STATE OF WEST VIRGINIA

PRELIMINARY PERFORMANCE REVIEW OF THE

Department of Health and Human Resources
Office of Health Facility Licensure and Certification

Greater Public Protection Could Be Achieved
If The West Virginia Nurse Aide Abuse Registry
Was Reviewed More Consistently and If It Was
Required to Be Reviewed by Other Health Care Providers

Complaint Response Times for Legally Unlicensed
Health Care Facilities Are Improving But
Further Improvement Is Needed to Increase Public Protection

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation and Research Division
Building 1, Room W-314
State Capitol Complex

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Issue 1: Greater Public Protection Could Be Achieved If The West Virginia Nurse Aide Abuse Registry Was Reviewed More Consistently and If It Was Required to Be Reviewed by Other Health Care Providers.

The Legislative Auditor found five nurse aides on the West Virginia Nurse Aide Abuse Registry that were working in nursing homes in direct violation of federal regulation several months or years after their names had been placed on the registry. While not in violation of state or federal regulations, 52 additional individuals on the abuse registry continued to work in other health care environments such as state hospitals, home health care services, behavioral health facilities, children's services, county senior services, assisted living facilities and ambulance transport services. Work as care-givers presents a proven risk to vulnerable populations such as the frail elderly, disabled adults and children. The Legislative Auditor surveyed 14 states, and found that seven of those surveyed prohibit nurse aides on the abuse registry from continued employment in health care settings other than nursing homes.

The Department of Health and Human Resources' Office of Facility Licensure and Certification (OHFLAC) also has a responsibility to create policies and procedures that will mitigate the problem of re-employment of proven abusers. Other states keep abusers away from vulnerable populations by limiting the types of health care settings where uncertified nurse aides can be employed. Changes in state statutes could achieve this goal. Another need all states are experiencing is the need for a national registry of nurse aide abusers. DHHR should explore how to establish such a national registry.

Issue 2: Complaint Response Times for Legally Unlicensed Health Care Facilities Are Improving But Further Improvement Is Needed to Increase Public Protection.

The Office of Health Facility Licensure and Certification (OHFLAC) is responsible for oversight of all health care facilities, including Legally Unlicensed Health Care Homes. Unlike all other types of long term care or assisted living facilities, legally unlicensed facilities do not receive annual inspections from OHFLAC. The only time OHFLAC inspectors visit legally unlicensed facilities is in response to a complaint allegation. The Legislative Auditor found that OHFLAC's complaint response time has improved; however, further improvement is needed in order to assure public protection.

Other areas of concern are the manner in which priority codes are assigned to complaints and the lack of management information. OHFLAC was unaware of how late its response times were until they were informed by the Legislative Auditor. As the nature of complaints are serious, it is in the public's interest for OHFLAC to continue improving the response times so that they are in compliance with their own policy.

Review Objective, Scope and Methodology

The Full Performance Review of the West Virginia Department of Health and Human Resources focuses on the Department's *Office of Health Facility Licensure and Certification* (OHFLAC). It is authorized and required by the West Virginia Sunset Law, Chapter 4, Article 10, Section 4 of the West Virginia *Code*, as amended. OHFLAC is responsible for determining the compliance of all health care facilities which are regulated through state licensure. It also determines a facility's compliance with the requirements set forth in the Social Security Act for the purposes of Medicare and Medicaid certification. As of May 2001, OHFLAC licensed or certified 912 facilities.

The **scope** of this review is limited to an examination of Legally Unlicensed Health Care Homes and the Nurse Aide Abuse Registry. The Legislative Auditor limited the scope of this full performance review in order to focus on public safety issues which do not have federal oversight.

The **objective** of this review is to determine if the Nurse Aide Abuse Registry protects the public by keeping those who were found to have abused patients from working in other health care environments and to determine if Legally Unlicensed Health Care Homes are effectively, efficiently and appropriately regulated.

The **methodology** included; interviews with OHFLAC staff; review of federal and state law and policies; analysis of budget and spending; surveys of other states' health facility licensing divisions; accompanying OHFLAC staff on facility inspections; sampling complaint files; comparing names on the abuse registry to the West Virginia Worker's Compensation database; reviewing records kept by the Secretary of State's Corporations Division and; reviewing other records kept by the agency. This performance evaluation complies with **Generally Accepted Government Auditing Standards** (GAGAS).

Issue 1: Greater Public Protection Could Be Achieved If The West Virginia Nurse Aide Abuse Registry Was Reviewed More Consistently and If It Was Required to Be Reviewed by Other Health Care Providers.

