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NEWS RELEASE

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FOR RELEASE August 31, 2004

Auditor of State David A. Vaudt today released an audit report on the oversight of nursing facilities performed by the Department of Inspections and Appeals (DIA) and the Department of Elder Affairs (DEA). DIA is responsible for the licensing and regulating of health care facilities in Iowa, including investigating complaints regarding care received at the health care facilities. As an advocate for older Iowans, the Long-Term Care Ombudsman of DEA is also responsible for investigating complaints about care received in nursing facilities in the state.

Vaudt reported DIA conducted 438 annual survey (inspection) visits, 501 revisits to facilities that had problems noted during the annual survey, 903 complaint survey visits and 219 revisits to follow-up on complaint surveys during fiscal year 2003.

The report includes a recommendation to the Legislature to make the Long-Term Care Ombudsman and Resident Advocate Committee members mandatory reporters of abuse. The report also includes a recommendation to DIA to implement procedures to ensure the Long-Term Care Ombudsman is notified of all complaints received by DIA and all DIA surveys that are scheduled.

Vaudt reported DIA does not have a process in place for determining if all health care facilities have applied for licensure. Currently, DIA may not identify an unlicensed facility unless a complaint is received. Vaudt recommended DIA, in cooperation with the Department of Human Services (DHS), periodically identify all health care facilities receiving funding from DHS and ensure each health care facility is properly licensed.

A copy of the report is available for review in the Office of Auditor of State and on the Auditor of State's website at www.state.ia.us/government/auditor/reports.

# # #

DEPARTMENT OF INSPECTIONS AND APPEALS
AND
DEPARTMENT OF ELDER AFFAIRS

A REVIEW OF THE
OVERSIGHT OF NURSING FACILITIES

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To the Directors of the Departments of
Inspections and Appeals and Elder Affairs:

In accordance with Chapter 11 of the *Code of Iowa*, we have conducted a review of the oversight of Iowa's nursing facilities provided by the Department of Inspections and Appeals (DIA) and the Department of Elder Affairs (DEA). Licensing and regulating Iowa health care facilities, including nursing facilities, is the responsibility of DIA. DEA is responsible for advocacy and other duties related to ensuring protection of residents in nursing facilities. Our review was conducted to determine whether DIA and DEA complied with federal and state laws, regulations, policies and procedures regarding the survey, monitoring and regulation of nursing facilities. In conducting our review, we performed the following procedures:

(1) Reviewed relevant sections of the *US Code*, Code of Federal Regulations, *Code of Iowa* and Iowa Administrative Code.

(2) Identified and tested DIA's and DEA's compliance with certain state and federal laws, regulations, policies and procedures.

(3) Determined the current status of all recommendations included in the Auditor of State's "*Health Care Facility Inspections in the State of Iowa*" report dated January 10, 1996.

(4) Examined certain documentation maintained by DIA for selected nursing facilities, including:

- Surveys of the nursing facilities.
- Investigations of complaints received.
- Fines and citations imposed.
- Any appeals of violations.

(5) Selected 60 complaints of substandard care and examined documentation of resulting investigations to determine if the procedures performed were appropriate.

(6) Distributed questionnaires to 25 nursing facilities to obtain an understanding of the facility administrator's perspective of the survey process and evaluated the 22 responses received.

Based on these procedures, we have developed certain recommendations and other relevant information we believe should be considered by the Department of Inspections and Appeals, the Department of Elder Affairs, the Governor and the General Assembly.

We extend our appreciation to the personnel of DIA and DEA for the courtesy, cooperation and assistance provided to us during this review.

David A. Vaudt

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Auditor of State

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Chief Deputy Auditor of State

November 26, 2003

A Review of the
Oversight of Nursing Facilities

Introduction

Licensing and regulating health care facilities in Iowa, including nursing facilities, is the responsibility of the Department of Inspections and Appeals (DIA). The Department of Elder Affairs (DEA) is responsible for advocacy and other duties related to ensuring protection of residents in nursing facilities. We have conducted a review of the oversight of nursing facilities provided by DIA and DEA. We reviewed how the Departments conduct surveys (inspections), investigate complaints, assess fines and citations and provide an appeal process. We did not perform testing of the licensing activities for nursing facilities or evaluate the standards established for health facilities by DIA.

Chapter 135C of the *Code of Iowa* was established to "promote and encourage adequate and safe care and housing for individuals who are aged, or who, regardless of age, are infirm, convalescent, or mentally or physically dependent." The chapter also provides for adoption and enforcement of rules and standards for the:

- Housing, care and treatment of individuals in health care facilities.
- Location, construction, maintenance, renovation, and sanitary operations of health care facilities.

Health care facilities are defined in Chapter 135C as "a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with mental retardation." This definition includes several types of entities providing care and housing services, such as skilled nursing facilities, intermediate care facilities and intermediate care facilities for the mentally retarded.

As defined in section 135C.1(13) of the *Code of Iowa*, a nursing facility is:

> "an institution or a distinct part of an institution housing three or more individuals…which is primarily engaged in providing health-related care and services, including rehabilitative service, but which is not engaged primarily in providing treatment or care for mental illness or mental retardation, for a period exceeding twenty-four consecutive hours for individuals who, because of a mental or physical condition, require nursing care and other services in addition to room and board."

Nursing facilities must be licensed to operate in the State of Iowa. To be eligible for Medicare or Medicaid funding, nursing facilities must also be certified under the applicable program(s). At July 21, 2003, 421 nursing facilities were licensed in Iowa. Eighty-five of the facilities were Medicaid certified, 326 were Medicare/Medicaid certified and 10 were licensed without a Medicare or Medicaid certification.

Our review was limited to the oversight of nursing facilities provided by DIA and DEA.

Department of Inspections and Appeals (DIA) - DIA is a regulatory agency charged with protecting the health, safety and well being of Iowans. DIA is responsible for inspecting, licensing and/or certifying health care providers and suppliers, restaurants and grocery stores, social and charitable gambling operations, hotels and motels, and barber and beauty shops. In addition, DIA staff investigate alleged fraud in the State's public assistance programs and conduct contested case hearings to settle disputes between Iowans and various state government agencies.

DIA's four major divisions are Administration, Administrative Hearings, Health Facilities and Investigations. Each division has specific duties and responsibilities. DIA also provides administrative support to five units attached to the Department pursuant to section 7E.2(5) of the *Code of Iowa*. The units are the Child Advocacy Board, the Employment Appeal Board, the Hospital Licensing Board, the Racing and Gaming Commission and the State Public Defender.

The Health Facilities Division is responsible for surveying (inspecting) and licensing each health care facility in Iowa. Survey teams from the Division conduct unannounced on-site surveys at health care facilities to assess the quality of care and services provided to residents and patients. The Division is also responsible for inspecting, licensing and/or certifying more than 4,200 health care providers and suppliers. This includes a wide variety of entities, including ambulatory surgical centers, community mental health centers and home health agencies.

The Division is also responsible for conducting surveys and certifying, as appropriate, facilities providing Medicare and/or Medicaid services. The Department of Human Services contracts with DIA to inspect and certify facilities receiving Medicaid funding. The Center for Medical Services (CMS), a federal agency, contracts with DIA to conduct inspections and certify facilities receiving Medicare funding. Medicare and Medicaid funding provide for items such as room and board, nursing services, minor medical supplies, pharmaceutical items and lab services.

In addition to licensing and certification surveys, the Health Facilities Division investigates complaints of substandard care or services in the facilities they license. Complaints are investigated through the use of inspections and interviews.

In late 2003, the Division had 123 staff members, including 48 long-term care surveyors, 15 surveyors for intermediate care facilities for the mentally retarded and State facilities and 13 surveyors for other types of facilities. At that date, 47 staff members also provided supervision, training, computer and administrative support.

Department of Elder Affairs (DEA) – The mission of DEA is "to provide advocacy, educational, and prevention services to older Iowans so they can find Iowa a healthy, safe, productive, and enjoyable place to live and work." The Department serves the fast-growing segment of Iowa's population of citizens 60 years of age and older. DEA has two divisions, Elder Rights and Policy and Administration. A primary focus of each division is to accomplish the wide-ranging goals of the Older Americans Act (OAA).

The OAA was enacted in 1965 to promote the well-being of older persons and help them remain independent in their communities. Each state is required by OAA to have a state unit on aging. DEA is responsible for this role in Iowa. OAA also requires the state unit to:

- Develop a State Plan on Aging.
- Serve as an effective and visible advocate for older persons.
- Assure preference for services are given to older individuals with greatest economic or social needs.
- Assure preference for services are given to low-income minority and rural older adults.

