

BOARD FOR LICENSING HEALTH CARE FACILITIES

JULY 1996

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The Honorable John S. Wilder
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Speaker of the House of Representatives
The Honorable Joe Haynes, 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, abolished, or restructured.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

WRS/tp
96-020

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Board for Licensing Health Care Facilities
July 1996

AUDIT OBJECTIVES

The objectives of the audit were to review the board's and the Department of Health's legislative mandate concerning health care facilities and the extent to which the board and department have carried out that mandate efficiently and effectively, and to make recommendations that might result in more efficient and effective regulation of health care facilities.

FINDINGS

Complaint Investigations Need to Be Improved*

The Division of Health Care Facilities' investigations of complaints (especially those alleging abuse or neglect) were not always conducted timely, and complaint logs did not always contain complete information. Because of the large number of complaints the division receives, it is understandable that some investigations must be postponed so that other higher priority complaints can be investigated. However, failure to investigate complaints in a timely manner makes it more difficult for division staff to substantiate allegations; to react to, and facilitate prompt correction of, problems; and to ensure that facilities are providing the best possible care (page 11).

Only Limited Actions Have Been Taken Against Some Health Care Facilities

The division and board may not be using their enforcement authority to the maximum level to ensure facilities are providing the best possible care. Reviews of division complaint and licen-sure files indicated that only limited actions had been taken against some facilities with substan-tiated complaints or deficiencies. Federal monitoring surveys also raised similar concerns (page 14).

The Abuse Registry Has Several Weaknesses

Statutes, as well as federal regulations, require the Division of Health Care Facilities to maintain a registry of certified nursing assistants and others who have abused elderly or vulnerable individuals. The overall effectiveness of the abuse registry is limited because (1) follow-up inquiries are not required; (2) there are delays in adding names to the registry; and (3) only federally certified nursing homes are required to check the registry when making hiring decisions (page 17).

Inspection Time Frames Are Not Always Met

The Division of Health Care Facilities inspects facilities for both state licensure and federal certification purposes. The division currently performs the two inspections simultaneously. However, the inspection time frames required under state and federal mandates are not always the same. As a result, the division has not always met state mandates. The division also has not always met all federal inspection criteria (page 20).

Numerous Waivers Are Considered by the Board

Typically, a facility will request a waiver to a specific rule or regulation on the grounds that it is inapplicable to the facility's situation. In 13 recent board meetings, 263 waivers were considered, and the majority were granted. Numerous waivers raise the following questions: are the regulations necessary; do the regulations need to be updated; are fairness and consistency being sacrificed; and are the waivers warranted or are too many facilities trying to bypass the regulations (page 24)?

The Division Lacks a Central Database to Track Surveys and Complaints

The division has no central database, accessible by both the regional offices and the central office, to track surveys and complaints. Without such a database, it is difficult to determine when all facilities were last surveyed or how effectively complaints are handled. Complaint information is logged manually by region with little involvement from the central office (page 25).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues that affect the regulation of health care facilities: unlicensed facilities, the possible need to license additional types of facilities, and delays in licensure and regulation of some types of facilities (page 6).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider giving the board and/or the department statutory authority to take direct action (e.g., issuing cease-and-desist orders or civil penalties) against unlicensed operators (page 8).

The General Assembly may wish to consider expanding the board's and department's responsibilities to include regulation of dialysis units and emergency care/walk-in clinics (page 8).

The General Assembly may wish to consider expanding Sections 68-11-1001 through 68-11-1008, *Tennessee Code Annotated*, to require all licensed health care facilities to check the abuse registry and to include a prohibition against employment of anyone whose name is on the registry (page 19).

* This issue was also discussed in the 1992 performance audit of the board.

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report which contains all findings, recommendations, and management comments, please contact

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PERFORMANCE AUDIT
BOARD FOR LICENSING HEALTH CARE FACILITIES

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PERFORMANCE AUDIT
BOARD FOR LICENSING HEALTH CARE FACILITIES

INTRODUCTION

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 4-29-217, the Board for Licensing Health Care Facilities was scheduled to terminate June 30, 1996. As provided for in Section 4-29-115, however, the board will continue through June 30, 1997, for review by the designated legislative committee. 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 the results 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 abolished, continued, or restructured.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the board and the Department of Health by the General Assembly;
2. to determine the extent to which the board and the department have met their legislative mandates;
3. to evaluate the efficiency and effectiveness of the board and the department's Division of Health Care Facilities; and
4. to recommend possible alternatives for legislative or administrative action that may result in more efficient and effective operation of the board and the Department of Health's Division of Health Care Facilities.

SCOPE AND METHODOLOGY OF THE AUDIT

The board's and the Division of Health Care Facilities' activities and procedures were reviewed, with the focus on procedures in effect at the time of field work (August to October 1995). The audit was conducted in accordance with generally accepted government auditing standards. The methods included

1. interviews with staff of the Board for Licensing Health Care Facilities and the Division of Health Care Facilities;
2. interviews with federal officials and health care industry representatives;
3. reviews of department files;
4. site visits to the division's regional offices;
5. review of statutes and state and federal rules and regulations; and
6. review of prior audit reports and documents.

ORGANIZATION AND RESPONSIBILITIES

The primary statutory purpose of the Board for Licensing Health Care Facilities is to license and regulate hospitals, recuperation centers, nursing homes, homes for the aged, home care organizations, residential hospices, ambulatory surgical treatment centers, and facilities operated for the provision of alcohol and drug prevention and/or treatment services.

The Department of Health is empowered to license and regulate the above facilities through Title 68, Chapter 11, *Tennessee Code Annotated*; this licensing and regulation are to be accomplished through the Board for Licensing Health Care Facilities. Pursuant to Section 68-11-209, *Tennessee Code Annotated*, the board "has the duty and power to adopt such rules and regulations pertaining to the operation and management of [licensed health care facilities] and to rescind, amend or modify such rules and regulations from time to time, as are necessary in the public interest and particularly for the establishment and maintenance of standards of hospitalization required for the efficient care of patients or home for the aged residents." The board 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
- one representative of the drug and alcohol abuse service profession
- two consumer members

- 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 board is required to meet at least twice a year.

The Division of Health Care Facilities, Manpower and Facilities Bureau, Department of Health, handles the administrative work of the board. This division monitors the quality of health care facilities through the 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 surveys (inspections) of health care facilities are conducted from the regional offices.