The West Virginia Nurse Aide Abuse Registry lists the names of certified[1] long term care nurse aides who have committed acts of abuse, neglect or misappropriation of property against patients in nursing homes, or long term nursing sections of hospitals. By federal regulation, only long term care facilities that participate in Medicare and Medicaid programs must not employ individuals whose names are placed on the state nurse aide abuse registry because of substantiated abuse. **The Legislative Auditor found that five nurse aides who are listed on the abuse registry were re-employed in nursing homes several months or years after their names had been placed on the registry.**

Furthermore, 52 additional individuals on the abuse registry continued to work in other health care environments such as ambulance services, hospitals, home health care services, behavioral health facilities, county senior services, state hospitals, assisted living facilities, and children's services. These health care providers are not prohibited by law from employing individuals listed on the abuse registry, yet these occupations present similar opportunities to cause harm to individuals. Individuals on the abuse register have demonstrated that the safety and well-being of patients in their care is not assured. Continued employment as care-givers, while not illegal, presents a proven risk to vulnerable populations such as the elderly, disabled adults and children. **The Legislative Auditor surveyed 14 states, and found that seven of those surveyed prohibit nurse aides on their abuse registries from continued employment in health care settings other than nursing homes.**

OHFLAC Should Ensure That Abusers are not Employed by Nursing Homes

It is apparent that some nursing homes have not fulfilled the federal requirement to not employ individuals on the abuse register. However, the Department of Health and Human Resources, through the Office of Facility Licensure and Certification (OHFLAC) also has a responsibility to facilitate the safety of nursing home residents through its licensing and inspection process. Therefore, OHFLAC should incorporate within its annual inspection process of nursing homes, a screening of all current employees against the abuse registry.

Names on Abuse Registry Are For Significant Offenses

The Nurse Aide Program office within OHFLAC is responsible for the Nurse Aide Abuse Registry, training nurse aides for certification and investigating allegations of abuse, neglect or theft against certified nurse aides. In December 2001, there were over 20,000 certified nurse aides either

[1] *The term "certified" was replaced in February 2002 with the term "registered" by the West Virginia Nurse Aide Program Office.*

working, or able to be employed. The Nurse Aide Abuse Registry database contained 219 names compiled since 1991. This represents 1% of the nurse aides who are currently certified. Of 2,074 allegations against nurse aides over the past three years, 21% resulted in investigations by the nurse aide program office. A little over one-fourth of these investigations resulted in a finding of abuse, neglect or theft. A nurse aide is no longer certified when his or her name is placed on the abuse registry. The Nurse Aide Abuse Registry is cumulative. Information from this registry is available to employers through the Nurse Aide Program office.

The Legislative Auditor was interested in the types of abuse substantiated against nurse aides in long term care facilities. A sample of 25 names on the Nurse Aide Abuse Registry revealed that a preponderance of substantiated cases were for physical, or physical/verbal abuse (See Table 1). Two names were placed on the registry due to felony convictions.

Table 1
Reasons For Placement on Nurse Aide Abuse Registry

Physical	Verbal/Physical	Verbal	Theft	Convictions	Neglect	Verbal/Neglect
9	5	4	2	2	2	1

Source: 2001 PERD analysis of case files provided by OHFLAC Nurse Aide Program Office.

Nurse aides are responsible for all aspects of personal care for patients. For example, nurse aides give baths and assist with toileting; physically move residents to lying, sitting or standing positions; and feed helpless patients. In addition to long term care facilities, nurse aides also provide these services for assisted living homes, home health services, behavioral health facilities, children's services, community adult care services, and services are also provided through temporary staffing agencies. The types of abuse committed by nurse aides are illustrated from some actual case files below:

1. Physical Abuse: *CNA slapped resident across the mouth after resident spit out orange juice. Victim was an 81-year-old man with a diagnosis of hip fracture, dementia, history of hematuria, hypertension and diabetes.*

2. Verbal/Physical: *CNA verbally abused resident and picked patient up and slammed her down in a chair. Victim was a 93-year-old woman with a diagnosis of humerous fracture, pacemaker, congestive heart failure, ulcer, confusion, hypertension, transient ischemic attacks, osteoporosis and coronary artery disease with stable angina.*

3. Neglect: *Six patients, ages 70-87, were discovered by morning shift CNAs to be lying in urine-soaked and fecal-splattered bedding. All lacked cognitive skills, required extensive assistance with toilet use, and*

were incontinent of bowel and bladder. The beds were cold, wet and the fecal matter was dried on the skin. In one patient, a catheter had not been positioned properly. In another, the condition of the skin indicated that proper skin cleaning had not occurred for some period of time.

The preceding examples did not necessarily result in a conviction. Placement of a perpetrator's name on the abuse registry does not show up on a criminal background check unless the nurse aide is also prosecuted, and found guilty of a crime.

Nurse Aide Abuse Registry Doubles in Three Years

The Nurse Aide Abuse Registry has expanded over the years. Between the years 1991-1998, 99 names of substantiated abusers were added to the nurse aide abuse registry database. At the time of this report, the database contained 219 names. Table 2 shows an increase in the volume of allegations, the number of investigations and the number of names added to the abuse registry. Within the past three years, the abuse registry has grown by over 50%.

