Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FLORIDA DID NOT ALWAYS VERIFY CORRECTION OF DEFICIENCIES IDENTIFIED DURING SURVEYS OF NURSING HOMES PARTICIPATING IN MEDICARE AND MEDICAID

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

April 2018
A-04-17-08052

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: April 2018
Report No. A-04-17-08052

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid

Why OIG Did This Review

For certain deficiencies, identified during surveys, Federal regulations require nursing and skilled nursing facilities (nursing homes) to submit correction plans to the Centers for Medicare & Medicaid Services (CMS) or to their respective State survey agencies. State survey agencies must verify the correction of identified deficiencies by obtaining evidence of correction or through onsite reviews.

Previous Office of Inspector General (OIG) reviews found that State survey agencies did not verify that selected nursing homes had corrected identified deficiencies. This review of the State survey agency in Florida is part of a series of OIG reviews.

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) verified nursing homes' correction of deficiencies identified during surveys in calendar year (CY) 2015 in accordance with Federal requirements.

How OIG Did This Review

Of the 2,381 deficiencies that required a corrective action plan during CY 2015, we selected a stratified random sample of 100. We reviewed State agency documentation to determine whether the State agency had verified the nursing homes' correction of the sampled deficiencies and interviewed State agency officials and employees.

What OIG Found

The State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2015 in accordance with Federal requirements.

For the 100 sampled deficiencies, the State agency verified the correction of 82 nursing home deficiencies but did not obtain evidence of correction or retain sufficient evidence for the remaining 18 deficiencies.

On the basis of our sample results, we estimated that the State agency did not obtain the nursing homes' evidence of correction for 455 of 2,381 of the deficiencies.

We also estimated that the State agency could not provide sufficient evidence that corrective actions had been taken by nursing homes for 130 of 2,381 of the deficiencies.

What OIG Recommends and State Agency Comments

We recommend that the State agency (1) improve its practices for verifying nursing homes' correction of identified deficiencies by obtaining nursing homes' evidence of correction for less serious deficiencies and (2) update information system controls to ensure that survey system data is protected against unauthorized or unintended modification or loss.

In written comments on our draft report, the State agency disagreed with our first recommendation and our interpretation of the State Operations Manual; however, it agreed to require facility documentation evidencing correction of citations for desk review revisits. For our second recommendation, the State agency agreed that some data was missing but stated that this was not the fault of the State agency because it was required to use CMS's database. We maintain that our findings and recommendations are correct. The State agency inappropriately certified facility compliance based only on a review of a Plan of Correction, which is an "allegation of compliance." Regarding the second recommendation, CMS's contractor identified that the State agency's surveyor did not upload the revisit survey information to CMS's system and that States may use additional controls to insure completeness of data.

The full report can be found at https://oig.hhs.gov/oas/reports/region4/41708052.asp.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1

Medicare and Medicaid Coverage of Nursing Homes 1

Standard and Complaint Surveys of Nursing Homes 1

Deficiencies and Deficiency Ratings 2

Correction Plans 3

Florida State Agency 4

How We Conducted This Review 4

FINDINGS 5

Federal Requirements 5

The State Agency Did Not Always Verify Correction of Deficiencies 6

The State Agency Did Not Obtain Nursing Homes' Evidence of Correction of Some Deficiencies 6

The State Agency Could Not Provide Nursing Homes' Evidence of Correction of Some Deficiencies 8

RECOMMENDATIONS 8

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE 9

State Agency Comments 9

Office of Inspector General Response 9

APPENDICES

A: Audit Scope and Methodology 11

B: Related Office of Inspector General Reports 13

C: Statistical Sampling Methodology 15

D: Sample Results and Estimates 17

E: State Agency Comments 18

INTRODUCTION

WHY WE DID THIS REVIEW

For certain deficiencies, identified during surveys, Federal regulations require nursing and skilled nursing facilities (nursing homes) that participate in Medicare and Medicaid to submit correction plans to the Centers for Medicare & Medicaid Services (CMS) or to their respective State survey agencies. State survey agencies must verify the correction of identified deficiencies by obtaining evidence of correction or through onsite reviews. Previous Office of Inspector General (OIG) reviews found that the State survey agencies did not always verify that selected nursing homes had corrected identified deficiencies. This review of the State survey agency in Florida is part of a series of OIG reviews. (Appendix B lists related OIG reports on nursing home compliance issues.)

OBJECTIVE

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) verified nursing homes' correction of deficiencies identified during surveys in calendar year (CY) 2015 in accordance with Federal requirements.

