

**Board for Licensing Health Care Facilities**

**December 1998**

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December 9, 1998

The Honorable John S. Wilder  
Speaker of the Senate  
The Honorable Jimmy Naifeh  
Speaker of the House of Representatives  
The Honorable Kenneth N. (Pete) Springer, Chair  
Senate Committee on Government Operations  
The Honorable Mike Kernell, Chair  
House Committee on Government Operations  
and  
Members of the General Assembly  
State Capitol  
Nashville, Tennessee 37243

Ladies and Gentlemen:

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

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

Very truly yours,

W. R. Snodgrass  
Comptroller of the Treasury

WRS/dlj  
98-043

State of Tennessee

# Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit  
**Board for Licensing Health Care Facilities**  
December 1998

## AUDIT OBJECTIVES

The objectives of the audit were to review the board's and the Department of Health's legislative mandates and the extent to which the board and the department's Division of Health Care Facilities have carried out those mandates efficiently and effectively, and to make recommendations that might result in more efficient and effective operation of the board and the division.

## FINDINGS

### **Range of Enforcement Actions Available Too Limited ♦**

Some types of health care facilities must commit violations serious enough to warrant suspension or revocation before the board can take any action. Facilities with violations that do not warrant such actions simply have to submit a plan of correction. State civil penalties, which apparently could have been imposed against a number of facilities over the last few years, are not being used, and, in any case, are only allowed by statute to be used against deficient nursing homes and in very limited cases against assisted-care living facilities. Federal civil penalties are also only available against deficient certified nursing homes but can be avoided or reduced in many cases. These restrictions all translate into limited consequences for most facilities that violate regulations and the law (page 15).

### **Abuse/Neglect Complaints Not Always Investigated in a Timely Manner\*\***

According to the Health Care Facilities Division's timeliness standard, staff did not investigate 18 percent of a sample of abuse and/or neglect complaints in a timely manner. Failure to promptly investigate an abuse or neglect complaint could reduce the chance of substantiating that complaint because bruises or bedsores heal, facilities correct problems that would have warranted investigators' citing deficiencies, or witnesses' accounts of events become cloudy or unsure. In addition, although in most cases staff appear to be placing the appropriate priority on abuse/neglect complaints, some complaints were not assigned as high a priority as it appears they could have been (page 20).

### **Noncompliance With and Limitations in the Law Lessen the Effectiveness of the Abuse Registry\***

The state's elderly abuse registry meets the requirements of federal regulations, since it actually is a registry of certified nurse aides in Tennessee and notes findings of abuse in individuals' files. However, this registry does not comply with state law, which requires that the Department of Health establish an abuse registry containing the names of anyone found to have abused or intentionally neglected elderly or vulnerable individuals. But even if the registry listed all abusers, certified nursing homes are the only health care facilities required to check the registry before hiring, and no facilities are required to act on the

information they find there. Furthermore, no facilities are required to periodically re-check the registry after hiring to ensure employees have not been placed on the registry after being hired. Finally, there is no national abuse registry, and little sharing of abuse registry data among states, to help ensure abusers do not simply move to another state and begin working with vulnerable persons again (page 22).

### **Surveys of Facilities Other Than Nursing Homes Not Always Completed Annually\***

We reviewed files to find the three most recent survey (inspection) reports and to determine whether the two most recent surveys were conducted in consecutive fiscal years following the first survey in the sample, regardless of how many months elapsed between the surveys. Twelve of 156 possible surveys (7.7 percent) were not conducted in the fiscal year following the previous survey. Allowing longer periods of time between surveys could allow deficiencies affecting the health, safety, and welfare of patients to go unchecked, increasing the likelihood of harm to patients (page 24).

### **No Central Database for Tracking Facility Surveys\***

The lack of central databases to track facility surveys and complaints was discussed in the 1996 Sunset Audit of the board. Since that audit, the division has developed and put into use a central database for tracking complaints, but no such database exists to track facility surveys (page 25).

- \* This issue was also discussed in the 1996 performance audit of the board.
- ◆ This issue was also discussed in the 1992 performance audit of the board.

## **OBSERVATIONS AND COMMENTS**

The audit also discusses the following issues that may affect the operations of the Division of Health Care Facilities, the Board for Licensing Health Care Facilities, and the health, safety, and welfare of the people of Tennessee: variations in numbers of enforcement actions and complaints among the division's three regions and among Tennessee and other states; waivers of board rules; the lack of jurisdiction over unlicensed facilities and certain types of facilities; conflict-of-interest issues; communication between state long-term care ombudsmen and the Division of Health Care Facilities; the regulation of methadone clinics in Tennessee; and the new federal minimum data set requirements (page 5).

## **ISSUES FOR LEGISLATIVE CONSIDERATION**

The General Assembly may wish to consider legislation (1) authorizing the Department of Health to enter and investigate unlicensed facilities in the state; (2) requiring emergency care walk-in clinics and dialysis clinics to obtain a license before operating; and (3) allowing the department to impose civil penalties against deficient facilities of all types, not just nursing homes, in order to encourage compliance with regulations and the law. The General Assembly may also wish to reassess those portions of the statute that require the state to prove "willful" disregard for regulations before Type B civil penalties can be imposed.

The General Assembly may wish to consider (1) requiring all health care facilities, not just certified nursing homes, to check the abuse registry before hiring staff members; (2) prohibiting facilities from hiring individuals whose names appear on the registry; and (3) requiring health care facilities to periodically check employees against the registry after they are hired, perhaps for a designated period of time (page 27).

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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**

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## **INTRODUCTION**

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

This performance audit of the Board for Licensing Health Care Facilities was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-219, the Board for Licensing Health Care Facilities was scheduled to terminate June 30, 1998. As provided for in Section 4-29-115, however, the board will continue through June 30, 1999, 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 continued, restructured, or terminated.

### **OBJECTIVES OF THE AUDIT**

The objectives of the audit were

1. to determine the authority and responsibility mandated to the board and the Department of Health by the General Assembly;
2. to determine the extent to which the board and 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 Health Care Facilities Division's activities and procedures were reviewed, with the focus on procedures in effect at the time of field work (January to July 1998). The audit

was conducted in accordance with generally accepted government auditing standards for performance audits. The methods included

1. interviews with staff of the Board for Licensing Health Care Facilities and the Health Care Facilities Division;
2. interviews with federal officials and health care industry representatives;
3. interviews with representatives of the Tennessee Commission on Aging and its State Ombudsman Program;
4. review of Department of Health files;
5. site visits to the division's regional offices;
6. observation of a licensure and certification survey of a nursing home conducted by division surveyors;
7. review of statutes and state and federal rules and regulations; and
8. 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, residential HIV supportive-living facilities, assisted-care living facilities, home-care organizations, residential hospices, birthing centers, 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, residential HIV supportive living facility, or assisted care living facility residents.

