake staff. 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. Self-reported incidents are entered by the facilities through the Incident Reporting System (IRS).

CCIU staff review complaints, complete complaint intake, and assign priority codes based on the severity of the allegations for all complaints (including self-reported incidents). Complaint information is entered into a database—the Automated Complaint Tracking System (ACTS). This database and its content are owned by CMS and accessed by the division in its capacity as Tennessee's state survey agency.

Complaints are assigned to the regional offices according to the location of the facility. Teams of surveyors investigate complaints and perform surveys. The team size varies depending on the experience levels of the evaluators assigned, the complexity of allegations within a complaint, the size of the facility, and the number of residents living at the facility. Based on the evidence obtained during the investigation, a 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 required to file a Plan of Correction and 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 3 for Complaint Investigation Guidelines and definitions of priority assignments. See Table 3 for surveyors and facilities by region and a comparison between current totals and those at the time of the prior audit.

Table 3
Division of Health Care Facilities
Surveyors and Facilities by Region

Regional Office	Number of Surveyors	Number of Facilities
East Tennessee Regional Office	26	912
West Tennessee Regional Office	30	875
Totals for Current Audit	56	1787
Totals for May 2008 Audit	83	2045

The division also has six contract surveyors—the two regions each have three, who are supervised by region management, assigned to them. According to division management, the contract surveyors (some of whom are former employees) provide the division the ability to initiate immediate jeopardy complaint investigations within the two-day requirement while other surveyors are completing work on investigations in progress.

The East Tennessee Regional Office is responsible for facilities in 52 counties and the West Tennessee Regional Office is responsible for facilities in 44 counties. (Davidson County is counted in both regions because the division assigns facilities in Davidson County by ZIP code to the two regions.)

CMS requires surveyors to have backgrounds in the health professions or health administration including hospital administrators, laboratory or medical technologists, medical record librarians, nurses, nutritionists, social workers, or "any professional category used within state merit systems for health professional positions" if the positions are commensurate with the professions CMS lists. Public Health Nurse Consultant 1 and 2 positions (surveyors hold this position title) are required to be licensed as a registered nurse in Tennessee. Of the 56 surveyors in the East and West Regional Offices, 53 have met the requirement to be SMQT (Surveyor Minimum Qualifications Test) certified. All six of the contract surveyors are SMQT certified. (The division has used contract surveyors since 2001 and in comments to the 2003 audit said the use of these contract surveyors had helped the division meet performance goals.) The Surveyor Minimum Qualifications Test, developed by CMS, focuses on areas such as the survey process; related laws, regulations, and guidelines; resident assessment and care plans; facility records; medical issues; quality of life; and nutrition. The test also focuses on skill in documenting, gathering, and integrating information. A surveyor can serve as a member of a survey team with at least one surveyor who has successfully completed the required training but cannot survey independently until the surveyor has successfully completed the SMQT. Six of the Centralized Complaint Intake Unit staff are also SMQT certified.

CMS ANNUAL REVIEWS

The Centers for Medicare and Medicaid Services (CMS) annually reviews the performance of the Division of Health Care Facilities in its capacity as state survey agency. Those reviews, referred to as State Agency Performance Reviews, include several performance measures CMS uses to determine whether the division is meeting CMS standards. In 2008, 2009, and 2010, CMS applied 18 performance measures to the division's operations. Examples are

- Frequency of Nursing Home Surveys,
- Documentation of Noncompliance in Accordance with Federal Standards, and
- Timeliness of Complaint and Incident Investigations.

In 2008, the division did not meet the CMS performance measures for 5 of 18 measures. In 2009 and 2010, the division did not meet CMS performance measures for 9 of 18 measures. (See the Complaint Backlog section on page 12 for an explanation of the CMS policy change in July 2007 that is a factor in the division not meeting some performance measures.) For all three of those years, the division did not meet the performance measure for "Timeliness of Complaint and Incident Investigations" and "Frequency of Nursing Home Surveys." Performance on "Frequency of Non-Nursing Facility Surveys" has three separate measures. The division failed to meet all three measures in 2009 and 2010. In 2008, the division met the performance measure for two of the three measures.

2011 GAO REPORT - CMS OVERSIGHT OF STATE COMPLAINT INVESTIGATIONS

In April 2011, the U.S. Government Accountability Office (GAO) released the report *More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations*. In the report, GAO said that concerns have been raised about the timeliness and adequacy of complaint investigations and Centers for Medicare and Medicaid Services (CMS) oversight. GAO analyzed CMS' national complaints data on the length of time taken by state survey agencies to investigate complaints in calendar year 2009 and whether those agencies were meeting performance standards, as well as the effectiveness of CMS' oversight. The GAO found that CMS' oversight of state survey agencies' complaint investigation processes is hampered by inconsistent application of standards by states, and that state survey performance scores are not always reliable, in part because of inadequate sample sizes and inconsistent interpretation of some standards by CMS reviewers. The GAO recommended that CMS improve the reliability of its database by clarifying guidance for state performance standards to assure more consistent application and interpretation.

Data from 2009 presented in the report shows that state survey agencies prioritized about 10 percent of complaints as immediate jeopardy (requiring investigation within 2 working days), and 45 percent as non-immediate jeopardy high (requiring investigation within 10 working days). The report noted that Tennessee prioritized 22 percent of complaints as immediate jeopardy and 45 percent as non-immediate jeopardy high. GAO also found that among the

complaints prioritized as immediate jeopardy or non-immediate jeopardy high, the percentage substantiated with at least one deficiency was higher if the investigation was initiated within required time frames than if it was not. (A description of substantiated complaints and deficiencies is in the Complaint Intake and Resolution section above.)

