

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NURSING HOME
COMPLAINT INVESTIGATIONS**



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OBJECTIVES

- (1) To assess whether State agencies investigate nursing home complaints in accordance with program requirements.
- (2) To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) monitors State agency performance of nursing home complaint investigations.

BACKGROUND

The nursing home complaint process is the front-line response system for addressing problems raised by residents, their families, and nursing home staff. However, in recent years various Government reports have documented vulnerabilities in nursing home complaint investigations.

CMS, in conjunction with the State agencies, oversees Medicare- and Medicaid-funded nursing homes to ensure that they meet Federal standards. State survey agencies investigate nursing home complaints on behalf of CMS. CMS's State Operations Manual (SOM), which is binding on Medicare-certified and Medicare-Medicaid dually certified nursing homes, provides State agencies with procedural guidelines for nursing home complaint investigations. These guidelines include a detailed protocol for the complaint investigation process, including directions on complaint intake, triage and prioritization, and followup.

CMS annually evaluates each State agency's nursing home complaint investigation process according to criteria set forth in the State Performance Standards that address complaint prioritization, investigation timeframes, and other procedural requirements. Beginning in 2004, CMS required all State agencies to enter all complaint investigation information into the ASPEN Complaints/Incidents Tracking System (ACTS). CMS uses the ACTS to evaluate complaint investigations nationwide.

This report draws on various data from all 50 States and the District of Columbia. We analyzed calendar year 2004 ACTS data, State agencies' written policies, data from a file review of selected complaints, State agency survey data, and CMS regional office interviews to evaluate State agency complaint investigation performance and CMS's oversight of that performance. Pennsylvania and Washington had waivers exempting them from using ACTS; therefore, we collected their data

separately. For these two States, we were unable to distinguish which nursing homes were certified only for Medicaid.

FINDINGS

State agencies did not investigate some of the most serious nursing home complaints within the SOM-required timeframes. In calendar year 2004, State agencies did not investigate 7 percent of complaints alleging immediate jeopardy, the most serious complaint category, in the required 2-day timeframe. Furthermore, State agencies did not investigate 27 percent of complaints alleging actual harm (high), the second most serious complaint category, within the required 10-day timeframe. CMS regional offices and State agencies report that staff shortages and insufficient training limit State agencies' ability to investigate complaints within the 10-day required timeframe.

While the ACTS shows potential for managing complaints, State agencies have not taken full advantage of this system. State agencies' use of their own data systems in addition to the ACTS, technical problems with the ACTS, and lack of training have hindered its use as a complaint management tool.

Most State agencies' written policies and procedures generally incorporate the SOM; however, those policies and procedures do not incorporate all of the SOM's guidelines. Several of the 42 State agencies' policies and procedures we reviewed do not incorporate guidelines pertaining to intake, triage and prioritization, and followup. For example, only 19 State agencies' policies and procedures incorporate the SOM requirement that agencies prioritize all nonimmediate jeopardy complaints within 2 days.

In a five-State file review, State agencies followed protocols for complaint intake and triage; however, many follow-up letters to complainants lacked meaningful information. Although 86 and 92 percent of the complaint files included letters to the nursing homes and complainants, respectively, letters to complainants often lacked comprehensive information about the complaints such as acknowledging the complainant's concern and summarizing the investigation methods.

CMS oversight of nursing home complaint investigations is limited. We identified four limitations to CMS oversight of nursing home complaint investigations. First, the State Performance Standard for complaints alleging actual harm (high) measures whether State agencies investigate all of these complaints within an average of

10 working days, with all complaint investigations completed within 20 working days. This standard is more lenient than the SOM's 10-day investigation timeframe for these complaints. Second, CMS conducts few Federal Oversight and Support Surveys (FOSS). The FOSS allows CMS's regional offices an opportunity to observe a State agency's complaint investigation process. However, the SOM states that State survey agencies should provide CMS with at least 2 weeks' advance notice, thus limiting the use of the FOSS for the most serious nursing home complaints. Third, CMS regional offices do not usually follow up on State Performance Standard failures until a year after the failure occurs. Finally, CMS regional offices lack sufficient expertise in the ACTS to use it for oversight or to help State agencies use it.

RECOMMENDATIONS

Our review found that: (1) many State agencies did not meet investigation timeframes for serious complaints, (2) State agencies do not incorporate some CMS guidelines for complaint investigations, (3) oversight by CMS regional offices is limited, and (4) State agencies are not fully utilizing the ACTS despite its potential for complaint management. To address these problems, we recommend that CMS:

Strengthen the oversight of nursing home complaint investigations by:

Requiring State agencies to meet the 10-day timeframe for investigating complaints alleging actual harm (high). CMS uses the State Performance Standards to hold State agencies accountable for the timeliness of their complaint investigations, yet the performance standard for complaints alleging actual harm (high) is more lenient than the 10-day standard required by the SOM. CMS should make the State Performance Standard timeframe consistent with the SOM. This would strengthen the State Performance Standards' emphasis on complaints alleging actual harm (high) in nursing homes by requiring State agencies to investigate 100 percent of these complaints within 10 working days.

Conducting additional followup to the State Performance Standard Reviews. Many CMS regional offices reported that they generally do not follow up on State Performance Standard failures until the next performance review, a year later. CMS regional offices should increase oversight of the State Performance Standards, which include the timely investigation of complaints alleging both immediate jeopardy and actual harm (high) and the proper

prioritization and investigation of complaints. This could be accomplished by following up throughout the year, either through onsite visits or regular checks of ACTS data.

Eliminating the 2-week advance notice for the FOSS required in the SOM to allow regional offices the option of overseeing complaint investigations for the most serious nursing home complaints. The FOSS provides CMS regional offices with a valuable oversight tool for nursing home complaint investigations. Pursuant to the SOM, State survey agencies should provide CMS with at least 2 weeks' notice of all scheduled surveys. Because of this provision, it is unlikely that CMS can conduct the FOSS for complaints alleging immediate jeopardy and actual harm (high) because of their respective 2- and 10-day investigation timeframes. CMS should eliminate this advance notice requirement to allow its regional offices to more fully oversee State agencies' investigations of the most severe complaints.

Offer additional ACTS training to its regional offices, as well as to State agencies. The ACTS has the potential to improve complaint management and oversight at the State agencies and CMS regional offices. However, both groups reported insufficient ACTS training to use the system to its full potential. CMS should offer the State agencies further training targeted to complaint management. In addition, CMS should continue to train its regional office staff on the ACTS functions specifically related to overseeing State agencies.

To help minimize the time State agencies spend manually entering complaint information into both ACTS and State-specific complaint tracking systems, CMS should provide specific training regarding how State agencies can use ACTS features designed to download information into a State system or capture State-required information.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with three of our four recommendations. The agency concurred with our recommendation to strengthen the oversight of nursing home complaint investigations. CMS also concurred with our recommendations to conduct meaningful followup to the State Performance Standards and to offer additional

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training to CMS regional offices and State agencies. CMS outlined specific steps it will take to address each of these recommendations.

CMS did not concur with our recommendation to eliminate the 2-week advance notice for the FOSS set forth in the SOM to allow regional offices the option of overseeing complaint investigations for the most serious nursing home complaints. CMS does not consider this advance notice to be an important barrier to conducting a FOSS survey and indicated it could not assume the added administrative costs and challenges under the current resource constraints. CMS also notes that regional offices have the authority to conduct onsite visits at nursing homes at any time and for any reason.