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

- Two medical doctors
- One oral surgeon
- One pharmacist
- One registered nurse
- Two hospital administrators
- One osteopath
- Three representatives of the nursing home industry
- One architect
- One operator of a home care organization
- One operator of a licensed residential home for the aged
- 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 Division of Health Care Facilities, Bureau of Manpower and Facilities, 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.

## **REVENUES AND EXPENDITURES**

The Division of Health Care Facilities, which in addition to licensing facilities also administers federal certification and monitors civil rights compliance, had expenditures of \$7,356,026 during fiscal year 1998. The division received \$4,068,108 in revenues during the same period; the rest of the operating budget came from state appropriations. Federal revenues accounted for 71 percent (\$2.9 million) of the division's revenues.

Revenues and expenditures for the Board for Licensing Health Care Facilities are included in the totals above. In fiscal year 1998, the board had revenues of \$732,600 and expenditures of \$125,686. 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; expenditures such as surveyors' salaries are included in the division's expenditures.

Section 68-11-827, *Tennessee Code Annotated*, provides that civil penalties collected by the state be deposited into the nursing home resident protection trust fund. This fund is intended to be used to protect residents of nursing homes whose noncompliance with law and regulations threatens the residents' continuous care, property, the nursing home's continued operation, or the nursing home's continued participation in the Medicaid medical assistance program. Section 828 allows the funds to be spent to assist with relocating indigent residents upon closure of a home, reimbursing residents for any personal funds lost while held in trust by a nursing home, or maintaining the operation of a nursing home pending the conclusion of legal proceedings. As of June 30, 1998, there was \$397,379 in the fund. No funds were collected or expended from the fund in fiscal year 1998.

## LICENSURE AND CERTIFICATION

Section 68-11-202, *Tennessee Code Annotated*, gives the Department of Health authority to license health care facilities in the state. The department has assigned this responsibility to the Health Care Facilities Division, which also provides administrative support to the Board for Licensing Health Care Facilities. Licenses for health care facilities are issued on July 1 and expire on June 30 each year, and state law requires that in order to be licensed, facilities must be inspected (surveyed) at least once a year to assess compliance with rules and regulations. The Board for Licensing Health Care Facilities is given the responsibility for regulating health care facilities by promulgating rules and regulations. The board has limited enforcement actions available for use against facilities that violate rules, regulations, or the law. (See discussion beginning on page 15.)

*United States Code* delegates responsibility for determining whether institutions and agencies meet the requirements for participation in the medical assistance program (Medicare or Medicaid) to the state survey agency, which in Tennessee is the Health Care Facilities Division. The division "partners" with the federal Health Care Financing Administration (HCFA) through a program known as the State Agency Quality Improvement Program (SAQUIP). The "partner" relationship is characterized by feedback from HCFA, conversations with regional HCFA officials, meetings, and teleconferences. Division management reported that this system is less punitive than in the past when federal officials regularly audited the division's work.

Certified nursing homes are required to be surveyed within 15 months of the previous survey, with an average time of 12 months between surveys. Other certification programs have different survey time-frame requirements, based on the date of the previous survey and the number and seriousness of the deficiencies cited. Division surveyors conduct licensure and certification surveys at the same time in most cases to avoid duplicating efforts. Medicare/Medicaid certification of long-term care facilities is the division's largest area of responsibility.

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## OBSERVATIONS AND COMMENTS

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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 Division of Health Care Facilities, the Board for Licensing Health Care Facilities, and the health, safety, and welfare of the people of Tennessee.

### **VARIATIONS IN NUMBERS OF ENFORCEMENT ACTIONS AND COMPLAINTS AMONG THE DIVISION'S THREE REGIONAL OFFICES AND AMONG TENNESSEE AND OTHER STATES**

Our review of information from the three regional offices and federal information comparing Tennessee to other states indicated wide variations in the numbers of complaints and enforcement actions recommended. The reason for these differences is unknown. The variations could be the result of differences in levels of consumer activism, the types and quality of facilities regulated, regulatory philosophy and processes used, or procedures for recording and categorizing information. These variations could, however, indicate that facilities in some regions or states are not regulated as strictly or as thoroughly as those in other areas. Officials with the federal Health Care Financing Administration (HCFA) have expressed concern with the differences among the three regions, as well as the differences between Tennessee and other states in the Southeast. But because of limited staff resources, HCFA has decided not to investigate the cause of these differences.

#### Differences Within Tennessee

Our reviews of complaint logs at the division's three regional offices indicated that the East Tennessee Regional Office received many more complaints than the other two regional offices in calendar years 1996 and 1997. The following table shows that the East Tennessee Regional Office received nearly 57 percent of all complaints logged in Tennessee in 1996 and over 64 percent of all complaints logged in the state in 1997, although only about 34 percent of licensed facilities are in East Tennessee.

HCFA and division officials suggested several possible reasons for the differences in the number of complaints among regional offices. Citizens in one region may be more vocal than those in other regions, or the ombudsman program may simply work better. The number of complaints could also vary because of different processes for addressing and recording complaints, and different levels of incident reporting by facilities (some facilities report every incident as required, resulting in the need for more investigations).

We also noted a difference in the number of federal civil penalties recommended by each of the three regional offices between January 1, 1996, and June 30, 1998. The Middle Tennessee

**Number of Complaints Received  
by Regional Office  
Calendar Years 1996 and 1997**

Regional Office	Complaints Received 1996	Complaints Received 1997
Middle Tennessee	253	235
West Tennessee	278	122
East Tennessee	<u>693</u>	<u>638</u>
State Total	1,224	995

Regional Office recommended nine federal civil penalties, the West Tennessee Regional Office recommended seven, and the East Tennessee Regional Office recommended three. [These numbers differ from the numbers in the table below because some of the penalties listed here were recommended against Medicaid-only certified facilities, which are referred to the state Medicaid agency (TennCare), not to HCFA.] Division management attribute this difference to the number of problem facilities located in and around Nashville, in the Middle Tennessee Region.

Division management conducted a State Agency Quality Improvement Program session in October 1998 to try to improve consistency among the regional offices.

Differences Within HCFA's Region IV

Our review of federal enforcement actions recommended to HCFA by states in Region IV showed a significant difference between Tennessee and other Southeastern states. The table below shows the number of federal civil monetary penalties recommended by each state against Medicare or Medicare/Medicaid facilities from July 1995, when federal enforcement procedures were implemented, through June 22, 1998, and the total dollar amount collected or to be collected from the penalized facilities.

State	Number of Penalties Recommended (1)	Total Dollar Value of Penalties
Georgia	35	\$888,194
North Carolina	23	\$513,023
Alabama (2)	21	\$279,142
Kentucky	18	\$820,014
South Carolina	16	\$371,600
Florida	15	\$692,580
Mississippi	12	\$407,260
Tennessee	5	\$113,248

Notes:

1. These numbers represent only those penalties recommended against Medicare or Medicare/Medicaid certified facilities, not Medicaid-only facilities.
2. After an appeal, HCFA rescinded one of the penalties recommended by Alabama.