Funding

The Division of Health Care Facilities, which in addition to licensing facilities also administers federal certification and monitors civil rights compliance, received \$8.1 million in fiscal year 1995. Expenditures also totaled nearly \$8.1 million. Approximately 52% of the division's total funding in fiscal year 1995 was through federal earnable grants. (See Certification section below.)

Revenues and expenditures for the Board for Licensing Health Care Facilities are included in the totals above. In fiscal year 1995, the board had revenues of \$672,571 and expenditures of \$191,189. All board revenues (most of which come from licensing fees) are deposited into the state's general fund; the board receives its funding through appropriations. Board expenditures include only costs specific to the board. For example, board expenditures include only three staff members' salaries (surveyors' salaries are included in the division's expenditures).

Licensure

Licenses for health care facilities are issued from the division's central office. As a rule, the board has no direct involvement with the licensing process, but it may recommend and approve the issuance of a license or may have a hearing on the application and conduct its own investigation to determine whether a license should be granted. Division staff stated that these types of situations are rare but could arise if the applicant was of questionable character or had a history of poor performance. Licenses for all types of facilities run from July 1 through June 30 of each year. Surveys are used to help ensure regulations are being adhered to before a license is issued or renewed. (Exhibit 1 details the number and types of licensed facilities.)

Certification

The Secretary for the United States Department of Health and Human Services has overall responsibility for Title XVIII of the Social Security Act (Medicare) and has delegated accountability for determining whether providers or suppliers meet health and safety standards to

TOTAL FACILITIES LICENSED AND CERTIFIED
JULY 1995

Licensed Facilities (a)

<u>Facility Type</u>	<u>Number Licensed</u>
Hospitals	137
Nursing Homes	331
Ambulatory Surgical Treatment Centers	68
Home Health Agencies	296
Homes for the Aged	240
Alcohol and Drug Treatment Centers	<u>141(b)</u>
Total Licensed	<u>1,213</u>

Certified Facilities (c)

<u>Facility Type</u>	<u>Number Certified</u>
Hospitals	154
Hospital Swingbeds	46
Nursing Facilities	326
Intermediate Care Facilities for the Mentally Retarded	73
Home Health Agencies	239
Rural Health Clinics	6
Rehabilitation Centers	71
Portable X-Rays	12
Physical Therapists/Occupational Therapists (d)	50
End-Stage Renal Disease Centers	78
Ambulatory Surgical Centers	58
Hospices	51
Comprehensive Outpatient Rehabilitation Facilities	5
Community Mental Health Centers	<u>10</u>
Total Certified	<u>1,240</u>

Notes:

- a. Recuperation centers are not listed because they have never been licensed separately from nursing homes. Regulations for residential hospices did not become effective until November 1, 1995, but hospices are currently licensed under home health agencies.
- b. The 141 licensed alcohol and drug treatment centers are those freestanding facilities licensed by the Department of Health. The Department of Mental Health and Mental Retardation licenses an additional 206 alcohol and drug treatment centers.
- c. The number of certified facilities refers to those facilities surveyed by the division and does not include federally qualified health centers and prospective payment system units, both of which, although certified, are not surveyed by the division.
- d. This total is the number of physical therapists and occupational therapists in independent practice.

Source: Division of Health Care Facilities central office staff.

the Health Care Financing Administration (HCFA), Division of Health Standards and Quality. HCFA has in turn contracted with the Tennessee Department of Health to conduct surveys and inform the Division of Health Standards and Quality if providers and suppliers in Tennessee meet federal requirements. The Division of Health Care Facilities' duties are thus two-fold: survey for and issue state licenses and conduct federal certification surveys. Any health care facility receiving Medicaid or Medicare payments must be certified. (Exhibit 1 details the number and types of certified facilities.)

Division staff conduct surveys by evaluating each facility against specified standards, rules, and regulations and by detailing deficiencies and violations of federal law involving health, safety, and quality of life. All surveyors use "time validation reports" to track the percentage of time spent on each activity. The amount of money the federal government provides the division is based on the number of hours spent conducting federal surveys—hence, the earnable grant. Because the standards are very similar, state licensure surveys are "piggy-backed" with the federal certification surveys.

Sanctions and Penalties

The board is responsible for setting minimum standards for health care facilities and for ensuring facilities operate in accordance with the standards. Since the standards define the minimum levels of care required to provide for patient health, safety, and welfare, practices that do not meet the standards may constitute a threat to patients. A variety of state and federal penalties and sanctions can be used, depending on the severity of the deficiency and the type of facility. However, Tennessee case law stipulates that state and federal penalties cannot be assessed concurrently.

State Penalties and Sanctions. According to Section 68-11-801, *Tennessee Code Annotated*, the Commissioner of Health is authorized to impose civil monetary penalties on nursing homes with deficiencies. The 1987 statute granted the commissioner three penalty options to impose:

- Type A penalty: a \$1,500–\$5,000 fine imposed whenever conditions are detrimental to the health, safety, or welfare of the patients.
- Type B penalty: a \$500–\$1,000 fine imposed when statutory standards directly affecting patient care have been violated.
- Type C penalty: a \$250 flat-rate fine imposed on offending facilities for violations that are not directly detrimental to the patients nor have a direct impact on their care; these penalties are intermediate sanctions to ensure consistent compliance when a violation is not corrected or when a violation is repeated.

However, because the state has chosen to use federal regulations and penalties for all certified long-term health care facilities (see federal penalties section), the above penalties are only to be used for the estimated 15 nursing homes in Tennessee that are not federally certified.

The sanctions available to the board are limited for facilities other than nursing homes. The board can suspend or revoke an offending facility's state license or can place conditions on licensure. If the facility's license is revoked, the facility has to reapply for and be issued a new license. This process includes reapplying to the Health Facilities Commission for a certificate of need, if such a certificate is required by statute. The board may suspend admissions to both nursing homes and homes for the aged. When admissions are suspended, a facility is not allowed to admit new residents until it has corrected deficiencies. If the deficiency threatens serious bodily harm to the patients or residents, the board may also place a special monitor in the facility during the suspension. The board may also summarily suspend a facility's or agency's license. In this case, all patients are relocated or all business activities are suspended while the facility or agency corrects the deficiencies.

Federal Penalties and Sanctions. The Health Care Financing Administration (HCFA) is responsible for determining whether providers or suppliers meet federal health and safety standards. In 1987, the federal government passed the Omnibus Budget Reconciliation Act (OBRA). This law set certain standards for certified long-term health care facilities and required states to enact these standards. However, the federal government did not fully enact OBRA enforcement regulations until July 1995. In the interim, Tennessee promulgated new rules concerning civil penalties in order to comply with OBRA.