Table 2
Over 50% of Names On Nurse Aide Abuse Registry Added In Past Three Years*

Year	Number of Allegations	Number of Investigations	Number Substantiated
1991-98	n/a	n/a	99
1999	542	82	22
2000	761	125	48
2001	771	231	50
Totals	2074	438	219*

Source: PERD analysis of Annual Reports provided by OHFLAC Nurse Aide Program Office.
**The Nurse Aide Program Office did not keep the number of allegations and investigations for the years 1991-1998. Numbers displayed for 2001 represent 11 months only; December is not represented. There could be a discrepancy in the agency's database suggesting that five additional names may be on the abuse registry.*

Nurse Aides on the Abuse Registry Continue to Work in Health Care

Nurse aides on the abuse registry continue to work in health care. This is an entry-level position in health care delivery with a high turnover rate of employees. The Legislative Auditor compared the abuse registry against records of "Employee Wage Data" provided by the West Virginia Bureau of Employment Programs. Place of employment was identified in the fiscal quarters following the date on which the name was placed on the abuse registry. **Fifty-seven individuals (26%) worked in a setting in which health care, or related health services are provided to the incapacitated, elderly, disabled or children (See Table 3). In clear violation of federal rules and the state program office policy, five nurse aides on the abuse registry worked in nursing homes after their names were placed on the registry.**

The Nurse Aide Abuse Registry was established for certified nurse aides in long term care nursing facilities only. This creates situations in which nurse aides on the Nurse Aide Abuse Registry can continue to work in hospitals as nurse aides. For example, a hospital with a long term care nursing section has a "double standard" in regard to employment of certified nurse aides. The hospital cannot employ a certified nurse aide in its long term care section if the nurse aide has been found to have perpetrated abuse, neglect or theft. **However, there is no prohibition for the nurse aide to continue to work in the same hospital, in the acute care section, even after the nurse aide has been placed on the Nurse Aide Abuse Registry.**

Table 3 Work Settings of Nurse Aides AFTER Placement on Nurse Aide Abuse Registry		
Private Duty/Staffing Services	9	15%
Home Health Care	7	12%
Hospitals	6	10%
Nursing Homes	5	9%
Behavioral Health Facilities	5	9%
Healthcare (Undefined)	5	9%
County Senior Services	4	7%
State Hospitals	4	7%
Residential Board and Care Homes	3	5%
Ambulance Services	3	5%
Legally Unlicensed Homes	2	4%
Personal Care Homes	2	4%
Children's Services	2	4%
Total	57	100%
Source: 2001 PERD analysis of wage data provided by the West Virginia Bureau of Employment Programs.		

Nursing homes and long term care sections of hospitals are required to check the Nurse Aide Abuse Registry. However, both use professional staffing services to supply nurse aides as temporary workers. Such services are not required to check the Nurse Aide Abuse Registry, therefore the nursing home is responsible to check if an employee provided by a temporary agency is on the abuse registry. The other health providers shown in Table 3 are not required to check the Nurse Aide Abuse Registry before hiring. The nurse aide can legally work in these placements despite the higher risk of abuse to the population in these settings.

After a nurse aide's name has been placed on the abuse registry, there is no penalty under law if the nurse aide continues to work as a nurse aide. The five nurse aides, abuse registry dates and last period of employment in a nursing home are listed in Table 4. The five nurse aides who continued to find employment in nursing homes were placed on the abuse registry in different years.

Table 4 Nurse Aides on Abuse Registry That Continued to Work in Nursing Homes				
Nurse Aide	**Reason For Placement**	**Date on Registry**	**Back in Nursing Home**	**Date Working in Nursing Home**
1	Sexual/Physical/Emotional Abuse	1/31/94	5 years later	1999
2	Physical/Verbal Abuse	4/1/98	3 years later	January -June 2001
3	Verbal Abuse/Neglect	2/18/00	1 month later	April-September 2000
4	Physical/Verbal Abuse	8/21/00	10 months later	April-June 2001
5	Verbal Abuse	2/22/01	1 month later	April-September 2001*
Source: 2001 PERD analysis of data provided by the OHFLAC Nurse Aide Program Office, and the West Virginia Bureau of Employment Programs. Last date for which employment information was available.*				

Nurse aides not only can, but also are working in health care settings that are very similar to long term care facilities. It is inconsistent for nurse aides on the abuse registry to be allowed to continue to work in such settings, as this allows nurse aides with documented histories of abuse, neglect or theft to continue to have access to extremely vulnerable populations and to have ongoing opportunities to take advantage of such patients. This places defenseless populations at great risk of harm.