With respect to our third recommendation, we remain concerned that the 2-week advance notice hinders CMS's ability to conduct FOSS for complaints alleging immediate jeopardy or actual harm (high). The 2-week advance notice requirement limits the effectiveness of CMS oversight of State agencies' investigations of nursing homes. We encourage CMS to develop a policy that balances the resource constraints and the logistical challenge of scheduling surveys in a tight timeframe with the need for CMS to monitor State agency investigations of the most serious nursing home complaints.

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OBJECTIVES

- (1) To assess whether State agencies investigate nursing home complaints in accordance with program requirements.
- (2) To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) monitors State agency performance of nursing home complaint investigations.

BACKGROUND

The nursing home complaint process is the front-line response system to address problems and concerns raised by residents, their families, and nursing home staff. However, recent studies have shown that weaknesses exist in survey and complaint investigation activities performed by CMS and the State survey agencies (State agencies) that oversee nursing homes.¹

Nursing Home Oversight

CMS, in conjunction with the State agencies, oversees nursing homes to ensure that they meet Federal standards. The State agencies, among other functions, conduct certification surveys on behalf of CMS. State agencies must conduct certification surveys, which evaluate the quality of care nursing homes provide, on average every 12 months but no less frequently than every 15 months.² In addition to certification surveys, State agencies conduct complaint investigations. While complaint investigations primarily serve as a response system for health and safety concerns, they also allow State agencies to evaluate the quality of care the nursing homes provide between certification surveys.

Complaint Investigations

Sections 1819(g)(4)(a) and 1819(g)(5)(a) of the Social Security Act require each State to maintain procedures and adequate staff to investigate and report on the nursing home complaints they receive.

CMS's State Operations Manual (SOM) outlines the process that State agencies must follow when managing complaint investigations.³ As part of the agreements with CMS under which State survey agencies operate, SOM requirements are contractually binding on Medicare-certified and Medicare-Medicaid dually certified nursing homes.⁴ In November 2003, CMS issued a program memorandum to provide State agencies with additional direction and guidelines for nursing home complaint management.⁵ This memorandum, which CMS

has since incorporated into the SOM, provides a detailed protocol for State agencies to follow throughout the complaint investigation process, including guidelines for complaint intake, triage and prioritization, and followup.⁶

Intake. The SOM instructs State agencies to collect comprehensive information from complainants. This information includes, but is not limited to, information about the complainant, the nursing home, the individuals involved and affected, a narrative of the allegation, how and why the complainant believes the problem leading to the allegation occurred, and the complainant's expectation for resolution.⁷ The SOM also directs State agencies to offer information to complainants during intake. This information includes, at a minimum, the State agency's policies and procedures, the course of action the State agency will take and the anticipated timeframes, relevant referral information, and a contact name and phone number for followup by the complainant.⁸

Triage and prioritization. The SOM requires that a qualified professional, who has knowledge of current clinical standards and Federal requirements, prioritize each complaint. Complaints alleging immediate jeopardy must be prioritized and investigated within 2 working days of receipt, while all nonimmediate jeopardy complaints must be prioritized within 2 working days of receipt. The priority category that the State agency assigns to a complaint is critical because it determines the action and timing of the investigation. The priority categories are:

- ***Immediate jeopardy:*** The SOM defines immediate jeopardy, the most serious allegation category, as “a situation in which 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.”⁹ If the State agency determines that immediate jeopardy may be present and ongoing, the SOM requires the agency to investigate these complaints onsite within 2 working days of receipt.
- ***Actual harm (high):*** The State agency assigns the highest level of actual harm, which is the second most serious allegation category, when “a provider’s alleged noncompliance with one or more requirements or conditions may have caused harm that negatively impacts the individual’s mental, physical, and/or psychosocial status and is of such consequence to the person’s well being that a rapid response by the State agency is indicated.”¹⁰ The SOM directs State

agencies to investigate complaints alleging actual harm (high) onsite within 10 working days of complaint receipt.

- *All others:* For complaints less serious than immediate jeopardy and actual harm (high), the State agency decides, based on the intake information, whether to investigate onsite, perform a desk review of the complaint, or refer the complaint to a more appropriate agency.

Followup. After investigating the allegation, the State agency must provide the complainant and the nursing home with a written report of the investigation findings. The SOM directs State agencies to draw upon the following information in these reports: acknowledgment of the complainant's concerns, the State agency's authority to investigate complaints, a summary of the investigation methods, an explanation of the decisionmaking process, a summary of the State agency's findings, any follow-up action to be taken, and referral of information to other agencies, when appropriate.¹¹

CMS Oversight of State Agency Complaint Investigations

In October 2000, CMS began the State Performance Standard Reviews, which establish performance standards for State agencies.¹² These annual reviews serve as CMS's primary oversight mechanism for State agencies. The 2004 performance standard for complaint investigations includes the following three conditions (referred to as emphases) pertaining to nursing homes:

- Prioritization of complaints—For 90 percent of randomly selected complaints, the CMS regional office must agree with the State agency's prioritization of the complaint.
- Investigation of complaints—
 - Immediate jeopardy: The State agency must investigate all immediate jeopardy complaints onsite within 2 working days.
 - Actual harm (high): The State agency must investigate all complaints alleging actual harm (high) onsite in an average of 10 working days, with all investigations completed within 20 working days.¹³
- Complaint investigation procedures—The State agency must follow CMS instructions for handling complaints for no less than 80 percent of nursing home complaints. These instructions include contacting complainants with investigation results and having

qualified surveyors complete the nursing home survey, among others.¹⁴

The 2004 State Performance Standard reports show that many State agencies failed to meet performance standard timeframes for investigating nursing home complaints. Of the 50 States and the District of Columbia, 21 State agencies failed to meet timeframes for investigating complaints assigned immediate jeopardy and 37 failed to meet timeframes for investigating complaints assigned actual harm (high).

ASPEN Complaints/Incidents Tracking System

Effective January 1, 2004, CMS requires State agencies to enter all complaint investigation information into the ASPEN Complaints/Incidents Tracking System (ACTS).¹⁵ CMS uses the ACTS to evaluate complaint investigations nationwide. For each complaint, the ACTS contains information from the complaint intake through closure, including key dates, the prioritization level, overall findings, proposed action, and the reason the complaint was closed. The ACTS includes more comprehensive complaint information than the previous repository for nationwide complaint data, the Online Survey Certification and Reporting system (OSCAR).

Federal Oversight and Support Surveys

Federal Oversight and Support Surveys (FOSS) provide CMS with valuable opportunities to observe a State agency's complaint investigation process in action. CMS regional offices conduct the FOSS for State agency nursing home surveys, including complaint investigations. During a FOSS, regional office surveyors accompany State agency surveyors and review their performance in conducting the survey or complaint investigation. Regional office surveyors discuss the State agency surveyors' performance with them following the survey; identify surveyor training needs, if appropriate; and provide the State agency with a numerical rating of the surveyors' performance.¹⁶

Concerns About Nursing Home Complaints

In recent years, various Government reports and press articles have documented vulnerabilities in nursing home complaint investigations. Some of these reports have resulted in policy modifications and increased oversight by CMS.

Two 1999 Government Accountability Office (GAO) reports documented problems with State agency complaint management and with CMS's oversight of the State agencies. In one report, GAO found that CMS

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provided minimal guidance to State agencies on prioritization and investigation timeframes for nonimmediate jeopardy complaints, resulting in varying timeframes for complaint investigations.¹⁷ Furthermore, GAO reported that CMS conducts very few oversight surveys for complaint investigations. CMS addressed some of these concerns by instituting the State Performance Standards and the ACTS, both of which provide CMS with greater oversight capabilities. CMS created the actual harm triage category in response to another 1999 GAO report that found that State agencies were understating the seriousness of complaints and were failing to investigate serious complaints promptly.¹⁸

In July 2003, a GAO official testified before the Senate Finance Committee that timeliness of complaint investigations by State agencies remained problematic and that the State Performance Standards did not provide CMS with enough information to foster improvement.¹⁹ Subsequently, in November 2003, CMS released a memorandum that addressed GAO recommendations to provide State agencies with additional guidelines for complaint investigations.