Facilities violating federal standards are subject to OBRA penalties. Under the OBRA regulations, HCFA can impose a variety of penalties, such as fines or a temporary change of management, depending on the severity of the infraction. The amount of the fine varies, depending on the nature of the incident, but can reach \$10,000 per day. Effective July 1, 1995, the regulations also give the commissioner the ability to assess monetary penalties on all certified long-term health care facilities. Since these penalties are more stringent and encompass more facilities than the state's nursing home penalties, the department has elected to use the federal penalties. (See Exhibit 2 for a listing of all federal and state penalties the department has collected and the sanctions it has assessed since fiscal year 1992.)

OBSERVATIONS AND COMMENTS

The issues discussed below did not warrant findings but are included in this report because of their effect or potential effect on the operations of the Board for Licensing Health Care Facilities and the health, safety, and welfare of the people of Tennessee.

SANCTIONS AND PENALTIES ASSESSED
FISCAL YEARS 1992-1995

Penalties Collected from Nursing Homes (a)

	<u>OBRA (b)</u>	<u>A (c)</u>	<u>B</u>	<u>C</u>
Fiscal Year				
1995	\$ 50,750	–	\$12,450	\$ 4,050
1994	87,500	–	12,600	6,475
1993	64,100	\$14,000	11,100	7,150
1992	<u>12,875</u>	<u>30,800</u>	<u>10,200</u>	<u>10,325</u>
Totals	<u>\$215,225</u>	<u>\$44,800</u>	<u>\$46,350</u>	<u>\$28,000</u>

Suspensions of Admissions

Fiscal Year	
1995	2
1994	2
1993	4
1992	<u>4</u>
Total	<u>12</u>

Notes:

- a. These amounts are the total penalties collected. Total penalties assessed may vary from those collected because of dismissed, reduced, or discounted penalties.
- b. OBRA refers to federal penalties available through the Omnibus Budget Reconciliation Act of 1987; effective October 1989, Tennessee revised its rules to authorize these penalties.
- c. OBRA refers to federal penalties; A, B, and C penalties are state monetary penalties authorized through *Tennessee Code Annotated*, Section 68-11-801.

Source: Division of Health Care Facilities, central office staff.

Unlicensed Facilities

The board cannot close a health care facility that is operating without a license because the board has no jurisdiction over unlicensed facilities. However, division surveyors routinely investigate allegations against unlicensed facilities. This use of surveyors' time may be unwise, since there is little investigators can do other than document the situation. In addition, if the owner of the facility refuses to allow an investigation, surveyors have no authority to demand entry. At the same time, there is a backlog of uninvestigated complaints (see Finding 1) involving issues and areas over which the division does have jurisdiction.

When an unlicensed facility is identified, the division sends a letter to the owner stating that the facility needs to be licensed and requesting compliance with licensing standards. The letter states that the facility must comply within 30 days or risk being forced to cease its operations. If the facility does not comply, Section 68-11-213, *Tennessee Code Annotated*, allows the department to initiate proceedings seeking injunctive relief (through the chancery court) against the unlicensed operator. Information on the facility is therefore forwarded to the Attorney General's office or the local district attorney for legal action. However, since these offices give such cases low priority few facilities are pursued legally.

Currently, despite the board's and the department's responsibility to license and regulate health care facilities and the routine investigation of complaints against unlicensed facilities, neither the board nor the department has the authority to ensure compliance by unlicensed facilities. Because of these responsibilities and the potential for harm to residents in unlicensed facilities, it appears reasonable that the Board for Licensing Health Care Facilities and the Department of Health should have statutory authority to take action (e.g., issuing cease-and-desist orders or civil penalties) against unlicensed operators.

Licensing of Additional Facilities

The Board for Licensing Health Care Facilities is charged through Section 68-11-202, *Tennessee Code Annotated*, with licensing and regulating hospitals, recuperation centers, nursing homes, homes for the aged, home care organizations, residential hospices, ambulatory surgical treatment centers, and alcohol and drug treatment facilities. Nineteen types of facilities are certified through HCFA; homes for the aged and alcohol and drug treatment facilities are not. On the other hand, some facilities are certified through HCFA but are not licensed by the state. If such a facility has problems and HCFA does not pursue sanctions, the state has no authority to close the facility. As the health care industry changes, the board may need the authority to license other types of facilities that, if unregulated by the state, could threaten public safety.

Dialysis Units

Dialysis units, according to division staff, are among the most potentially dangerous types of facilities (because both the disease and the treatment procedures can be life threatening), yet they are not licensed by the state. As of July 1995, there were 78 dialysis units (renal disease centers) in Tennessee. Although there have been no chronic problems with dialysis units, staff did

believe one dialysis unit should have been closed. However, because the unit had no license to revoke, the division could only report the situation to HCFA. Additionally, dialysis units are not required to obtain a certificate of need, another method of health facility regulation.

Emergency Care/Walk-In Clinics

Emergency care/walk-in clinics are neither licensed by the state nor certified by the federal government, although division staff stated that they have received many complaints about such facilities. Because of the prevalence of these clinics and the large number of people who could be affected, regulation may eventually be needed to ensure the public's health, safety, and welfare.

Regulatory Activities

The Department of Health does not currently license and regulate all facilities for which it is responsible. As of October 1995, the department did not license and regulate all home care organizations and performed only limited licensure and regulation of alcohol and drug treatment centers. One factor delaying licensure and regulation is the lack of rules and regulations. Unfortunately, the rulemaking process is lengthy and time-consuming because of the many levels of review and approval required. After board approval, the rules are sent to the Department of Health's Office of General Counsel, to the Attorney General's office, and then to the Secretary of State's office. The rules are also subject to legislative review through the Government Operations Committee.

Home Care Organizations

Legislation enacted in April 1995 gave the department and board authority to license home medical equipment services (effective September 1, 1995) and grouped home health services, hospice services, and home medical equipment services under the broad category "home care organizations." The Division of Health Care Facilities is in the process of generating home care regulations which will include separate regulations for hospices, home medical equipment services, and home health services. Revised home health services regulations (with only minor changes) will be effective July 9, 1996. Hospice regulations will also become effective at that time. Home medical equipment regulations will be presented to the board for final filing in August 1996.