Section 231.41 of the *Code of Iowa* established a long-term care resident's advocate program within DEA. The State Long-Term Care Ombudsman's Office was established to act as an advocate for residents of long-term care facilities and their families. The duties of the Ombudsman, as outlined in the *Code,* include:

- Investigation and resolution of complaints about administrative actions that may adversely affect the health, safety, welfare or rights of elderly in long-term care facilities.
- Monitoring the development and implementation of federal, state and local laws, regulations and policies that relate to long-term care facilities.
- Providing information to other agencies and to the public about problems of the elderly in long-term care facilities.

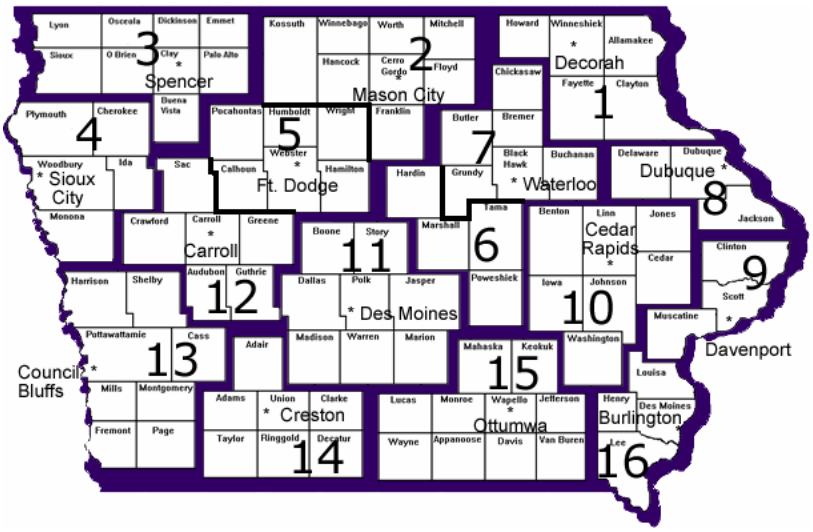
- Administering the Resident Advocate Committee program.
- Reporting the Office's activities annually to the General Assembly.

Chapter 231 of the *Code of Iowa* establishes the Commission of Elder Affairs. The commission is the policymaking body of DEA and consists of eleven members, seven of whom are appointed by the Governor. The remaining four members are Senators and Representatives appointed by their chamber of the legislature to serve as non-voting members.

Area Agencies on Aging (AAAs) - AAAs were also established by the OAA. The U.S. Administration on Aging distributes federal OAA funds to states which, in turn, designate AAAs that provide information and services to older persons.

AAAs in Iowa provide resources to older Iowans, including, but not limited to, adult day services, chore services, companion and respite care, congregate meals, consultations about other problems, employment assistance, health-care aides, home-delivered meals, home repairs, legal assistance, meal sites, modifying homes for disabilities, nursing and home services, senior centers and transportation.

The Commission of Elder Affairs has designated 13 AAAs in the state. Each AAA has a Resident Advocate Committee (RAC) Coordinator who is responsible for recruiting and assisting members of the Resident Advocate Committee in their area. The following map shows the regional areas of each of the AAAs.



Resident Advocate Committees (RAC) - Section 321, chapter 9 of the Iowa Administrative Code (IAC) requires the establishment of a RAC in each licensed health care facility. The committee is to be comprised of community volunteers who work to improve conditions for residents of the facilities. In accordance with the IAC, duties of the RACs are:

- Represent and advocate for the rights of the facility's residents.
- Make visits to the facility to observe residents at different times of day and schedule at least one private interview annually with each resident of the facility.
- Investigate complaints and grievances.
- Participate in an annual training session approved by DEA.

Complaints received by RAC members are to be investigated and the results documented in summary form and forwarded to the area RAC Coordinator. The RAC Coordinator then forwards the documentation and summary of the review to the Long-Term Care Ombudsman.

Scope and Methodology

Our review was conducted to determine whether DIA and DEA complied with federal and state laws, regulations, policies and procedures regarding the survey, monitoring and regulation of nursing facilities. We also evaluated the effectiveness and efficiency of the procedures followed by the Departments and determined whether there is any duplication of efforts in the processes reviewed.

While we have included an overview of the licensing process in this report, we did not review the licensing procedures performed by DIA, nor did we examine any other responsibilities of DIA or DEA. In addition, we did not evaluate the standards established for health facilities by DIA.

In conducting our review, we performed the procedures detailed in the Auditor's Transmittal Letter. As a result of the procedures performed, we have developed certain recommendations we believe should be considered by the Department of Inspections and Appeals, the Department of Elder Affairs, the Governor and the General Assembly.

Regulations

DIA follows federal statutes and regulations in licensing and conducting surveys of health care facilities. Federal law and regulations for nursing facilities are established by the Center for Medicare and Medicaid Services (CMS). These guidelines are detailed in the State Operations Manual (SOM), as well as in policy documents referred to as Survey and Certification Regional Letters (SCRL's). These guidelines cover nearly every aspect of resident care and include topics such as the size of a resident's room and the temperature of food served.

In addition, DIA is required to conduct surveys of health care facilities in accordance with state and federal laws and regulations. The applicable federal and state regulations are summarized below.

Federal:

1. Social Security Act, 42 USC 1396r Section 1919, "Requirements for Nursing Facilities" - Establishes basic responsibilities of nursing facilities regarding care, services and residents' rights. Also establishes the requirements for annual surveys.
2. Code of Federal Regulations, Title 42 Public Health Part 483, "Requirements for States for Long-Term Care Facilities" - Provides details and specific regulations regarding nursing facilities.
3. State Operations Manual (SOM) [from CMS "Survey and Enforcement Process for Nursing Facilities"] - Provides detailed instructions on survey requirements and guidance on how to conduct surveys and enforcement of regulations.

State:

***Code of Iowa*:**

1. Chapter 135C, "Health Care Facilities" - State law regarding licensing, survey and fine/citation of health care facilities.
2. Section 17A.19, "Judicial Review" - State law regarding the judicial review process available to facilities that have received a fine or citation.
3. Chapter 231, "Department of Elder Affairs" - Establishes the Department of Elder Affairs, the Long-Term Care Ombudsman and the Resident Advocate Committees.

Iowa Administrative Code (IAC):

1. Section 321, Chapter 8: Long-Term Care Resident's Advocate/Ombudsman
2. Section 321, Chapter 9: Resident Advocate Committees
3. Section 481, Chapter 50: Health Care Facilities Administration
4. Section 481, Chapter 56: Fining and Citations

Federal Oversight - CMS conducts an annual review of each state's survey process to determine compliance with federal guidelines. The "Federal Oversight of Survey Standards" includes three types of activities. The first is a comparative survey in which federal surveyors visit a facility within 30 days of the state surveyors' visit and conduct the same standard survey activities to determine concurrence with the state's results. The second is an oversight survey, during which federal surveyors accompany the state surveyors on an annual survey of a facility. The third activity is a chart review, where Federal surveyors examine the paperwork completed during a survey to determine if the paperwork is complete and thorough.

We reviewed CMS's annual review of the State's performance standards for the federal fiscal year ended September 30, 2002. The State met four of CMS's seven performance standards. The four performance standards met included:

- Surveys are planned, scheduled and conducted timely.
- Survey findings are supportable.
- Certifications are fully documented and consistent with applicable laws, regulations and general instructions.
- The conduct and reporting of complaint investigations are timely, accurate and comply with general instructions for complaint handling and with the State's own policies and procedures.

The performance standard dealing with certifying noncompliance was partially met. One of the three criteria in this area was not applicable to Iowa, one criteria was met, but Iowa did not meet the third criteria of timely reporting of noncompliance. Only 60% of Iowa's cases requiring revisits had the revisit surveys conducted and the enforcement packets sent within 70 days. Federal standards require a 95% completion rate.

The performance standard related to substantiated expenditures was also partially met. The review found Iowa had an acceptable method of monitoring expenditures and workload. However, several reports were not submitted to CMS in a timely manner.

Iowa did not meet either of the two criteria in the seventh performance standard. The State did not enter data into the federal online survey and certification data system within the required timeframe. In addition, Iowa's 67% accuracy rate for data entry was below the required 85% level.

Regulatory Activities

DIA's Health Facilities Division is responsible for adopting and enforcing minimum standards for nursing facilities, as well as all other types of health care facilities. These standards are subject to the approval of the State Board of Health and include the following areas:

- Location and construction of the facility.
- Number and qualifications of all personnel with responsibility for providing any type of care to residents.
- All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling and general hygiene.
- Diet related to the needs of each resident, based on good nutritional practice.

- Equipment essential to the health and welfare of the resident.
- Staff-to-resident ratios.
- Social services and rehabilitative services provided for the residents.
- Facility policies and procedures regarding treatment care and rights of residents.