Despite these policy changes and the provision of additional guidance in the SOM, accounts from individual States document continued problems with nursing home complaint investigations. For example, an Office of Inspector General June 2004 report (A-04-03-07027) documented vulnerabilities in Alabama's survey agency relative to physical and sexual abuse complaints in nursing homes.²⁰ The State agency did not investigate these complaints within established timeframes, nor did it appropriately track and monitor complaints. The review also found that the State agency did not have adequate policies and procedures for the intake of abuse complaints.

Similarly, in August 2004, a series of articles in the "Providence Journal" highlighted a Rhode Island nursing home about which the State agency received multiple complaints.²¹ Despite numerous complaint investigations and a declaration of immediate jeopardy, the nursing home remained in operation. Ultimately, one of the home's residents died of heart failure after suffering from severe pressure sores. In July, Rhode Island enacted the Long Term Care Reform Act of 2005 to strengthen oversight of the State's nursing homes.²²

METHODOLOGY

We based this review on 5 data sources: (1) ACTS data, (2) a file review of 498 complaint records from 5 States, (3) a mail survey of the State agencies' directors, (4) a review of State agencies' policies and procedures for complaint investigations, and (5) interviews with CMS regional office survey and certification staff. Appendix A contains a detailed description of our methodology.

ACTS

We analyzed ACTS data for calendar year 2004 to determine the percentage of complaints alleging immediate jeopardy and actual harm (high) in Medicare-certified nursing homes that State agencies investigated within the respective timeframes of 2 and 10 working days. We also used the ACTS to determine whether State agencies were using the system for required complaint data entry. Pennsylvania and Washington had waivers exempting them from using the ACTS; therefore, we collected and analyzed their complaint data separately. We were unable to distinguish which nursing homes in Pennsylvania and Washington were not Medicare-certified or Medicare-Medicaid dually certified; however, only 17 complaints for both States combined (out of a total of 3,197 immediate jeopardy and actual harm (high) complaints in these States) were not investigated within the 2- and 10-day timeframes for immediate jeopardy and actual harm (high).

We conducted onsite reviews of 498 nursing home complaint files in the State agencies of Florida, Illinois, Louisiana, Massachusetts, and Oklahoma to assess whether the State agencies followed SOM guidelines for complaint intake, triage and prioritization, and followup. We selected these States based on complaint volume in 2002 and 2003, State Performance Standard reports, and geographic considerations.

We did not determine whether the State agency prioritized each complaint accurately. We calculated the time that elapsed between complaint receipt and investigation, assuming that the State prioritized the complaint correctly.

Mail survey of State agency directors

We surveyed State agency directors in all 50 States and the District of Columbia on intake, triage and prioritization, and followup of nursing home complaints; feedback provided by CMS pertaining to management of nursing home complaint investigations; and ACTS usage. We

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received completed surveys from 50 State agencies, representing a response rate of 98 percent.

Review of policies and procedures for complaint investigations

We received nursing home complaint investigation policies and procedures from 42 of the 51 State agencies. We reviewed these policies to determine whether they followed the SOM guidelines for complaint intake, triage and prioritization, and followup.

Interviews with CMS regional office staff

We used a structured interview guide to conduct telephone interviews with all 10 CMS regional survey and certification branch chiefs. The interviews focused on information the regional offices provided to State agencies concerning management of complaint investigations, ACTS training for State agencies, and the regional offices' complaint investigation oversight activities.

We conducted this inspection in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

State agencies did not investigate some of the most serious nursing home complaints within SOM-required timeframes

In 2004, State agencies did not investigate 7 percent of complaints alleging immediate jeopardy in the required 2-day timeframe

Nationally, State agencies did not investigate 233 of 3,467 complaints alleging immediate jeopardy (7 percent) within 2 working days. (See Table 1.) State agencies took more than 10 working days to investigate 155 of these complaints (4 percent). The potential for further harm to a nursing home's residents makes it essential that State agencies promptly investigate complaints alleging immediate jeopardy onsite within the required 2-day timeframe.

Number of Workdays	Number of Immediate Jeopardy Complaints Investigated	Percentage of Immediate Jeopardy Complaints Investigated
2 days or fewer	3,234	93
3–10 days	78	2
11–45 days	49	1
46–365 days	76	2
No survey	30	1
Total	3,467	100*

*Data may not add to 100 because of rounding.

Source: Office of Inspector General Analysis of ACTS and State complaint data, 2005.

State-level analysis of the data showed that 27 State agencies did not investigate all of their complaints alleging immediate jeopardy within 2 working days.²³ Eight State agencies did not investigate more than 20 percent of their complaints alleging immediate jeopardy within the 2-day timeframe. Mississippi did not investigate 93 percent of complaints alleging immediate jeopardy within 2 working days. Mississippi also accounts for 67 of the 76 immediate jeopardy complaints nationwide that State agencies investigated more than 45 days after complaint receipt.

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In 2004, State agencies did not investigate 27 percent of complaints alleging actual harm (high) in the required 10-day timeframe

In 2004, complaints alleging actual harm (high) accounted for 44 percent of complaints in the ACTS database. Because of their severity, the SOM requires State agencies to investigate complaints alleging actual harm (high) onsite within 10 working days of complaint receipt. The 2004 complaint data show that, nationwide, State agencies did not investigate 8,398 of 30,588 complaints (27 percent) alleging actual harm (high) within this timeframe. (See Table 2.) As an example of a complaint alleging actual harm (high), one State agency assigned actual harm (high) when a complainant alleged that a family member’s nursing home failed to treat her urinary tract infection, locked her in a dark room, and then dropped her in the bathroom, fracturing her arm and injuring her knee. Even based on the weaker State Performance Standard of investigating all complaints within 20 working days, State agencies did not investigate all complaints alleging actual harm (high) timely. State agencies took more than 20 working days to investigate 5,437 of these complaints (18 percent).

Number of Workdays	Number of Actual Harm (High) Complaints Investigated	Percentage of Actual Harm (High) Complaints Investigated*
10 days or fewer	22,190	73
11–15 days	1,822	6
16–20 days	1,139	4
21–24 days	699	2
25–45 days	1,943	6
46–365 days	2,422	8
No survey	373	1
Total	30,588	100

*Percentages are rounded.

Source: Office of Inspector General Analysis of ACTS and State complaint data, 2005.

The 2004 data show that 46 State agencies did not investigate all of their complaints alleging actual harm (high) within 10 working days.²⁴ While 24 of these State agencies investigated more than 90 percent of complaints alleging actual harm (high) within 10 working days, some State agencies fell considerably short of the 10-day standard. Eleven State agencies did not investigate over 50 percent of complaints alleging actual harm (high) within 10 working days. For example, Maryland did

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not investigate 66 percent of complaints alleging actual harm (high) within 10 working days. In addition, 24 State agencies took more than 45 working days to investigate at least 1 complaint alleging actual harm (high), and 5 of these State agencies took more than 45 working days to investigate at least 200 of their complaints alleging actual harm (high). Appendix B presents 2004 data concerning timeliness of complaint investigations for every State agency.