The variations in enforcement actions and complaints may be the result of factors unrelated to the thoroughness or strictness of regulation. However, such substantial variations do need to be investigated. The Division of Health Care Facilities should examine the policies and procedures each regional office uses to record and address complaints to ensure all three offices follow the same guidelines. Management should also examine and compare the federal enforcement actions each regional office recommended to determine (1) whether regional staff are following federal regulations in a similar manner when determining whether to recommend federal civil penalties, and (2) whether different surveyors are citing similar deficiencies at the same levels, which could have an effect on penalty recommendations. Furthermore, division management should discuss procedures for recommending federal civil penalties with officials from HCFA and other states, if needed, to ensure that facilities in Tennessee are regulated as strictly and as thoroughly as those in other states.

### **WAIVERS OF BOARD RULES**

The 1996 Sunset Audit of the board discussed the numerous waivers of board rules that facilities request and the possible effect of outdated rules on the number of waivers requested and granted. Since that audit, the board has been working to draft and adopt new rules for all facility types and has finalized several sets of rules (see table below). Division management reported that the board used data on waivers, which has been tracked since 1996, to help draft the new rules. Management believes the number of waivers requested will drop once new rules become effective, although some waivers will still be needed because no rules can cover every situation. In calendar year 1997, health care facilities requested 178 waivers—149 of these requests were granted, 20 were denied, and the rest were deferred, withdrawn by the facilities, determined not to be required, etc.

#### **Board for Licensing Health Care Facilities Rules Status of Rules as of November 18, 1998**

<b>Rules – Amendments</b>	<b>Status of Rules</b>
Hospitals	To Attorney General’s Office (AG) April 2, 1998
Nursing Homes	To Office of General Counsel (OGC) July 29, 1998*
Home Care Amendment	Effective August 11, 1998
Ambulatory Surgical Treatment Centers	To AG April 2, 1998
Home for the Aged	To OGC September 3, 1998*
Residential Hospice	To OGC November 18, 1998*
Alcohol and Drug (A&D) Residential Rehabilitation	To OGC July 6, 1998**
A&D Non-Residential	To OGC July 6, 1998**

**Board for Licensing Health Care Facilities Rules  
Status of Rules as of November 18, 1998 (cont.)**

<b>Rules – Amendments</b>	<b>Status of Rules</b>
A&D DUI School	To OGC July 7, 1998**
A&D Primary Prevention	To OGC July 6, 1998**
A&D Non-Residential Narcotic (Methadone)	To AG September 24, 1998
A&D Halfway House	To OGC July 6, 1998**
A&D Residential Detoxification	To OGC July 6, 1998**
Birthing Centers	Effective June 12, 1998
Assisted-Care Living Facilities	Effective April 25, 1998
Health Care Organizations providing Home Health Services	To OGC August 5, 1998*
Health Care Organizations providing Hospice	To OGC August 5, 1998*
HIV Supportive Living	Board approval for hearing given November 4, 1998

\* These rules have been through hearings and final board review and are with OGC for a final review before submission to the Office of the Attorney General.

\*\* These rules have been sent back to Health Care Facilities to be reworked.

The board and division should continue to track requests for waivers to determine whether updated rules reduce the need for waivers. Using the waiver data, they should also periodically identify rules that need to be revised because of new technologies or developments that conflict with current rules, but have no adverse impact on the health, safety, and welfare of facility patients or residents.

**LACK OF JURISDICTION OVER UNLICENSED FACILITIES AND CERTAIN TYPES OF FACILITIES**

Section 68-11-204, *Tennessee Code Annotated*, requires that all hospitals, recuperation centers, nursing homes, homes for the aged, residential HIV supportive-living facilities, assisted-care living facilities, home-care organizations, alcohol and drug prevention and/or treatment facilities, residential hospices, birthing centers, or ambulatory surgical treatment centers be licensed in order to operate in Tennessee. Section 68-11-213(b) further makes it unlawful for any such facility to receive patients or residents without having obtained a license and makes a

violation of this statute a Class B misdemeanor. Part (a) of this section authorizes the Department of Health to initiate proceedings seeking injunctive and any other form of relief available in law against anyone violating the law or rules and regulations of the Board for Licensing Health Care Facilities. However, nothing in the law authorizes division staff to enter a facility to investigate allegations that the facility is operating without a license. Only if the owner allows inspectors inside can the division check to see if a particular facility should actually be licensed. Although division management stated that reports of unlicensed facilities in the state are rare, the division's inability to enter and investigate such allegations could allow facilities to continue to operate without meeting the required health and safety standards designed to protect residents or patients.

State law also does not require emergency care walk-in clinics or dialysis clinics to obtain a license before operating. Division management stated that infection controls, hazardous medical waste handling, laboratory staffing, and drug storage can be problems at emergency care walk-in clinics. Also, some persons providing care at these clinics (e.g., staff giving injections) are not licensed professionals. Because of the major health risks and the specialized level of care dialysis clinics provide, management believes such clinics probably need to be licensed, even though most are certified by a national organization. Requiring these types of facilities to be licensed would provide an added measure of accountability, ensuring that they meet certain minimum standards for health, safety, and personnel.

The General Assembly may wish to consider legislation authorizing the Department of Health to enter and investigate unlicensed facilities in the state. The General Assembly may also wish to consider legislation requiring that emergency care walk-in clinics and dialysis clinics obtain a license before operating.

## **CONFLICT-OF-INTEREST ISSUES**

During this audit, we identified three conflict-of-interest issues. Although the most serious issues have apparently been resolved, it is important that board members continue to be aware of and avoid situations that may be, or may present the appearance of, conflicts of interest.

First, one board member represented (on three separate occasions) facilities that were requesting waivers of certain rules. The board member (who is no longer on the board) was an employee of a corporation that owns various health care facilities licensed by the board. The board member's actions appear to be a conflict of interest because of the difficulty of separating his actions as a board member from actions taken on behalf of his employer. General counsel for the board stated that she addressed this issue (and its apparent impropriety) at a subsequent board meeting. Our review of board meeting minutes since that time indicated no further incidents of this nature.

Second, the chairman of the Board for Licensing Health Care Facilities, who is also a state employee, did not have a signed conflict-of-interest disclosure form on file with board staff at the time audit field work began. There was a state employee conflict-of-interest disclosure form in his personnel file. However, we believe the general state employee disclosure is not sufficient for

board members who also happen to be state employees. The chairman has since signed and placed on file a board conflict-of-interest disclosure form.

Finally, many board members' conflict-of-interest disclosures were dated several years ago. The board's policy states that each board member shall disclose annually any financial interests in any facilities licensed by the board. If board members do not update conflict-of-interest disclosures, other board members, regulated facilities, or the public may not be aware of changes in members' situations.