BACKGROUND

Medicare and Medicaid Coverage of Nursing Homes

The Medicare and Medicaid programs cover care in skilled nursing and nursing facilities, respectively, for eligible beneficiaries in need of nursing services, specialized rehabilitation services, medically related social services, pharmaceutical services, and dietary services. Sections 1819 and 1919 of the Social Security Act (the Act) provide that nursing homes participating in the Medicare and Medicaid programs, respectively, must meet certain specified requirements (Federal participation requirements), such as quality of care, nursing services, and infection control. These sections also establish requirements for CMS and States to survey nursing homes to determine whether they meet Federal participation requirements. For both Medicare and Medicaid, these statutory participation and survey requirements are implemented in Federal regulations at 42 CFR part 483, subpart B, and 42 CFR part 488, subpart E, respectively.

Standard and Complaint Surveys of Nursing Homes

The Secretary of Health and Human Services (Secretary) must use the State health agency, or other appropriate State agency, to determine whether nursing homes meet Federal participation requirements (the Act § 1864(a)). Further, the State must use the same State agency to determine whether nursing homes meet the participation requirements in the State Medicaid plan (the Act § 1902(a)(33)).

Under an agreement with the Secretary, the State agency must conduct standard surveys to determine whether nursing homes are in compliance with Federal participation requirements[1] (42 CFR § 488.305(a) and § 7200 of CMS's *State Operations Manual* (the Manual), Pub. No. 100-07). A standard survey is a periodic nursing home inspection using procedures specified in the Manual that focuses on a sample of residents selected by the State agency to gather information about the quality of resident care furnished to Medicare or Medicaid beneficiaries in a nursing home. A standard survey must be conducted at least once every 15 months (42 CFR § 488.308(a)).

The State agency must review all nursing home complaint allegations (42 CFR § 488.308(e)(2)).[2] Depending on the outcome of the review, the State agency may conduct a standard survey or an abbreviated standard survey (complaint survey) to investigate noncompliance with Federal participation requirements. A nursing home's noncompliance with a Federal participation requirement is defined as a deficiency (42 CFR § 488.301). Examples of deficiencies include a nursing home's failure to adhere to proper infection control measures or failure to provide necessary care and services.

Deficiencies and Deficiency Ratings

The State agency must report each deficiency identified during a survey on the appropriate CMS form[3] and provide the form to the nursing home and CMS. These forms include (1) a statement describing the deficiency, (2) a citation of the specific Federal participation requirement that was not met, and (3) a rating for the seriousness of the deficiency (deficiency rating).

The State agency must determine the deficiency rating using severity and scope components (42 CFR § 488.404(b)). Each deficiency is given a letter rating of *A* through *L*, which corresponds to a severity and scope level. (*A*-rated deficiencies are the least serious, and *L*-rated deficiencies are the most serious.) Severity is the degree of or potential for resident harm and has four levels, beginning with the most severe: (1) immediate jeopardy to resident health or safety, (2) actual harm that is not immediate jeopardy, (3) no actual harm with potential for more than minimal harm but not immediate jeopardy, and (4) no actual harm with potential for minimal harm. Scope is the number of residents affected or pervasiveness of the deficiency in the nursing home and has three levels: (1) isolated, (2) pattern, and (3) widespread. The Manual provides information on the severity and scope levels used to determine the deficiency

[1] CMS and the State agency certify compliance with Federal participation requirements for State-operated and non-State-operated nursing homes, respectively (42 CFR § 488.330).

[2] An allegation of improper care or treatment of beneficiaries at a nursing home may come from a variety of sources, including beneficiaries, family members, and health care providers.

[3] Form CMS-2567, Statement of Deficiencies and Plan of Correction, is used for all deficiencies except those determined to be isolated and with the potential for minimal harm. For these deficiencies, Form A, Statement of Isolated Deficiencies Which Cause No Harm with Only a Potential for Minimal Harm, is used.

rating (§ 7400.5.1). Table 1 below shows the letter for each deficiency rating and its severity and scope levels.

Table 1: Severity and Scope Levels for Deficiency Ratings

SEVERITY	SCOPE		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm but not immediate jeopardy	D	E	F
No actual harm with potential for minimal harm	A	B	C

Correction Plans

Nursing homes must submit for approval correction plans to the State agency or CMS for all deficiencies except *A*-rated deficiencies (with the severity level of no actual harm with potential for minimal harm and the scope level of isolated) (42 CFR § 488.402(d)). An acceptable correction plan must specify exactly how the nursing home corrected or plans to correct each deficiency (the Manual § 7304.4). Nursing homes use Form CMS-2567, Statement of Deficiencies and Plan of Correction, to submit correction plans.

