# 98-2 An Evaluation of Nursing Home Regulation, Department of Health and Family Services and Board on Aging and Long Term Care

## Summary

Both the federal government and the State exercise significant regulatory authority over Wisconsin's 430 nursing homes because of the vulnerability of their approximately 43,000 residents, and because public funds reimburse most care provided to those residents. The Department of Health and Family Services inspects nursing homes, investigates complaints, and imposes corrective actions and penalties when it notes violations of state licensure regulations or federal regulations governing participation in the Medicare and Medical Assistance programs. In addition, the Board on Aging and Long Term Care assists residents, families, and nursing home staff in the resolution of concerns and complaints through ombudsmen who report problems to the Department and perform other consumer education and advocacy roles.

A number of concerns have been raised about the adequacy of the regulatory effort in Wisconsin. Some observers believe the Department maintains an inadequate presence in nursing homes, issues too few citations, and does not fully utilize its authority to impose penalties. Others believe state rules are too weak and too confusing to residents, families, and other lay people interested in nursing home quality to provide the basis for effective enforcement. Finally, some observers are concerned that ombudsmen are not adequately participating in quality assurance efforts.

The Department's Bureau of Quality Assurance, within the Division of Supportive Living, is responsible for regulating nursing homes. The Bureau's fiscal year (FY) 1997-98 budget for regulating nursing homes is $13.4 million, and it employs 255 staff, including 100.75 full-time equivalent staff known as surveyors, who inspect nursing homes. These surveyors conduct routine inspections, known as surveys, to determine compliance with state and federal regulations and to investigate complaints. The Department conducted 2,328 surveys in FY 1995-96 and FY 1996-97. During the same two years, the Department cited 751 violations of state regulations, of which 2.7 percent involved a substantial probability of death or serious harm to residents, and 5,642 violations of federal regulations, 6.9 percent of which involved harm to residents.

The Board on Aging and Long Term Care has an annual budget of $975,300 in FY 1997-98 and employs 17 staff, including 8 ombudsmen (increased to 11 by 1997 Wisconsin Act 27) who serve as liaisons between residents, social service workers, nursing home facilities, and surveyors. Although exact numbers are not maintained by the Board, ombudsmen estimate they visited approximately 70 percent of nursing homes in Wisconsin at least once in 1996.

Evidence suggests nursing home regulation in Wisconsin is working reasonably well: federal regulations were recently revised to place more emphasis on meeting residents' needs, although long-awaited revisions to state rules are not expected to be ready for implementation until 1999. Nursing homes are inspected on a timely basis, and reviews appear to be thorough. However, it is possible to identify some areas in which improvements could be made, including the consistency with which violations are cited by investigators across the state. The Legislature could also review the state penalty amounts imposed on violators and the Department's process for reducing penalties on appeal.

Currently, federal regulations provide an adequate basis for nursing home quality assurance. Comprehensive reform of federal nursing home requirements was legislated in 1987. The last set of regulations codifying these reforms went into effect in July 1995. It extensively changed the process by which the regulations are enforced by shifting the focus of the surveyors' efforts from nursing home attributes, such as services and resources provided, to the well-being of residents. Current federal regulations provide the Department with an improved array of corrective actions and penalties.

The state administrative code, however, is outdated and in need of revision. For example, the current minimum staffing requirement was adopted in 1974, when the state's nursing home population included a higher proportion of relatively

high-functioning residents. All knowledgeable observers with whom we spoke agreed it is doubtful any nursing home staffed only at the minimum level prescribed in the current state code could provide quality care, and the average weekly staffing level found among Wisconsin nursing homes surveyed in FY 1995-96 was 146.7 percent of the minimum required. The Department began drafting a comprehensive revision to the administrative code in 1996 but does not expect to complete rule revisions before 1999. While there has been discussion of updated minimum staffing requirements and areas in which federal regulations are considered weak, such as safeguards relating to the use of locked units, the actual revised rules will need careful review.

Although it is clearly advisable to update staffing requirements, many factors other than the number and types of staff affect the quality of care in a given home. These include staff experience and turnover, the involvement of families, the effectiveness of supervisors and management, and the physical layout of the facility. Consequently, numeric staffing requirements have limitations for quality assurance purposes and cannot mandate adequate staffing in all homes without mandating inefficient overstaffing in some homes. Another type of regulation, known as an outcome-based staffing standard, is being considered for inclusion in the revised state administrative code. This standard requires sufficient staffing to meet residents' needs without prescribing specific numbers or types of staff. Although outcome-based staffing requirements can, in principle, ensure quality care in all situations, enforcement is complicated because it requires surveyors to document that residents' needs are not met and to determine that understaffing is a contributing cause.