When CMS performs its annual review of a state survey agency, CMS' prioritization standard requires that the complaint priority assigned by the state survey agency be a priority level at or above the level assigned by CMS reviewers. The GAO report says that this standard may create an incentive for state survey agencies to assign higher priority levels than are warranted.

The report includes a table summarizing 2009 state survey agency performance for three nursing home facility complaint performance standards. The information on Tennessee's performance is summarized in Table 4 below:

Table 4
Performance Scores
Fiscal Year 2009

	Prioritization of Complaints	Timeliness of Immediate Jeopardy Investigations	Timeliness of Non-Immediate Jeopardy High Investigations
Passing Score	90%	95%	95%
Tennessee's Score	83%	42%	48%

Source: April 2011, GAO Report *Nursing Homes – More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations.*

Division of Health Care Facilities management said that CMS has conducted some teleconference training with the Centralized Complaint Intake Unit on complaint prioritization. In the CMS 2010 State Agency Performance Review, Tennessee met the CMS performance measure for prioritization of complaints but did not meet the measures for timeliness of complaint investigations.

FINDING AND RECOMMENDATION

1. The Division of Health Care Facilities has not investigated complaints timely; some concerns have been addressed by amending statute and implementing a plan to close a backlog of complaints, but timeliness of complaint investigations is an ongoing problem

Finding

Performance audits of the Board for Licensing Health Care Facilities and the Division of Health Care Facilities issued by the Division of State Audit in August 2003 and May 2008 found that complaint investigations were not always timely. In 2008, 2009, and 2010 State Agency Performance Reviews by the Centers for Medicare and Medicaid Services (CMS), the division did not meet the performance measures for timely complaint investigations. Division management has taken steps to alleviate some factors contributing to a lack of timeliness including working with the General Assembly to amend state statute applicable to self-reported incidents and focusing on closing a backlog of approximately 2,800 complaints. However, timeliness continues to be a problem. Management emphasizes that staffing issues are problematic and an obstacle contributing to the lack of timeliness and has stated so in prior management comments to Division of State Audit reports and six-month audit follow-up reports, and in Plans of Correction submitted to CMS in response to its annual performance reviews.

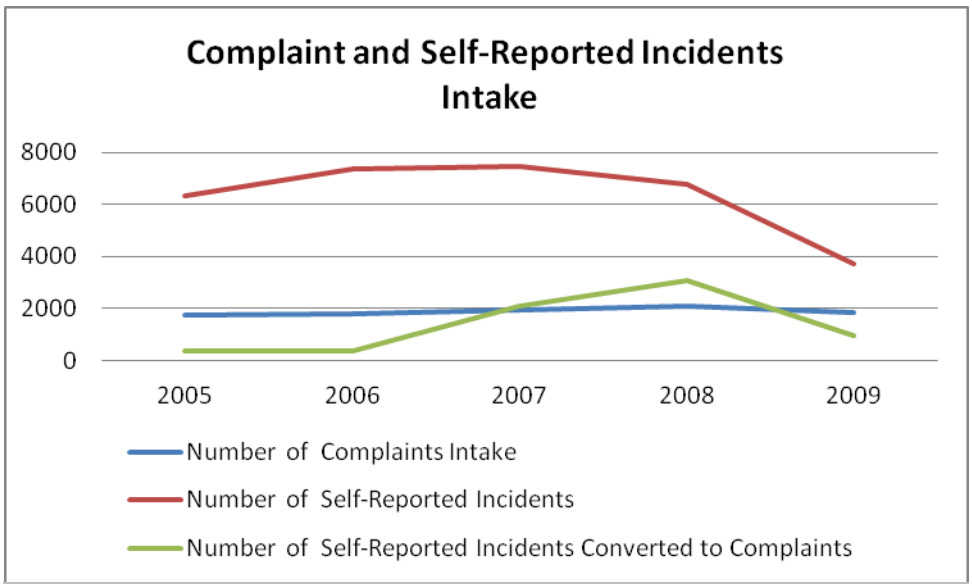
The Division of Health Care Facilities is responsible for licensing health care facilities operating in Tennessee; for recommending to the federal government certification for facilities meeting the requirements to receive Medicare and Medicaid funding; and for receiving and investigating complaints. There are 1,787 licensed health care facilities in the state including nursing homes, hospitals, home health agencies, hospice programs, surgical outpatient facilities, and agencies providing home medical equipment and professional support services. The purpose of licensing and federally certifying health care facilities is to protect the health, safety, rights, and well-being of patients by requiring providers of services to meet standards of care and physical environment. The licensure and certification laws provide the structure for monitoring performance of the Division of Health Care Facilities in two ways: the survey process and the complaint investigation process. Our audit work focuses on the complaint investigation process.

The Centers for Medicare and Medicaid Services and state statute establish time frame standards for licensing and certification surveys and for complaint investigations that the Division of Health Care Facilities is responsible for meeting. Those time frames are used as performance measures to determine the division's performance and compliance with the State of Tennessee Strategic Plan performance measures and by CMS in the annual State Agency Performance Review.