CMS regional offices and State agencies report that staff shortages and insufficient training hinder timely nursing home complaint investigations

Twenty-two State agencies and 9 of the 10 CMS regional offices cited insufficient State agency staffing as a major barrier to timely complaint investigations. Seven CMS regional offices reported that State agencies in their regions have difficulty recruiting and retaining qualified staff. Nursing home complaint investigations require both clinical and regulatory knowledge. Staff who lack these skills may have difficulty completing investigations timely and appropriately. Officials at State agencies and CMS regional offices explained that a rise in complaint volume, high staff turnover, and the demands of higher-priority State agency tasks (such as nursing home recertification surveys) all contribute to insufficient complaint investigation staffing levels at the State agencies.

CMS regional offices and State agencies identified two types of State agency training limitations that hinder timely complaint investigations. First, 39 State agencies reported a need for additional ACTS training to make the system a more useful complaint management tool. CMS regional offices and State agencies explained that sufficient ACTS training is crucial because small data errors create time-consuming data problems. Second, 12 State agencies reported a need for additional staff training on CMS complaint investigation policy, particularly regarding complaint prioritization.²⁵

While the ACTS shows potential for managing complaints, State agencies have not taken full advantage of this system

In addition to capturing required complaint data, the ACTS enables State agencies to manage complaint

investigation information, schedule surveys, generate letters to complainants and nursing homes, and create reports related to complaint investigation performance. Despite these capabilities, 21 State agencies reported operating their own complaint system in addition to the ACTS. State agencies that maintain separate systems say they do so to fulfill State licensure requirements, State regulations, and State reporting needs since, to date, the ACTS is unable to accommodate these needs. As a result, these State agencies enter the same complaint data into two systems: their own and the ACTS.

Technical problems with the ACTS hinder its use as a complaint management tool. First, State agencies reported that using the ACTS is cumbersome during complaint intake. The ACTS was designed to allow State agency staff to enter intake information directly while the complainant is on the phone. Notwithstanding this design, 26 State agencies cited the ACTS as a barrier to collecting the necessary information during complaint intake; 9 of these 26 State agencies specifically mentioned that the ACTS is unreliable for real-time entry. State agencies stated that intake information must be entered in a certain order in the ACTS, which may not reflect the way the complainant gives the information. Additionally, State agencies mentioned that the ACTS becomes unavailable during upgrades and can be too slow to keep up with the complainant's comments. To deal with these data entry problems, 11 State agencies reported entering intake data somewhere else first and then taking additional time to enter the data into the ACTS.

Most State agencies received ACTS training, but many reported that it did not sufficiently prepare them to use the system effectively. Forty State agencies reported receiving ACTS training prior to implementation. While 33 of these State agencies rated the training's content as very or somewhat useful, 24 reported that they received too little ACTS training. State agencies explained that the training occurred too long before ACTS implementation; thus, many of the trainees had forgotten the details of the training by the time CMS implemented the ACTS. The only classroom training CMS offered was in April 2002, which was over a year and a half prior to ACTS implementation. In addition, CMS upgraded the ACTS in the period between training and implementation, which made some of the training

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outdated by the time of implementation. Finally, State agencies cited limits with the “train the trainer” approach, whereby each State agency sent at least two people to training who then tried to train the rest of the State agency staff. State agencies reported problems with this training method when trained persons were unable to convey the information to the rest of the staff or left the State agency.

To address the need for more ACTS guidance, CMS convenes a national ACTS workgroup. Representatives from State agencies, CMS regional offices, and CMS central office participate in a monthly conference call to discuss updates to the system or problems they have encountered. CMS has also offered Internet-based training for the States and regional offices prior to each ACTS update. In addition, CMS contracts with a technical support hotline that State agencies can call for assistance. Of the 30 State agencies that told us they reported problems to the hotline, 25 found the technical support somewhat or very useful while 5 found it not useful. State agencies can also electronically post suggestions for ACTS improvement and participate in scheduled technical conference calls with CMS central office and regional offices.

Most State agencies’ written policies and procedures generally incorporate the SOM; however, those policies do not incorporate all of the SOM’s guidelines

State agencies’ policies and procedures do not incorporate several SOM guidelines pertaining to intake, triage and prioritization, and followup.

While all 42 State agencies’ policies and procedures we received specifically listed some of the intake items addressed in the SOM, only 5 State agencies require the collection of all the suggested intake items. The items most frequently absent concern information that the State agencies should provide to the complainant. For example, fewer than half of the State agencies direct intake staff to determine the complainant’s expectations for the complaint or to provide the complainant with State agency complaint policies, including timeframes and expected actions, or with specific contact information, all of which the SOM addresses.

Most State agencies’ policies, triage categories, and timelines incorporate the SOM guidelines. Of the 42 State agencies for which we reviewed policies, almost all require that complaints alleging immediate jeopardy and actual harm (high) be investigated within the SOM-required timeframes. However, only 19 State agencies’ policies

incorporate the SOM requirement that the agencies prioritize all nonimmediate jeopardy complaints “within two working days of receipt, unless there are extenuating circumstances that impede the collection of relevant information.”²⁶

While most of the State agencies’ policies direct their staff to send follow-up letters to complainants, many of the policies provide little or no detail about the required content of these letters. The SOM lists several pieces of information that State agencies should convey to complainants in follow-up letters. However, of the 42 policies we reviewed, only 9 require that follow-up letters to complainants include all of the components cited in the SOM. Conversely, seven State agencies’ policies did not include any of the letter components cited in the SOM.

In a five-State file review, State agencies followed protocols for complaint intake and triage; however, many follow-up letters to complainants lacked meaningful information

Our file review of 498 nursing home complaints that resulted in an onsite survey found that State agencies generally collected appropriate information during

intake, employed qualified professionals to assign priorities to the complaints, and provided the complainant and the nursing home with a written report of the investigation findings.

Although 86 and 92 percent of complaint files included letters to the nursing homes and complainants, respectively, letters sent to complainants often lacked comprehensive information about the complaints. The SOM lists several items to guide State agencies in the preparation of follow-up letters to complainants. These elements are important because, for most complainants, this is the only official feedback they receive from the State agencies. Letters to complainants mostly lacked references to the State agency’s decisionmaking process. Table 3 shows the percentage of follow-up letters to complainants that lack each of the letter items the SOM suggests State agencies include.

The information contained in the letters was inconsistent both across and within some States. Oklahoma and Massachusetts sent complainants standard letters that contained all of the SOM items. In contrast, Florida’s follow-up letters varied based on which field office sent them. While some letters contained all of the elements suggested by the SOM, others contained just the date the State agency conducted the survey and whether the State agency cited deficiencies.

Table 3: Percentage of Follow-Up Letters in the Five States That Lacked Information Listed in the SOM	
Letter Items Cited by the SOM	Letters to Complainant Missing Item (n=327*)
Acknowledge the complainant's concern	47
Summarize the investigation methods	50
Provide the date of investigation	28
Discuss the State agency's decisionmaking process	27
Provide a summary of the State agency's findings	9
*Due to nursing home self-reports and anonymous complaints, 171 of the 498 complaints do not include a complainant letter.	

Source: Office of Inspector General analysis of State agency nursing home complaint files, 2005.

CMS oversight of nursing home complaint investigations is limited

CMS's State Performance Standard emphasis for nursing home complaints is not consistent with SOM requirements for complaints alleging actual harm (high)

While the State Performance Standard emphasis for complaints alleging immediate jeopardy reflects the SOM requirement, its emphasis for complaints alleging actual harm (high) has changed since 2002 and is presently inconsistent with and weaker than the SOM requirement. The 2004–2005 State Performance Standard emphasis for complaints alleging actual harm (high) is more lenient than both the SOM's requirement of investigating complaints alleging actual harm (high) within 10 working days and prior State Performance Standard emphases for these complaints. The State Performance Standard emphasis for complaints alleging actual harm (high) no longer measures whether State agencies investigate all complaints alleging actual harm (high) within the SOM requirement of 10 working days. In 2002 and 2003, the emphasis for complaints alleging actual harm (high) measured whether State agencies investigated 100 percent and 95 percent of complaints alleging actual harm (high), respectively, within 10 working days. (See the box below.) In fiscal year 2004, the emphasis changed to measure whether State agencies

investigated all complaints alleging actual harm (high) within an average of 10 working days, with all complaints completed within 20 working days.²⁷

CMS’s State Performance Standard Emphases for Complaints Alleging Actual Harm (High), 2002–2005

2002: The State agency triages and initiates investigation of 100 percent of the complaints it receives alleging or involving actual harm (high) to individuals consistent with CMS and State policy.