Alcohol and Drug Treatment Centers

Alcohol and drug treatment centers were originally licensed by the Department of Mental Health and Mental Retardation. Executive Order Number 49, signed June 19, 1991, transferred the Division of Alcohol and Drug Abuse Services to the Department of Health. This order also transferred to the Department of Health the authority, effective July 1, 1992, to license facilities operated for the provision of alcohol and drug services. However, through an oral agreement between the Commissioners of Mental Health and Mental Retardation and Health, a change in the licensing was deferred until 1995, and even then the Department of Health became responsible only for freestanding alcohol and drug treatment facilities. As of August 1995, the Division of

Health Care Facilities had licensed 141 freestanding alcohol and drug treatment facilities, and as of September 1995, the Department of Mental Health and Mental Retardation had licensed 206 such facilities. Since the 1991 executive order, the division has conducted only one cycle of licensure inspections (fiscal year 1995), and staff indicated that during this initial cycle, some licenses were issued before any inspections were conducted by division surveyors.

FINDINGS AND RECOMMENDATIONS

COMPLAINT INVESTIGATIONS NEED TO BE IMPROVED

1. FINDING:

The Division of Health Care Facilities' investigations of complaints (especially those alleging abuse or neglect) were not always conducted timely, and complaint logs did not always contain complete information. Division staff give serious allegations priority at the expense of other investigations which must be delayed. Because of the large number of complaints the division receives, it is understandable that some investigations must be postponed so that other higher priority complaints can be investigated. However, failure to investigate complaints in a timely manner makes it more difficult for division staff to substantiate allegations; to react to, and facilitate prompt correction of, problems; and to ensure that facilities are providing the best possible care.

Timeliness of Complaint Investigations

Review of Complaint Logs. According to a review of the complaint log at the Middle Tennessee Regional Office, 693 complaints were logged during the year ended June 30, 1995. One hundred fifty-five of these complaints, or 22%, had not yet been investigated by September 5, 1995. Of these 155 complaints, 87 involved allegations of abuse or neglect. According to the log, two complaints, one alleging abuse and the other neglect, had never been investigated even though the office received them in July 1994. The East Tennessee Regional Office logged 819 complaints in fiscal year 1995. According to the complaint log, 29 of the complaints from fiscal year 1995, or 3.5%, had not been investigated by October 6, 1995. Of these 29 complaints, 11 alleged abuse or neglect.

File Review. In addition to the review of complaint logs, an in-depth review of several complaint files was conducted. At the Middle Tennessee Regional Office, the files for 61 complaint investigations from 16 facilities were reviewed. The average time from the receipt of the complaint to the complaint investigation date was approximately 35 days. At the East Tennessee Regional Office, complaint files from 26 facilities were reviewed for a total of 114 individual complaint investigations. The average time at the East Tennessee office before a complaint was investigated was approximately 40 days. A review of 17 investigations of alleged abuse and neglect (all of which resulted in a referral to the abuse registry) indicated that on average those complaints were not investigated until 53 days after receipt. On three separate occasions, the investigations of alleged abuse and/or neglect did not begin until over 100 days after the date the complaint was reported. Below is a chart of complaints reviewed, broken down by the number of days between receipt of a complaint and investigation.

Breakdown of Complaints by Number of Days Between Receipt and Investigation

	Total Complaints <u>Reviewed</u>	Number of Days*				Average Number of Days Before Investigation <u>Was Initiated</u>
		<u>0-10</u>	<u>11-30</u>	<u>31-59</u>	<u>0-60</u>	
Middle Tennessee Regional Office	61	14	21	13	13	35
East Tennessee Regional Office	114	28	34	24	28	40
Abuse Registry Referrals	17	0	6	4	7	53

* Times were computed by counting the days between the date the division received the complaint and the date the complaint was investigated. Complaints that were investigated on the day of the complaint were given a value of zero.

Current departmental policy requires the timely investigation of abuse complaints but specifies no time frame. Division policy at the time of the 1992 performance audit had specified time frames for investigating allegations of abuse or neglect. For example, category I complaints, those that present an immediate and serious threat to the patient's health and safety, were to be investigated within two days. Division staff indicated that the priority given the complaint is determined by the immediacy of the situation. However, until the complaint is investigated, it may be difficult to adequately judge if the patient's health and safety are no longer threatened. In addition, the alleged incident could signal greater problems within the facility or violations which, if uncorrected, could mean less than optimal care for the residents. The prompt investigation of abuse complaints is necessary to stop patient abuse, to prevent abuse from recurring, and to ensure that vital physical evidence is not lost. Timely investigation of abuse and neglect complaints is particularly vital because of the vulnerability of facility residents.

Incomplete Information

A complaint form is used by the regional offices to log complaints received; however, the content and extent of use of this form vary by region. For example, the East Tennessee Regional Office's log includes a space to indicate if a plan of correction is required, when it is due, and when it was received. The Middle Tennessee Regional Office's log does not. East Tennessee Regional Office staff indicated that they had revised their form to better facilitate the new requirements in the federal regulations. Staff at the Middle Tennessee Regional Office did not always update the log to indicate the category of each complaint, if the complaint was substantiated, or whether a follow-up was conducted. The East Tennessee Regional Office apparently documents more on their log.

All complaint information is kept regionally on the complaint logs or in the complaint investigation files. The central office maintains little data on complaints. A centralized, computerized database for complaints would help reduce the variances in recordkeeping among regions and would provide a valuable management tool for the central and regional offices. With such a database, division management could monitor and supervise the progress of investigations and would be better able to determine whether staff adequately responded to and resolved complaints in a timely manner. Trends in complaints against specific types of facilities, repeated complaints at a particular facility, and industry-wide changes could also be determined. A computerized log would not only make it easier for staff to record a complaint, it would also provide the data in a format that could be easily read, updated, and summarized.

RECOMMENDATION:

Division of Health Care Facilities management should (1) review the process for assigning and investigating complaints, (2) revise procedures as needed to improve timeliness of complaint investigations (particularly for abuse and neglect complaints), and (3) monitor the division's performance and take further corrective action if necessary.

Upper management in the Division of Health Care Facilities should implement a centralized, computerized complaint system to facilitate efficient and effective management of complaints. Until such a system can be developed, division management should review the format of the complaint logs, revise the log as necessary to incorporate the information essential for tracking the investigation and resolution of complaints, and require all regions to use and fully complete the complaint log.