Complaint Backlog

Prior to June 2007, self-reported incidents involving abuse, neglect, misappropriation, and injuries of unknown origin were the only types of self-reported events entered in the CMS Automated Complaint Tracking System (ACTS). In June 2007, CMS initiated a policy change instructing the division to investigate all self-reported incidents violating federal levels of participation. This change, which required a wider scope of self-reported incidents to be entered into the ACTS system, dramatically increased the number of complaints to be investigated. The number of self-reported complaints to be investigated increased from about 183 a month to 520 a month. The result was a backlog of open complaints of about 2,800 on June 30, 2010. Approximately 1,700 of those were self-reported incidents that, under the 2007 CMS policy change, were required to be investigated.

In May 2009, Chapter 318 of the Public Acts of 2009 amended *Tennessee Code Annotated*, Section 68-11-211, related to self-reported incidents. The amendment defines abuse, neglect, and misappropriation consistent with federal law and removes a list of unusual incidents facilities were required to report as neglect that could possibly prompt a potential violation of federal participation, but are not required to be reported by federal standards. Instead of reporting all unusual incidents, licensed facilities are now only required to report incidents of abuse, neglect, and misappropriation. The amendment reduced the number of self-reported incidents that would need to be investigated. (See Complaint Intake and Resolution on page 7 for a description of self-reported incidents.) This reduced the number of self-reported incidents as shown in the following chart:



The number of self-reported (or entity-reported) incidents decreased from about 7,470 in 2007 to about 3,750 in 2009. The number of self-reported incidents converted to complaints decreased from about 2,100 in 2007 to 975 in 2009.

CMS and Backlog Plan

In April of 2010, CMS informed the division of its concern about the large number of complaints not investigated. As of June 30, 2010, the division had a complaint backlog of 2,800 open complaints not investigated—some of which were received in 2007 and included the self-reported incidents required to be investigated by the CMS 2007 policy change. The division formed a task force of management, complaint intake staff, and surveyors to formulate a plan in August 2010 to reduce the backlog. The plan was presented to CMS, a teleconference was held between CMS and the task force, and CMS approved the plan. Division management told CMS that all backlog complaints would be investigated and closed by September 30, 2011. See Exhibit 2 for the timeline.

CMS' Perspective on the Backlog and on the Division's Performance

We discussed the backlog plan with CMS regional office management. Because the ACTS system used by the division for complaint tracking is a CMS system, CMS periodically monitors the division's complaint progress. In June 2011, CMS said, based on its review of the division's progress, that it anticipated that the division would meet or be close to meeting the September 30, 2011, deadline to close the backlog of complaints. CMS also said it does not want this situation to occur again.

On August 31, 2011, the division reported, based on ACTS information, that the East Tennessee Regional Office (ETRO) had 13 backlog complaints still open and the West Tennessee Regional Office (WTRO) had 17 open backlog complaints.

File Reviews of Complaint Investigations

File Reviews of a Sample of Backlog Complaint Investigations

Using complaint files at both regional offices and data from ACTS, we analyzed a sample of backlog complaints for investigative timeliness and compliance with the plan approved by CMS to close those complaints. We conducted file reviews and analyzed ACTS information for July 2007 to June 2010 (the dates attributed to the backlog). We reviewed a sample of 64 complaint files randomly selected from the backlog complaint case files. Of those 64 complaints, 62 had been closed as of August 2011. The number of days from the due date of the investigation to the closure of the complaint ranged from 312 to 1,490. For immediate jeopardy complaints, the range was 312 to 1,143 days. See Table 5.