Licensing - All health care facilities in the State of Iowa, including nursing facilities, are required to be licensed by DIA. Licenses expire one year after the date of issuance. A health care facility license may not be issued or renewed until DIA has performed a survey of a facility and determined:

- The staff and equipment of the facility are adequate to provide the care and services required for the type of license sought. The applicant must provide a written resume of the programs and services to be furnished and the means available to the applicant for providing them. The resume must include plans for fulfilling staffing, equipment and operation requirements.
- The State Fire Marshal or appointee has inspected the facility.

In lieu of a survey performed by DIA, nursing facilities may be inspected by the Joint Commission on Accreditation of Healthcare Organizations. No state agencies or political subdivisions of the State may provide funding to a health care facility unless it is currently licensed by DIA.

Annual Survey Process - Federal and state law require each facility to receive an unannounced survey no later than 15 months after the last day of the previous survey, with the statewide average interval between annual surveys not to exceed 12 months. The SOM requires the following seven tasks be accomplished during each survey.

1. **Off-site Survey Preparation** - Prior to the on-site survey, the team leader is to review information about the facility to identify potential concerns and select an initial resident sample for testing. In accordance with section 135C.14(8)(e) of the *Code of Iowa,* the preparation includes communication with the Long-Term Care Ombudsman inquiring about any unresolved issues.
2. **Entrance Conference/Onsite Preparatory Activities** - The survey team is to meet with the facility administrator to explain the survey process and obtain information needed to conduct the survey, such as meal times, medication pass times and a list of recent admissions.
3. **Initial Tour** - The tour is to provide the surveyors with an initial assessment of the facility, residents and staff. Also, the tour is to provide the surveyors an initial evaluation of the facility's physical environment and confirm or invalidate the preselected concerns (if any) and add any concerns.
4. **Sample Selection** - In order to assess compliance with the resident-centered long term care requirements, a sample of facility residents is to be selected based on "quality of life" indicators and other sources of information (such as information from prior surveys and complaints received by DIA or the Long-term Care Ombudsman).
5. **Information Gathering** – The survey team is required to use an organized, systematic and consistent method of gathering information to make decisions about the facility's compliance with requirements, as follows:

    - *General Observations of the Facility*: An assessment of the environment of the facility affecting the residents' life, health and safety.
    - *Kitchen/Food Service Observation*: An assessment of the facility's food storage, preparation and service.

- *Resident Review:* An assessment of the sampled residents, which includes an assessment of drug therapies, the quality of life of the residents and assessment of the pertinent care concerns identified for each sampled resident by the survey team. Closed record reviews and dining observations are integrated in the resident review.
- *Quality of Life Assessment:* An assessment of residents' quality of life through individual interviews, a group interview, family interview and observations of residents who are not interviewable.
- *Medication Pass:* Observation of the distribution of medications to detect errors.
- *Quality Assessment and Assurance Review:* An assessment of the facility's Quality Assessment and Assurance program to determine if the facility identifies and addresses specific care and quality issues and implements a program to resolve those issues.
- *Abuse Prohibition Review:* A determination of whether the facility has developed and placed in operation policies and procedures designed to protect residents from abuse, neglect, involuntary seclusion and misappropriation of their property. This includes policies and procedures for hiring practices, training and ongoing supervision for employees and volunteers who provide services, and the reporting and investigation of allegations and occurrences that may indicate abuse.

6. **Information Analysis for Deficiency Determination** - The survey team is to review and analyze all information collected to determine if the facility has met each of the regulatory requirements. The survey team must also determine whether an extended survey is necessary, in which additional procedures are performed.
7. **Exit Conference** – The survey team is to hold an exit conference with facility representatives to inform them of the team's observations and preliminary findings. Information is to be presented in a manner that is understandable to those present. Preliminary deficiency findings are described to facility representatives and the timeframe of the resulting report is discussed. Facility representatives are also provided the opportunity to discuss the findings and supply additional information pertinent to the identified findings.

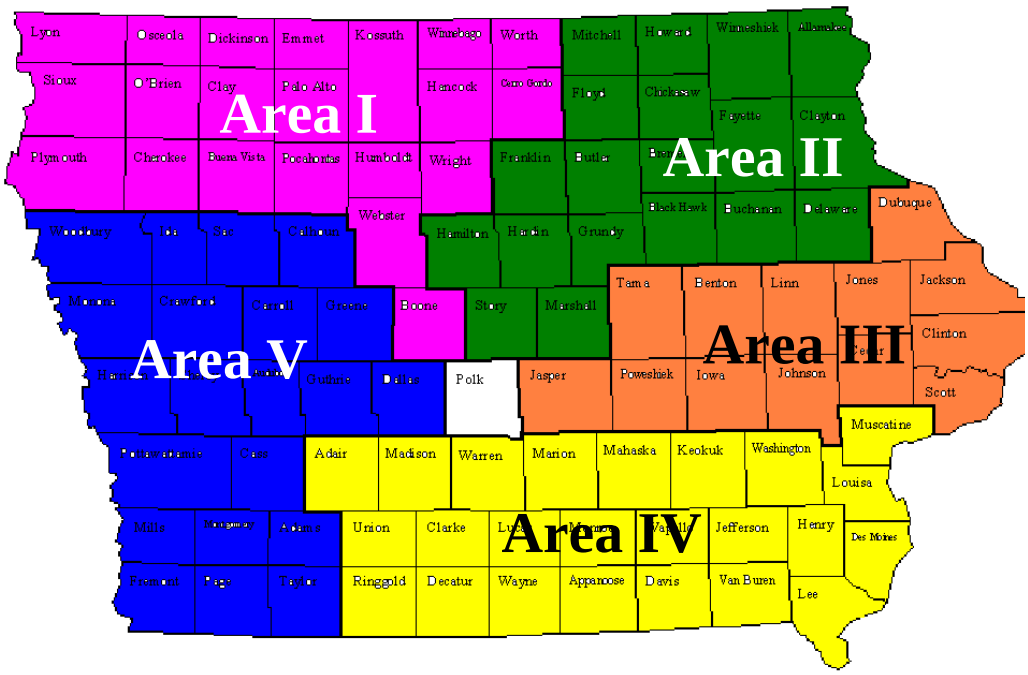
A Life Safety Code (LSC) survey is also conducted as part of the annual review process. The LSC survey includes an inspection of the facility structure and a review of safety and fire prevention policies and procedures. These surveys are conducted by the State Fire Marshal and are coordinated with the annual survey.

Other Types of Surveys – In addition to annual surveys, DIA performs revisits, or follow-up surveys, to determine whether identified deficiencies have been corrected. Revisits must be conducted within 90 days of the date a facility was to have implemented a plan of correction for previous deficiencies.

DIA also conducts surveys in response to complaints. Other visits to nursing facilities may also be made relating to functional or structural changes and changes in ownership or management. These visits do not affect the timeframe of the annual survey.

Performance of Surveys – To facilitate the performance of the surveys, DIA has divided the state into the five areas shown in the following map. Facilities in Polk County are divided among the five areas. Each area has a Program Coordinator assigned to it. All five Program Coordinators are located in Des Moines and function as the administrative liaison between the surveyors and the facilities for their assigned area. The Program Coordinators are responsible for monitoring the interval between surveys for the facilities in their area and scheduling all facility visits within the appropriate time to meet federal guidelines.

Long-Term Care Program Coordinator Areas



Source: DIA

Each survey is conducted by a team of surveyors. A group of surveyors is assigned to each area of the state. The individual surveyors are health care professionals. While they are usually registered nurses, they may also be specialists in mental retardation and social work. Each survey team includes a "team leader" who is responsible for the preliminary planning of the survey and assuring survey tasks are completed. The "team leader" considers several factors, such as previous survey results and staffing needs, when determining the staffing of the survey team. The surveys generally take three to five days to conduct, depending on the size of the facility and the number of surveyors.

The following table summarizes the number and type of surveys conducted during fiscal years 2000 through 2003.

Table 1

Number of Surveys Conducted

	Fiscal Year			
Type of Surveys	**2000**	**2001**	**2002**	**2003**
Annual Survey	469	475	461	438
Survey Revisits	492	531	671	501
Complaint Investigations	651	764	790	903
Complaint Revisits	178	204	225	219

Source: DIA Health Facilities Division

Completion of Surveys - After the on-site survey is completed, the surveyors determine if deficiencies identified will be included in the deficiency report. Deficiencies are classified into one of 12 categories established by CMS standards. **Table 2** summarizes the twelve categories. They vary depending on the "severity" of the deficiency identified and the "scope" of the deficiency. Severity refers to the harm or risk of harm to residents. The severity levels, as defined in DIA's policy manual, are described as follows:

Immediate Jeopardy – A situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. Examples include elopement, physical abuse involving serious bodily harm, sexual abuse, torture, cruel confinement, medical neglect and medication errors.