2003: The State agency investigates 95 percent of the complaints about Medicare- and Medicaid-certified facilities it receives alleging or involving actual harm (high) to residents consistent with CMS and State policy.

2004: The State agency investigates all complaints about long term care Medicare- and Medicaid-certified facilities it receives alleging or involving actual harm (high) to individuals within an average of 10 working days, with all complaints completed within 20 working days (long term care only).

2005: For Medicare- and Medicaid-certified nursing homes, the State agency initiates an investigation for all complaints and those incidents that require a Federal onsite survey alleging a higher level of actual harm within an average of 10 working days, with all onsite investigations completed by 20 working days. For fiscal year 2005, measuring the 20-working-day completion is in a developmental stage (nursing homes only).

Source: Office of Inspector General analysis of CMS State Agency Performance Review Standards, 2005.

Changes to the State Performance Standard emphases also limit CMS’s ability to track State agency performance over time. In addition, the weakening of this standard can mask deteriorating State agency performance over time. For example, a State agency that failed to meet this emphasis in 2002 could meet the 2004 standards while performing worse in 2004 than in 2002.

CMS regional offices conduct few FOSSs

The FOSS provides CMS regional offices with a valuable oversight tool for nursing home complaint investigations. However, the SOM states that State survey agencies should provide CMS with at least 2 weeks’ notice of all complaint investigations. Because this 2-week period exceeds the investigation timeframes for complaints alleging immediate jeopardy and actual harm (high), such advance scheduling hinders regional offices from conducting the FOSSs for the most serious nursing home complaints.²⁸

Overall, CMS regional offices conduct few FOSSs of complaint investigations. Nine of the ten CMS regional offices conducted FOSSs

F I N D I N G S

for nursing home complaint investigations in 2004. However, regional offices reported conducting the FOSS in only half of the States in their region. Five regional offices reported they would like to conduct more of these surveys.

Many CMS regional offices do not follow up formally on State Performance Standard Reviews until the subsequent performance review

All 10 CMS regional offices require State agencies to submit a plan of correction when the agency fails to meet a performance standard. However, six regional offices do not conduct any additional followup on the performance reviews until the subsequent annual performance review, a year after the State agency fails to meet a performance standard. Two CMS regional offices report that although they do not go onsite for formal followup, they do evaluate midyear data samples from the State agencies and require State agencies that fail to meet performance standards to provide performance updates between performance reviews.

Some CMS regional offices lack sufficient expertise in the ACTS to help State agencies or to use it for oversight

The ACTS equips CMS to examine complaint investigations in detail and to assess State agency actions. However, 6 of the 10 CMS regional offices reported that they lacked sufficient staff with enough knowledge about the ACTS to provide assistance to the State agencies.

CMS regional offices cite staffing shortages and insufficient training as reasons for the lack of ACTS expertise within their offices. Three regional offices report that ACTS training did not prepare staff to use the ACTS for oversight functions, such as running reports or troubleshooting State agencies' data entry, because the training primarily covered data entry rather than complaint management. Five regional offices cite staff turnover and shortage for the lack of ACTS expertise within their offices. Four of these regions report that the only person proficient with the ACTS in their office is also responsible for using it to oversee other provider types and has insufficient time to focus on nursing home complaint investigations.

► R E C O M M E N D A T I O N S

The nursing home complaint investigations process continues to have problems. Many State agencies did not meet investigation timeframes for the most serious complaints, State policies and file reviews indicate that State agencies did not incorporate some aspects of the investigation process suggested in the SOM, and oversight by CMS regional offices is limited. In addition, State agencies are not fully utilizing the ACTS despite its potential for complaint management. To address these problems, we recommend that CMS take the steps listed below.

Strengthen the oversight of nursing home complaint investigations by:

Requiring State agencies to meet the 10-day timeframe for investigating complaints alleging actual harm (high)

CMS uses the State Performance Standard to hold State agencies accountable for the timeliness of their complaint investigations, yet the performance standard for complaints alleging actual harm (high) is more lenient than the 10-day standard required by the SOM. The 2004 and 2005 State Performance Standard emphasis for complaints of actual harm (high) requires that State agencies initiate investigations for complaints alleging a higher level of actual harm within an average of 10 working days, with all onsite investigations completed by 20 working days. CMS should make the State Performance Standard timeframe consistent with the SOM. This would strengthen the State Performance Standard emphasis for complaints alleging actual harm (high) in nursing homes by measuring whether State agencies investigate 100 percent of these complaints within 10 working days.

Conducting meaningful followup to the State Performance Standard Reviews

Many CMS regional offices reported that they generally do not follow up with the State Performance Standard failures until the next performance review, a year later, despite the fact that the annual State Performance Standard is CMS's primary oversight mechanism for State agencies' nursing home complaint investigations. Rather than waiting until the next annual performance review, CMS regional offices should increase oversight on the State Performance Standard, which includes the timely investigation of complaints that allege both immediate jeopardy and actual harm (high) and the proper prioritization and investigation of complaints. This could be accomplished by following up throughout

R E C O M M E N D A T I O N S

the year, either through onsite visits or regular checks of the State agency's ACTS data.

Eliminating the 2-week advance notice for FOSS contained in the SOM to allow regional offices the option of overseeing complaint investigations for the most serious nursing home complaints

The FOSS provides CMS regional offices with a valuable oversight tool for nursing home complaint investigations. The SOM, however, states that State survey agencies must provide CMS with at least 2 weeks' notice of all scheduled surveys. Because of this provision, it is unlikely that CMS can conduct the FOSS for complaints alleging immediate jeopardy and actual harm (high) because of the respective 2- and 10-day investigation timeframes. CMS should eliminate this advance notification to allow its regional offices to more fully oversee State agencies' investigations of the most severe complaints.

Offer additional ACTS training to its regional offices, as well as to State agencies

The ACTS has the potential to improve complaint management and oversight at the State agencies and CMS regional offices. However, both groups reported insufficient ACTS training to fully utilize the system. CMS should offer the State agencies further training targeted to complaint management. In addition, CMS should continue to train its regional office staff on the ACTS functions specifically related to overseeing State agencies.

To help minimize the time State agencies spend manually entering complaint information into both the ACTS and State-specific complaint tracking systems, CMS should provide specific training regarding how State agencies can use ACTS features designed to download information into a State system or capture State-required information.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with three of our four recommendations. CMS concurred with our recommendation to strengthen the oversight of nursing home complaint investigations by requiring State agencies to meet the 10-day timeframe for investigating complaints alleging actual harm (high). While CMS outlined specific steps it would take to address this recommendation, such as clarifying the language in the State Performance Standard for 2007, it also noted

that the increase in nursing home complaints as well as resource limitations affect its ability to meet these performance expectations.

CMS concurred with our recommendation to conduct meaningful followup to the State Performance Standards and listed steps it is implementing to enhance followup. These steps include strengthening regional office followup, particularly in States with significant performance failures; holding face-to-face meetings with States at least twice per year, with performance as a prominent agenda item; making performance standard fulfillment a significant feature of CMS's annual National Leadership Summit; and ensuring that ACTS produces reports that provide feedback to States on their performance.