Exhibit 2
Chronology of Health Care Facilities Complaint Backlog Resolution

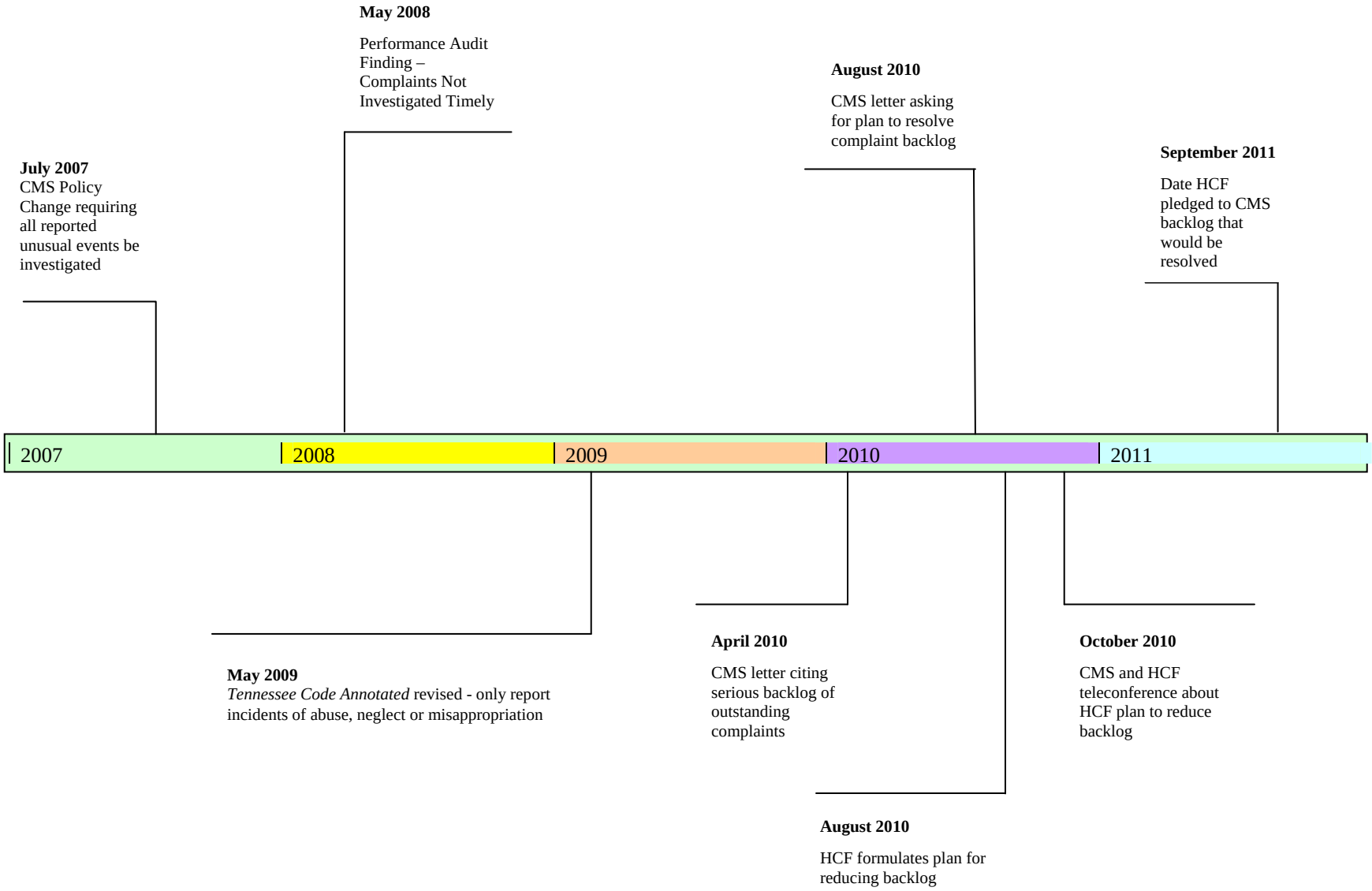


Table 5
Regional Office Complaint File Review
Sample of 64 Complaints Received Before July 1, 2010

Priority Assigned At Intake	Region					
	ETRO		WTRO		Totals	
	Number Investigated	Number Open	Number Investigated	Number Open	Number Investigated	Number Open
Immediate Jeopardy	5	1*	18	0	23	1
	Complaints reviewed ranged from 540 to 778 days late		Complaints reviewed ranged from 312 to 1,143 days late			
Non-Immediate Jeopardy High	18	1	6	0	24	1
	Complaints reviewed ranged from 715 to 1,490 days late		Complaints reviewed ranged from 1,039 to 1,212 days late			
Non-Immediate Jeopardy Medium	11	0	4	0	15	0
	Complaints reviewed ranged from 744 to 930 days late		Complaints reviewed ranged from 807 to 1,009 days late			
Totals	34	2	28	0	62	2

*Open complaint for a closed facility.

Based on ACTS information and discussions with management and staff of the division, it appears that the closures for the sample of backlog complaints are in compliance with the plan presented to and approved by CMS. The review included 45 incidents and 19 complaints. (Facilities self-report incidents via the division's Incident Reporting System. Centralized Complaint Intake Unit staff review all self-reported incidents and determine whether they meet the criteria to become a complaint for investigation. CCIU staff enter all incidents they determine to be complaints in the ACTS system. The self-reported incidents are then referred to as complaints.) Of the 62 closed items in the sample, 90% were closed with a non-immediate jeopardy administrative closure (83% of immediate jeopardy priority complaints were closed with a non-immediate jeopardy administrative closure). This closure type means that written communications and documentation from the facility were reviewed and the facility may have been contacted for further information, if the reviewer considered it necessary. See Table 6.

To meet the deadline for closing the backlog, regional office management assigned backlog complaints to various surveyors in each office. Those surveyors were responsible for reviewing all information related to a complaint and determining whether it was sufficient (according to the backlog plan) for closing the complaint. Once they determined that the complaint could be closed, the surveyors were to instruct support staff to close the complaint in the ACTS system. For 36 of the 64 backlog cases we reviewed, the name of the surveyor who reviewed and determined to close the case was not documented in the ACTS system. Regional

office management said they would instruct surveyors to ensure that they enter their name and describe the documentation they reviewed on all complaints. Management also stated they will work with the information systems contractor to require that a surveyor name, along with documentation, is entered before closure can be completed.

Table 6
Backlog Complaints
By Priority and Closure Type

	Immediate Jeopardy	Non-Immediate Jeopardy High	Non-Immediate Jeopardy Medium	Totals
Not Closed	1*	1	0	2
Closed by Closure Type				
Non- Immediate Jeopardy Administrative	19	23	14	56
Unsubstantiated	4	0	1	5
No Action Necessary	0	1	0	1
Totals	24	25	15	64

*Open complaint for a closed facility.

File Reviews of a Sample of Current Complaints

Using complaint files from the two regional offices and data from the CMS Automated Complaint Tracking System (ACTS), we analyzed the timeliness of complaint investigations for complaints received after July 2010. As of July 6, 2011, there were 475 open complaints dated from July 1, 2010, to July 6, 2011. We reviewed a sample of these current complaint files using data from the complaint survey and from the ACTS system. As shown in Table 7, 4 of 28 files had been investigated (not closed) as of our file review date. At the time of our review, the 4 complaints that had been investigated were investigated 12 to 384 days late. The 24 complaints that had not been investigated were 35 to 399 days late at the time of our review.