After a nursing home submits a correction plan, the State agency or CMS must certify whether the nursing home is in substantial compliance with Federal participation requirements (the Manual § 7317.1).[4] A nursing home is in substantial compliance when identified deficiencies have ratings that represent no greater risk than potential for minimal harm to resident health and safety (*A*, *B*, or *C*). The State agency must determine whether there is substantial compliance by verifying correction of the identified deficiencies through obtaining evidence of correction[5] or conducting an onsite review (followup survey).[6] The deficiency rating guides which verification method the State agency uses. For less serious deficiencies (with the ratings

[4] The State agency provides the certification information to CMS on Form CMS-1539, Medicare/Medicaid Certification and Transmittal (the Manual § 2762).

[5] The Manual § 7317.2 lists examples of evidence of correction that include sign-in sheets verifying attendance at inservice trainings and interviews about training with more than one participant.

[6] The State agency is not required to verify the correction of deficiencies with the ratings *B* or *C*; however, correction plans are still required for deficiencies with those ratings.

D or *E*, or *F* without substandard quality of care[7]), the State agency may accept the nursing home's evidence of correction in lieu of conducting a followup survey to determine substantial compliance. For more serious deficiencies (with the ratings *G* through *L*, or *F* with substandard quality of care), the State agency must conduct a followup survey to determine substantial compliance.

Florida State Agency

In Florida, the State agency determines whether nursing homes meet Federal participation requirements and recommends to CMS whether nursing homes should be certified for participation in the Medicare and Medicaid programs. As of December 31, 2015, the State agency had 8 field offices with 281 surveyors to conduct surveys of all State licensure and federally certified providers and suppliers. The types of providers and suppliers surveyed included, but were not limited to, assisted living facilities, hospitals, ambulatory surgery centers, health care clinics, clinical laboratories, and nursing homes. There were approximately 688 nursing homes participating in the Federal Medicare and/or Medicaid programs in 2015.

HOW WE CONDUCTED THIS REVIEW

According to CMS and State agency deficiency data, the State agency identified 5,511 deficiencies that required a correction plan during CY 2015. We excluded from our review 3,130 deficiencies that (1) were not directly related to resident health services or (2) had the ratings *B* or *C*, which did not require verification of correction. The remaining 2,381 deficiencies had ratings that required the State agency to verify correction by either obtaining evidence of correction (2,277 deficiencies) or conducting a followup survey (104 deficiencies). We selected a stratified random sample of 100 deficiencies and reviewed State agency documentation to determine whether the State agency had verified the nursing homes' correction of the sampled deficiencies. We also interviewed State agency officials and employees regarding survey operations, quality assurance, and training.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

[7] The Manual, § 7001, defines "substandard quality of care" with reference to the lettered ratings discussed in this paragraph. CMS's website has further information that cites to 42 CFR § 483. Subparagraphs of this regulation identify "Federal Regulatory Groups" and itemize, within each group, specific coded listings of possible issues. For instance, the Federal Regulatory Group identified as "Quality of Care" includes coded issue F327: "Sufficient Fluid to Maintain Hydration" and cites to 42 CFR § 483.25. Accordingly, a less serious deficiency can have a rating of *F* without substandard quality of care only if that deficiency (1) meets the severity and scope criteria as depicted in Table 1 and (2) does not feature any of the coded listings of possible issues for any of the Federal Regulatory Groups. This CMS information is available online at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Federal-Regulatory-Group-LTC.pdf. Accessed on November 2, 2017.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2015 in accordance with Federal requirements. For the 100 sampled deficiencies, the State agency verified the nursing homes' correction of 82 deficiencies. Of the remaining 18 deficiencies, the State agency:

- did not obtain the nursing homes' evidence of correction for deficiencies, all of which had a *D* rating (14 deficiencies), and

- was unable to provide sufficient evidence (other than from CMS Forms completed during the survey process) that it had verified that the nursing homes had taken corrective actions (4 deficiencies).

On the basis of our sample results, we estimated that the State agency did not obtain the nursing homes' evidence verifying correction of deficiencies in accordance with Federal requirements for 455 (19 percent) of the 2,381 deficiencies identified during surveys in CY 2015. The State agency's practice was to accept the nursing homes' correction plans as confirmation of substantial compliance without obtaining the required evidence of correction for less serious deficiencies.