Other States Prohibit Abusers From Work in Other Health Care Settings

The Legislative Auditor surveyed 14 states to determine how other states implement 42 CFR § 483.156. Seven of the states surveyed require a greatly expanded number of health care employers to verify that certified nurse aides are not listed as substantiated abusers before employment. A listing on the nurse aide abuse registry prohibits employment in these health care settings. **This survey identifies a trend of states expanding their Abuse Registry beyond the long term care facilities and long term nursing section of hospitals.** Some states also have an expanded registry with different types of information.

- *Arkansas* maintains a Long Term Care Facility Employee Clearance registry. This registry contains certification information on nurse aides who have successfully completed training;

substantiated abuse findings; employment restrictions and certain criminal history information on nurse aides, various other potential employees and job applicants. There are about 4,000 names of "unemployables" on this registry. All nursing homes, long term care facilities, residential care facilities, adult day care centers and intermediate care facilities for the mentally retarded are required by state law to make a criminal records check for positions in these facilities that require patient contact. **They are not allowed to hire anyone on the "unemployables" listing for positions with any patient contact.**

- *Iowa* has a "single contact repository" which contains the nurse aide abuse registry; registry of sex offenders; registry of child and adult abusers; the health professional licensure database and the criminal background history. Long term care and skilled nursing facilities, in addition to intermediate care facilities for the mentally retarded or mentally ill, home health, licensed hospitals and staffing services are all required to verify that names are not on the single contact repository before hiring nurse aides. **Nurse aides on the "single contact repository" are not employable in any of the health care settings listed.**

- *Kansas* requires all nursing homes and long term care facilities; all homes licensed under adult care such as assisted living and boarding homes; some hospitals (depending on license); home health agencies and social rehabilitative services facilities (such as homes for the mentally disabled) to check the registry for nurse aide certification, substantiated abuse and the date when the last criminal background check was made before hiring. Temporary staffing agencies also use the registry to screen new employees because they are required to obtain a criminal background check. **None of these employers are allowed to hire nurse aides whose names are on the abuse registry.**

- *Idaho* requires nursing facilities licensed by the state that participate in Medicaid, and skilled nursing facilities that participate in Medicare, home health services and personal care services funded by Medicaid to check for substantiated findings of abuse before hiring nurse aides. **Nurse aides on the abuse registry are not employable in these health care settings.**

- *Maine* requires employers to check the nurse aide abuse registry when employing certified nurse aides to work in long term care facilities, hospitals, home health services, some residential care settings that are medical models (such as assisted living) and temporary employment agencies. **Nurse aides named on the nurse aide abuse registry are not employable in these settings.**

- *Rhode Island* requires all health facilities, including home health services and hospitals, to check the nurse aide's license. **Nurse aides must be certified, and not on the abuse registry before they are able to be employed.** The exceptions to this requirement are assisted living facilities, and group homes.

- *Florida* does not maintain a registry. Instead, it requires that employers verify nurse aide certification through contacting the program office. **Nurse aides who are investigated and**

found perpetrators of abuse lose certification and cannot be employed. Health care providers who must verify certification before employment include all long term care facilities except hospitals. Included in long term care are home health, adult living, nurse registries, personnel pools and nursing homes.

- *Arizona* has an *expanded registry*, but only requires long term care facilities that are Medicaid or Medicare funded to verify nurse aide certification through the registry, prior to employment. The registry contains licensed and registered nurses, as well as certification holders. It includes the information that a complaint has been entered against a CNA, that an investigation is underway, and when there has been prior discipline.

States take different approaches to protecting their vulnerable populations. Some require verification of nurse aide certification by Medicaid and Medicare-funded nursing homes and long term care sections of hospitals only. Others have expanded state requirements to include other types of health care providers that are prohibited from employing nurse aides on the nurse aide abuse registry, and some states have expanded their abuse registry to contain multiple registries and even criminal history information.

Lack of National Abuse Registry Hinders State's Efforts to Protect Patients

While states are required to maintain an individual cumulative registry of nurse aides found to have committed acts of physical, verbal or sexual abuse, neglect or misappropriation of patient's belongings, there is no national abuse registry. States have limited access to other state's registries. For example, Ohio does not send its register to West Virginia. When information is provided by other states it is limited to the nurse aide name, and the state's nurse aide registration number. Social security numbers, used as an identifier when a nursing home calls the state registry, are not shared between states on registry lists that are mailed, so that identification can be difficult. In addition, persons on the registry in one state can easily move to another state and conceal their prior history **by taking training and certification as if for the first time** in the new state. A person prohibited from working in a neighboring state may only have to travel a few miles to obtain employment either as a certified nurse aide (by re-training) or in a similar health care setting such as a state hospital, hospice program, home health setting or behavioral health program that does not require certification.