CMS Notification of Changed Allocation of Funding

In June 2011, CMS notified the division that, because of its lack of performance in using allocated Medicare survey and certification activity funds, CMS was reducing the allocation for the division's fiscal year 2011 funds by $700,000. CMS states that the basis for its concern includes timeliness of complaint investigations and timeliness of surveys. (Timeliness of surveys was not an audit objective for this audit, but the division did not meet the performance measures for timely surveys in the 2008, 2009, and 2010 CMS State Agency Performance Reviews.)

However, CMS said if the division could demonstrate that "barriers to effective use of federal resources have been removed," CMS would restore the funds. Division management, in its reply to CMS, said it intended to increase the filled surveyor positions by 50% in each region in order to remedy the situation.

The FY 2011 Performance Appendix for CMS, published by the U.S. Department of Health and Human Services, states that CMS makes a "non-delivery deduction from the states'

subsequent year survey and certification funds" for states that do not meet timeliness for surveys. For FY 2011, the target for CMS performance was 90%. It is interesting to note, however, that the document mentions that imposing these deductions can "exacerbate future state performance."

Table 7
Regional Office Complaint File Review
Sample of 28 Complaints Received After July 1, 2010

Priority Assigned At Intake	**Region**					
	ETRO		**WTRO**		**Totals**	
	Number Investigated	Number Open	Number Investigated	Number Open	Number Investigated	Number Open
Immediate Jeopardy	0	3	1	4	1	7
	Complaints reviewed ranged from 68 to 399 days late		Complaints reviewed ranged from 61 to 384 days late			
Non-Immediate Jeopardy High	1	6	1	6	2	12
	Complaints reviewed ranged from 12 to 313 days late		Complaints reviewed ranged from 35 to 216 days late			
Non-Immediate Jeopardy Medium	0	3	1	2	1	5
	Complaints reviewed ranged from 106 to 354 days late		Complaints reviewed ranged from 152 to 347 days late			
Totals	1	12	3	12	4	24

Staffing Issues

Staffing shortages hinder timely responses to complaints, and filling vacant positions remains difficult. Relying on registered nurses to fill the positions is problematic because of competition from other health care organizations that may offer higher salaries and less travel. During the prior audit, the division had three regional offices whose surveyors were assigned to investigate complaints for the facilities assigned to their offices. In December 2008, division management chose to close one of the three, the Middle Tennessee Regional Office (MTRO), because of staffing issues. Management attributed the decision to close the office to problems maintaining filled positions. Facilities that had been the responsibility of MTRO were divided between the ETRO and the WTRO. Management does not foresee reopening the MTRO because of competition from health care organizations in the Nashville area for registered nurses to fill the surveyor positions.

Management has documented the division's lack of filled surveyor positions many times. For example:

- The 2008, 2009, and 2010 Plans of Correction to the CMS State Annual Performance Review assert that lack of staff is a reason for failing to meet CMS performance measures. In the 2009 plan, the division told CMS that surveyor positions had a 34% attrition rate in 2009.
- In its December 2008 follow-up to the May 2008 Performance Audit, management said it was trying to fill eight additional surveyor positions that had been approved and that central office staff were being used to "augment" field survey staff.
- In its management comments to the 2003 Performance Audit, management said it had approval to fill new positions that would help with the timeliness.
- In a letter to CMS in June 2011, management said that a lack of staff was continuing to impact the division's ability to meet performance measures and expressed an intent to use the positions allocated to the former MTRO for hiring as many as 50% more surveyors for the ETRO and WTRO offices.

The division had 28 unfilled positions as of July 2011; 26 of the 28 vacancies were for the surveyor entry-level position. In 2009, the division had 27 resignations for surveyor positions and 14 in 2010. As of July 2011, the division had 12 resignations in surveyor positions. See Table 8.

Table 8
Public Health Nurse Consultant 1 and 2 Positions Approved, Filled as of July 2011

Approved Positions	91
Filled Positions	63*
Vacant Positions	28

Terminations by Calendar Years

Terminations	2009	2010	2011 (through July 2011)
	27**	14**	12

Public Health Nurse Consultant 1 and 2 is the name of the position for surveyors.
*Seven of the positions are in the Centralized Complaint Intake Unit.
**Two employees rehired in subsequent year.

A CMS requirement for the surveyor position lists professions other than nurses. Although the regional offices do employ social workers and dieticians, the majority of the surveyors are in positions that require a licensed nurse. The division should determine whether other health professions would qualify for the surveyor positions, thereby increasing the number of available applicants.

Surveyor travel also presents a challenge. Surveyors travel to health-care facility destinations within their assigned areas to conduct surveys and complaint investigations. As shown on the map on page 5, surveyors must travel sizeable distances between their regional office and the location of the facility. This presents logistical difficulties for conducting surveys

and investigations in an efficient and timely manner. In August 2011, regional office management said two surveyors hired as recently as January 2011 resigned because of the travel required by the position. CMS requires some off-hours surveys so that observations can be made about the care of patients during evenings and early mornings. These off-hours surveys often begin on a Sunday evening, and surveyors may work more than the normal 7.5 hour workday in order to observe the facility's medical rounds in the morning and bedtime procedures in the evening. Because the division is part of the Department of Health, which has offices in each county in the state, the division should determine whether locating some surveyors in county health offices would reduce travel.