Actual Harm – Complaints received in which a determination is made actual harm is present but does not rise to the level of immediate jeopardy. Higher level harm would exist if the situations are not readily correctable and have caused, or have the potential to cause, harm that would temporarily or permanently impact the resident's functional abilities or significantly disrupt the resident's normal activities. Examples include sexual harassment or coercion, physical abuse that does not result in serious injury, financial exploitation, missing money, theft of personal property, inappropriate use of restraints and inadequate supervision resulting in an accident with injury.

Others – Those complaints that indicated minimal harm or discomfort has occurred or the potential exists for minimal harm to occur to the resident for whom the complaint was filed or any other residents at the facility. These are situations that do not disrupt a resident's activities and routines and/or situations that have been resolved. Examples include inadequate hygiene care, inadequate clothing, lack of infection control and staff shortages that do not cause outcomes that rise to the actual harm level.

Scope refers to the number of residents potentially or actually affected. There are three different scope levels: isolated, pattern and widespread.

The scale for assessing deficiencies ranges from **A**, which is a deficiency with potential for minor harm isolated to one person, to **L**, a deficiency that has the resident at risk for severe injury and is widespread throughout the facility.

Table 2 also summarizes the appropriate remedies for each category of deficiency. The remedies range from a "Plan of Correction" (PoC) prepared by the facility to a "Category 3" remedy which involves placement of temporary management at the facility and/or civil penalties. (Categories of remedies are further explained on pages 20 and 21.)

Table 2

Severity Levels	Scope			Remedies Available
	Isolated	Pattern	Wide-spread	
Immediate Jeopardy: Residents are at immediate risk for severe injury or death.	J	K	L	Plan of Correction (PoC) is required. Category 3 remedy is required. Category 1 and 2 remedies are optional.
The deficiency results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and psycho-social well-being.	G	H	I	PoC is required. Category 2 remedy is required. Category 1 remedy is optional.
The deficiency results in no more than minimal physical, mental, and/or psychosocial discomfort to the resident(s) and/or has the potential to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being.	D	E	F	PoC is required. Category 1 remedy is usually required. Category 2 remedy is optional.
The deficiency has potential for causing no more than a minor negative impact on the resident(s).	A	B	C	Usually a PoC is required, or no remedy is needed.

Source: CMS State Operations Manual for Surveys
Note: Categories 1 through 3 are defined in **Table 5**.

The survey results are sent to the Program Coordinator for review and approval. The results are reported to the facility within 10 days of the survey. The survey report is a standardized form required by CMS. If no deficiencies are identified, the facility receives a report stating such. When applicable, the facility is required to submit an acceptable plan of correction (PoC) identifying how deficiencies will be addressed. The PoC is also documented on the survey report and a copy of the report is forwarded to the regional CMS office.

If determined necessary by DIA officials, a revisit of the facility will be performed to determine progress made toward correction of the deficiencies. The following time frames must be met unless additional time is granted by DIA:

- Within 15 days of receiving the report identifying deficiencies, a Plan of Correction is required to be submitted to DIA by the facility.
- Within 45 days of receiving the report, most actions in the Plan of Correction should be completed.
- Within 90 days of receiving the report of the original survey, the revisit must be completed by DIA and results submitted to CMS.

The Plan of Correction is a standard form provided by CMS. The deficiency and the corrective method identified by the facility must be included. CMS also receives a copy of the results of any follow-up or complaint investigation visits.

Results of Survey Testing – As a result of our testing of DIA's survey process, we determined the following:

- For the surveys we tested, DIA complied with federal and state laws and regulations. DIA's procedures for the survey of nursing facilities are in accordance with federal guidelines. However, 3 of the 25 surveys reviewed were missing one of the documents required to be completed during the survey.

- By reviewing the most recent Federal Oversight of Survey Standards, we determined there were no major areas of concern identified by CMS representatives.

- We sent a survey to 25 nursing facilities to obtain the administrators' views about the survey process and the role of the facilities' Resident Advocate Committees. We received responses from 22 of the facilities. Thirteen of the facilities indicated there were inconsistencies between inspectors and between visits. **Appendix A** summarizes the results of the returned questionnaires.

Complaint Process

Complaints Received by DIA – The Health Facilities Division is responsible for the intake and oversight of complaints made to DIA about health care facilities. The unit is headed by a Program Coordinator and is staffed by two intake workers. Complaints may be received by phone, online on the Department's website or by mail.

Section 135C.38 of the *Code of Iowa* and CFR 42 488.10 and 480.11 govern the complaint intake process. The intake worker records the pertinent information from the complainant and a complaint intake form is generated. In accordance with CFR 42 Part 483, subparts B-C, the intake worker determines the prioritization of the complaint. Complaints are classified into one of the 12 classifications summarized in **Table 2**, depending on the scope and severity of the complaint.

The complaint intake form is sent to the appropriate Program Coordinator. A copy is also provided to the Complaint Unit Program Coordinator who conducts a preliminary review of the complaint. An on-site survey is conducted within 20 working days of the complaint if the Coordinator determines the complaint was not intended to harass a facility or made without reasonable basis.

The Complaint Unit Program Coordinator reviews the classification of each complaint to ensure it is proper. Complaints classified as "immediate jeopardy" are investigated within two business days of receipt of the complaint. "Actual harm" complaints are investigated within ten business days. All other complaints are investigated within twenty business days. The required investigation timeframes are specified in the SOM.

Each of the five areas of the state has a full-time investigator to respond to complaints. There is also a pool of four temporary part-time surveyors available to investigate complaints. **Table 3** summarizes the number of complaints received during the last four fiscal years.

Table 3

Type of Facility	Number of Complaints Fiscal year ended June 30, 2000	2001	2002	2003
Nursing facilities:				
Long-term care	773	904	1,047	1,125
Licensed only facility (includes all residential care facilities)	137	111	129	172
Intermediate care facility for mentally retarded	108	66	63	66
Hospital	63	89	83	82
Home health agency	26	22	19	15
Unlicensed	7	5	5	10
Assisted living program	-	-	17	59
Totals	1,114	1,197	1,363	1,529

Source: DIA Compliance Unit

In accordance with section 135C.38 1(b) of the *Code of Iowa*, "the complaint investigation shall include an interview with the complainant, the alleged perpetrator and the victim of the alleged violation, if the victim is able to communicate, if the complainant alleged perpetrator and victim are identifiable, and if the complainant, alleged perpetrator, or victim is available. Additionally, witnesses who have knowledge of facts related to the complaint shall be interviewed, if identifiable and available."

Once a complaint has been received and investigated, the results of the investigation are sent to the appropriate Program Coordinator. The Coordinator reviews the results of the investigation and any deficiencies identified. The results are communicated to the facility in a letter. The letter includes the statutory or regulatory provisions alleged to have been violated, a statement of the factual findings as determined by the investigator and a summary of the reasons for which the complaint was or was not substantiated. If a fine/sanction is assessed, it is treated in the same manner as a regular survey.

Complaints Received by DEA - As allowed by section 231.42 of the *Code of Iowa,* the Long-Term Care Ombudsman's Office has the authority to investigate and resolve complaints about administrative actions which may adversely affect the health, safety, welfare or rights of elderly in long-term care facilities. Complaints are forwarded to one of the three Ombudsman staff. Information is also entered into the "Ombudsmanager" database, which is a nationwide computerized database.

When a complaint is received, the options available for resolution of the concern are explained to the complainant. The Ombudsman staff may also refer the complainant to DIA or another appropriate agency. IAC Section 321, Chapter 8.4(2) identifies specific instances when a referral is required:

- Facts indicate a possible failure to comply with state or federal laws or regulations.
- Facts warrant civil proceedings.
- Facts indicate the misconduct or breach of duty of any officer or employee of a long-term care facility or government agency.

However, according to the Long-Term Care Ombudsman, neither the Long-Term Care Ombudsman nor the members of the RACs are mandatory reporters of Dependent Adult Abuse. Mandatory reporters are required, in appropriate circumstances, to report instances of suspected abuse or neglect to appropriate authorities, including DIA, DHS and law enforcement agencies.

According to the Long-Term Care Ombudsman, if a resident of a nursing facility complained of abuse and then refused to allow the Long-Term Care Ombudsman or the RAC member to report the abuse to DIA, no report would be filed.

Members of the Ombudsman's staff investigate complaints based on priority of severity and availability of staff. The Ombudsman also receives a weekly schedule from DIA identifying the facilities scheduled for a survey or complaint investigation. This information allows the Ombudsman to coordinate activities with DIA surveyors and enables the Ombudsman to inform the surveyors of any concerns justified by complainants.

The goal of the Ombudsman's staff is to resolve the complaint to the satisfaction of the complainant, not to determine if the facility is in violation of any rule or regulation. The Ombudsman has no enforcement powers and can only recommend changes to the facility.