On the basis of our sample results, we also estimated that the State agency could not provide sufficient evidence that corrective actions had been taken for 130 (5 percent) of the 2,381 deficiencies identified during surveys in CY 2015. Documentation that might have provided this evidence was either not recorded or verified by the Surveyor or had been deleted from the State agency's survey database system.

FEDERAL REQUIREMENTS

For deficiencies rated *D* or *E*, or *F* not involving substandard quality of care, the State agency has the option to accept evidence of correction to confirm substantial compliance in lieu of conducting a followup survey (i.e., an onsite review) (the Manual § 7300.3). However, the State agency must conduct a followup survey to determine whether a nursing home is in substantial compliance for deficiencies rated *G* through *L*, or *F* involving substandard quality of care (the Manual § 7300.3).

Section 7317.1 of the Manual states: "While the plan of correction serves as the facility's allegation of compliance in non-immediate jeopardy cases, substantial compliance cannot be certified and any remedies imposed cannot be lifted until facility compliance has been verified."

Section 7317.2 of the Manual lists examples of acceptable evidence of a nursing home's correction of a deficiency, which include invoices verifying purchases or repairs, sign-in sheets verifying attendance of staff at inservice training, or interviews with more than one training participant about training.

Section I of Appendix P of the Manual states: "The [followup survey] is an onsite visit intended to verify correction of deficiencies cited in a prior survey."

Section II.B.3 of Appendix P of the Manual states:

> In accordance with §7317 [of the Manual], the State agency conducts a revisit, as applicable, to confirm that the facility is in compliance and has the ability to remain in compliance. The purpose of the [followup survey] is to re-evaluate the specific care and services that were cited as noncompliant during the original standard, abbreviated standard, extended or partial extended survey(s). Ascertain the status of corrective actions being taken on all requirements not in substantial compliance.

THE STATE AGENCY DID NOT ALWAYS VERIFY CORRECTION OF DEFICIENCIES

The State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2015 in accordance with Federal requirements. For the 100 sampled deficiencies, the State agency verified the correction of 82 deficiencies but did not obtain evidence of correction or retain sufficient evidence for the remaining 18 deficiencies.

The State Agency Did Not Obtain Nursing Homes' Evidence of Correction of Some Deficiencies

For 14 sampled deficiencies, the State agency accepted the nursing homes' correction plans without obtaining evidence of correction. These deficiencies had *D* ratings, which required the State agency to obtain, at a minimum, evidence of correction from the nursing homes before certifying their substantial compliance with Federal participation requirements.

For example, on August 3, 2015, the State agency completed a nursing home complaint investigation survey and identified several deficiencies, including a *D*-rated deficiency related to resident falls. The surveyor noted: "Based on record review and staff interview, the facility failed to ensure appropriate supervision was provided . . . for the prevention of falls."

To address this deficiency, the nursing home's correction plan listed one corrective action to ensure that the deficient practice would not recur. The corrective action was:

> Licensed nursing staff will be re-educated on the importance of accurate documentation e.g. accuracy, follow up, neuro checks initiated if indicated on any resident/patient who falls. If a resident has a fall, the chart will be brought to morning meeting for three days to check that the documentation is complete, that an intervention has been put into place and that neuro checks were initiated if needed. Interdisciplinary team will assess the need for further intervention or increased supervision if it is needed as another intervention. The fall chart will also be reviewed at "At Risk" meeting to ensure that interventions are working and that compliance is met.

Form 2567 indicated that these corrections were completed on August 28, 2015. We determined that the State agency did not obtain any evidence from the nursing home to show that any of these corrective actions had taken place. Additionally, the State agency had issued the following documents that made it appear that the corrective actions had been verified.

- On August 24, 2015, the State agency issued CMS Form 1539, indicating the facility was certified as in compliance with program requirements, compliance based on acceptable plan of correction (POC).

- On September 8, 2015, the State agency issued a letter to the nursing home, which stated, "This letter reports the findings of complaint survey revisit conducted by desk review on . . . by representative(s) of this office. Attached are the provider's copies of the Revisit Reports, which indicates the previously cited deficiencies were found corrected on the day of the revisit . . . ."

The State agency's practice for addressing less serious deficiencies did not comply with Federal requirements. Specifically, a State agency official explained that the practice for less serious deficiencies was to accept the nursing homes' correction plans as confirmation of substantial compliance without obtaining from the nursing homes the required evidence of correction of deficiencies,[8] citing the Manual section 2734A as allowing for this practice. However, the State agency's cited section of the Manual is not applicable to nursing homes.