Conclusion

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. The April 2011 report by GAO found that the percentage of complaints substantiated with at least one federal deficiency cited was higher if the investigation was initiated on time. Complaints often involve physical evidence (e.g., bruises, scratches) and eyewitnesses, and therefore would necessitate a timely response in order to accurately evaluate and/or substantiate the complaint.

Legitimate complaints should be substantiated as soon as possible to prevent further problems or escalation of a problem where delayed action could put multiple patients at risk. The division should require surveyors and support staff to maintain the surveyor name and documentation for each closed complaint in the ACTS system, to ensure the appropriate level of protective oversight and quality of care is maintained.

In addition to jeopardizing patient welfare, the Division of Health Care Facilities could incur additional monetary penalties for failing to meet CMS requirements. Reduction of the funds to survey and investigate could eventually impact the ability of the division to certify facilities for participation in the Medicare and Medicaid program.

Recommendation

The Division of Health Care Facilities should investigate complaints timely and in accordance with the time frames established by statute and the Centers for Medicare and Medicaid Services (CMS). Division management and staff should ensure that a backlog of complaints does not occur again, particularly for those complaints prioritized immediate jeopardy and non-immediate jeopardy high.

The division should work with the Department of Health's Bureau of Health Licensure and Regulation and fill vacant surveyor positions quickly so that CMS and state performance measures can be met.

The division, the Department of Health's Bureau of Health Licensure and Regulation, and the Department of Human Resources should collaborate to determine if the minimum qualifications for surveyor positions could be revised to include more health professions. In order to minimize the amount of travel by current surveyors, the division and Department of Health should consider the feasibility of locating some surveyors in county health departments.

The division should require that all closed complaints include documentation of the surveyor's review prior to closing, and should work with the information systems contractor to ensure that this information has been included before a complaint can be closed.

Management's Comment

We concur and agree that complaints should be investigated in accordance with time frames established by statute and CMS. We understand the importance of investigating these complaints timely and every effort is being made by the Department to meet these guidelines.

However, the department has operated at two-thirds its surveyor capacity for the past three years despite efforts to remedy that. The two salient challenges that continue to saddle the department are hiring constraints due to both fiscal concerns and surveyor availability.

As enumerated in the performance audit, the Division has, through a concerted effort, worked through a backlog of approximately 2,800 cases over the course of nine months. However, the high vacancy rates have not permitted us to maintain the intensity of that effort, allowing a current backlog to resurface. As of October 30, 2011, our data indicates 256 outstanding complaints across all priorities; 23% of those are immediate jeopardy.

To address this current backlog, and get the Division in a situation where complaints can be investigated according to the required deadlines, the following steps have been, or will be, taken:

1. The Department has received approval to fill all vacancies that exist in the surveyor positions. Since receiving approval to fill surveyor positions, 9 of the vacant surveyor positions were filled in October 2011, with 24 vacancies remaining.

2. We have, and will continue, to consider whether other health care professions would qualify for the surveyor positions.

   On the positive side, Section 7201.2 of Chapter 7 in the State Operations Manual, recommends multidisciplinary survey teams to include duly qualified Surveyor Minimum Qualifications Test (SMQT) certified professionals, which may include social workers, registered dieticians, physical therapists, nurse practitioners, pharmacists, and physicians. The Division currently has two master's prepared social workers, one registered dietician, and one part-time pharmacist that conduct surveys as members of survey teams.

   However, other efforts to that effect so far have been somewhat ineffectual. For instance:

   To increase the pool of RN surveyors, the division considered relaxing the State's current requirement of hiring registered nurses with three years of experience. In September 2010, we queried other state agencies across the country and found that, in addition to requirements of three to five years of post-RN degree experience, some states also required master-level-prepared nurses. A year later, in September 2011, not having found any federal guidelines or requirements for number of years of experience a nurse

surveyor must have, we inquired of the Centers for Medicare and Medicaid Services (CMS) and were informed that:

> The survey process is very complex and to be effective in the position, an individual would need to have developed a broad range of clinical skills that would allow them to properly identify and assess whether or not care is being properly planned, provided and executed in a myriad of settings. You can't teach clinical experience in surveyor training and most of the individuals encountered in health care settings that we regulate have complex co-morbidities that require <u>at least a few years of experience</u> working in a clinical setting in order to make accurate compliance decisions.

The Department briefly considered hiring licensed practical nurses (LPN's) as nurse surveyors but eliminated that as an opportunity because by law, in the state of Tennessee, LPN's are unable to supervise RN's or the provision of care by RN's; they cannot assess patients, therefore, the LPN surveyor would not be able to assess the provision of care by facility staff. We found that LPN's were not used in any state agency across the nation for the same or similar reasons.

3. Regarding the challenges of travel for the surveyors, the Department has taken steps to reassign equally the 26 vacant positions—supervisory, survey and support staff—currently assigned to the Middle Tennessee satellite office to the West and East Tennessee regional offices. If all the positions are allowed to be retained and filled, this will effectively increase the number of staff in each of those two remaining Grand Divisions by approximately 50%, which we believe will remove the current survey and certification (S&C) performance barriers (greater frequency on the road, for longer durations of time, with an insufficient number of staff to cover the larger catchment area) that have prevented full performance of S&C functions by those two regions, enabling us to meet the quality performance and certification and survey standards across the State as required by CMS.