The board chairman, general counsel, and board staff should ensure that all board members (1) submit signed conflict-of-interest disclosures, (2) update this information annually or whenever a conflict arises, and (3) recuse themselves from votes or other board activities, if necessary. Board staff and the general counsel should ensure that all board members are familiar with the board's conflict-of-interest policy and are aware of and avoid situations that may be, or may present the appearance of, conflicts of interest.

## **COMMUNICATION BETWEEN OMBUDSMEN AND HEALTH CARE FACILITIES STAFF**

State Long-Term Care Ombudsman Program officials have reported concerns about (1) the division's regulation of long-term care facilities in Tennessee and (2) communication between ombudsmen and division staff. Both groups are apparently now working to improve the relationship.

The State Ombudsman Program is federally mandated by the Older Americans Act, which calls for a state office to delegate authority to local offices to provide volunteer ombudsman representatives for districts across the state. District and volunteer ombudsmen establish and maintain relationships with residents and staff of long-term care facilities in their area, with the goal of improving the safety and well-being of facility residents. The ombudsmen's first responsibility is to act as an advocate for residents, although they may also act as a mediator among facilities, residents, and residents' families. Another function of the ombudsman program is to ensure that long-term care patients receive all the benefits they are entitled to under Medicare, Medicaid, and other state and federal programs. Ombudsmen also train facility employees on patient rights and pre-admission evaluation for Medicaid certification.

Ombudsmen voiced concerns that they did not receive timely, complete information from division staff. For example, ombudsman program officials reported that district and volunteer ombudsmen often do not receive feedback on the complaints they forward to the division's regional offices until six months or more after they submitted the complaints. Even then, the letters they receive may simply state whether the complaint was substantiated, rather than detailing the results of the investigation and the reason the complaint was, or was not, substantiated. Often, division investigators do not speak with ombudsmen during the investigations. Survey reports also apparently take a long time to get to ombudsmen, and all reports do not contain the same level of detail.

The extent of ombudsmen's access to information is a major point of contention. Ombudsmen believe that they need timely and complete information, so they can update residents and their families on the status of their cases. Division management stated that staff send ombudsmen the information required by federal regulations and contact the ombudsmen as required during surveys. According to staff, some specific information about cases they are investigating is confidential under the law and, therefore, should not be provided to ombudsmen. Ombudsman Program officials concede that they are not designated in state law as one of the parties allowed access to this information, but state that since they have the same confidentiality requirements as division staff, information sharing should be possible.

Several district ombudsmen we interviewed were also concerned about some regulatory issues. They believe that facility staffing levels required by state law are insufficient to allow facilities to provide quality care. In addition, they expressed concern that the conditions division surveyors see when they visit facilities are very different (i.e., better) than conditions the ombudsmen see. One ombudsmen speculated that facilities know or anticipate when division staff will arrive for a survey or investigation and prepare by bringing in additional staff or taking other actions to improve care.

Division staff and management have made efforts to improve communication and relationships with Ombudsman Program personnel. In February 1998, Department of Health officials met with Ombudsman Program representatives to discuss both groups' concerns. In addition, Bureau of Manpower and Facilities management instructed regional administrators (1) to send out questionnaires to district ombudsmen, eliciting information on their specific concerns; (2) to schedule quarterly regional meetings with the Assistant Commissioner for the Bureau of Manpower and Facilities, the State Health Officer, the Executive Director of the Commission on Aging, and the district ombudsmen; (3) to attend the ombudsmen's annual conference at Paris Landing on October 12 through 14, 1998, to address ombudsmen's concerns; and (4) to make arrangements for district ombudsmen to accompany division staff conducting nursing home surveys, so the ombudsmen can get a better understanding of the process.

District ombudsmen reported that since the February meeting, some division staff have provided better and more timely information, including explaining particular regulations and investigation methods and results. The ombudsmen expressed the hope that additional meetings with more participants would further improve communications between the two agencies, help each group understand the other's role and responsibilities, and identify ways in which each group can help the other do their jobs better, e.g., identifying actions ombudsmen can take to better help surveyors substantiate complaints.

## **REGULATION OF METHADONE CLINICS IN TENNESSEE**

Both the General Assembly and the Department of Health have taken actions in recent years to address concerns regarding methadone clinics. On May 28, 1997, the General Assembly adopted House Joint Resolution No. 287, which created a Special Joint Committee (1) to study "availability, individual and societal benefits and costs, as well as the efficacy and efficiency of

governmental efforts to monitor, control and regulate methadone” and (2) to examine, compare, and contrast the operations of for-profit and not-for-profit methadone treatment facilities. The committee began meeting October 6, 1997. After hearing testimony from representatives of the Department of Health, the Tennessee Bureau of Investigation, local law enforcement, the medical profession, methadone clinic operators from Tennessee, the American Methadone Treatment Association, and methadone regulating entities in other states, the committee concluded that regional coordination is essential in regulating methadone clinics and that Tennessee’s efforts fell significantly behind the programs of some neighboring states. Based on these conclusions, the committee made the following recommendations:

1. The Department of Health should promulgate amendments to its administrative rules and regulations to bring them into line with those now in effect in the state of Georgia.
2. The General Assembly should pass legislation requiring the county legislative body’s approval before the Health Facilities Commission may consider a certificate-of-need (CON) application for a new methadone treatment facility.

The General Assembly passed the recommended legislation, which the Governor signed into law May 19, 1998. However, the final version of the bill does not require the approval of the county legislative body before the Health Facilities Commission considers CON applications for methadone clinics. Instead, the bill requires applicants for a methadone clinic CON to notify (within 10 days of filing) the county executive and mayor of the municipality in the area where the clinic is planned, so that officials of the local governing body will have the opportunity to appear before the commission and express support for and/or opposition to granting a CON. The bill also provides that the already existing moratorium on methadone clinic CONs continue until rules and regulations concerning a central registry and outcomes-based program evaluation are final and effective.

New Board for Licensing Health Care Facilities rules for methadone clinics have been given final board and Office of General Counsel approval and were sent to the Attorney General’s Office on September 24, 1998. After the Attorney General’s and Secretary of State’s approval, the rules will become final. The draft rules have a provision for a central methadone registry and require clinics to track outcome measures and should therefore fulfill the requirement in the law, ending the moratorium on methadone clinic CONs. Currently, six methadone clinics operate in Tennessee: one in Memphis, one in Jackson, two in Nashville, one in Chattanooga, and one in Knoxville. When draft rules become final and the moratorium is lifted, several companies appear ready to apply for CONs.

The Department of Health should continue to monitor methadone clinics under the new law and rules (when they become effective), keep members of the General Assembly informed, and make any rule changes needed to effectively regulate the clinics.