Nursing homes, and long term care sections of hospitals are required by federal regulation to seek information from every state registry the facility believes will include information on the individual before allowing the person to serve as a nurse aide. However, the nursing home is dependent on the nurse aide to present accurate information. With a national registry, the nursing home would not depend on the employee, but could quickly and easily check all states using the employee's social security number.

The West Virginia Nurse Aide Program office immediately brought this problem to the attention of the Legislative Auditor. The program manager noted: "*If we had a national database, we could check a central source for substantiated abuse whenever a registry check is required.*"

Her assistant added: "*This is a sorely needed resource.*" Other states surveyed echoed the same concerns. The coordinator of the Criminal Records Check program in Kansas stated: "*There is no connection between states, and there needs to be a national registry to screen out nurse aides with a criminal background, or substantiated abuse."* The supervisor for the Maine Registry of Nursing Assistants stated: "*I would like to see better access to other states' criminal background checks. Our state lacks the ability to check people out who are coming from other states."* The supervisor for Long Term Care in Idaho commented that: *"Nurse aide abuse registries should be nationalized."*

Program Information Contains Discrepancies

As the final draft of this report was being completed, information from the Nurse Aide Program Office was requested in order to reconcile an apparent discrepancy between the master list of the Nurse Aide Abuse Registry, and annual reports containing numerical data regarding the number of allegations, substantiated cases and individuals on the Nurse Aide Abuse Registry. The Nurse Aide Program office indicated that the master list was wrong, and contained more names than the list provided to the Legislative Auditor in December, 2001. The December list contained 220 names; a 2nd list received February 15, 2002 and covering the same time period contained 229 names. Since this list covered the same dates, but had nine additional names, the Performance Evaluation and Research Division (PERD) sent an inquiry back to the Nurse Aide Program office about the difference of nine names. The answer was that this list is separately prepared, and not used to answer inquiries. The Nurse Aide Program office then indicated that the actual abuse database was used to answer all inquiries from employers. When this database was received February 22, 2002 it contained 219 names. PERD analysis showed that 12 names had been omitted from the database. A final response from the Nurse Program Office indicated that one name should not have been omitted; one name was removed following remedial action and a petition by the nurse aide, two names were in appeals; and the remaining eight names were on the register from other states.

This is a management of information problem which could have serious consequences. Such consequences might include:

- Reporting that someone who is on the list is not on the list, and therefore eligible to work in a nursing home.

- Reporting inaccurate information to state, or federal authorities.

Problems of information management were also discovered within the Residential Program office, and discussed in Issue 3 of this report. Both offices fall under the Office of Health Facility Licensure and Certification (OHFLAC) and both information problems reportedly are the result of the databases being used to store, and retrieve information.

Conclusion

The Nurse Aide Abuse Registry in West Virginia is funded entirely by federal money from the Centers for Medicaid and Medicare Services. The use of the registry is restricted to requirements of the federal rule, which is to preclude any employment of individuals on the abuse registry from nursing homes and long term care units within hospitals that receive Medicaid or Medicare. However, there is no national registry and no consistent way for individual states to determine if a nurse aide without a criminal conviction has been an abuser in another state if the nurse aide does not reveal this information to the state, or the employer. The abuse registry is growing. In the last three years, it has more than doubled in size. There have been a small number of abusers that have worked in nursing homes. It is apparent that some nursing homes have not fulfilled the federal requirement to not employ individuals on the abuse register. Despite the nursing home's responsibility to check the abuse registry before hiring nurse aides, OHFLAC is also responsible to facilitate the safety of nursing home residents through its licensing and inspection process. Therefore, **OHFLAC should incorporate within its annual nursing home inspection process a screening of all current employees against the abuse registry.** Furthermore, public protection could be enhanced if the use of the Nurse Aide Abuse Registry is expanded to preclude employment in other health care settings. Nurse aides on the abuse registry continue to seek, and find employment in other health care settings where there is often less oversight than in long term care facilities, and similar vulnerable populations can be harmed. To enhance public protection, DHHR should consider a policy that all Medicaid providers and all facilities and programs, either monitored or licensed by the state, be prohibited from employing nurse aides on the Nurse Aide Abuse Registry. The Legislature should also consider expanding the use of the Nurse Aide Abuse Registry to prohibit hiring in other related health settings. Finally, the Department of Health and Human Resources should examine how a national nurse aide abuse registry could be established.

Recommendation 1

The Department of Health and Human Resources should immediately inform the five nursing home facilities where nurse aides on the abuse registry were determined to be employed of the nurse aides' employment.

Recommendation 2

The Department of Health and Human Resources should consider having the Office of Facility Licensure and Certification incorporate within its inspection process a screening of current nursing home employees against the Nurse Aide Abuse Registry.

Recommendation 3

The Department of Health and Human Resources should consider policy changes to expand the preclusion of hiring individuals on the abuse register to other health care providers that receive Medicaid or Medicare.