Enforcement of the federal outcome-based staffing standard, which began only two years ago, is not yet consistent either within Wisconsin or in other midwestern states. The Department could improve enforcement of the staffing standards by bringing together ideas from the federal Health Care Financing Administration and from the knowledge and experiences of Wisconsin surveyors, in order to develop guidance and training for surveyors in the application of the standards. However, because of the limitations of both numeric and outcome-based staffing standards, observers in both the regulatory agencies and the industry believe that quality assurance can be addressed more effectively through enforcement of regulations that directly address quality of care-such as those requiring that all residents receive prompt and thorough assessments and plans of care, and those requiring that each resident receive care appropriate to his or her plan or care-rather than through the enforcement of minimum staffing requirements.

Effective enforcement of any regulation also depends upon the surveyors' presence in the nursing homes. With the exception of investigations into reports of nurse aide misconduct, as described in Audit Bureau report 97-19, the Department conducts routine inspections and complaint investigations as frequently as federally required and on a timely basis. All surveys completed from January 1995 through September 1997 were conducted an average of 11.6 months after the previous survey for each home, a frequency that meets federal requirements. For a group of homes that we identified as having a relatively large number of citations for violations of state or federal regulations, the average period between surveys was 10.1 months; for a group of homes we identified as having a record of relatively serious citations, the average period between surveys was 9.2 months. The Department is in the process of implementing safeguards to ensure the dates of scheduled surveys remain unknown to the homes. In addition, surveyors have been investigating complaints within specified time periods, which vary depending upon the seriousness of the situations reported.

Effective regulation further requires that surveyors consistently issue appropriate citations for the violations they observe. We could not directly determine whether surveyors in Wisconsin were appropriately issuing citations because they must use substantial situation-specific judgment, and because citation patterns have been changing within Wisconsin and in other states as surveyors gain familiarity with the federally required process that changed most recently in July 1995. For example, there were changes in the level of severity identified for federal citations issued by the Department. In FY 1995-96, it issued 2,959 federal citations, 5.7 percent of which were at a severity level signifying actual harm to residents. During the next full year, 2,683 federal citations were issued but more (8.3 percent) signified higher levels of severity, perhaps because surveyors had gained experience in detecting and documenting the effects of poor practices upon residents.

Based on comparisons with other states, it is difficult to conclude whether Wisconsin's surveyors are appropriately enforcing the federal regulations because other states' practices have been inconsistent over time, nursing home quality may differ among the states, and changes in citation rates may differ over time as a result of changing conditions within

homes. However, significant differences in the rate at which homes are cited among the Department's five regions are not likely to be the result of differences in the quality of the homes surveyed. For example, during the first nine months of 1997, one of the two units of Milwaukee surveyors found no deficiencies in 28.8 percent of the homes it surveyed, while the other unit found no deficiencies in only 2.3 percent of the homes it surveyed. Among other units in the state, comparable rates ranged from 2.8 percent to 37.9 percent. Although the Department has undertaken some measures to standardize surveyor decisions, we have included recommendations that it conduct further analysis of these regional differences and provide training as appropriate to ensure surveyors statewide issue citations consistently.

After citations are issued, the next step in the enforcement process is the imposition of remedies and penalties. For those nursing homes with only isolated violations that are corrected promptly, penalties appear to be effective. However, the existence of unresponsive nursing homes, which are repeatedly cited with many or serious violations, indicates weakness in the regulatory system. Unresponsive nursing homes could be defined as those with a relatively large number of violations in two or more consecutive periods, or those with more than one serious citation in each of two or more consecutive periods. When we compared the 10 percent of the nursing homes that received the most citations for each year from FY 1993-94 through FY 1996-97, we found that 29 homes ranked among the most-cited 10 percent in two or more consecutive years. During the same four-year period, 13 nursing homes were cited for multiple serious violations in two or more consecutive years.