## **NEW FEDERAL MINIMUM DATA SETS (MDS) REQUIREMENTS**

The Division of Health Care Facilities has apparently been successful in helping facilities prepare to meet new federal requirements concerning minimum data sets (MDS), information which must be collected on every recipient of Medicare or Medicaid funds. In 1990, the federal Health Care Financing Administration (HCFA) began requiring certified facilities to collect information on initial assessments of patients, transfers, exits from the program, re-entries, etc. HCFA uses the data to assess Medicare and/or Medicaid patients in the state's 354 certified long-term care facilities; the facilities use the data as a starting point for developing patient care plans. In December 1997, HCFA adopted and transmitted to states new MDS regulations requiring that the data be automated, that states maintain an MDS database, and that all certified facilities transmit the data to the state electronically. The state survey agency (the Health Care Facilities Division) is then required to periodically transmit the data to HCFA headquarters in Baltimore, Maryland. The regulations became effective June 22, 1998.

In January 1998, HCFA provided and installed computer equipment and most of the software required for the division to comply with the new regulations. Certified facilities were required to purchase their own computers and modems capable of transmitting the data to the state. HCFA also made available to facilities free software which met the bare minimum MDS requirements. Many facilities, however, have purchased more elaborate software packages which tie the facilities' finances to the MDS data, thus helping facilities track reimbursements and enabling them to better manage patient care and finances in anticipation of HCFA's linking reimbursements to MDS data. The division has installed phone lines and equipment to enable them to accept data from several different facilities at once.

In response to the new MDS regulations, the division developed a plan of action to help Tennessee facilities prepare for the change. Division staff notified all facilities of the new requirements and the MDS identification numbers and passwords needed for data transmissions, conducted surveys to determine the facilities' preparedness, and set up an e-mail address, website, and technical support line to help address facilities' questions and problems. Staff also kept in close contact with MDS staff in HCFA's Atlanta office and set up meetings with personnel in the Department of Health's TennCare Bureau, because the Medicaid payments the bureau administers will be tied to MDS data. In addition, division MDS staff conducted 18 training sessions for facility personnel from April through June 1998, at locations throughout the state. These sessions were co-sponsored by the state and the two nursing home associations in Tennessee.

Facilities had until July 23, 1998, to actually transmit data to the state. As of July 28, 1998, MDS staff reported that all facilities had successfully transmitted MDS data. There are, however, still some potential problems facing Tennessee's MDS system—maintaining confidentiality of the data and protecting the state-of-the-art equipment provided by HCFA. The room now housing the system also contains a phone panel to which several people in the building must have access. Although MDS staff try to ensure that one person is in the room at all times during normal work hours, this is not always possible with a staff of only three.

The system must operate 24 hours a day, seven days a week and therefore requires an uninterrupted power supply, an emergency power supply, and a separate, uninterrupted heating and cooling system. The room has an uninterrupted power supply, but no emergency power supply or separate, uninterrupted heating and cooling system. This inadequacy has caused problems: one day the air conditioning in the building failed, and the uninterrupted power sources heated up to 117 degrees—over 30 degrees above the desired maximum temperature of 86 degrees. Staff currently keep a fan blowing directly on these power sources to keep them close to the proper temperature. The department needs to act quickly to move the MDS equipment to a secure room meeting all the technical requirements for power supply and temperature control.

Another concern is that in order to meet deadlines, facilities may submit data they know are incorrect and rely on MDS staff to make corrections. (HCFA has given state MDS programs the authority to go into certain key fields and change information.) Facilities may also inadvertently submit large volumes of incorrect data at first, because of unfamiliarity with the new requirements and computer systems. Either situation could result in a large volume of needed changes, which may be difficult for a staff of three to handle.

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## FINDINGS AND RECOMMENDATIONS

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### **1. The range of enforcement actions available for use against some types of facilities is too limited**

#### **Finding**

The enforcement actions available for use against some types of health care facilities may not be adequate to encourage compliance with regulations. Facilities must commit violations serious enough to warrant suspension or revocation before the board can take any action. Facilities with violations that do not warrant such actions simply have to submit a plan of correction. State civil penalties, which apparently could have been imposed against a number of facilities over the last few years, are not being used, and, in any case, are only allowed by statute to be used against deficient nursing homes and in very limited cases against assisted-care living facilities. Federal civil penalties are also only available against deficient certified nursing homes, and these penalties can be avoided or reduced in many cases. These restrictions all translate into limited consequences for most facilities that violate regulations and the law. (See the table on page 16 for enforcement actions available against the different types of facilities.)

#### Available Federal Enforcement Actions

If the deficiencies are serious enough, division staff may recommend to the federal Health Care Financing Administration (HCFA) that federal penalties be imposed against deficient nursing homes which are federally certified (i.e., eligible to receive Medicare or Medicaid reimbursements, or both). Federal penalties available include (1) requiring a directed plan of correction (a written plan indicating how the facility intends to correct the deficiency), state monitoring of the facility, or directed in-service training for facility staff; (2) denying payment for new admissions or all patients; (3) assessing civil monetary penalties of \$50 to \$10,000 per day; (4) temporarily taking over management of the facility; and (5) terminating the facility's Medicare/Medicaid certification. The table on page 17 summarizes the federal grid that division staff use in determining under what circumstances the different penalties are appropriate.

Facility Type (1)	Federal Sanctions (2)	Federal Civil Monetary Penalties	State Licensure Sanctions	State Civil Monetary Penalties
Nursing Homes (Certified)	Division recommends; HCFA and/or TennCare impose	Division recommends; HCFA and/or TennCare impose	Board may suspend or revoke license, or suspend admissions	Department can impose under current statute, but does not use
Nursing Homes (Licensed-only)	Not available	Not available	Board may suspend or revoke license, or suspend admissions	Department can impose under current statute
Home-Care Agencies	Not available	Not available	Board may suspend or revoke license	Not available
Hospitals	Not available	Not available	Board may suspend or revoke license	Not available
Recuperation Centers	Not available	Not available	Board may suspend or revoke license	Not available
Homes for the Aged	Not available	Not available	Board may suspend/revoke license, or suspend admissions	Not available
Assisted-Care Living Facilities	Not available	Not available	Board may suspend or revoke license	Available only for limited, specific violations
Residential Hospices	Not available	Not available	Board may suspend or revoke license	Not available
Birthing Centers	Not available	Not available	Board may suspend or revoke license	Not available
Ambulatory Surgical Treatment Centers	Not available	Not available	Board may suspend or revoke license	Not available
Alcohol & Drug Prevention/Treatment Centers	Not available	Not available	Board may suspend or revoke license	Not available
Dialysis Clinics	Not available	Not available	State does not regulate	State does not regulate
Emergency Care Walk-In Clinics	Not available	Not available	State does not regulate	State does not regulate

Notes:

1. Some facilities (e.g., hospitals) may also be subject to enforcement by a national accrediting organization.
2. The division may recommend decertification of any federally certified facility. However, although all facilities receiving Medicare and/or Medicaid reimbursements must be federally certified, federal enforcement actions such as those described in the *Federal Deficiency Scope and Severity Grid* on page 17 are only available for use against long-term care facilities, i.e., nursing facilities, skilled nursing facilities, and intermediate care facilities for the mentally retarded.