MANAGEMENT'S COMMENT:

We concur. The division began revising the complaint investigation procedures in October 1995, and these new procedures were implemented beginning January 25, 1996. All complaints are now promptly reviewed and prioritized. All complaints warranting an investigation are then logged on the newly developed computer complaint log and a date scheduled for investigation. Priority 1 complaints which constitute possible immediate jeopardy are investigated within two working days, Priority 2 complaints which involve situations that have been controlled by the facility and have resulted in less serious harm are investigated within sixty days, and Priority 3 complaints which are not detrimental to the patients or their care are conducted at the discretion of the Regional Administrator or during the facility's next survey. Each region's complaint log is reviewed for discrepancies or missed investigations on a regular basis by the Regional Administrator and every six months by the Director or his or her designee.

A centralized database network computer system is not feasible at this time due to fiscal constraints.

LIMITED ACTIONS HAVE BEEN TAKEN AGAINST
SOME HEALTH CARE FACILITIES

2. FINDING:

The division and board may not be using their enforcement authority to the maximum level to ensure facilities are providing the best possible care. Reviews of division complaint and licensure files indicated that only limited actions had been taken against some facilities with substantiated complaints or deficiencies. (See Exhibit 3 for examples.) Federal monitoring surveys also raised similar concerns. Each year, HCFA reviews the division's activities to assess the division's effectiveness in applying federal regulations, policies, guidelines, and instructions. The 1994 HCFA Comprehensive Evaluation Report cited the division's handling of complaints as an area that needed improvement: 22 of 110 complaints reviewed needed additional investigation and/or development; several deficiencies were not cited at the correct level; and the division failed to arrive at the correct compliance decisions in four cases; e.g., cases that should have been cited as immediate and serious threats were cited at a lesser level or were not cited. HCFA's 1995 report noted similar problems and stated that management needs to review the complaint investigations to determine if appropriate action has been taken and to review the decision-making process.

A Division of State Audit review of complaint files at the Middle and East Tennessee Regional Offices indicated that despite investigations resulting in substantiated claims, the division often took only minimal actions, such as recommending a corrective plan of action. The complaint files reviewed from the East Tennessee Regional Office included 46 substantiated complaints (i.e., investigators found evidence to support the complaint) and 69 unsubstantiated complaints. Deficiencies (violations of specific state or federal standards) were cited in four of the 46 cases, and two cases were referred to the abuse registry. The complaint files reviewed from the Middle Tennessee Regional Office included 12 substantiated complaints and 51 unsubstantiated complaints. Deficiencies were cited in two of the 12 cases, and two were referred to the abuse registry. (See finding 3 for discussion of the abuse registry.) Overall, the division

THREE CASES SHOWING EXAMPLES OF REPEATED DEFICIENCIES
WHERE LIMITED ACTION WAS TAKEN

Case 1

February 15, 1995, certification and licensure survey; initial comments under statement of deficiencies stated that as a result of continuing complaint allegations and the magnitude of the problems identified during the complaint investigation, a full survey was conducted; 27 pages of deficiencies were cited; many level B deficiencies, including care of residents, accommodation of needs, and nutrition; 5/12/95 post-licensure revisit indicated five pages of deficiencies; a plan of correction was submitted, but no evidence of any other follow-ups, penalties, or sanctions; facility also had seven substantiated complaints, three alleging abuse or neglect, in fiscal year 1995; one C penalty (\$250) was assessed in October 1994.

Case 2

December 19, 1994, annual survey (home for the aged) stated three residents were identified as unable to respond to fire drill without assistance; other deficiencies included improper use of restraints; 3/1/95 follow-up survey noted no corrections and stated some of the residents required continued professional medical care that the facility cannot legally provide; the plan of correction was found to be unacceptable; 4/3/95 memo from Division of Health Care Facilities staff member stated that the home was visited on a follow-up survey and six residents were viewed as “unable to preserve themselves in case of a fire”; 5/22/95 Division of Health Care Facilities’ medical director reassessed five residents and found several were not able to evacuate on their own; report stated some residents have needs that cannot be legally met in a home for the aged; home had two weeks to make other placement arrangements; 5/25/95 letter to the Middle Tennessee Regional Office from the home requested a hearing before the Board; 7/27/95 letter from facility stated that one of the residents in question had expired; no evidence of any other actions in file.

Case 3

March 30, 1995, certification and licensure survey; many level B deficiencies cited; fire safety survey showed eight elements of standards of the Life Safety Code Standard were violated and fire safety licensure deficiencies were cited in two areas; plan of correction was submitted on 5/11/95 and follow-up survey was conducted 6/23/95; many deficiencies were also cited in the follow-up survey, but there was no indication of any other follow-up; facility also had six complaints in fiscal year 1995 that were not investigated, three of which alleged abuse or neglect, as well as three substantiated complaints.

Source: Licensure Files, Middle Tennessee Regional Office, Division of Health Care Facilities.

referred few cases to the abuse registry and assessed few penalties. In addition, many substantiated complaints did not result in any recommendations. Division surveyors did recommend that certain actions be taken in response to some abuse and neglect incidents; however, the files did not indicate any follow-up. For example, despite the recommendation that the level of care be increased for certain individuals, there was no indication in the file that the division ever conducted a follow-up visit to ensure those persons had been moved to a more appropriate setting.

Licensure personnel stated that only two facilities have had their licenses revoked in the past four years, both in March 1995. (See Exhibit 2 for other sanctions and penalties assessed.) According to a review of nursing home licensure files, several facilities were cited with what appeared to be a large number of deficiencies yet were assessed very limited civil penalties. According to one licensure file reviewed, a nursing home had been issued a pending C penalty in October 1994 and another in February 1995 for the same deficiency. A pending C penalty issued to a facility is a warning, and the same violation cited within the year is supposed to result in an automatic penalty. However, a note in the file stated that a penalty was not assessed because there was “no one available to sign it.”

The August 1995 edition of *Consumer Reports* stated that nationwide about 40% of all facilities certified by HCFA have repeatedly violated federal standards over the last four inspection surveys. Despite widespread noncompliance, as evidenced in Tennessee by the deficiencies cited in the overwhelming majority of licensure files reviewed, enforcement actions appear to be infrequent.

RECOMMENDATION:

The Department of Health and the Board for Licensing Health Care Facilities should assess and impose appropriate punitive actions when investigations have proved abuse and neglect or when the situation merits the action. Division of Health Care Facilities staff should develop a system to monitor follow-up recommendations to ensure they are being implemented.