Without verification of evidence of correction, the State agency cannot ensure CMS that nursing homes have complied with Federal participation requirements and that residents are adequately protected. On the basis of our sample results, we estimated that the State agency did not obtain the nursing homes' evidence of correction in accordance with Federal requirements for 455 (19 percent) of the 2,381 deficiencies identified during surveys in CY 2015.

[8] However, if a nursing home had serious deficiencies in addition to the less serious deficiencies, the State agency would verify the correction of both types of deficiencies during its followup survey.

The State Agency Could Not Provide Nursing Homes' Evidence of Correction of Some Deficiencies

For 4 sampled deficiencies, the State agency was unable to provide sufficient evidence (other than from CMS Forms completed during the survey process) that it had verified that the nursing homes had taken corrective actions.

For example, on February 26, 2015, the State agency completed a nursing home unannounced complaint survey and identified several deficiencies, including a *D*-rated deficiency related to accuracy of resident assessments. The surveyor noted that "Based on record review and interview, the facility failed to accurately assess one resident . . . for receiving oxygen per physician orders." The finding indicated that a "review of the medical record revealed a physician order" for oxygen. "The Minimum Data Set . . . revealed no indication that the resident was receiving oxygen." "The nurse stated she had 'overlooked' the administration of the oxygen. The nurse said she would do a correction for this oversight." On March 26. 2015, the nursing home's corrective action plan indicated, among other things, "Nursing staff have been educated on documentation required for residents who are receiving oxygen." The CMS Form-670 indicates that an investigation followup visit was conducted on April 6, 2015. However, the State agency was unable to provide us with any evidence of correction to show that the corrections had actually taken place. For example, there was no indication that the resident's oxygen was corrected and there were no interview notes with nursing staff that attended the training.

For two of these four deficiencies, the State agency did not indicate a reason for why the Surveyors either did not verify or record sufficient evidence to verify correction. For two other deficiencies, State agency staff indicated that resident specific data had been deleted from the Automated Survey Processing Environment database after completion of the survey. The State agency anticipates that enhanced stability within the database will potentially prevent future data losses.

On the basis of our sample results, we estimated that the State agency could not provide sufficient evidence that corrective actions had been taken for 130 (5 percent) of the 2,381 deficiencies identified during surveys in CY 2015.

RECOMMENDATIONS

We recommend that the State agency:

- improve its practices for verifying nursing homes' correction of identified deficiencies by obtaining nursing homes' evidence of correction for less serious deficiencies and

- update information system controls to ensure that survey system data is protected against unauthorized or unintended modification or loss.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, although the State agency disagreed with our first recommendation and our interpretation of the Manual, it described actions that it had taken or planned to take to address our recommendations.

Regarding our first finding and corresponding recommendation, the State agency generally disagreed with our interpretation of the Manual's requirements for desk reviews. It stated that Chapter 7 provides guidance but does not specifically require a State to collect additional documentation beyond the required POC to verify compliance when conducting desk review revisits. Despite its disagreement with our interpretation of the Manual's requirements, the State agency will begin requiring documentation from nursing homes as evidence that the facility corrected those citations at a severity and scope of D or higher. The State agency communicated this policy change to management and supervisory staff in February 2018. Additionally, the State agency plans to conduct quarterly quality audits of desk reviews.

For our second finding and corresponding recommendation, the State agency agreed with our finding, but it did not agree that it was responsible for the unintended data loss. Instead, the State agency said that it was required to use the database, which was maintained by a CMS contractor. The State agency indicated that, although controls were in place to maintain data integrity, at times the program may have lost data through no fault of an individual surveyor or office. CMS replaced the previous system with a new software program on November 28, 2017, which the State agency anticipates will provide added data reliability.

Finally, the State agency requested that we modify the title of our report because it believes the title significantly misrepresents the findings for Florida.

The State agency's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain that our findings and recommendations are correct. Regarding the State agency's comments on our first finding and corresponding recommendation, the Manual requires the State agency to conduct an onsite revisit or to obtain evidence of correction to confirm substantial compliance for all *D*-rated deficiencies. However, the State agency did not conduct onsite reviews for the 14 deficiencies, nor did it obtain evidence beyond reviewing the facilities' submitted POC.