### Summary of HCFA's Deficiency Scope & Severity Grid

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	Plan of Correction Required - Category 3 Optional - Category 1 Optional - Category 2	Plan of Correction Required - Category 3 Optional - Category 1 Optional - Category 2	Plan of Correction Required - Category 3 Optional - Category 2 Optional - Category 1
Actual harm that is not immediate jeopardy	Plan of Correction Required - Category 2 Optional - Category 1	Plan of Correction Required - Category 2 Optional - Category 1	Plan of Correction Required - Category 2 Optional - Category 1 Optional - Temporary Management
No actual harm with potential for more than minimal harm that is not immediate jeopardy	Plan of Correction Required - Category 1 Optional - Category 2	Plan of Correction Required - Category 1 Optional - Category 2	Plan of Correction Required - Category 2 Optional - Category 1
No actual harm with potential for minimal harm	<b>No Plan of Correction, No remedies, Commitment to Correct</b>	<b>Plan of Correction</b>	<b>Plan of Correction</b>

Scope and severity level constitutes substandard quality of care.

Deficiencies in these scope and severity levels do not indicate a facility is out of substantial compliance with standards.

Category 1

Directed Plan of Correction  
State Monitoring\*\*, and/or  
Directed In-Service Training

Category 3

Temporary Management  
Termination (may be imposed by the state or HCFA at any appropriate time)  
Optional CMP from \$3,050 to \$10,000 per day of deficiency

Category 2

Denial of Payment for New Admissions\*;  
Denial of Payment for All Individuals\*\*; and/or  
Civil Monetary Penalties (CMPs) from \$50 to \$3,000 per day of deficiency

\* Must be imposed when a facility is not in substantial compliance within three months after being found out of compliance.

\*\* Must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

From January 1, 1996, through June 30, 1998, the division recommended federal civil monetary penalties against 19 nursing homes. Of the 19 penalties recommended, five have been imposed (four of those were reduced), four have been appealed, four will not be collected because of successful appeals or operational problems within HCFA and the division, and six are still pending with HCFA.

**Status of Enforcement Actions Recommended by Division  
January 1, 1996, Through June 30, 1998**

<b>Regional Office</b>	<b>Actions Recommended</b>	<b>Pending at HCFA</b>	<b>Imposed</b>	<b>Pending Appeals</b>	<b>Not to be Collected</b>
Middle	9	2	3	3	1
West	7	3	2	0	2
East	<u>3</u>	<u>1</u>	<u>0</u>	<u>1</u>	<u>1</u>
Totals	19	6 of 19 (32%)	5 of 19 (26%)	4 of 19 (21%)	4 of 19 (21%)

Facilities may avoid federal penalties if they (1) correct deficiencies that do not constitute immediate jeopardy within a certain timeframe set by division staff, (2) successfully argue against penalties in an informal review of deficiencies with division staff, or (3) win a HCFA appeal hearing. Immediate jeopardy penalties and those recommended against facilities designated as “poor performers” may be avoided only through a successful appeal or informal review. Facilities may reduce the total amount of their penalty by 35 percent if they waive their right to an appeal hearing within 60 days of being notified about the penalty, or HCFA staff may reduce the penalty when they review the case.

Available State Enforcement Actions

State enforcement actions currently available to the board are limited to suspension or revocation of the facility’s license, and suspension of admissions for nursing homes and homes for the aged. Between January 1996 and June 1998, only five facilities in the state were referred to the board for some sort of action. Four of these facilities were residential homes for the aged, and one was an alcohol and drug treatment facility. The charges against one of the five facilities were dismissed, the board reprimanded one facility, summary suspensions were imposed against two, and one facility’s license was revoked. In addition to enforcement actions available to the board, Section 68-11-801, *Tennessee Code Annotated*, gives the Commissioner of Health the power to impose civil monetary penalties against deficient nursing homes. (Such penalties cannot be imposed against other types of health care facilities, except assisted-care living facilities for a few specific violations.) Penalties available for use against deficient nursing homes range from \$250 for type C penalties, to \$5,000, the maximum amount for a Type A penalty. A second penalty imposed for the same violation within 12 months of the first doubles the amount of the penalty. (See below for description of available state civil monetary penalties.)

- 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.

The department has not used state civil penalties since the federal enforcement provisions were implemented in July 1995—the federal penalties were considered more stringent than state penalties. In practice, however, the division found that although the immediate jeopardy portion of the federal enforcement provisions was very clear-cut and effective, provisions for less severe deficiencies were confusing and inefficient. The department has requested (but has not yet been granted) a waiver from HCFA that would allow the use of federal penalties only when immediate jeopardy is present and the use of state penalties in all other cases. There is, however, nothing in state or federal law or regulations to prevent the division from using both state and federal penalties in their entirety and simultaneously as enforcement actions against deficient nursing homes.

During a review of a sample of nursing home files, we noted the deficiencies identified by division surveyors to determine if state civil penalties could have been imposed (if the division were using such penalties). Our analysis indicated that type B and/or type C penalties could have been imposed against approximately 81 percent of those facilities that had deficiencies. (See table below.) Type A penalties would not have been possible against any of the facilities in the sample because such penalties can only be imposed if the facility’s admissions are being suspended.

<b>Regional Office</b>	<b>Number of Facilities in Sample with Deficiencies</b>	<b>Type B</b>	<b>Type C</b>	<b>Some State Penalty Possible*</b>
Middle	12	6 of 12	10 of 12	11 of 12 (92%)
West	10	3 of 10	4 of 10	5 of 10 (50%)
East	<u>9</u>	<u>5 of 9</u>	<u>9 of 9</u>	<u>9 of 9 (100%)</u>
State Totals	31	14 of 31	23 of 31	25 of 31 (81%)

\* Some facilities could have had both Type B and Type C penalties imposed.

Our conclusion regarding the imposition of type B and/or type C penalties assumes that surveyors could prove “consistent and willful neglect of the requirements, fundamental flaws in the facility’s operation, knowing refusal to comply with the minimum standards, or willful inattention to the patient’s basic needs,” which is required by statute before some types of B penalties can be

imposed. According to division management, the word “willful” in the statute makes it difficult to impose type B penalties. Since portions of the statute for type B penalties (e.g., in cases of insufficient number of licensed nurses on duty) and the entire statute for type C penalties do not include the word “willful,” some of these penalties could have been imposed without as much difficulty.