MANAGEMENT’S COMMENT:

We concur in part. Licensure is a state process for which the Board is responsible. Certification is a federal process over which the Board has no jurisdiction. State enforcement actions are limited. The Board for Licensing Health Care Facilities is not required to conduct follow-up assessments. This is a federal requirement. Nor is the Board authorized to issue civil monetary penalties against facilities. The Commissioner is the designee for the issuance of civil monetary penalties on nursing homes only, and those penalties can only be issued for specific violations of the law, as enumerated in *Tennessee*

Code Annotated 68-11-801, et seq. There is no statutory authority for issuance of penalties to any other type of licensed health care facility.

Between 1992 and July 1, 1995, the Division was mandated to issue federal civil monetary daily penalties against certified nursing homes. These federal daily penalties superseded state civil monetary penalties, could be assessed at a greater monetary amount, and were assessed for the duration of the violation, thereby proving more effective and expedient than state penalties.

Effective July 1, 1995, the Department of Finance and Administration's Bureau of TennCare became the issuing agency for federal monetary penalties, for temporary management services, and for mandated facility decertifications upon recommendation by this Division.

The Board does have the authority to revoke licenses, but this authority is exercised only in the most severe cases because closing a facility is extremely traumatic to patients and families.

The new computer complaint log system and policies should increase the efficiency of the regional offices regarding priorities and scheduling of investigations and follow-up surveys.

THE ABUSE REGISTRY HAS SEVERAL WEAKNESSES

3. FINDING:

Several weaknesses in the abuse registry process reduce its overall effectiveness: follow-up inquiries are not required; there are delays in adding names to the registry; and only nursing homes are required to check the registry when making hiring decisions. Pursuant to Section 68-11-1001, *Tennessee Code Annotated*, as well as federal regulations, the Division of Health Care Facilities maintains an abuse registry, a registry of certified nursing assistants (CNAs) and others who have abused elderly or vulnerable individuals. The registry is not for licensed professionals since those complaints would be referred to the proper licensing board. Placement of an individual's name on this registry precludes that person from obtaining future employment in a nursing home. As of September 1995, the abuse registry in Tennessee contained 391 names.

Follow-Up Inquiries

Federal regulations require a nursing home to check the abuse registry before hiring a certified nursing assistant. If the individual's name is on the abuse registry, the nursing home cannot legally employ that person. However, because investigations into incidents of abuse may be prolonged and are kept confidential, a person's name may not be added to the registry until months after the incident.

An employee involved in an incident of abuse is often terminated by the employer after an internal investigation is conducted. However, this is only the beginning of the process that may eventually lead to that individual's name appearing on the registry. If an employer checks the abuse registry for this individual's name while the individual is under the investigation, the prospective employee's name will not appear on the registry. By the time the employee's name is added to the registry at the conclusion of the investigation, the individual could already be working in another facility.

Division of Health Care Facilities surveyors are not required to check the abuse registry but may if a facility's employee records do not indicate a prior check. There are no provisions in place that will automatically bring this information to the attention of either the new employer or the division, and facilities are not required to check the abuse registry after their initial check.

Lack of Timeliness

According to a review of 30 complaint investigations referred to the abuse and neglect registry, the offenders' names were not placed on the abuse registry until an average of 295 days after the incidents occurred. In nine cases, over a year had elapsed before the process was completed. Completion of the steps necessary to place a person's name on the abuse registry took between three and a half months to one year and ten months.

The referral to the abuse registry starts with the incident itself. The facility is required to report any unusual incidents to the division within five days. The regional office then investigates and determines whether sufficient evidence of abuse or neglect exists. If the office decides to proceed with referral to the abuse registry, it must notify the implicated individual and the facility administrator within ten days. Individuals contesting their referral to the abuse registry may request a hearing before an administrative judge. If the person requests a hearing, the investigation materials are forwarded to the department's Office of General Counsel (OGC) for a determination of whether the state has a "provable case." If so, a hearing is scheduled and held. (According to Office of General Counsel staff, under the new system, which uses decision trees in determining whether to pursue an abuse complaint, the vast majority of cases that reach OGC are provable.) Only at the conclusion of the entire process can the individual's name be added to the registry.

It appears that individuals involved in incidents of abuse are usually discharged from their current positions rather quickly, yet they have at least three and a half months, and often longer, to obtain employment at another nursing home without employer inquiries uncovering the investigation and alleged abuse. In essence, an individual can effectively evade the purpose of the abuse registry by obtaining employment between the time of discharge and the time his or her name appears on the registry.

Limitation of Inquiry

Certain limitations lessen the registry's effectiveness. The requirement to use the abuse registry and the prohibition of employing anyone on the abuse registry apply only to nursing homes and only those with federal certification. Therefore, approximately 15 noncertified nursing homes in the state are not affected. According to division staff, many licensed facilities other than nursing homes already check the registry, and requiring all licensed health care facilities to use the registry would not be a great burden. Extending this requirement to home health agencies would be especially beneficial since these agencies employ CNAs. It appears doubtful that the intent of the abuse registry was to allow CNAs who have been prohibited from working in one type of facility to perform almost identical tasks in another type of health care facility. Extending the requirement to check the abuse registry to all health care facility types would provide additional safeguards to prevent known abusers from remaining actively employed in Tennessee's health care industry.

RECOMMENDATION:

A follow-up inquiry of the abuse registry should be required sometime after an employee has been hired by a facility. This second check of the abuse registry should prevent almost all abusers from "slipping through the system."

Division of Health Care Facilities management, in consultation with the Office of General Counsel staff, should review the process for placing an individual's name on the abuse registry, identify ways to expedite the process (including ways to improve the timeliness of abuse and neglect investigations and the hearing process), and revise the process accordingly.

The General Assembly may wish to consider expanding Sections 68-11-1001 through 68-11-1008, *Tennessee Code Annotated*, to require all licensed health care facilities to check the registry and to include a prohibition against employment of anyone whose name is on the abuse registry.

MANAGEMENT'S COMMENT:

We concur. The statute should be amended to require all licensed facilities to check the abuse registry and to check it a second time at a later date following the hiring of any employee, and the statute should include a prohibition against employment of listed abusers. Also, all boards which license health care professionals should be re-quired by statute to submit proven abusers for inclusion on the abuse registry.

The process for placing a person's name on the abuse registry was reviewed and revised at the same time the complaint procedures were revised and are now in effect utilizing decision trees.

INSPECTION TIME FRAMES ARE NOT ALWAYS MET

4. FINDING:

The Division of Health Care Facilities inspects facilities for both state licensure and federal certification purposes. The division currently performs the two inspections simultaneously. However, the inspection time frames required under state and federal mandates are not always the same. As a result, the division has not always met state mandates. The division also has not always met all federal inspection criteria.