CMS also concurred with our recommendation to offer additional training to CMS regional offices as well as State agencies. The agency highlighted a pilot program that would evaluate the extent to which the ASPEN information system is integrated with office business practices and other State operations. CMS noted that while it recognizes the potential benefits of using ACTS to support States' management, ACTS is a Federal system and was not intended to support all States' possible uses.

CMS did not concur with our recommendation to eliminate the 2-week advance notice for the FOSS set forth in the SOM to allow regional offices the option of overseeing complaint investigations for the most serious nursing home complaints. CMS does not consider this advance notice to be an important barrier to conducting a FOSS survey and indicated it could not assume the added administrative costs and challenges under the current resource constraints. CMS also notes that regional offices have the authority to conduct onsite visits at nursing homes at any time and for any reason. The full text of CMS's comments is in Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

With respect to our third recommendation, we remain concerned that the 2-week advance notice hinders CMS's ability to conduct FOSS for complaints alleging immediate jeopardy or actual harm (high). The 2-week advance notice requirement limits the effectiveness of CMS oversight of State agencies' investigations of nursing homes. We encourage CMS to develop a policy that balances the resource constraints and the logistical challenge of scheduling surveys in a tight

timeframe with the need for CMS to monitor State agency investigations of the most serious nursing home complaints.

▶ E N D N O T E S

¹ See Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services, Final Report, “Survey of Physical and Sexual Abuse in Alabama Nursing Homes,” A-04-03-07027, June 2004; Government Accountability Office (GAO), “Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline,” GAO/03-1016T, July 2003.

² 42 CFR § 488.308.

³ Centers for Medicare & Medicaid Services (CMS), “State Operations Manual,” Chapter 5—Complaint Procedures.

⁴ We refer in this report to provisions of the State Operations Manual as “requirements” even though for two of the States reviewed, Pennsylvania and Washington, we were unable to distinguish which nursing homes were certified for Medicare and which were certified for Medicaid only.

⁵ CMS, “Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System,” S&C-04-09, November 13, 2003.

⁶ In June 2005, CMS released another memorandum to State agency directors that offered guidance on complaint allegation intake and triage. The memorandum offers specific intake questions for collecting comprehensive information as well as criteria for making triage assessments. CMS based the memorandum on complaint management practices shared by State agencies. However, because these are not statutory requirements, State agencies are not required to incorporate the practices from the memorandum.

⁷ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5010A).

⁸ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5010B).

⁹ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5030A); 42 CFR § 489.3.

¹⁰ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5030B).

¹¹ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5040).

¹² GAO, “Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline,” GAO/03-1016T, July 2003.

¹³ CMS, “FY 2004 State Performance Review Protocol Guidance,” October 2003.

¹⁴ CMS, “FY 2004 State Performance Review Protocol Guidance,” October 2003, p. 42.

¹⁵ To date, CMS has waived this requirement for two States (Pennsylvania and Washington).

¹⁶ CMS, “State Operations Manual,” Chapter 4—Federal Oversight Support Survey (FOSS) Expectations and Responsibility (Section 4158).

¹⁷ GAO, “Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards,” HEHS-99-46, March 18, 1999.

¹⁸ GAO, “Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents,” GAO-HEHS-99-80, March 22, 1999.

¹⁹ GAO, “Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline,” GAO/03-1016T, July 2003.

²⁰ HHS, OIG, Office of Audit Services, Final Report, “Survey of Physical and Sexual Abuse in Alabama Nursing Homes,” A-04-03-07027, June 2004.

²¹ The Providence Journal, “Resident #1,” August 22, 2004; “Few Complaints Lead to Probes of Nursing Homes,” August 23, 2004; “Carcieri Calls for Stricter Nursing Home Supervision,” August 25, 2004; “Nursing Home Death Stirs R.I. Officials to Find Fixes,” August 28, 2004.

²² Rhode Island General Assembly, “Press Release: Long Term Care Reform Act of 2005 Signed Into Law,” Rhode Island, July 5, 2005.

²³ Five States (Hawaii, North Dakota, South Dakota, Virginia, and Washington, D.C.) had no complaints alleging immediate jeopardy in the 2004 ASPEN Complaints/Incidents Tracking System (ACTS) data. Pennsylvania had a waiver and is not included in 2004 ACTS data.

²⁴ South Dakota had no complaints alleging actual harm in the 2004 ACTS data. Pennsylvania had a waiver and is not included in 2004 ACTS data.

²⁵ After our survey, CMS offered additional guidance to State agencies on complaint prioritization and intake in a memorandum released in June 2005. See CMS, “Promising Practices to Support the Intake of Nursing Home Complaints,” S&C-05-31, June 9, 2005.

²⁶ CMS, “State Operations Manual,” Chapter 5—Complaint Procedures (Section 5020).

²⁷ Centers for Medicare & Medicaid Services, “FY 2004 State Performance Review Protocol Guidance,” p. 10.

²⁸ CMS, “State Operations Manual,” Chapter 4—Federal Oversight Support Survey (FOSS) Expectations and Responsibility (Section 4158).

METHODOLOGY

We based this review on 5 data sources: (1) ASPEN Complaints/Incidents Tracking System (ACTS) data, (2) a file review of 498 complaint records from 5 States, (3) a mail survey of the State agencies' directors, (4) a review of 42 State agencies' policies and procedures, and (5) interviews with the Centers for Medicare & Medicaid Services (CMS) regional office survey and certification staff.

ACTS

We analyzed ACTS data for calendar year 2004 to determine the percentage of complaints alleging immediate jeopardy and actual harm (high) in Medicare-certified nursing homes that State agencies investigated within the respective 2- and 10-working day timeframes. We also analyzed ACTS data to determine whether State agencies were using ACTS for required complaint data entry. We received ACTS data for all State agencies from CMS on June 16, 2005. These data included 208,690 records. We removed duplicate records and records in which the State agency entered a complaint receipt date after December 31, 2004. We then collapsed records that had the same complaint intake identification number but multiple allegation categories down to one record. We also excluded 1,406 complaints because the date investigated was prior to the date received. The final ACTS database included 68,826 complaint records. These data included a total of 35,800 immediate jeopardy and actual harm (high) complaints.

Pennsylvania and Washington had waivers exempting them from using the ACTS, so we collected and analyzed their complaint data separately from ACTS data. Like our ACTS analysis, we included both complaints and incidents for calendar year 2004 for all types of nursing homes. Though the State Operations Manual (SOM) requirements are binding on Medicare-certified and Medicare-Medicaid dually certified nursing homes, we were unable to distinguish which nursing homes in these two States were certified only for Medicaid. However, only 17 complaints for Pennsylvania and Washington combined (out of a total of 3,197 immediate jeopardy and actual harm (high) complaints in these States) were not investigated within the 2- and 10-day timeframes for immediate jeopardy and actual harm (high).

We analyzed the fields in the ACTS that the SOM requires State agencies to enter for every complaint. We did not verify the accuracy of the information in the fields, but rather whether the State agency

populated them. We also used SAS[®] to calculate whether State agencies met the required timeframes for complaints prioritized as immediate jeopardy and actual harm (high). Excluding weekend days and Federal holidays, we calculated the number of days from the date the State agency received the complaint to the date the complaint survey started. (We did not exclude State holidays from our analysis.) This allowed us to determine whether State agencies met the Federal requirements that all complaints alleging immediate jeopardy be investigated within 2 working days and all complaints alleging actual harm (high) within 10 working days.