Recommendation 4

The Legislature should consider statutory changes that would expand the types of health care providers required to exclude employment of persons on the Nurse Aide Abuse Registry beyond the present requirement of nursing homes and long-term care sections of hospitals.

Recommendation 5

The Department of Health and Human Resources should insure that the Nurse Aide Abuse Registry database is complete, comprehensive and accurate.

Recommendation 6

The Department of Health and Human Resources should examine and evaluate how a national nurse aide abuse registry can be established.

Issue 2: Complaint Response Times for Legally Unlicensed Health Care Facilities Are Improving But Further Improvement Is Needed to Increase Public Protection.

The Office of Health Facility Licensure and Certification (OHFLAC) within the Department of Health and Human Resources is responsible for the oversight of all health facilities, including Long Term Care facilities, Assisted Living facilities, and Legally Unlicensed Health Care Homes. OHFLAC's oversight of long term care and assisted living facilities includes annual inspections. However, OHFLAC does not have statutory authority to conduct annual inspections of legally unlicensed health care homes. The only time OHFLAC has authority to enter legally unlicensed facilities is when a complaint is made against a facility or provider. This issue focuses on OHFLAC's oversight of legally unlicensed facilities through its complaint process. **The Legislative Auditor finds that OHFLAC's complaint response time has improved; however, further improvement is needed in order to increase public protection.** Table 5 indicates OHFLAC's response time to complaints of legally unlicensed facilities.

OHFLAC Unaware of How Late It Was In Responding to Complaints

Other areas of concern are the manner in which priority codes are assigned to complaints. Although OHFLAC has established definitions and different response times depending on the seriousness of the complaint, there are some complaints that have descriptions of a serious nature yet were assigned lower priority. In addition, management information used to monitor response time should be improved. **OHFLAC was not monitoring its response time in order to measure its performance and determine any need for improvement. Consequently, OHFLAC was unaware of how late it was in responding to some complaints.** In response to this audit, management information is being improved.

Table 5
Legally Unlicensed Health Care Facilities
Complaint Response Time

Fiscal Year	Total Complaints	Percent of Complaints with Late Response Time	Average Number of Days Late
1999	95	51%	115
2000	56	43%	35
2001	75	16%	20

Source: PERD analysis of data provided by OHFLAC.

The Nature of Complaints Can Be Serious

Legally Unlicensed Health Care Homes are defined in 64 CSR 50-2.6 as:

> *Any place in this state in which a service provider provides accommodations and personal assistance, whether for compensation or not, for a period of more than twenty-four (24) hours, to one (1) to three (3) residents who are not related to the service provider or his or her spouse by blood or marriage...*

The time period in which a complaint must be investigated is determined by the priority code assigned by OHFLAC. They are defined as follows:

Priority Code 1 - Investigate within 2 days (48) hours. Immediate jeopardy to resident health or safety;

Priority Code 2 - Investigate within 10 days. Actual harm that is not immediate jeopardy;

Priority Code 3 - Investigate within 45 days. No actual harm with potential for more than minimal harm;

Priority Code 4 - Investigate at next site visit. No actual harm with potential for minimal harm; (*This priority code is not used for complaints against Legally Unlicensed facilities, as they do not undergo annual survey inspections*.)

Priority Code 6 - Do not investigate.

The most common complaints OHFLAC's Residential Program receives regarding Legally Unlicensed facilities are available in Figure 1. All of the complaints in Figure 1 represent issues that can endanger a resident's health, safety and quality of life:

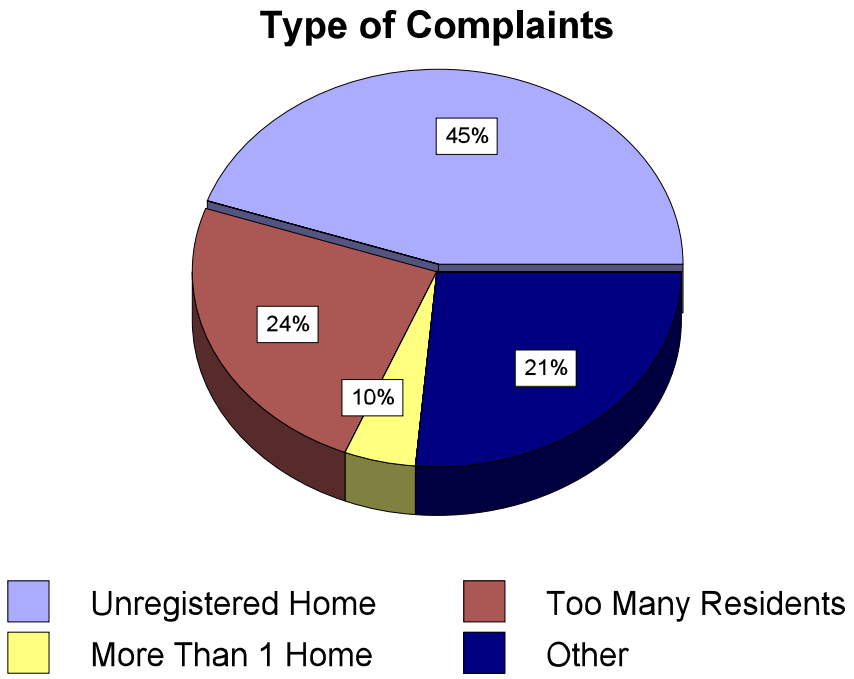
- Unregistered - Registration is the only way the state knows the facility is providing care to vulnerable residents. Once OHFLAC investigates and determines the facility is in operation, it may either register the facility or in the worst case, order the facility to cease operation;