State Annual Inspections

The Division of Health Care Facilities does not always inspect every hospital, recuperation center, nursing home, home for the aged, home care organization, residential hospice, ambulatory surgical treatment center, and alcohol and drug prevention/treatment facility every 12 months as required by *Tennessee Code Annotated*, Section 68-11-210. (See Exhibits 4 and 5.) A September 1995 Department of Health Internal Audit also noted the division's failure to always meet the 12-month time frame. The purpose of annual inspections is to ensure that health care facilities licensed in Tennessee comply with applicable laws and regulations and promptly correct identified deficiencies. Failure to complete required inspections fundamentally undercuts the purpose of regulation and could endanger the health, safety, and welfare of patients in those facilities.

MIDDLE TENNESSEE REGIONAL OFFICE
LICENSURE FILE REVIEWS

<u>Facility Type</u>	<u>Files Reviewed (a)</u>	<u>Surveyed Within Last Licensure Period (b)</u>	<u>Files with Deficiencies Cited (c)</u>
Nursing Homes	17	16	15
Hospitals	7	6	6
Homes for the Aged	11	10	9
Alcohol and Drug Treatment Centers	16	16	15
Ambulatory Surgical Treatment Centers	3	2	3
Home Health Agencies	<u>15</u>	<u>12</u>	<u>6</u>
	<u>69</u>	<u>62</u>	<u>54</u>

Notes:

- a. Approximately 5% of the total number of licenses in each facility type were reviewed with the exception of alcohol and drug treatment centers, of which 11% were reviewed. More of these were reviewed because the division had just begun licensing this type of facility.
- b. This number indicates how many files contained evidence of the most recent annual survey.
- c. This refers to deficiencies within the last licensure period and includes fire safety deficiencies and general licensure/certification deficiencies.

Source: Middle Tennessee Regional Office Licensure Files and Division of Health Care Facilities central office staff.

CERTIFICATION DATABASE REVIEW (a)
SURVEYS CONDUCTED FISCAL YEAR 1995

Facility Type	Number of Certified Facilities (b)	Surveyed Within FY 1995	Not Surveyed in FY 1995	Percent Surveyed In FY 1995
Skilled Nursing Facilities	323	311	12	96.3
Hospitals	153	108	45	70.6
Home Health Agencies	239	236	3	98.7
Ambulatory Surgical Treatment Centers	57	22	35	38.6

Notes:

- a. There is no state database of all licensed facilities that tracks when the last licensure surveys were completed. The federal certification database was used; this lists all certified facilities and the dates of the last surveys conducted by the Division of Health Care Facilities. Since certification and licensure surveys are conducted concurrently, these figures should show how many of the above facilities were surveyed in fiscal year 1995.
- b. Other facilities and programs licensed by the state—homes for the aged and alcohol and drug prevention and/or treatment programs—are not included because they are not certified.

Source: Health Care Financing Administration certification database.

Federal Certification Inspections

In addition to conducting its annual licensure inspections, the division is also responsible for inspecting at least once every 15 months facilities receiving Medicaid and Medicare money. The 15-month federal certification requirement applies to home health agencies and long-term health care facilities; all other facilities must be inspected within 12 months. Federal inspection guidelines also require the division, as the contract agency for the federal government, to ensure that the statewide average interval between certification inspections of each home health agency and long-term health care facility does not exceed 12 months. These guidelines are not always met, as the HCFA Comprehensive Evaluation Report for fiscal year 1994 indicated: (1) not all home health agencies and long-term health care facilities were inspected no later than 15 months after the previous survey, and (2) the statewide certification average interval for home health agencies exceeded the established criteria by 2.5 months.

The federal government funds certification inspections through earnable grants. By combining state licensure inspections with the certification surveys, the state is essentially reimbursed for licensure inspections required by state statute. Therefore, the failure to comply with federal certification inspection requirements not only results in the failure to maximize earnable federal grants, but also may require additional expenditures by the state.

Combining State and Federal Inspections

When combining state and federal inspections, the division currently focuses on meeting the 15-month federal certification requirement. Combining inspections allows the state to avoid duplication of effort and to save money. The longer time frame could also make it easier for surveyors to vary the timing of inspections (making them less predictable) and to schedule and survey facilities in accordance with their compliance and complaint history. However, the longer inspection period conflicts with the state's licensing process, which is based on 12-month inspections.

RECOMMENDATION:

The Division of Health Care Facilities' executive director should work with the regional administrators to establish scheduling controls and procedures that will ensure the division meets state and federal requirements. The Department of Health should consider whether the benefits of adopting the federal inspection time frame outweigh the potential negative effect on regulation and on residents of health care facilities. If the department determines benefits outweigh costs, it should request that the General Assembly consider changing the inspection requirements in Section 68-11-210, *Tennessee Code Annotated*.

MANAGEMENT'S COMMENT:

We concur. There are 37 vacant positions in the Division. We will continue to request those positions necessary to allow us to be more timely in our surveys. We will consider requesting additional funding for all new licensing programs added during the past two legislative sessions, and we will discuss the possibility of a statutory amendment to change the required annual surveys to match federal requirements for facilities which are both licensed and certified.

NUMEROUS WAIVERS ARE CONSIDERED BY THE BOARD

5. FINDING:

The Board for Licensing Health Care Facilities considers and grants numerous waivers. As a rule, a facility will request a waiver to a specific rule or regulation on the grounds that it is inapplicable to the facility's situation. Waivers typically requested include the following: to waive (for a specified time period) the requirement that the facility have a full-time licensed administrator; to waive separate licenses at a single facility; to waive providing a particular service; to allow a patient to remain at a facility; and to waive certain physical/structural requirements. In 13 recent board meetings, 263 waivers were considered, for an average of approximately 20 waivers per meeting. Also, the majority of these waivers were granted. Numerous waivers raise the following questions:

- Are the regulations necessary?
- Do the regulations need to be updated?
- Are fairness and consistency being sacrificed?
- Are the waivers warranted, or are too many facilities trying to bypass the regulations?

Outdated Regulations

Waiver requests may also be prevalent because many of the regulations need revision. Many of the division's regulations were written in the 1970's and do not reflect current practice. Although rulemaking is a continual process, it is also lengthy and requires the promulgation of specific rules and regulations for each facility type. As a result, the state may not be able to promulgate rules as swiftly as necessary to reflect changes in the health care industry.