The Manual § 7317.1 states, "[t]he [POC] serves as the facility's allegation of compliance in non-immediate jeopardy cases, substantial compliance cannot be certified by the State agency and any remedies imposed cannot be lifted until facility compliance has been verified." The State

agency disagrees and believes that "desk review" revisits that only review the POC are acceptable. Although we recognize that the State agency has the option to verify substantial compliance by conducting an onsite revisit or by obtaining evidence, those options require the State agency to do more than review and approve the facilities' POC. Without obtaining evidence of deficiency correction with which to verify substantial compliance, the State agency would inappropriately certify facility compliance based only on a review of a POC, which is an "allegation of compliance." Although the State agency disagreed with our interpretation of the Manual, we acknowledge the steps that it has taken to address our recommendation to improve its practices for verifying corrections of deficiencies.

In evaluating the State agency's comments on our second finding and corresponding recommendation, the State agency's comments do not appropriately acknowledge its responsibility or address actions it should take to ensure data integrity and prevent unintended data loss. CMS's contractor has stated that its records indicate that the State agency did not upload the revisit survey information for the two sample items once the surveys were completed. Other surveys conducted in Florida during the same period as the missing revisit data demonstrate that this was not a systems issue. CMS allows each State to define its own process for archiving survey data and to define its own process for reviewing and verifying survey findings. With the implementation of the new system in November 2017, we reiterate our recommendation that the State agency update controls to the extent possible to guard against unauthorized or unintended modification or loss of data.

Regarding the State agency's request that we revise our report title, although we understand the State agency's concern, the title is consistent with the findings and other similar reports issued nationwide. Based on its comments and the results of our statistical sample, the State agency may not have verified compliance for deficiencies cited in as many as 504 desk reviews during CY 2015.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to CMS's deficiency data, the State agency identified 5,486 deficiencies that required a correction plan during CY 2015. We compared CMS deficiency data with State agency data and identified 25 additional deficiencies that we added to the target population, resulting in 5,511 deficiencies. We excluded from our review 3,130 deficiencies that (1) were not directly related to resident health services or (2) had the ratings *B* or *C*, which did not require verification of correction. The remaining 2,381 deficiencies had ratings that required the State agency to verify correction by either obtaining evidence of correction (2,277 deficiencies) or conducting a followup survey (104 deficiencies). We selected for review a stratified random sample of 100 deficiencies.

We did not review the overall internal control structure of the State agency or the nursing homes associated with the selected sample items. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit, which included fieldwork at the State agency's office in Tallahassee, Florida, from January to November 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to gain an understanding of the State agency's oversight responsibilities for nursing homes and CMS's guidance to the State agency regarding verification of corrections of deficiencies identified during nursing home surveys;
- interviewed State agency officials and employees regarding survey operations, quality assurance, and training;
- obtained from CMS a database containing 5,486 deficiencies[9] that required a correction plan and were identified during standard and complaint surveys in Florida nursing homes in CY 2015;
- added 25 deficiencies that had not uploaded to the CMS database and removed 3,130 deficiencies that:

[9] This figure does not include A-rated deficiencies.

- were not directly related to resident health services[10] or
- had the ratings *B* or *C* (not requiring verification of correction);

- developed a stratified random sample from the remaining 2,381 deficiencies by:
  - creating 2 strata, representing deficiencies that required the State agency to obtain, at a minimum, evidence of correction (stratum 1) or that required the State agency to conduct a followup survey (stratum 2) and
  - selecting a total of 100 sample units, consisting of 70 sample units from stratum 1 and 30 sample units from stratum 2;

- reviewed State agency documentation for each sampled deficiency to determine whether the State agency had verified the nursing home's correction of the deficiency;[11]

- estimated the number and percentage of deficiencies in the sampling frame for which the State agency did not verify the nursing homes' correction in accordance with Federal requirements; and

- discussed the results of our review with State agency officials.

See Appendix C for the details of our statistical sampling methodology and Appendix D for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[10] We excluded deficiencies that were related to physical environment, residents' rights; admission, transfer, and discharge rights; dietary services, quality of life, and administration.