Members of the Resident Advocate Committees may also receive complaints from residents or as referrals from DIA. These complaints can also be referred to the Long-Term Care Ombudsman, Fire Marshal or other appropriate agency. The RAC member acts as an advocate for the residents and can attempt to resolve issues by working with the facility administrator. IAC Section 321, Chapter 9.11(2)(b) requires "a committee member will investigate the complaint or grievance within seven calendar days of receipt or forward the complaint or grievance to the ombudsman. Life or health-threatening complaints will be forwarded within 72 hours."

The RAC member obtains an understanding of the situation, when possible, by talking with residents, staff and others who might have information regarding the matter. In addition, the RAC member will make personal observations of conditions and activities in the nursing facility. IAC Section 321, Chapter 9.11(1) states "The purpose of the committee response to complaints or grievances is to seek the resolution of problems and prevent unnecessary recourse to regulatory action against a facility. This purpose shall not, however, prevent such regulatory action when necessary to protect or achieve the rights of residents".

Complaints are discussed at RAC meetings and a summary of each meeting is sent to the local Area Agency on Aging (AAA) RAC coordinator, who then sends the summaries to the Long-Term Care Ombudsman. The Ombudsman reviews the concerns to determine if further investigation is needed or if a referral to another agency is appropriate.

During our testing of the complaint process as described below, we determined the following:

- We selected 35 complaint files received by DIA between March 31, 2002 and March 31, 2003. We selected an additional 20 complaints received by DIA between April 1, 2003 and June 30, 2003. The 20 complaints were recorded by DIA in a new computer program. We examined the selected complaints to determine if:

  - It was classified into the appropriate category and investigated within the timeframe specified by federal and state laws and regulations.

  - There was documentation of the complaint in the file.

- In accordance with section 135C.14(8)e of the *Code of Iowa*, the Long-Term Care Ombudsman was notified of the complaint.

The complaints tested were classified properly and were investigated within the timeframe required by federal and state laws and regulations.

Three of the 55 complaint files tested did not include documentation showing the nursing facility was notified of the investigation's results.

Fifteen of the 55 complaint files tested did not contain documentation of the required notification to the Long-Term Care Ombudsman.

- We examined the log system used by the Ombudsman to record DIA's notifications of investigations to determine if the log was complete.

  Thirty-six of the 55 complaints tested were not recorded in the log maintained by the Long-Term Care Ombudsman.

- We selected 10 complaints from the files of the facilities tested during the survey process testing. We traced the complaints into the computerized database to determine if the database contained all of the complaints received by DIA.

  Each of the 10 complaints was found in the complaint database.

- We selected 25 complaints received by the Long-Term Care Ombudsman to determine if the complaints were properly categorized and the results of the investigation were documented.

  Each of the 25 complaints was appropriately categorized and appropriate forms were complete. Of the 25 complaints, four were violations of the *Code of Iowa* or the Iowa Administrative Code. DEA is required to report all violations to DIA. However, the four complaints involving violations were not referred to DIA for investigation.

- We selected 10 facilities to determine whether the RAC was meeting regularly as required by the *Code of Iowa* and if the meeting summaries were filed at the Ombudsman's Office.

  The RAC for 6 of the 10 facilities tested did not meet regularly as required by the *Code of Iowa*.

Citation Process

If a deficiency is identified at a facility as a result of a survey or complaint investigation, a citation may be issued. Guidelines are specified in section 135C.481 of the *Code of Iowa*, Chapter 56 of the Iowa Administrative Code and federal regulations for determining the classification of a violation and the resulting citation. The guidelines are summarized in **Table 2**, presented previously. However, the surveyor's judgment is involved in determining the classification of a violation and the resulting citation, if any.

The factors used by the surveyor to determine the violation classification and the citation are to be documented. This information, along with all of the information from the survey, is reviewed by the appropriate Program Coordinator and is then sent to the Compliance section where one of the two Compliance Officers starts the processing of the fine.

After the surveyor has provided the information to the Program Coordinator, a Compliance Officer, Program Coordinator and Bureau Chief (determination committee) meet to review the documentation and determine if the evidence is sufficient to warrant a citation and, if appropriate, what the amount of the citation should be. As specified in IAC section 481, Chapter 56.9, the following factors are used in determining which class of violation will be designated in the citation.

1. The length of time during which the violation occurred;
2. The frequency of the violation;
3. The past history of the facility, as it relates to the reasons the violation occurred;
4. The intent of the facility (accidental, oversight or deliberate), as it relates to the reasons the violation occurred;
5. The extent of any harm to the residents or the effect on the health, safety, or security of the residents which resulted from the violation;
6. The relationship of the violation to any other types of violations which have occurred in the facility, i.e., whether other violations in combination with the violation in question caused increased harm or adverse effects to the residents of the facility;
7. The actions of the facility after the occurrence of the violation, including when corrective measures, if any, were implemented;
8. The accuracy and extent of records kept by the facility which relate to the violation, and the availability of such records to the department;
9. The number of other types of related violations occurring simultaneously or within a short period of time of the violation in question.

The determination committee may recommend a state fine, federal fine or one of the other sanctions available. According to DIA's Compliance Officers, most first time violations are not referred for federal fines because federal rules allow a facility to delay a fine until a revisit is done to determine if the facility's Plan of Correction is being implemented. DIA will sometimes levy a fine initially using the guidelines established in section 135C.36 of the *Code of Iowa* (as listed in **Table 2**.) DIA may levy a fine on the facility before the revisit is performed, but usually does not collect it until after the revisit. If the Plan of Correction is followed and the facility has corrected the deficiency, the fine is then collected. If the facility has not corrected the deficiency by the time of the revisit, the facility is typically referred to CMS for a federal citation. **Table 4** summarizes the classification of state fines.

Table 4

Classification of State Fines

Violation Class	Description of Deficiency	Penalties
Class I	One which presents an imminent danger or substantial probability of resultant death or physical harm.	$2,000-$10,000 for each violation.
Class II	One which has a direct or immediate relationship to the health, safety, or security of resident, but which presents no imminent danger nor substantial probability of death or physical harm to them. Could include physical abuse of any resident with consideration, respect and full recognition of the resident's dignity and individuality.	$100-$500 for each violation.
Class III	Any violation not classified as either Class I or Class II.	None unless violation not corrected timely.

Source: Chapter 135C.36 of the *Code of Iowa*.

The fines collected by DIA for Class I and Class II violations are deposited in the State's General Fund.

In addition, there is a daily fine that can be imposed by DIA on health care facilities that are not certified. The fine is usually assessed at $50 per day and is called a Civil Money Penalty (CMP). The money from this fine is collected by DIA and sent to the Civil Money Penalty Fund controlled by the Department of Human Services (DHS). The fund is used to pay for resident-related issues, such as assisting in the relocation of residents if a facility closes or reimbursements to residents in cases of theft of personal property not covered by insurance or bond.

Fines are due within 20 days of the facility receiving notification of the fine. Fines are monitored by DIA's Compliance Officers. If payment is not made within the 20 day time frame, the claim is submitted to the Attorney General's Office for collection. If a facility files an appeal, the collection of the fine is delayed until the outcome of the appeal is finalized.

If DIA decides to refer the facility to CMS for a federal fine, CMS must approve DIA's recommendation. If a federal fine is issued, it is collected and retained by CMS. CMS also has authority to institute a number of sanctions instead of or in conjunction with a fine. These are divided into the following three categories.

Category 1
- Directed Plan of Correction
- State Monitoring and/or
- Directed In-service Training

Category 2
- Denial of payment for new admissions
- Denial of payment for all individuals
- Civil money penalties of $50-$3,000/day
- $1,000-$10,000/instance

Category 3
- Temporary management
- Termination of program participation
- Optional Civil Money Penalties of $3,050-$10,000/day or $1,000-$10,000/instance

Source: CMS State Operations Manual for Surveys

During our testing of the citation process, we selected 25 citations to determine if the fines imposed by DIA were properly supported, were within the guidelines established by the state and/or federal government and were collected within the time frame allowed as evidenced by copy of payment in the file. We also determined whether a follow-up visit was performed and adequate documentation was maintained. As a result of our testing of the fine/citation process, we determined the fines tested were properly supported, were within the guidelines established and were collected within the time frames allowed. Follow-up visits were completed and documentation was maintained.

Appeal Process

Once the facility has been notified a citation has been assessed as a result of a violation, the facility may file an appeal. The appeal process is governed by 42 CFR 488.331 (federal law), and guidance is provided by CMS in the SOM (Chapter 7, Section 7212), section 135C.42 of the *Code of Iowa,* and Iowa Administrative Code Section 481, Chapter 56.15.