### **Recommendation**

The department should begin imposing state civil penalties against deficient nursing homes in all cases allowed by law, in addition to recommending federal penalties where applicable. The department should compare the dollar amounts of civil penalties allowed under current state law to those used in other states and determine whether the current level of state civil penalties is sufficient. This information should be communicated to the General Assembly for its consideration.

The General Assembly may wish to consider legislation allowing the department to impose civil penalties against deficient facilities of all types, not just nursing homes, in order to encourage compliance with regulations and the law. The General Assembly may also wish to reassess those portions of the statute that require the state to prove “willful” disregard for regulations before Type B civil penalties can be imposed.

### **Management’s Comment**

We concur. The Department of Health has requested a state plan amendment from the Health Care Financing Administration (HCFA) that would allow the state to use a combination of both state and federal enforcement remedies for nursing homes. A final decision from HCFA should be received within the next month. When the department receives HCFA’s reply, a plan will be developed to implement both the federal and state civil penalties if necessary.

The division would implement any enforcement program in which the General Assembly passes legislation to impose civil penalties against deficient facilities of all types.

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## **2. The division did not always investigate abuse/neglect complaints in a timely manner**

### **Finding**

According to the Health Care Facilities Division’s timeliness standard, staff did not investigate 18 percent of a sample of abuse and/or neglect complaints in a timely manner. Failure to promptly investigate an abuse or neglect complaint could reduce the chance of substantiating that complaint because bruises or bedsores heal, facilities correct problems that would have

warranted investigators' citing deficiencies, or witnesses' accounts of events become cloudy or unsure. In addition, although in most cases staff appear to be placing the appropriate priority on abuse/neglect complaints, some complaints were not assigned as high a priority as it appears they could have been.

Division policy provides three priority levels and requires staff to assign a priority level to each complaint when it is received:

- Priority 1 - Immediate jeopardy to resident health or safety. "Immediate jeopardy" means the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Respond within two working days.
- Priority 2 - Complaints in this category involve situations that have been controlled by the facility and have resulted in less serious harm, impairment, or injury than immediate jeopardy (for example, resident-to-resident abuse). Respond within 60 days.
- Priority 3 - Allegations of situations that are not directly detrimental to the patient or that do not directly affect their care, resulting in minimal or no actual harm. On-site investigations are not always required. Investigations, if warranted, may be conducted at the next on-site visit to the facility. Telephone intervention may substitute for an on-site visit. The regional administrator may authorize an on-site visit to investigate complaints in this category whenever multiple complaints are received against the same facility in a short period of time.

For the 50 abuse/neglect complaint files we reviewed, nine complaints (18 percent) were not investigated timely based on the division policy above. Although the rate at which complaints are substantiated in Tennessee appears to be close to the national average (31 percent in Tennessee for 1996 and 1997, as compared to the national average of 29 percent for those two years), we believe more valid abuse/neglect complaints could be substantiated in Tennessee if they were investigated more timely.

Eighty percent (40 of 50) of the abuse/neglect complaints reviewed were designated priority 2; 12 percent (6 of 50) were designated priority 3; and 8 percent (4 of 50) were designated priority 1. Assigning the majority of abuse/neglect complaints priority 2 allows the division 60 days to investigate them. Although the facility may have removed the danger to patients' health and welfare, investigating these types of complaints more quickly could increase the chances that legitimate complaints would be substantiated and allow proven abusers to be placed on the abuse registry or reported to their licensing authority sooner. In addition, it appears that by definition, legitimate abuse/neglect complaints represent possible conduct which would be "directly detrimental to the patient" or would "directly impact their care," and it is not clear how such complaints could fall into the priority 3 category.

## **Recommendation**

The division should investigate all complaints, especially abuse and neglect complaints, as quickly as possible to help ensure legitimate complaints are substantiated. The division should reevaluate whether it is appropriate to designate abuse/neglect complaints as priority 3.

## **Management's Comment**

We concur. The Division of Health Care Facilities staff should investigate all complaints in the time frames established by the complaint investigation policy. All complaints that have been assigned a priority 1 should be investigated within the two-day time frame. All complaints that have been assigned a priority 2 should be investigated within the 60-day time frame. Division staff will review and evaluate before November 1998 whether it is appropriate to designate any abuse/neglect complaint in a priority 3 category. The complaint policy and procedures are being reviewed and revised. Also, the average response time of each category is being monitored on a monthly basis for a comparison of regional offices.

All abuse and neglect complaints do not result in the recommendation of placing an individual on the abuse registry. Many times, it is impossible to determine the cause of the injury or incident and not possible to identify an individual who might have caused the injury.

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### **3. Noncompliance with and limitations in the law lessen the effectiveness of the abuse registry**

#### **Finding**

The state's elderly abuse registry meets the requirements of federal regulations, since it actually is a registry of certified nurse aides in Tennessee and notes findings of abuse in individuals' files. However, this registry does not comply with state law, which requires that the Department of Health establish an abuse registry containing the names of anyone found to have abused or intentionally neglected elderly or vulnerable individuals. But even if the registry listed all abusers, certified nursing homes are the only health care facilities required to check the registry before hiring, and no facilities are required to act on the information they find there. Furthermore, no facilities are required to periodically re-check the registry after hiring to ensure employees have not been placed on the registry after being hired. Finally, there is no national abuse registry, and little sharing of abuse registry data among states, to help ensure abusers do not simply move to another state and begin working with vulnerable persons again.

The federal code and state law both require the Department of Health to establish an abuse registry. *United States Code*, Title 42, Section 1396r(e)(2)(A), requires that each state "establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide

training and competency evaluation program, or a nurse aide competency evaluation program.” Section 1396r(e)(2)(B) requires that the registry “shall provide...for the inclusion of specific documented findings by a State...[of] resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings.” Section 68-11-1001(a), *Tennessee Code Annotated*, says, “The department of health shall establish and maintain a registry containing the names of any persons who have been determined to have abused or intentionally neglected elderly or vulnerable individuals.” The federal code further prohibits nursing facilities from using individuals as nurse aides unless they have inquired of the state registry concerning the individual; state law does not require that any facility check the registry prior to hiring.

The Department of Health has complied with the federal requirement by establishing a certified nurse aide registry on which findings of abuse are noted. They also place the names of other workers who abuse elderly or vulnerable individuals on the registry, but do not place the names of other licensed professionals such as doctors, nurses, or therapists who abuse on the registry. Findings concerning licensed professionals are reported to the appropriate licensing board; however, facilities are not required to check with these boards before hiring licensed professionals. This process does not appear to meet the requirement in state law that “any person” found to have abused elderly or vulnerable individuals be placed on an abuse registry established by the department.