[11] Documentation included surveyor notes, training sign-in sheets, and invoices verifying purchase and repairs, if available.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
North Carolina Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-04-17-02500	1/4/18
New York Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-02-15-01024	10/19/17
Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-07-17-03218	9/6/17
Missouri Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes	A-07-16-03217	3/17/17
Arizona Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-09-16-02013	10/20/17
Oregon Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-09-16-02007	3/14/2016
Washington State Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid	A-09-13-02039	7/9/2015
Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect	OEI-07-13-00010	8/15/2014
CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries	A-09-12-02037	6/4/2014
Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries	OEI-06-11-00370	2/27/2014
Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements	OEI-02-09-00201	2/27/2013

Report Title	Report Number	Date Issued
Federal Survey Requirements Not Always Met for Three California Nursing Homes Participating in the Medicare and Medicaid Programs	A-09-11-02019	2/27/2012
Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs	A-09-09-00114	9/21/2011

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of all health deficiencies identified during nursing home surveys conducted by the State agency in CY 2015 and that required the State agency to verify the correction of deficiencies.

SAMPLING FRAME

We obtained from CMS a Microsoft Excel spreadsheet containing 5,486 deficiencies that required a correction plan and were identified during standard and complaint surveys of Florida nursing homes in CY 2015. CMS extracted the data from the Certification and Survey Provider Enforcement Reporting system. We then adjusted the deficiencies as shown in Table 2.

Table 2: Deficiencies Added or Removed

Reason for Adding or Removing Deficiencies	No. of Deficiencies Added or (Removed)
Added State agency survey deficiencies that did not upload to the CMS system	25
Removed deficiencies with ratings *B* or *C* that did not require verification of correction	(81)
Removed deficiencies not directly related to resident health services (e.g., fire safety, administration, residents' rights)	(3,049)
Net Total Removed	**(3,105)**

After we adjusted these deficiencies, the sampling frame consisted of 2,381 deficiencies.

SAMPLE UNIT

The sample unit was a health deficiency that was identified during a nursing home survey in CY 2015 and that required the State agency to verify the correction.

SAMPLE DESIGN

We used a stratified random sample containing two strata. Table 3 details the deficiency ratings and number of deficiencies in each stratum.

Table 3: Number of Deficiencies in Each Stratum

Stratum	Description	No. of Deficiencies
1	Deficiencies with ratings of *D* or *E*, or *F* without substandard quality of care	2,277
2	Deficiencies with ratings of *G* through *L*, or *F* with substandard quality of care	104
Total		**2,381**

SAMPLE SIZE

We selected a total of 100 sample units, consisting of 70 sample units from stratum 1 and 30 sample units from stratum 2.

SOURCE OF RANDOM NUMBERS

We generated the random numbers for each stratum using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After generating random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, OAS statistical software to estimate the statewide number and percentage of deficiencies for which the State agency did not verify the nursing homes' correction of deficiencies in accordance with Federal requirements.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Results

Stratum	No. of Deficiencies	Sample Size	No. of Deficiencies Not Verified by the State Agency
1	2,277	70	14
2	104	30	0
Total	**2,381**	**100**	**14**

Table 5: Estimated Statewide Number and Percentage of Deficiencies for Which the State Agency Did Not Obtain Nursing Homes' Evidence of Correction
(Limits Calculated at the 90-Percent Confidence Level)

	No. of Deficiencies Not Verified	Percentage of Deficiencies Not Verified by the State Agency
Point estimate	455	19%
Lower limit	278	12%
Upper limit	633	27%

Table 6: Sample Results

Stratum	No. of Deficiencies	Sample Size	No. of Deficiencies Evidence Not Provided by the State Agency
1	2,277	70	4
2	104	30	0
Total	**2,381**	**100**	**4**

Table 7: Estimated Statewide Number and Percentage of Deficiencies for Which the State Agency Could Not Provide Nursing Homes' Evidence of Correction
(Limits Calculated at the 90-Percent Confidence Level)

	No. of Deficiencies Evidence Not Provided	Percentage of Deficiencies Evidence Not Provided by the State Agency
Point estimate	130	5%
Lower limit	27	1%
Upper limit	233	10%

APPENDIX E: STATE AGENCY COMMENTS

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

February 23, 2018

Report Number: A-04-17-08052

Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

In response to review the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), draft report entitled *Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid*, please find our comments to the recommendations below. As an initial matter, and as described further herein, we have concerns about the accuracy of the audit's title. Thank you for the opportunity to review.

Recommendation #1
Improve its practices for verifying nursing homes' correction of identified deficiencies by obtaining nursing homes' evidence of correction for less serious deficiencies.

Agency Response and Corrective Action Plan

The Florida State Agency (SA) has interpreted the Centers for Medicare & Medicaid Services (CMS) requirement (Chapter 2 of the State Operations Manual, "The Certification Process") to allow for acceptance of the Plan of Correction (POC). Routine CMS reviews of the work process within the State of Florida has never identified a concern with the desk review process in Florida.