Federal penalties are intended to encourage compliance by allowing nursing homes to avoid all penalties if they correct problems promptly. As a result, federal financial penalties are rarely imposed. During FY 1995-96 and FY 1996-97, 356 nursing homes were cited with violations of federal regulations but corrected them and, therefore, incurred no penalty. However, federal penalties are imposed when nursing homes do not correct cited violations, and they are applied with more severity in cases of unresponsive homes. Possible federal penalties include:

- plans of correction, which specify how and by when nursing homes must correct violations cited by surveyors and prevent them in the future, and which were imposed in 47 instances during FY 1995-96 and FY 1996-97;

- civil monetary penalties that range from $50 to $10,000 per day and are assessed daily until the nursing home has corrected violations: an average of $20,504 in penalties has been assessed on 20 homes during the two-year period;

- denial of Medicare and Medical Assistance payments for services provided to newly admitted nursing home residents if the home has not corrected violations within 90 days after the survey, an action that has been taken in nine instances during the same period; and

- termination of the nursing home from the Medicare and Medical Assistance programs, which can occur if a nursing home has not corrected violations within 180 days after the survey, an action that has been taken only once under the new regulations.

Repeated federal violations of a serious nature can lead to a nursing home's designation as a "poor performer," which makes the home subject to federal penalties for future violations regardless of correction. However, a nursing home cannot be designated a poor performer unless the repeated violations are very severe and are widespread. Since July 1995, when this penalty structure went into effect, only two nursing homes in this state have been designated as poor performers.

In contrast to federal financial penalties, state financial penalties are intended to punish rule violators and are, therefore, considered for every state rule violation. State statutes, however, give the Department wide discretion in determining the amounts of state forfeitures required of cited nursing homes, taking into account the homes' good-faith efforts to correct problems. No financial penalty is assessed for some state violations.

Although the state penalty structure is intended to punish rule violators consistently, it has weaknesses that may be limiting its effectiveness with unresponsive nursing homes. First, many believe the financial penalties provided by state statutes are too small to be significant incentives for homes to remain in compliance with regulations. The maximum amounts have not been adjusted since 1977. If they were adjusted simply to reflect inflation, the maximum penalty would increase from $5,000 to $20,870 for class A violations, which are the most serious category; from $1,000 to

$4,174 for class B violations; and from $100 to $417 for class C violations, the least serious category.

Second, the Department's statutory authority for taking strong action against unresponsive homes has ambiguities that result in more lenient application than the Legislature may have intended. For nursing homes that have repeated violations above a certain level of seriousness, statutes allow the Department to assess triple forfeitures for the second violation. In practice, the Department has decided against assessing enhanced penalties in cases in which it cited repeat violations of the same rule but determined that the circumstances surrounding the two violations were different. During FY 1995-96 and FY 1996-97, triple forfeitures were assessed only 38 times, even though repeat violations of the same section of code occurred 77 times.

Because only a few nursing homes have serious violations in consecutive surveys, strengthening the triple forfeiture provision would not affect the large majority of nursing homes in Wisconsin. To strengthen state penalties, the Legislature could consider:

- reducing the Department's discretion in deciding whether to impose enhanced penalties for repeat violations by clarifying, in statute, the circumstances under which enhanced penalties are to be assessed;
- requiring enhanced penalties for violations of the same statute or rule, without regard to the circumstances;
- requiring enhanced penalties for any consecutive class A or class B violations, the two most serious categories, without regard to the statute or rule violated; or
- providing the Department with enforcement options in addition to financial penalties, such as limiting admission of new residents, which might enable effective action in the cases of nursing homes that are less responsive to financial penalties.

Furthermore, in the last step of the regulatory process, appeals of cited violations and assessed penalties can lead to substantial reductions in the amounts paid by nursing homes that violate state rules. When a nursing home objects to a citation, the first step is for the nursing home to request an informal dispute resolution conference. This conference, part of the required federal survey process, provides the nursing home with an opportunity to present all evidence pertaining to the alleged violation. We found that although the Department has changed a large proportion of its citations as a result of these conferences, the majority of changes were of no consequence to the enforcement action taken. However, nursing homes also appeal a large number of the citations issued and penalties assessed. Appeals of most federal citations and penalties are outside the control of the Department, but nursing homes that appeal state citations and forfeitures frequently obtain significant reductions through settlement conferences with the Department's legal staff.

Nursing homes can separately appeal the statements of deficiency, which include citations issued as the result of a survey, and the forfeitures themselves. Department attorneys schedule informal settlement conferences for each appeal, to attempt to resolve the appeal without litigation. In FY 1995-96 and FY 1996-97, nursing homes appealed 192, or 60.6 percent, of the 317 state statements of deficiency issued, and 153, or 67.7 percent, of the 226 state forfeitures assessed. As a result of settlement conferences initiated by its attorneys, 23.8 percent of the appealed statements of deficiency were withdrawn by the Department and 4.8 percent were changed in some way, such as by withdrawing at least one citation. The Department agreed to reduce or withdraw 67.0 percent of the appealed forfeitures as a result of settlement conferences.