- Too Many Residents - The complaint that there are too many residents in the home is a serious allegation because a facility providing care for more than three residents may not be able to evacuate all residents in case of a fire or other emergencies. Too many residents in a facility may also prohibit the residents from receiving adequate nourishment, assistance or supervision;

- Operating More Than One Facility - Individuals operating more than one facility are required to be licensed as opposed to simply being registered. Licensure requires greater oversight and regulation, including annual inspections and the hiring of qualified personnel;

- Other - This category includes allegations such as no running water or sewage; false advertising; inadequate food; physical abuse; resident neglect; restrained residents and; that residents require nursing needs beyond those allowed in the facility.

Figure 1



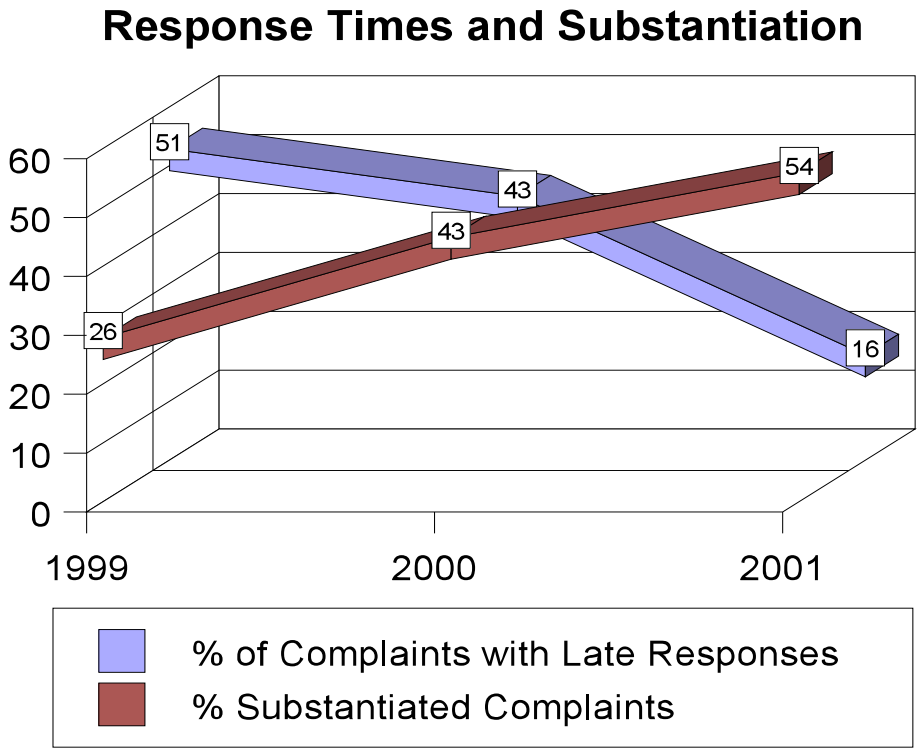
Timely responses to all of these complaints are essential for protecting a vulnerable population. Although response times have improved over the last three fiscal years, the Legislative Auditor is concerned that OHFLAC is late in responding to the small number of Code 1 complaints it receives and its response to Code 3 complaints remains in excess of OHFLAC policy. Data provided by OHFLAC indicates that in fiscal year 1999, eight complaints were responded to more than 200 days after the complaint was received, and one case took 459 days to respond. Table 6 shows a detailed analysis of response times and priority codes for fiscal years 1999 to 2001.

Table 6 Complaint Response Times				
Fiscal Year	**Priority Code**	**Total Number Complaints**	**Percentage Late**	**Average Days Late**
1999	1	4	100%	14
	2	9	11%	59
	3	82	52%	126
2000	1	0	0	0
	2	0	0	0
	3	56	43%	35
2001	1	1	100%	4
	2	3	0	0
	3	71	15%	21
Source: PERD analysis of Legally Unlicensed Complaint Database provided by OHFLAC.				