The references quoted by the auditors from Chapter 7 of the State Operations Manual (SOM) provide guidance to the SA. The language does not specifically require a state to collect additional documentation beyond the required POC to verify compliance when conducting desk review revisits. SOM Section 7317.2 specifically addresses onsite revisits; the SOM serves as CMS' guidance/direction to the state agencies. Many states have been reviewed under this audit, yet states have received no additional direction from CMS nor have revisions been made to the SOM.

Although we respectfully disagree with the interpretation by the auditors, as this has never been CMS' interpretation before, going forward staff of the Florida SA will require documentation to provide evidence of facility correction of those citations at a severity and scope of D or higher.

2727 Mahan Drive • Mail Stop 1
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

This will be, or has been, communicated to our management/ and supervisory staff as follows:

- During the February 2018 Field Office Managers' meeting supervisory/ management staff for the Bureau of Field Operations received an overview of the desk review process & required documentation.

- Upon completion of this staff training, quarterly quality audits of the desk review audit will be completed through 2018. A sample of nursing home desk reviews will be completed for each office. Concerns with the audit findings must be reported to the Chief of Field Operations and the individual Field Office Manager. Corrective actions will be required for any office not following the new process.

Also, the Agency respectfully requests that the title of the draft report, *Florida Did Not Always Verify Correction of Deficiencies Identified during Surveys of Nursing Homes Participating in Medicare and Medicaid,* be modified. In Calendar Year (CY) 2015, the Agency's Bureau of Field Operations conducted 20,770 routine and complaint surveys across all provider types. Of these surveys, 4,800 were conducted in nursing homes. During these 4,800 nursing home surveys, 10,274 deficiencies were cited. The Agency conducted 1,158 onsite revisits and 504 desk reviews during CY 2015 to verify that the deficiencies were corrected. Of the 10,274 deficiencies, 4,225 were for deficiencies with a severity/scope rating of A, B, or C, which qualify for correction by desk review. Given the volume of inspections and enormity of deficiencies cited and corrective actions, the 18 deficiencies identified in the audit represents a very small percent (0.42% of eligible deficiencies). **Moreover, all 18 of the deficiencies in question were isolated incidents (not patterns or widespread), and none of them involved patient harm or immediate jeopardy.** We are therefore concerned that the title significantly misrepresents the findings for Florida.

The following chart illustrates how Florida compares to other states with similar audits in the total number of deficiencies for which there was purportedly no evidence that corrections were verified. Florida has more certified nursing homes than any of the other comparative states but still only had 18 isolated deficiencies identified as having lacked evidence that corrections were verified. Given the volume of inspections, the deficiencies cited, and corrective actions taken, the 18 deficiencies identified in Florida's audit represent a very small percent (0.42% of eligible deficiencies). Again, we are concerned that the title significantly misrepresents the findings for Florida, given the extremely small number of isolated deficiencies and the apparent departure here from how CMS has normally required evidence of their correction.

Comparison of Florida with Other States

State	Audit Year	Number of certified NHs	Total Number of Deficiencies Investigated that Required a Correction Plan*	Audit Sample	Total Number of Deficiencies for which there was no evidence that corrections were verified
North Carolina	CY 2015	419	1,150	100	4
Florida	CY 2015	688	2,381	100	18

Arizona	CY 2014	144	650	100	42
Kansas	CY 2014	310	2,127	100	52
New York	CY 2014	626	4,361	100	57
Washington	CY 2012	234	1,390	100	70

*Excluded from review were deficiencies that were not directly related to resident health services or had the ratings B or C, which did not require verification of correction, or were not under the State's jurisdiction (This note was not included for New York).
Source: Department of Health and Human Services, Office of Inspector General reports A-09-16-02013, A-02-15-01024, A-04-17-02500, A-07-17-03218, A-09-13-02039, A-04-17-08052.

Recommendation #2
Update information system controls to ensure that survey system data is protected against unauthorized or unintended modification or loss.

Agency Response and Corrective Action Plan

As reported to staff of the HHS/OIG, the database for nursing home surveys during this period was developed and maintained by CMS. The SA was required to use this database, which was maintained by a CMS contractor. Although systems were in place to maintain data integrity, at times the program may have lost data, through no fault of an individual surveyor/ office. CMS initiated a new software program on November 28, 2017, replacing the previous system. It is anticipated this should provide added data reliability.

Thank you for the opportunity to respond to the draft report.

Sincerely,

Justin M. Senior
Secretary