File review

For our file review, we drew a sample of 500 nursing home complaints from a purposive sample of 5 States: Florida, Illinois, Louisiana, Massachusetts, and Oklahoma. From the Online Survey Certification and Reporting (OSCAR) system, we randomly selected 100 complaints from each State that were reported in calendar year 2004. We used the OSCAR system to select the complaints because ACTS data were not available to us until June 2005. We selected our sample in February 2005 and conducted the file reviews at the State agencies in March, April, and May 2005. We excluded 2 complaint files that did not pertain to Federal requirements, resulting in a review of 498 complaint files.

We used several criteria to select the five States. We selected States that had a medium or high volume of complaints in 2002 and 2003. Due to travel constraints, we limited the file review to States with centrally maintained complaint files. Additionally, we selected States with different levels of performance on the three State Performance Standards' emphases pertaining to nursing home complaint investigations. Two States we chose met all three emphases in 2002 and 2003, one did not meet any, and the other two States met only one emphasis in 2002 or 2003.

We reviewed the files using a protocol we developed and entered the data into a Microsoft Access[®] database. Our protocol followed CMS's SOM guidelines for complaint intake, triage and prioritization, and complainant and nursing home followup. We evaluated complaint files for completeness and conformity with SOM procedural guidelines. However, we did not assess whether State agency staff made appropriate triage assignments. While onsite at the State agencies, we interviewed managers, surveyors, and other relevant personnel to learn

more about complaint management in each State. We analyzed data from the file reviews using SAS®.

Mail survey of State agency directors

We surveyed State agency directors in the 50 States and the District of Columbia on nursing home complaint investigations. Our survey solicited information in the following areas: complaint management, feedback provided by CMS pertaining to management of nursing home complaint investigations, and ACTS use. We also included open-ended sections for additional comments and to solicit further explanations for some closed-ended answers. Before sending the survey, we solicited comments from CMS central office officials and a State survey director about the survey's content and clarity. We incorporated their feedback into the final survey.

To ensure a high response rate, in March 2005 we sent each State agency director in all 50 States and the District of Columbia an introductory letter explaining the survey and the review. Later in the month, we mailed the survey. In April 2005, we sent a follow-up mailing to those who had not responded. In May 2005, we called the State agencies that had not yet replied. We received completed surveys from 49 State agencies and the District of Columbia for a response rate of 98 percent. Tennessee did not respond to the survey.

Review of policies and procedures for complaint investigations

In conjunction with the survey of State agency directors, we requested State nursing home complaint investigation policies and procedures. We received documents from 46 State agencies. Of these, two State agencies responded that they rely on the SOM for nursing home complaint investigations and do not maintain separate policies and procedures. Two additional State agencies sent only CMS documents and did not offer additional State-specific policies and procedures. We excluded these States and based our analysis on 42 State agencies' documents.

We reviewed the policies and procedures using a protocol based on CMS's SOM guidelines for complaint intake, triage and prioritization, and followup. The review protocol includes 58 SOM guidelines regarding the information to be collected during intake, the establishment of triage categories and response timelines, and the information included in follow-up letters to complainants. We reviewed each State agency's documents and noted whether written State agency policies addressed and incorporated these CMS guidelines.

Interviews with CMS regional office staff

We used a structured interview guide to conduct telephone interviews with the 10 CMS regional survey and certification branch chiefs. The interviews focused on information the regional offices provided to State agencies concerning management of complaint investigations, ACTS training for State agencies, and the regional offices' complaint investigation oversight activities. Before the interviews, we solicited comments from the CMS central office and a CMS regional office branch chief about the interview guide's content and clarity. We incorporated their feedback into the final interview guide.

We conducted the interviews in June 2005. We asked the CMS regional offices to provide us with any documentation they had from State agency training activities; oversight actions; and any formal communications the regional office had with the State agencies, including feedback on State agency performance. Prior to each interview, we sent the interview guide to the CMS regional survey and certification branch chiefs and invited them to ask any regional staff members with expertise in the covered areas to participate in the interviews. At least two OIG staff participated in each interview.

▶ A P P E N D I X B

Table 4: 2004 State Agency Complaint Investigation Timeliness for Complaints Alleging Immediate Jeopardy and Actual Harm (High)

State	Immediate Jeopardy Complaints		Actual Harm (High) Complaints	
	Percentage Not Investigated Within 2 Working Days	Total Immediate Jeopardy Complaints in 2004	Percentage Not Investigated Within 10 Working Days	Total Actual Harm (High) Complaints in 2004
Alabama	0%	16	10%	289
Alaska	0	2	17	6
Arizona	7	29	83	587
Arkansas	0	53	76	569
California	5	173	27	903
Colorado	16	37	20	224
Connecticut	33	9	26	78
Delaware	25	4	39	28
Florida	7	153	3	896
Georgia	0	30	3	933
Hawaii	N/A*	0	32	19
Idaho	0	16	0	55
Illinois	2	62	1	1,285
Indiana	1	89	3	604
Iowa	3	66	4	701
Kansas	2	101	8	143
Kentucky	0	41	5	463
Louisiana	15	53	16	339
Maine	21	14	4	196
Maryland	33	6	66	804
Massachusetts	25	4	1	643
Michigan	0	98	71	965
Minnesota	11	19	2	260
Mississippi	93	131	98	461
Missouri	0	168	12	2,167
Montana	0	7	56	9
Nebraska	0	25	3	129
Nevada	0	10	17	547
New Hampshire	0	5	0	14
New Jersey	8	76	1	145
New Mexico	33	6	81	156
New York	4	255	24	2,725
North Carolina	2	200	7	849
North Dakota	N/A*	0	100	1
Ohio	1	100	6	973
Oklahoma	2	258	56	552
Oregon	0	14	12	217
Pennsylvania	0**	40	0	2,095
Rhode Island	0	1	43	7
South Carolina	17	46	90	653
South Dakota	N/A*	0	N/A*	0
Tennessee	6	205	4	636
Texas	2	497	50	5,731
Utah	0	56	0	68
Vermont	25	8	39	75
Virginia	N/A*	0	19	138
Washington	0**	213	1	849
Washington D.C.	N/A*	0	0	3
West Virginia	0	6	7	134
Wisconsin	2	62	8	224
Wyoming	0	3	25	40

*The State agency entered no complaints for this category into ACTS for calendar year 2004.

**Pennsylvania and Washington had waivers from ACTS in 2004. Data for these States come from the State agencies' complaint systems.

Source: Office of Inspector General analysis of 2004 ACTS data, 2005.

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 17 2006

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Nursing Home Complaint Investigations" (OEI-01-04-00340)

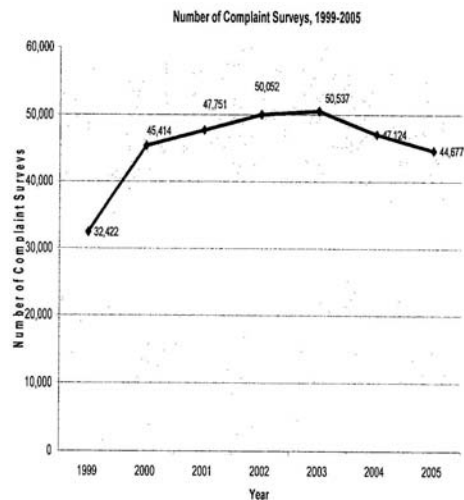
We appreciate OIG's work to (a) assess whether State agencies investigate nursing home complaints in accordance with program requirements, and (b) determine the extent to which the Centers for Medicare & Medicaid Services (CMS) monitors State agency performance of nursing home complaint investigations. Thank you for the opportunity to review and comment on the report.