In the case of violations for Class II and Class III violations, the facility may request an Informal Dispute Resolution (IDR). The notification of request must be made within 20 days after receipt of the citation. The notification of request for an informal review must be accompanied by a letter stating which specific deficiencies are contested and supporting documentation disputing the deficiencies. The facility must request either a face to face meeting or a desk review. Even if an IDR is requested, the facility still must provide their Plan of Correction (PoC) within 15 days.

Table 5 summarizes the number of IDRs between October 1, 2001 and March 31, 2003.

Table 5

IDRs Conducted from 10/01/01 - 03/31/03	
Number of IDRs requested	287
Number of disputes withdrawn	10
Total number of IDRs completed	277
Number of face to face meetings	138
Number of desk reviews	139
Total number of IDRs completed	277

Source: DIA Compliance Officers

The 277 IDRs completed between October 1, 2001 and March 31, 2003 included 623 deficiencies. Of the 623 disputed deficiencies, also referred to as “tags,” 339 were disputed at face to face meetings and 284 were disputed at desk reviews.

The IDR review is to occur within 10 business days after the receipt of the Plan of Correction and the supporting documentation. The review is conducted by an Administrative Law Judge from DIA's Administrative Hearings Division. During a face to face review, the provider will be allowed one hour to present information and an explanation of the supporting documentation that refute the contested deficiencies. Attendance at this conference is limited to the Independent Reviewer, the Compliance Officer who acts as DIA's representative, facility staff and their attorney (if requested by facility), and persons with factual information.

The results of the review are mailed to the facility within 10 business days after the date of the conference, unless additional information is requested. If additional information is requested, the facility has two business days to provide additional materials to DIA. The 10-day time limit starts after the additional information is received.

Table 6 illustrates the outcomes of the disputed tags.

Table 6

Outcome of Tags Disputed from 10/01/01 - 03/31/03

Result of Dispute	Number	Percentage
Number of tags retained	434	69.66%
Number of tags deleted	123	19.74%
Number of tags modified	66	10.59%
Total number of tags disputed	623	

Source: DIA Compliance Officers

After the informal review, the facility has the option of seeking a formal review. A second Administrative Law Judge conducts this review in accordance with section 17A.19 of the *Code of Iowa*.

A facility wishing to contest a Class I violation or to further pursue a Class II or III violation may do so in the manner prescribed in Chapter 17A of the *Code of Iowa*. Notice of intent to formally contest a violation in this manner must be made within five days after the Class I citation was served or within five days after the IDR.

The *Code of Iowa,* section 135C.42, and the Iowa Administrative Code, Section 481, Chapter 56.15, provide the facility one opportunity for an informal dispute resolution. According to federal guidelines, as found in Chapter 7, Section 7212 of the SOM, the IDR can not be used to challenge the scope and severity of the deficiencies, except for those assessments that constitute substandard quality of care or immediate jeopardy.

During our testing of the appeal process, as described below, we determined the following.

- We selected 10 facilities that requested appeals of fines/deficiencies and determined the appeals tested were filed appropriately and within the time frame allowed.

- We determined the results of the appeals tested were properly documented and communicated to the facility within the time frame allowed.

Findings from Prior Report

The Office of Auditor of State issued a report dated January 10, 1996 and titled *"Health Care Facility Inspections in the State of Iowa."* The report was a review of nursing facility surveys conducted during the fiscal year ended June 30, 1995. Its objective was to review compliance with laws, regulations and guidelines regarding the monitoring of nursing homes. The report identified opportunities for DIA to improve its organization of functions in providing services to the elderly. We identified the specific findings and recommendations included in that report and determined the current status of each recommendation. The recommendations and their status are summarized in **Appendix B**. Each of the items identified were resolved, with the following exceptions:

- Concerns were identified regarding inconsistencies among inspectors' interpretations of regulations. It was recommended DIA better define internal policies to emphasize consistency among inspectors.

  Current status: Inspectors are trained about standards established by CMS. However, based on a current survey of facilities, there continue to be concerns regarding inconsistencies among inspectors.

- Although DIA substantially complied with the standard inspection process requirements, some instances were identified in which the nursing facility inspection files did not contain documentation the inspectors performed certain required inspection tasks. It was recommended DIA maintain the required inspection task documentation in appropriate files.

  Current status: During our testing, we determined three of the 25 surveys reviewed did not contain all of the required documentation.

- In eight instances, documentation was lacking for the required communication with the Long-Term Care Ombudsman. Long-Term Care Ombudsman personnel at DEA could not locate notification documentation pertaining to the eight complaints. It was recommended DIA strive to comply with all established laws and regulations.

  Current status: During our testing, we determined 15 of the 55 complaint files tested did not contain documentation of communication from DIA to DEA.

Findings and Recommendations

As a result of our review, we have developed certain recommendations we believe should be considered by the Department of Inspections and Appeals, the Department of Elder Affairs, the Governor and the General Assembly. The findings and recommendations are summarized below.

(1) **Mandatory Reporters** – According to the Long-Term Care Ombudsman, neither the Long-Term Care Ombudsman nor the members of the RACs are mandatory reporters of Dependent Adult Abuse. Also, according to the Ombudsman, if a resident of a nursing facility complained of abuse and then refused to allow the Ombudsman or the RAC member to report the abuse to DIA, no report would be filed. Section 235B.3 of the *Code of Iowa* requires RAC members of elder group homes to report suspected dependent adult abuse to DHS. However, a similar requirement has not been established for RAC members of nursing facilities to report suspected dependent adult abuse.

Section 321-8.4(2) of IAC requires the Ombudsman to refer a case to the appropriate agency if the Ombudsman encounters facts which may indicate a failure to comply with state or federal laws or regulations. IAC Section 321-9.11(2)b requires the RAC member to forward a life or health-threatening complaint to the Long-Term Care Ombudsman within 72 hours. During our testing, we identified four complaints that were required to be referred to DIA for possible investigation but were not.

While we understand and concur with the Ombudsman and RAC members' roles as an advocate for the elderly, the safety and security of residents should be the paramount concern. According to the Ombudsman, the wishes of the complainant should be the overall determining factor. However, this should not be the primary concern in a potential abuse complaint.

Recommendation – The Legislature should consider making the Long-Term Care Ombudsman and RAC members mandatory reporters of abuse. In addition, the Department of Elder Affairs should review the current rules and develop procedures for the reporting of potential abuse to ensure all cases of abuse are reported to the appropriate regulatory agency.

DEA's Response – Currently the Long Term Care Ombudsman's Office is operating consistent with direction received from the Administration on Aging (AoA). As recently as the week of May 11th, the Administration on Aging confirmed in a national teleconference its opposition to state rules requiring LTC Ombudsman to be mandatory reporters because state laws violate confidentiality provisions in the Older Americans Act.

Unquestionably the Department of Elder Affairs and the Long-Term Care Ombudsman's Office would never condone any form of elder abuse nor walk away from any situation where a dependent adult is being abused. However, requiring reporting and protecting the resident are two different issues. An open discussion and deliberation of mandatory reporting in the context of the existing adult protective system and the values of the Long Term Care Ombudsman program can explore the best avenues for reconciling these two different issues.

Requiring 3,000 Resident Advocate volunteers to be mandatory reporters would involve significant cost for training the volunteers as well as staff to establish a system to ensure volunteer compliance and regulatory staff to investigate referrals. The fiscal realities would need to be included in any discussion of expanding the definition of mandatory reports to include Resident Advocate volunteers.

Regarding the cases referenced, please note that in the complaint involving the facility in Des Moines, Ombudsman staff were not given the name of the resident which would be necessary for an abuse referral to be made even if the complainant had given us permission to do so.

Also, in the complaint involving the facility in Davenport, we were in error by not documenting that a referral was indeed made to the Department of Inspections and Appeals pursuant to the complainant's request. Confirmation of DIA involvement can be found in the case notation of 05/02/2002 which says "…(complainant) talked with DIA surveyor." We have corrected our records to reflect this contact with DIA.

We take exception to the statement in your report that four cases were required to be referred to DIA. This statement implies that staff was in error for not reporting when in reality the *Code of Iowa* does not state that LTC Ombudsman staff are mandatory reporters. It remains our position that staff within the Long-Term Care Ombudsman's unit are operating consistent with the direction provided by the Administration on Aging which is that mandatory reporting by LTC Ombudsmen is a breach of the confidentiality requirements of the Older American's Act.

Conclusion – Response acknowledged. As stated previously, we understand the Ombudsman's role as an advocate for the elderly. However, to ensure all cases of abuse are reported to the appropriate regulatory agency, we believe the Legislature should consider making the Long-Term Care Ombudsman and RAC members mandatory reporters of abuse.