Complaint Substantiation Increases When Response Times Improve

Investigating complaints in a timely manner may uncover evidence that the complaint is valid, thus substantiating the complaint and better protecting resident health and safety. The substantiation of complaints allows OHFLAC to take action against the facility. This may involve Directed Plans of Correction, where the provider is informed what actions need to be taken in order to continue operation. In the worst cases, OHFLAC may shut down a facility and relocate the residents to a more appropriate care facility. **Data provided by OHFLAC and examined by the Legislative Auditor provides evidence that when response times improve, the rate of substantiation also increases.** Figure 2 indicates the correlation between response time and substantiation and shows that substantiation has doubled between fiscal year 1999 and 2001 at the same time that response time has improved.

Figure 2



No Criteria for the Assignment of Priority Codes

Priority codes indicate the seriousness of the complaint and determine the time period in which a response is to occur. Inaccurate assignment of priority codes may place residents of Legally Unlicensed facilities at risk. When asked to provide an explanation of how priority codes are assigned, OHFLAC only responded that ***"There is a document describing the priority codes, but nothing that explains how priority codes were assigned."***

From fiscal year 1999 to fiscal year 2001, 93% of complaints against Legally Unlicensed facilities received a priority code 3. The Legislative Auditor noticed that many priority 6 codes had the same complaint description as many priority 3 codes. When asked to explain this, OHFLAC responded that:

> *The nature of these priority codes may appear identical and in many cases they are. The difference with those that are assigned a priority 6 is that the issues were resolved and no investigation was conducted because of additional information or research being conducted.*

This leads the Legislative Auditor to believe that the assignment of priority codes is

inconsistent and does not represent the severity of the complaint allegation. **It appears as if the priority code is not an important indicator of the severity of the complaint allegation, but rather is a representation of the time it will take to investigate complaints.** For example, the Legislative Auditor found a complaint alleging a threatened murder-suicide at a facility. This complaint was assigned a priority code 3, which requires investigation within 45 days and denotes only a potential for minimal harm. OHFLAC did investigate this complaint the same day. However, when asked why the complaint did not receive a priority code 1, OHFLAC responded:

> *[We] agree that the nature of the complaint certainly suggest[s] a priority 1, but there is no documentation on the complaint record to indicate the reason for the status code.*

It seems logical that allegations regarding an unregistered home would receive a priority code 3, yet this type of complaint also receives priority code 2. The complaint that there are too many residents in an unlicensed facility often receives a priority code 3, but it also receives priority codes 1, 2 and 6. **Although the overall response times are improving, OHFLAC needs to develop criteria for the assignment of priority codes, so that the most serious allegations are responded to in the least amount of time.**

OHFLAC's Management Information Is Inaccurate, Incomplete and Not Utilized

The Legislative Auditor's analysis of complaint data revealed that OHFLAC was not aware of the severity of complaint response times because the information was not included as part of its database. Information supplied by OHFLAC in September 2001 indicates 233 complaints for fiscal years 1999 to 2001 in Legally Unlicensed facilities. When the Legislative Auditor requested an electronic file of data from the Residential Program, incorrect data was provided. In a letter to the Legislative Auditor's Office dated December 11, 2001, the Residential Program Manager stated that ***"our database is not correct in many of the report formats."*** The letter provided additional corrections to information OHFLAC had already provided to the Legislative Auditor. The final data set used by the Legislative Auditor indicates that in fiscal years 1999 to 2001 there were 226 complaints against Legally Unlicensed Health Care Homes, seven less than initially reported.

In the Legislative Auditor's review of 226 complaints, fields of data, such as the nature of the complaint and the resolution date, were not available in the agency's database. In response to a request for additional information, the agency responded that:

> *The information that was given to you in report format was put into access to make sure the report pulled up for you. We actually just put this in our database (conducted date), since you requested the additional information from OHFLAC, i.e., nature, date conducted and resolved. After your request, we actually went through all the complaint files for the last three years and put the "nature" of the complaint into our database, date conducted (if not already there) and date resolved, in a field that would pull the information for the report that you requested. This information was never kept in the database prior to that. This will be*

revised once the new data base is completed.

Without sound management information, OHFLAC cannot effectively track performance or allocate personnel and resources.

Conclusion

Continued improvement in response times is the only method OHFLAC's Residential Program can utilize in its mission of protecting residents in Legally Unlicensed Health Care Homes. Timely responses allows OHFLAC to obtain the most current and accurate information Residents are assured protection when OHFLAC responds to complaints in a timely manner because substantiation allows OHFLAC to take action against problem providers. In order to continue improving response times, OHFLAC needs to develop and implement sound information management to track its own response times, and develop criteria for the assignment of priority codes.

Recommendation 7

OHFLAC should continue to improve its response times while developing and implementing guidelines and criteria for the assignment of priority codes.

Recommendation 8

OHFLAC should develop and implement a plan to improve its management information and its use, including tracking response times so that it is able to identify problems hindering compliance.