The usefulness of the abuse registry is further limited by incomplete requirements for registry use. First, because all health care facilities are not required to check the registry prior to hiring, abusers may secure employment at other facilities or home health agencies where they may have individual contact with vulnerable individuals. Second, facilities which are required to check the registry before hiring are not required to periodically re-check the registry to ensure that employees have not been placed on the registry after being hired. Because the process for placing a person on the registry can take several months (an average of nearly 10 months for cases reviewed during the 1996 Sunset Audit), an abuser could conceivably get a job at another health care facility before his or her name is actually placed on the registry. Third, facilities which are required to check the registry are not required to act on the information they find. In other words, nursing homes which find out from the registry that a potential employee has abused may still hire that person. (This possibility seems unlikely, however, because if that person were to abuse again, the facility could be found negligent in a civil suit for hiring someone it knew had abused in the past.) Finally, there is no national compilation of abuse registry data and only very limited sharing of abuse registry data among states. Consequently, an individual found to have abused in one state could move to another state and continue working with elderly or vulnerable individuals.

According to division management, staff in the Office of General Counsel are developing a second abuse registry, which would include all individuals found to have abused or neglected vulnerable individuals. Although this new registry will apparently meet the requirements in state law, the effectiveness of the registry will continue to be limited if the other issues discussed above are not addressed.

## **Recommendation**

To comply with state law, the Department of Health should immediately establish a registry containing the names of any persons found to have abused or intentionally neglected vulnerable individuals. The Division of Health Care Facilities should participate with other states, federal agencies, and national advocacy groups in any efforts to compile abuse registry data nationally so that abusers could not move to another state and continue working with vulnerable individuals.

The General Assembly may wish to consider (1) requiring all health care facilities, not just certified nursing homes, to check the abuse registry before hiring staff members and (2) prohibiting facilities from hiring individuals whose names appear on the registry. The General Assembly may also wish to consider requiring health care facilities to periodically check employees against the registry after they are hired, perhaps for a designated period of time.

## **Management's Comment**

We concur. The Office of General Counsel, in conjunction with the Department of Health, is in the process of developing a registry that will comply with the state statute. The Division of Health Care Facilities would participate with any state or federal agency in an effort to compile national abuse registry data.

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## **4. Surveys of facilities other than nursing homes were not always completed annually**

### **Finding**

The division did not always comply with the statutory requirement for annual surveys of health care facilities, other than nursing homes. Allowing longer periods of time between surveys could allow deficiencies affecting the health, safety, and welfare of patients to go unchecked, increasing the likelihood of harm to patients.

Section 68-11-210, *Tennessee Code Annotated*, requires that all health care facilities in the state be inspected at least once each year. We reviewed files to find the three most recent survey (inspection) reports and to determine whether the two most recent surveys were conducted in consecutive fiscal years following the first survey in the sample, regardless of how many months elapsed between the surveys. Twelve of 156 possible surveys (7.7 percent) were not conducted in the fiscal year following the previous survey. Most of the surveys which were not conducted timely (seven of the twelve) were the responsibility of the West Tennessee Regional Office. The Regional Administrator at the office stated that they have been short of staff recently and have had trouble completing some surveys on time.

### **Recommendation**

The Executive Director of the Division of Health Care Facilities should work with the regional administrators to improve scheduling controls and procedures to help ensure the division meets state survey requirements for all facilities.

### **Management's Comment**

We concur. Division staff should perform an annual survey on each licensed health care facility. There have been staff shortages in some regional offices that could have contributed to the lack of timely surveys. The division director and the licensure and certification managers will confer with regional administrators to ensure that annual surveys are conducted on all licensed facilities. The addition of scheduling software would reduce the likelihood of any oversight of needed surveys.

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## **5. The division lacks a central database for tracking facility surveys**

### **Finding**

The lack of central databases to track facility surveys and complaints was discussed in the 1996 Sunset Audit of the board. Since that audit, the division has developed and put into use a central database for tracking complaints, but no such database exists to track facility surveys.

Division staff can use a federal certification computer system to track certification surveys, but the system is not set up for state licensure purposes, and the division's RBS (Regulatory Boards System) will not track surveys. Regional administrators have developed their own methods to keep track of and schedule facility surveys, with the goal of making them as unpredictable as possible while still complying with state and federal requirements. However, without a database accessible to the central office and the three regional offices, it is difficult for management to determine when all facilities were last surveyed. The availability of one computerized, centralized list would be a more efficient and effective method to track when surveys are due and when they have been completed. Management could then ensure surveys were conducted on all facilities at least once a year, as required.

### **Recommendation**

Division of Health Care Facilities management should work with the Department of Health's computer support personnel to develop a central database to track facility surveys.

### **Management's Comment**

The Division of Health Care Facilities is in the process of searching for software that will establish a database to track facility surveys on a timely basis. Also, the central office management staff have increased their oversight of the survey process.

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## **RECOMMENDATIONS**

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### **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 for Licensing Health Care Facilities' and/or the Division of Health Care Facilities' operations.

1. The General Assembly may wish to consider legislation authorizing the Department of Health to enter and investigate unlicensed facilities in the state. The General Assembly may also wish to consider legislation requiring emergency care walk-in clinics and dialysis clinics to obtain a license before operating.
2. The General Assembly may wish to consider legislation allowing the department to impose civil penalties against deficient facilities of all types, not just nursing homes, in order to encourage compliance with regulations and the law. The General Assembly may also wish to reassess those portions of the statute that require the state to prove "willful" disregard for regulations before Type B civil penalties can be imposed.
3. The General Assembly may wish to consider (1) requiring all health care facilities, not just certified nursing homes, to check the abuse registry before hiring staff members and (2) prohibiting facilities from hiring individuals whose names appear on the registry. The General Assembly may also wish to consider requiring health care facilities to periodically check employees against the registry after they are hired, perhaps for a designated period of time.

### **ADMINISTRATIVE**

The following areas should be addressed to improve the efficiency and effectiveness of the Division of Health Care Facilities' operations.

1. The Department of Health should begin imposing state civil penalties against deficient nursing homes in all cases allowed by law, in addition to recommending federal penalties where applicable. The department should compare the dollar amounts of civil penalties allowed under current state law to those used in other states and determine whether the current level of state civil penalties is sufficient. This information should be communicated to the General Assembly for its consideration.
2. The Division of Health Care Facilities should investigate all complaints, especially abuse and neglect complaints, as quickly as possible to help ensure legitimate complaints are substantiated. The division should reevaluate whether it is appropriate to designate abuse/neglect complaints as priority 3.

3. To comply with state law, the Department of Health should immediately establish a registry containing the names of any persons found to have abused or intentionally neglected vulnerable individuals. The Division of Health Care Facilities should participate with other states, federal agencies, and national advocacy groups in any efforts to compile abuse registry data nationally so that abusers could not move to another state and continue working with vulnerable individuals.
4. The Executive Director of the Division of Health Care Facilities should work with the regional administrators to improve scheduling controls and procedures to help ensure the division meets state survey requirements for all facilities.
5. Division of Health Care Facilities management should work with the Department of Health's computer support personnel to develop a central database to track facility surveys.