Limited Recordkeeping

Division records concerning waivers contain limited information. The manual system currently being used does not facilitate analysis of the facilities requesting waivers, or even of the types of waivers requested. Collection and analysis of such information through an automated database would help the division and board focus on issues that need attention and regulations that may need to be changed.

The waiver process appears a reasonable way to control needed exceptions to the rules and regulations. Waivers can denote changes in health care and, in some cases, may even be innovations. Just as there may always be a need for waivers, there is a need for the board and division staff to monitor waivers to ensure that circumvention of the regulations is not detrimental to patient care or unfair to other facilities.

RECOMMENDATION:

The division should develop and use an automated database to monitor and analyze waiver requests and waivers granted. The board should then use this information to determine if current regulations are necessary or if they need to be updated, and to determine if all facilities are treated fairly and consistently.

MANAGEMENT'S COMMENT:

We concur. Staff is currently developing a computerized waiver request log that will provide the Division and the Board guidance as to trends in health care and which regulations need to be revised. Information from the log will provide the Board background information on previously issued waivers which will allow them to be more consistent in the granting of waivers.

THE DIVISION LACKS A CENTRAL DATABASE TO TRACK SURVEYS AND COMPLAINTS

6. FINDING:

The division has no central database, accessible by both the regional offices and the central office, to track surveys and complaints. Without such a database, it is difficult to determine when all facilities were last surveyed or how effectively complaints are handled. The division does have a database to track federal certification surveys, but facilities that are licensed only are not included. Complaint information is logged manually by region

with little involvement from the central office. (See Finding 1 for a discussion of improvements needed in complaint investigations.)

Surveys

The division currently uses manual checks and controls to ensure that annual surveys and fire and safety surveys are conducted before licenses are issued or renewed. Licensing personnel at the central office maintain a list of health care facilities and notify the regional offices of the facilities that need to be surveyed. There is no automated flagging system. To determine when a licensed-only facility has last been surveyed, that particular facility's file must be pulled. In addition, each regional office uses a manual card system to track when licensed-only facilities are due to be surveyed. The availability of one computerized, centralized list with the most current information (that could be used by the central and regional offices) would be a more efficient and effective method to track when surveys are due and when they have been completed.

Complaints

Complaints are handled by the regional offices; the central office maintains very little data on complaints. Regional office staff manually log complaints using a standardized complaint form (the use and content of which varies among the regions). By centralizing complaint data, the division may be able to improve the timeliness of complaint investigations and more effectively manage the caseload.

Regulatory Board System

The regulatory board system is a computer system developed to capture and track information on the Health Regulatory Boards' applicants and/or licenses. However, the system does not currently handle any survey tracking or complaint information. The system is used for the board's licensing renewal system, but even this function has not been completely implemented. Although the system has a listing of each facility type, there is no information indicating the last survey date.

A state database of licensed-only facilities, or a database that includes all facilities, would assist in effective and efficient management of the survey and complaint caseload. A centralized database may also help with interaction between the central and regional offices and with the resolution of issues before they develop into problems.

RECOMMENDATION:

Division of Health Care Facilities management should consult with the department's Bureau of Information Resources to determine the exact capabilities of the regulatory board system and determine if the system has the capabilities to track survey

dates and complaint data. If not, the division should centralize this information in some form to facilitate central office management of division duties.

MANAGEMENT'S COMMENT:

We concur. See response to finding 1.

The Division requested assistance from the Bureau of Information Resources (BIR) to determine whether the existing regulatory boards system (RBS) is capable of tracking survey dates. BIR advised that this would require a major modification of the system which would be very time consuming and extremely costly. Therefore, staff will explore various options for centralizing survey dates and complaint data within existing resources.

RECOMMENDATIONS

LEGISLATIVE

This performance audit identified areas in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the board's operations.

1. The General Assembly may wish to consider giving the board and/or the department statutory authority to take direct action (e.g., issuing cease and desist orders or civil penalties) against unlicensed operators.
2. The General Assembly may wish to consider expanding the board's and department's responsibilities to include regulation of dialysis units and emergency care/walk-in clinics.
3. The General Assembly may wish to consider expanding Sections 68-11-1001 through 68-11-1008, *Tennessee Code Annotated*, to require all licensed health care facilities to check the abuse registry and to include a prohibition against employment of anyone whose name is on the registry.

ADMINISTRATIVE

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

1. Division of Health Care Facilities management should (1) review the process for assigning and investigating complaints, (2) revise procedures as needed to improve timeliness of complaint investigations (particularly for abuse and neglect complaints), and (3) monitor the division's performance and take further corrective action if necessary.
2. Upper management in the Division of Health Care Facilities should implement a centralized, computerized complaint system to facilitate efficient and effective management of complaints. Until such a system can be developed, division management should review the format of the complaint logs, revise the log as necessary to incorporate the information essential for tracking the investigation and resolution of complaints, and require all regions to use and fully complete the complaint log.
3. The Department of Health and the Board for Licensing Health Care Facilities should assess and impose appropriate punitive actions when investigations have proved abuse and neglect or when the situation merits the action. Division of Health Care Facilities

staff should develop a system to monitor follow-up recommendations to ensure they are being implemented.

4. A follow-up inquiry of the abuse registry should be required sometime after an employee has been hired by a facility. This second check of the abuse registry should prevent almost all abusers from “slipping through the system.”
5. Division of Health Care Facilities management, in consultation with the Office of General Counsel staff, should review the process for placing an individual’s name on the abuse registry, identify ways to expedite the process (including ways to improve the timeliness of abuse and neglect investigations and the hearing process), and revise the process accordingly.
6. The Division of Health Care Facilities’ executive director should work with the regional administrators to establish scheduling controls and procedures that will ensure the division meets state and federal requirements. The Department of Health should consider whether the benefits of adopting the federal inspection time frame outweigh the potential negative effect on regulation and on residents of health care facilities. If the department determines benefits outweigh costs, it should request that the General Assembly consider changing the inspection requirements in Section 68-11-210, *Tennessee Code Annotated*.
7. The division should develop and use an automated database to monitor and analyze waiver requests and waivers granted. The board should then use this information to determine if current regulations are necessary or if they need to be updated, and to determine if all facilities are treated fairly and consistently.
8. Division of Health Care Facilities management should consult with the department’s Bureau of Information Resources to determine the exact capabilities of the regulatory board system and determine if the system has the capabilities to track survey dates and complaint data. If not, the division should centralize this information in some form to facilitate central office management of division duties.