(2) **Notification of Surveys and Complaints** – As established by DIA's Informational Letter 96-06, DIA is to notify the Long-Term Care Ombudsman and the Resident Advocate Committee of any complaint received about a nursing facility. According to the Letter, the notification is to be documented on the "Resident Advocate Committee Notification Checklist Form." Of the 55 complaint files we tested, 15 did not contain documentation of DIA notifying the Long-Term Care Ombudsman of a complaint. Of these 15, 8 were recorded in the Long-Term Care Ombudsman's system.

Conversely, the file maintained by the Long-Term Care Ombudsman did not include 36 of the 55 survey/investigation visits. Seven of the 36 complaints were not recorded in either DIA's or DEA's systems. The remaining 29 of the 55 contained documentation in DIA's files of the notification of the Long-Term Care Ombudsman but were not in the Long-Term Care Ombudsman's system.

Recommendation – DIA surveyors should follow up phone call notification of the Long-Term Care Ombudsman with an email of all survey/investigation visits. This would ensure the Long-Term Care Ombudsman is aware of DIA's surveys. A copy of this email should be printed and maintained in the file for the facility. The Long-Term Care Ombudsman should also print a copy of the email. After reviewing the message, Ombudsman staff should initial it and note any recommendations made to the surveyor/investigator. The document should be maintained.

DIA's Response - Pursuant to Informational Letter 96-06, Health Facility Division surveyors conducting complaint investigations provide telephone notification to the LTC Ombudsman and document this contact on the "Resident Advocacy Committee Notification Checklist" form. The Resident Advocacy Committee, pursuant to section 135C.14(8)(d), also is notified. This contact, too, is noted on the form. The completed form is returned with the investigative file to the surveyor's Program Coordinator who conducts a thorough quality control check of the file to ensure its completeness. As a result of this audit comment, Program Coordinators have been instructed to be more thorough in their quality control checks. Appropriate notification will be made pursuant to DIA Informational Letter

96-06, which exceeds federal requirements. DEA should appropriately document this contact by a memorandum for record for its files.

Additionally, the Division already provides to the LTC Ombudsman (one week in advance) a projected weekly complaint investigation schedule, which identifies the facility to be visited, date of the investigation, and the surveyor conducting he investigation. With all of these safeguards, the recommendation that the surveyor also send an email to the LTC Ombudsman appears unnecessary. Requiring survey staff to find an appropriate location to connect their laptops (which they might not be carrying with them at the time) for the purpose of sending the suggested email notification is inefficient and time consuming given the significant issues that need to be addressed during the investigation. Stated another way, the recommendation has the potential to impede the investigation.

Complaints have increased two-fold over the last year and surveyors need to dedicate their limited time to getting the complaint investigation completed, then proceeding to the next complaint or re-joining their survey team. We will continue the long-standing and effective communication process already established with the LTC Ombudsman, pursuant to DIA's Informational Letter 96-06. To the extent that the LTC Ombudsman determines that internal documentation of contact with DIA's surveyors is key to ensuring effective on-going communication, it must determine whether completing a "Memo for Record" is useful.

Conclusion – Response acknowledged. According to individuals we spoke with at DEA, they primarily rely on the email notifications they currently receive rather than the phone calls. To ensure effective communication, it is important both DIA and DEA agree on the primary form of contact and adjust procedures accordingly.

DEA's Response – The notification requirement is in place to facilitate communication between DIA and the Long Term Care Ombudsman's Office. The responsibility to document this communication rests with DIA. The core notification issue for the Long Term Care Ombudsman's Office is that timely communication take place so that information obtained by LTC Ombudsmen staff can be used in DIA's investigation.

The spread sheet reviewed by the Auditors was created prior to the establishment of electronic communication protocols between the two agencies and is not the primary mechanism used to facilitate communication between the Long-Term Care Ombudsman's Office and DIA regarding survey and complaint activity. Staff within the LTC Ombudsman Unit now receive an e-mail from DIA containing dates of upcoming surveys and complaint investigations prior to DIA entering the facility. It is this e-mail, not the phone call from the DIA surveyor that triggers communication between the two offices.

It has been our experience that there is greater benefit in providing DIA with our input before the investigator enters the facility so that information can be incorporated into survey/complaint investigation activity. Additionally LTC Ombudsmen staff are frequently traveling which can make it difficult, and often impossible to confer with DIA within the time frames under which DIA must operate when LTC Ombudsmen staff wait until DIA is actually in the facility.

Regarding the recommendation to keep documentation of LTC Ombudsman contact with DIA in a facility file, it should be noted that LTC Ombudsman staff keep case information in case files, not facility files. When LTC Ombudsman staff confer with DIA regarding a complaint investigation, that contact is written as a "Journal Entry" in the individual case record.

Conclusion – Response acknowledged. We were told by DEA staff during our fieldwork the spreadsheet we reviewed was the initial recording of all notifications made by DIA to DEA. In addition, while we concur the notification requirement is to facilitate communication

between DIA and DEA, we disagree the responsibility to document the communication rests solely with DIA. DEA must also document the notification to ensure appropriate follow-up occurs.

(3) **Lack of Written Policies** – There are no written policies and procedures for the investigation of complaints received by the Long-Term Care Ombudsman.

While we realize there are only three members of the Ombudsman staff to conduct investigations, the absence of written standards could lead to inconsistencies in the investigation of complaints. Thus, proper investigative procedures may not be followed by Ombudsman staff.

Recommendation – Written procedures for the investigation of complaints should be established and followed by the Long-Term Care Ombudsman.

DEA's Response – We concur with this recommendation and have begun creating procedures for not only conducting investigations but also complaint intake.

Conclusion – Response accepted.

(4) **Unlicensed Facilities** – Section 135C.6 of the *Code of Iowa* requires all health care facilities in the state to be licensed. DIA relies upon the receipt of a complaint to identify any unlicensed health care facilities.

Recommendation – Ideally, DIA should identify any unlicensed health care facilities prior to receipt of a complaint. To facilitate this, DIA should periodically obtain from DHS a list of facilities receiving funding. DIA should compare the list to licensed facilities to ensure all facilities receiving funding are properly licensed and inspected.

DIA's Response – The current process of identifying both unlicensed health care facilities and uncertified assisted living programs is by complaint. This process sufficiently addresses statutory and regulatory obligations of the department. Funding by another department should not be permitted in the absence of proof of licensure or certification, if necessary, for the entity to operate in the State of Iowa.

It is critical that we prioritize the appropriate use of the Health Facility Division's limited staff and direct them toward investigating actual harm level complaints and ensuring that we meet our federally mandated survey frequency cycle. Reported incidents of unlicensed health care facilities operating with finding from DHS is *de minimis*. Directing already scarce resources to double check that DHS is appropriately applying its funding sources under license (long-term care) or certification (assisted living/adult day) would strap already limited resources.

Conclusion – Response acknowledged. However, our recommendation remains as stated.

(5) **Timely Collection of Fines** – In response to a finding included in the "*Health Care Facility Inspections in the State of Iowa*" report by the Auditor of State dated January 10, 1996, DIA responded a policy regarding the timely collection of fines was to be developed. This has not been done, although a draft policy is currently going through the approval process at DIA.

Recommendation – DIA should implement a policy to ensure fines are collected in a timely manner.

DIA's Response – DIA is responsible for assessing and collecting both federal civil money penalties and state fines, depending upon whether a facility is federally certified (and state licensed), or state licensed only. When federal civil money penalties are imposed along with state fines for the same type of violation, the state fines must be held in abeyance, then ultimately perhaps waived, as they may not be imposed for the same violations. See *Iowa Code* section 249A.19. Additionally, facilities waiving their appeal rights on federal civil money penalties over which the department has jurisdiction (via settlement) are legally entitled to an automatic reduction in the amount of the civil money penalty imposed. The department has in place a procedure by which a facility must pay both federal civil money penalties and/or State fines before a settlement in signed. In this way, fines are automatically "in the bank" before the document is complete, leaving no chance for untimely collection.

As to other fines, the department implemented Policy #1801 to formalize its tracking and collection procedures. The policy was in place and operational before January 5, 2004. It was available to field survey and central office staff on the department's GroupWise mail system. The division did not have the ability to have it "auto signed." It was signed as a result after the completion of the Auditor's fieldwork. This is really "form" over "substance."

Conclusion – Response accepted.

(6) **Inconsistency Among Surveyors** – Administrators of 13 of the 22 facilities responding to our survey stated they feel the survey process was inefficient and there were "hot button" items specific surveyors focused on during their visit. The Administrators also indicated there were inconsistencies among the surveyors between visits.

Recommendation – DIA should define internal policies and train staff to emphasize consistency among surveyors.