Although citations and assessed penalties have been considered and discussed at several levels within the Department by the time they are appealed, and although nursing homes have had an opportunity to present evidence that might contradict the surveyors' findings before the settlement conference, it appears that the Department's legal staff is concerned that these citations and penalties might be overturned on appeal if they are not settled informally through negotiation. To obtain greater consistency, we suggest the Department examine the reasons for the discrepancy between the actions recommended by the regulatory staff and those taken by the legal staff.

Because surveyors cannot constantly be present in every nursing home, effective regulatory enforcement also depends, in large part, upon the ability and willingness of residents and their families to take appropriate action when they experience or observe incidents of poor-quality care. Both the Department and the ombudsmen could be doing more to

enable residents, families, and others interested in long-term care to contribute more effectively to the process of ensuring that consistent, high-quality care is provided. First, the results of recent surveys could be made more readily available to potential residents and their families when they are selecting a nursing home.

Second, the Department could communicate more effectively with complainants. Federal regulations require that information on how to contact ombudsmen and departmental officials be posted in each nursing home, and both state and federal regulations require that residents have access to regulatory agencies and client advocates. Although the Department has directed surveyors to speak with all complainants before or during a complaint investigation, this is not consistently done. Form letters acknowledging receipt of complaints do not describe the complaint-resolution process or suggest when the process might be completed. When an investigation is complete, the Department's form letter to the complainant states whether citations were issued as a result of the reported problem, but not whether the investigation found other circumstances for which citations were issued. When the original complaint was not verified but other citations were issued, this practice leaves complainants unaware that their initiative in filing a complaint had a positive effect.

Although ombudsmen employed by the Board on Aging and Long Term Care are expected to provide assistance to the surveyors by monitoring conditions in nursing homes, reporting questionable conditions in a timely and useful manner, observing the surveys themselves, and providing assistance to nursing home staff, residents, and their families that might serve to prevent or correct some problems without departmental action, the number of ombudsmen has limited their ability to perform all the roles assigned to them in federal and state statutes. The ombudsmen are responsible for monitoring approximately 2,300 facilities, including nursing homes, community-based residential facilities, adult family homes, and facilities for the developmentally disabled, as well as for responding to complaints from individuals participating in the Community Options Program. More than 92,300 individuals are receiving services for which they could request the assistance of an ombudsman. Currently, eight ombudsmen are employed; three additional positions were authorized in 1997 Wisconsin Act 27, the 1997-99 biennial budget. The ombudsmen give priority to working with the concerns of nursing home residents and their families, in response to which they may counsel callers over the telephone, investigate reported problems, help to resolve problems, refer complainants to the Department, or file a complaint directly. In 1996, ombudsmen reported receiving approximately 9,000 contacts from individuals requesting help with long-term care; ombudsmen reported taking action beyond the initial contact in 3,339 of these cases.

Ombudsmen report less activity in their other roles of monitoring long-term care and providing outreach. These responsibilities require the ombudsmen to maintain a presence in the nursing homes and other long-term care facilities, but ombudsmen estimated they visited approximately 70 percent of nursing homes in Wisconsin at least once in 1996. In addition, ombudsmen rarely accompany surveyors during surveys or investigations, although both ombudsmen and surveyors acknowledged that the ombudsmen's participation could be useful.

The Board and ombudsmen attribute their inability to carry out all the missions assigned to them to an insufficient number of staff. A national standard set by the federal Institute of Medicine recommends 1 ombudsmen for every 2,000 long-term care beds; the 1992 median ratio among all states was 1 ombudsman for every 3,024 beds. With three additional ombudsmen positions authorized by Act 27, Wisconsin will have 11 ombudsmen, or 1 for every 6,264 beds.

The Board and ombudsmen have adopted some practices to alleviate the effects of low staff numbers, including focusing the efforts of each ombudsman on five or six nursing homes in which the ombudsman suspects less-than-adequate quality of care, to ensure a significant level of attention to at least these homes, and creating a volunteer ombudsman program in which approximately 50 to 60 volunteers visit nursing homes in four counties on a weekly basis.

In addition, the Department and the Board are undertaking some efforts to improve cooperation and coordination by expanding a memorandum of agreement to establish:

- requirements that the ombudsmen provide pre-survey information to surveyors;
- guidelines for ombudsman participation in surveys and presence at informal dispute resolutions;
- authority for ombudsmen to request and receive the Department's nursing home data; and

- a requirement that staff from both agencies meet quarterly.

We include an additional suggestion that the Board and the Department encourage more direct communication between surveyors and ombudsmen.