   The five currently filled Middle Tennessee satellite surveyor positions will remain assigned to the Middle Tennessee satellite office until such time as they become vacant, and will then be appropriately reassigned to the East Tennessee or West Tennessee regional offices. The two vacant Middle Tennessee satellite supervisory (PHNC2) positions will be reassigned—one to each region—in order to appropriately manage the survey staff increase and provide quality training and oversight of timely complaint and survey investigations. A vacant Administrative Assistant 1 (AA1) support staff position will be reassigned to the West Tennessee region to assist with the increased data management, facility and government correspondence, and timely uploads of survey results to the Federal ASPEN (Assisted Survey Provider Environment) system. In addition, the four Administrative Secretary positions—three in East Tennessee and one in West Tennessee—will be reclassified as Administrative Assistant 1 (AA1), as they will all necessarily continue to fulfill the same AA1 support staff duties as they have since February 1, 2009, when the workload consolidation into two regions occurred.

To further facilitate the timeliness of surveys and incident investigations of both State licensed-only facilities and federally certified facilities, twelve of the reassigned positions (six in each region) will be dedicated to surveying the state licensed-only facilities. This will allow both a rapid hiring and rapid utilization of these surveyors who will not have to undergo the intensive federal certification training otherwise required for federal certification, which can take up to two years before the surveyor is truly able to independently survey the various provider types. This will also result in an overall cost reduction to the State as the State pays a portion of most federal training costs.

It is hoped that the reassignment of these positions from the Nashville Middle Tennessee area will allow for more potential applicants to fill the vacant registered nurse positions because of the high demand for these positions in the Nashville area.

In summary, it is believed that these changes, and the filling of the vacant positions as noted, will help ensure that a backlog of complaints will not reoccur and the division will be able to meet the required survey time frames.

OTHER AUDIT WORK

Statute Refers to Terminated Entity

Sections 68-11-201(11) and 68-11-203(a)(1), *Tennessee Code Annotated*, refer to the Public Health Council and its chair as an ex-officio member of the Board for Licensing Health Care Facilities. However, Chapter 951 of the Public Acts of 2008 terminated the Public Health Council effective July 1, 2008. The General Assembly may wish to amend statute and remove references to the Public Health Council and its chair from *Tennessee Code Annotated* where appropriate.

Board Member Vacancies

Section 68-11-203 (a)(1), *Tennessee Code Annotated*, requires that the Board for Licensing Health Care Facilities include one member licensed to practice osteopathic medicine in Tennessee and a member who is an architect knowledgeable by training or experienced in health care facility design. The osteopath appointment has been vacant since October 2010; the architect appointment, since July 2011.

RECOMMENDATIONS

LEGISLATIVE

This performance audit identified an area in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the Board for Licensing Health Care's operations.

1. The General Assembly may wish to consider legislation to amend Sections 68-11-201(11) and 68-11-203(a)(1), *Tennessee Code Annotated*, to remove references to the Public Health Council (which was terminated in 2008) and its chair.

ADMINISTRATIVE

The Division of Health Care Facilities should address the following areas to improve the efficiency and effectiveness of its operations.

1. The Division of Health Care Facilities should investigate complaints timely and in accordance with the time frames established by statute and the Centers for Medicare and Medicaid Services (CMS). Division management and staff should ensure that a backlog of complaints does not occur again, particularly for those complaints prioritized immediate jeopardy and non-immediate jeopardy high.

2. The Division of Health Care Facilities should work with the Department of Health's Bureau of Health Licensure and Regulation and fill vacant surveyor positions quickly so that CMS and state performance measures can be met.

3. The Division of Health Care Facilities, the Department of Health's Bureau of Health Licensure and Regulation, and the Department of Human Resources should collaborate to determine if the minimum qualifications for surveyor positions could be revised to include more health professions. In order to minimize the amount of travel by current surveyors, the division and Department of Health should consider the feasibility of locating some surveyors in county health departments.

4. The Division of Health Care Facilities should require that all closed complaints include documentation of the surveyor's review prior to closing, and should work with the information systems contractor to ensure that this information has been included before a complaint can be closed.

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 Division of Health Care Facilities and (2) their efforts 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 2010, the division received federal financial assistance of $7.0 million. Neither the board nor the division prepares a Title VI plan or reports 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 conducted a review of that plan as part of the October 2008 Performance Audit of the Department of Health.

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, and
- 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 civil penalties in an amount not to exceed $5,000 for such a violation.

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 2008 performance audit.

Information detailing the membership of the Board for Licensing Health Care Facilities, by gender and ethnicity, is presented below.

Board for Licensing Health Care Facilities Members
By Gender and Ethnicity
As of October 2011

	Gender			**Ethnicity**					
	Male	Female		Asian	Black	Hispanic	Indian	White	Other
Total	9	7		1	1	0	0	14	0
Percentage	56%	44%		6%	6%	0%	0%	88%	0%

Notes: Includes Ex-Officio Members.

As of October 2011, the board had two vacancies (osteopath member position vacant since October 2010 and architect member position vacant since July 2011).