DIA's Response – The department already has in place multiple initiatives to ensure survey consistency and to enhance a better understanding of the process by the facilities we survey. The results of the Auditor's survey appear to be somewhat inconsistent with several years of monthly survey results submitted by facilities to an independent entity for reporting to the department (Customer Services Questionnaire). For example, on a Likert scale of 1-5, with 5 being the highest, the department's composite score for overall facility satisfaction with the Survey Experience is 4.54. Two specific questions relating to "explanation of surveyor findings" and "surveyor professionalism" rate the department at 4.48 and 4.42, respectively. In addition, the survey allows the facility to comment on its opportunity to provide information to the surveyors related to the survey. Analysis of the Data indicates that survey participants ranked the department at 4.42 when asked whether they had ample opportunity to contribute information to the survey process. The survey allows for "Additional Information," and asks for comments and suggestions about the survey experience and suggested improvements to the process. Rarely, if ever, was "inconsistency among surveyors" noted.

Health facilities surveyors are subject to continuous and ongoing training and education throughout their tenure with the department. Before a new surveyor is allowed to work alone, he or she must undergo a six-month federal training program that assures consistency in the survey process. In addition, all DIA surveyors are certified according to standards maintained by the Centers for Medicare and Medicaid Services (CMS). This federal training and certification assures standardization among surveyors in the application of survey protocols.

Additionally, the department provides thrice-yearly training for its surveyors during which time new protocols and standards are discussed. This training also meets the needs of the staffs' professional licensing standards, which must be maintained by the surveying staff. CMS, too, provides monthly, and sometimes weekly, satellite broadcast transmissions to update surveyors on new policies and procedures. Additionally, Iowa is one of a handful of states to conduct joint provider/surveyor training to share the same learning environment with facilities. This, too, promotes consistency and positive interaction.

As a safeguard to all state surveying agencies, the federal government performs regular "oversight" surveys to spot-check the department's application of survey protocols and procedures. Any areas of inconsistency would be immediately addressed if they were observed during these oversight surveys. To date, DIA has consistently scored very high in all federal oversight surveys. Allegations dealing with "hot buttons" may well indicate a special focus taken during the survey process as a result of a facility's compliance history and/or areas of concern as identified on the federal government's OSCAR system.

Membership on DIA survey teams is routinely scrambled so that no one surveyor becomes too familiar with a particular facility. This scrambling approach may give the appearance of a different survey team philosophy. However, the process is designed to avoid complacency among surveyors and the consistent application of survey protocols.

The department strives to provide the best possible survey process for the facilities it inspects. Whenever necessary, training is provided to staff to acquaint them with new policies and procedures, and to encourage surveyors to be sensitive to the facilities' perceptions.

Conclusion – Response accepted. DIA has developed appropriate procedures to ensure surveys are conducted as consistently as possible without bias. DIA should continue to utilize the procedures established to ensure consistency among surveyors.

(7) **Resident Advocate Committees** – Six of the ten Resident Advocate Committees tested did not meet at least quarterly as required by IAC 321-9.6(2). The Long-Term Care Ombudsman stated approximately 20-25% of all facilities in Iowa do not have an active Resident Advocate Committee.

Recommendation – The Long-Term Care Ombudsman should develop a plan, in coordination with the Resident Advocate Committee Coordinators, to implement procedures to ensure guidelines are complied with.

DEA's Response – We concur that there should be more oversight of and assistance to the Resident Advocate Committees. We will continue to request funding to enable this to take place. Effective July 1, 2004, the local Area Agencies on Aging will no longer be involved in the Resident Advocate Committee program which further diminishes the resources available to ensure the program meets legislative intent.

Conclusion – Response accepted.

Staff

This review was conducted by:

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Appendices

A Review of the
Oversight of Nursing Facilities

Oversight of Nursing Facilities
Department of Inspections and Appeals and Department of Elder Affairs

Summary of Survey Results

1.) How much notification was provided prior to the facility's last inspection?

- Twenty (20) facilities responded they were not notified by DIA prior to their last inspection.
- One (1) facility responded they received a one-day notice of an inspection related to a complaint investigation. The complaint was made by the facility itself. Notification of the facility was not inappropriate.
- One (1) facility did not respond to the question.

2.) How often does the facility's Resident Advocate Committee meet?

- Twelve (12) facilities responded their Resident Advocate Committee meets at least quarterly.
- Nine (9) facilities responded their Resident Advocate Committee meets monthly.
- One (1) facility responded their Resident Advocate Committee never meets.

3.) What is the primary function of your Resident Advocate Committee?

- Twenty-one (21) facilities responded the Resident Advocate Committee acts as an advocate for the residents and provides communication to the facility about residents' concerns.
- One (1) facility responded "to point out problems and report them to DIA. They do not advocate for our residents they are concerned with getting the facility in trouble."

4.) Is the inspection process efficient and fair?

- Thirteen (13) facilities responded there were inconsistencies between inspectors and between visits. Some comments indicated there are specific issues or points surveyors focused on during each visit, but they vary between surveyors and visits.
- Four (4) facilities responded the process was fair and efficient.
- Four (4) facilities did not answer the question.
- One (1) facility responded the process was inefficient. It suggested DIA shorten the inspection process for facilities with few flags identified on the "Facility Quality Indicator Profile."

Appendix B

Oversight of Nursing Facilities
Department of Inspections and Appeals and Department of Elder Affairs

Summary of Recommendations made in
"*Health Care Facility Inspections in the State of Iowa*" report
by the Auditor of State dated January 10, 1996

Recommendation	Current Status
• It was determined more inspectors were needed to meet state inspection requirements. It was recommended DIA develop short- and long-term strategies to adequately maintain staffing levels for compliance with the current federal regulations while continuing to anticipate future needs.	DIA has maintained adequate staffing for compliance with federal regulations. During the most recent survey conducted by federal oversight officials, it was determined DIA conducted annual surveys within the 15 month requirement.
• At the time of the report, DIA was not current in their review of facilities. It was recommended DIA obtain sufficient staff to complete all required residential care facility inspections and investigations to comply with state requirements.	DIA obtained funding for additional inspectors after issuance of the report and is completing all annual inspections of residential care facilities within the required one-year period.
• Many facilities offer multi-level services (such as combinations of nursing care and residential care services.) Because of DIA's organizational structure, different bureaus perform inspections of different types of service. Services that overlap between levels (such as pharmacy or dietary) are reviewed multiple times. It was recommended DIA explore options to avoid the duplication of efforts when inspection multi-level facilities.	DIA performs inspections of all facets of multi-level facilities simultaneously whenever possible. This was noted during testing of the survey process by viewing the results of the various facets of the inspection conducted during the same visit.
• Concerns were identified regarding inconsistencies among inspectors' interpretations of regulations. It was recommended DIA better define internal policies to emphasize consistency among inspectors.	Inspectors are trained about standards established by CMS. However, based on a current survey of facilities, there continues to be a concern regarding inconsistencies among inspectors.
• It was noted inspectors are not allowed to offer suggestions for improvement at facilities. It was recommended DIA coordinate with industry groups to offer training courses to highlight common deficiencies in facility inspections.	Prior agency response accepted. No follow-up necessary.

Oversight of Nursing Facilities
Department of Inspections and Appeals and Department of Elder Affairs

Summary of Recommendations made in
"*Health Care Facility Inspections in the State of Iowa*" report
by the Auditor of State dated January 10, 1996

Recommendation	Current Status
• Although DIA substantially complied with the standard inspection process requirements, some instances were identified in which the nursing facility inspection files did not contain documentation that the inspectors performed certain required inspection tasks. It was recommended DIA maintain the required inspection task documentation in appropriate files.	During our testing, we determined three of the 25 files reviewed did not contain all of the required documentation.
• Penalty payments were identified that had not been remitted within the required number of business days. No indication of DIA's pursuit of the collection or reason for nonpayment was identified. It was recommended DIA develop a more complete system for collection of fines to ensure all assessed fines are received. It was also recommended the large disparity between fine categories be lessened to make the structure more flexible for assessing appropriate fines and more comparable to the federal fine structure. In addition, it was recommended DIA take full advantage of alternate deficiency remedies to ensure and promote facilities' compliance with laws and regulations.	In September 2003, DIA developed a computerized spreadsheet that tracks fines levied against facilities, when payment notices are sent, when payment is received and any pending appeals. Bills were introduced during the 1999 and 2000 sessions of the General Assembly that would lessen the disparity between fine categories. However, the bills were not successful. DIA has been referring facilities for federal fines which has helped close the disparity between the fines on the federal level but not on the state level. By levying federal fines and using the federal fine structure and other remedies available, DIA has taken advantage of alternative deficiency remedies to promote facilities' compliance with laws and regulations.
• In eight instances, documentation was lacking for the required communication with the Long-Term Care Ombudsman. The Long-Term Care Ombudsman personnel at DEA could not • locate notification documentation pertaining to the eight complaints. It was recommended DIA strive to comply with all established laws and regulations.	During our testing, we identified 15 of the 55 complaint files tested did not contain documentation of the communication from DIA to DEA.