CMS and State agencies accord a high priority to nursing home complaint investigations. For example, as illustrated in the graph below, the number of completed complaint investigations has increased by 37 percent from 1999 to 2005 (from 32,422 to 44,677). The increase in complaint investigations represents both stronger performance and stronger commitment to be as responsive as possible to nursing home residents and their families.

In addition, later this year we will unveil a new multi-purpose video training module that states may use to improve staff skills in the conduct of complaint investigations.

CMS has also made significant improvements to the complaint investigation process. Such innovations include stronger protocols for the intake, prioritization, and response of complaints.

In 2004 we further strengthened the tracking and management of investigations through a new, electronic complaint tracking system for complaints and self-reported incidents (the Aspen Complaint Tracking System, or "ACTS").



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We continue to work to improve CMS oversight activities and ensure beneficiaries receive quality services. We therefore appreciate OIG's suggestions for further improvement. Our responses to the report's recommendations are provided in the remarks below.

OIG Recommendation

Strengthen the oversight of nursing home complaint investigations by requiring State agencies to meet the 10-day timeframe for investigating complaints alleging actual harm (high).

CMS Response

CMS agrees with the OIG that allegations of a serious nature about the care and services provided to residents in our nations' nursing homes should be investigated by State agencies in as timely a manner as possible. CMS will:

- (a) ***Clarify the Standard:*** CMS will revise the language in our State Performance Standard for 2007 so that it better reflects the language articulated in our policy; namely, the State agency must initiate an onsite survey within 10 working days for nursing home intakes assigned a priority of "Non-Immediate Jeopardy-High"¹.
- (b) ***Assess Potential for Other Improvements:*** CMS will assess the extent to which additional improvements can be made within existing resources.
- (c) ***Reconcile Resources and Standards:*** CMS will assess whether performance expectations for "Non-Immediate Jeopardy" allegations need to be adjusted to reflect resource limitations or additions.

The ability of states to meet the CMS 10-day standard is primarily affected by (a) budgetary resources, (b) the volume of complaints², and (c) personnel availability and training. Resource challenges continue to present barriers to high performance. For example, in FY 2005 the final budget amount available for Medicare survey & certification activities was \$11.8 million less than the amount requested in the President's budget; and in 2006 it was an additional \$2.6 million less (for a cumulative two-year total in 2006 of \$14.3 million).

However, the President's budget for 2007 proposes to address much of this resource problem through an 8.8 percent increase in survey & certification budget as compared to the 2006 President's budget. If adopted by Congress, this increase would assist states in nursing home complaint investigations and certain other key areas (such as hospital oversight and dialysis facility surveys). We will make appropriate adjustment in the performance expectations for states to reflect either increasing scarcity of resources or improvement in resource availability.

¹ Nursing home complaint intakes are assigned the priority category of non-immediate jeopardy high if the alleged noncompliance with one or more requirements may have caused harm that negatively impacts an individual's mental, physical, and/or psychosocial status and are of such consequence to the person's well-being that a rapid response by the State agency is indicated.

² The State of California, for example, reports a 38% increase in complaints received by the State survey agency from FY 2000 to 2005. The combination of (a) resource constraints and (b) more complaints to be addressed continues to create special challenges for states as they seek to meet performance expectations.

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OIG Recommendation

Strengthen the oversight of nursing home complaint investigations by conducting meaningful followup to the State Performance Standard Reviews.

CMS Response

The CMS concurs with the OIG recommendation to conduct meaningful follow-up when State failures are identified through the State Performance Standards System (SPSS) and has been taking steps to enhance follow up. CMS is implementing steps to accomplish the following:

- (a) ***Regional Performance Follow-Up:*** CMS will strengthen the Regional Office follow-up systems with States, particularly those with significant performance failures, to assure that corrections identified in States' corrective action plans are completed.
- (b) ***Communication with States:*** CMS will ensure that face-to face meetings are held with states in each region at least twice per year, with state performance as one of the prominent agenda items.
- (c) ***Leadership Summit:*** CMS will ensure that state performance standards fulfillment is a significant feature of the CMS national Leadership Summit each year.
- (d) ***Complaint Tracking System Reports:*** CMS will ensure that the ASPEN Complaints/Incidents Tracking System (ACTS) produces reliably useful output reports that can be used to provide effective feedback to states on their performance and areas that. Such reports will be valuable in helping the regions follow-up on areas that the State Standards Performance System indicates require improvement.

OIG Recommendation

Strengthen the oversight of nursing home complaint investigations by eliminating the two-week advance notice for the FOSS contained in the SOM to allow Regional Offices the option of overseeing complaint investigations for the most serious nursing home complaints.

CMS Response

We do not concur with the OIG recommendation that would eliminate the two-week advance notice for the Federal Observational and Support Survey (FOSS) as described in the SOM. While we support the recommendation of CMS Regional Office oversight of complaint investigations, we do not consider the two week advance notice to be an important barrier to conducting a FOSS survey in response to the most serious nursing home complaint allegations. In addition, the added administrative costs and challenges that would accrue by eliminating the 2-week advance notice are not ones that can be borne under the current resource constraints.

The CMS Regional Offices work with their respective State agencies to schedule and coordinate a FOSS survey during the State agencies' investigation of complaint allegations following the procedures outlined in the FOSS Evaluator's Manual. The CMS Regional Offices currently do have the authority to conduct an onsite visit of a nursing home at any time for any reason.

Page 4 – Daniel R. Levinson

OIG Recommendation

Offer additional ACTS training to CMS Regional Offices, as well as to State agencies.

CMS Response

We agree that an emphasis on training is vital to these activities.

- (a) ***Assess and Provide Training:*** Assess the extent to which additional training is needed, and provide such training to the extent needed and resources permit.
- (b) ***Integration Pilot:*** Work with at least one large state to (a) evaluate the extent to which the ASPEN information system, particularly ACTS, is integrated with office business practices and other state operations, and (b) promote a higher level of such integration.

The reason for the second initiative is that, to the extent that the ASPEN system is viewed as an “add-on” to pre-existing systems rather than integrated into normal business operations, then no amount of training will achieve the levels of competent application that we desire. Inefficiencies will also persist as data are inputted into multiple systems.

The CMS has recognized the potential benefits of using ACTS to support States’ management and CMS oversight of the complaint process and the value of targeted training on ACTS for State and Regional Office users. This has been reflected through our actions described below.

The CMS has conducted Internet-based (Web-Ex) training for all States and CMS Regional Offices before each major system update release. These training sessions are recorded and posted to the Quality Improvement Evaluation System (QIES) Technical Support Office Web site, thus allowing users to view the sessions at their convenience. Following is a list of available training:

- RO ACTS 8.5 Overview Part II – September 2005
- RO ACTS 8.5 Overview Part I– July 2005
- ACTS Features – July 2005
- ASPEN 8.2 – February 2005
- ACTS Overview – January 2005
- ACTS Download – ASPEN Data Monitoring System (ADM) – November 2004
- ACTS 7.5 Overview – July 2004
- ACTS 7.5 Release – April 2004

We will work with our Regional Offices and State survey agencies to assess the nature and scope of the training needed. CMS will consider the training requested to support the utilization of ACTS to its full potential.

While ACTS is a Federal system and was not intended to support all States’ possible uses, CMS developed the ASPEN Data Monitoring System (ADM) to help bridge the gap between the Federal system and States’ internal systems. The ADM provides a system of messages that inform States when changes occur in the ASPEN database, including what kind of change has occurred, and where the data are located. States can then develop applications that use this

information to update their own systems, or to perform other custom automated responses. The ADM allows States to use ACTS as their primary complaint management system while minimizing double data entry to maintain related State complaint data systems.



A C K N O W L E D G M E N T S

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