Appendix 2
Performance Measures Information

As stated in the Tennessee Governmental Accountability Act of 2002, "accountability in program performance is vital to effective and efficient delivery of governmental services, and to maintain public confidence and trust in government." In accordance with this act, all executive branch agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The department publishes the resulting information in two volumes of *Agency Strategic Plans*: *Volume 1 - Five-Year Strategic Plans* and *Volume 2 - Program Performance Measures*. Agencies were required to begin submitting performance-based budget requests according to a schedule developed by the department, beginning with three agencies in fiscal year 2005, with all executive-branch agencies included no later than fiscal year 2012. The Department of Health (including the Division of Health Care Facilities, which provides administrative support to the Board for Licensing Health Care Facilities) began submitting performance-based budget requests effective for fiscal year 2010.

Detailed below are the Department of Health's Division of Health Care Facilities' performance standards and performance measures, as reported in the September 2011 *Volume 2 - Program Performance Measures*. Also reported below is a description of the agency's processes for (1) identifying/developing the standards and measures; (2) collecting the data used in the measures; and (3) ensuring that the standards and measures reported are appropriate and that the data are accurate.

Performance Standards and Measures

Performance Standard 1

Through maintenance of inspection protocols, protect the health and safety of the public by surveying healthcare facilities to verify compliance with state and federal regulations for purposes of annual licensure or certification.

Performance Measure 1

The percent of required licensure and certification surveys completed within the timelines established by the division and by CMS according to facility type.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
94%	100%	100%

Note: Division reported an actual of 78% for FY 2009-2010 in its FY 2011-2012 budget proposal.

Performance Standard 2

Through maintenance of inspection protocols, protect the health and safety of the public by investigating every complaint and unusual incident to determine healthcare facilities' compliance with state and federal regulations.

Performance Measure 2

The percent of complaints and unusual incidents investigated within timeframes mandated by priority designation.

Actual (FY 2009-2010)	Estimate (FY 2010-2011)	Target (FY 2011-2012)
50%	100%	60%

Note: Division reported an actual of 71% for FY 2009-2010 in its FY 2011-2012 budget proposal.

According to the Division of Health Care Facilities, state and federal survey and complaint data are collected in the CMS ASPEN (Automated Survey Processing Environment) system and ACTS (Automated Complaint Tracking System, a module of ASPEN). Survey and complaint data are entered at the completion of each survey and complaint investigation. Data from this system generate reports used to compute timeliness.

Division management does not expect to reach the performance measures target for 2011-2012 because of turnover and vacancies in surveyor positions (staff who inspect facilities and investigate complaints). According to division management, the division has had a 23-36% surveyor vacancy rate for the past four years.

The Centers for Medicare and Medicaid Services (CMS) annually reviews the performance of the Division of Health Care Facilities in its capacity as Tennessee's state survey agency. Those reviews, referred to as State Agency Performance Reviews (SAPR), include several performance measures CMS uses to determine whether the division is meeting CMS standards. Two of the CMS performance measures are (1) Frequency of Nursing Home Surveys and (2) Timeliness of Complaint and Incident Investigations. The 2008, 2009, and 2010 SAPR review results found that the division did not meet CMS standards for those two performance measures.

In its Corrective Action Plan response to CMS for all three years, the division named position vacancies and turnover as reasons for failure to meet CMS standards.

Appendix 3
Complaint Priority Categories

	Intake Prioritization			
Provider Type	**Immediate Jeopardy (IJ)** (2)	**Non-IJ High** (3)	**Non-IJ Medium** (4)	**Non-IJ Low** (5)
Nursing Homes	Initiate an onsite survey within 2 working days	Initiate onsite survey within 10 working days	CMS - No timeframe specified, but schedule onsite survey HCF – Initiate an onsite survey within 90 working days	Investigate during next onsite survey
Non-deemed providers/suppliers, other than nursing homes	Initiate an onsite survey within 2 working days	N/A	Initiate an onsite survey within 45 calendar days	Investigate during next onsite survey
Deemed providers/suppliers (1)	Initiate onsite survey within 2 working days of CMS authorization	N/A	Initiate onsite survey within 45 calendar days of CMS authorization	Investigate during next onsite survey
CLIA (Clinical Laboratory Improvement Amendments)**, non-exempt, non-accredited**	Investigate within 2 working days	N/A	N/A	N/A
CLIA, exempt	Notify CMS within 10 calendar days	N/A	N/A	N/A
CLIA, accredited	Submit allegations to CMS within 2 calendar days	N/A	N/A	N/A
EMTALA (Emergency Medical Treatment and Active Labor Act)	Complete investigation within 5 days of receipt of CMS authorization	N/A	N/A	N/A
Death related to restraint/seclusion used for behavior management –hospitals	Complete onsite investigation within 5 days of CMS authorization	N/A	N/A	N/A
Fires resulting in serious injury or death	Survey within 2 working days	N/A	N/A	N/A
Licensed only	Initiate an onsite survey within 2 working days	N/A	Initiate onsite survey within 90 working days	Investigate during next onsite survey

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

Notes:

(1) Deemed facilities – facilities accredited by a federally recognized accrediting health care organization.

(2) Immediate Jeopardy – Noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident.

(3) Non-immediate Jeopardy High – Noncompliance with one or more requirements or conditions may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well being that a rapid response is indicated.

(4) Non-immediate Jeopardy Medium – Noncompliance with one or more requirements/conditions/rules caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status or function.

(5) Non-immediate Jeopardy Low – Noncompliance with one or more requirements/conditions/rules may have caused physical, mental, and/or psychosocial discomfort that does not constitute injury or damage.