Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WEST CARROLL CARE CENTER DID NOT ALWAYS FOLLOW CARE PLANS FOR RESIDENTS WHO WERE LATER HOSPITALIZED WITH POTENTIALLY AVOIDABLE URINARY TRACT INFECTIONS

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

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Deputy Inspector General
for Audit Services

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Office of Inspector General

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EXECUTIVE SUMMARY

West Carroll Care Center did not always provide services to its Medicare- and Medicaid-eligible residents in accordance with their care plans before the residents were hospitalized with urinary tract infections.

WHY WE DID THIS REVIEW

An Office of Inspector General study found that in Federal fiscal year 2011, nursing homes transferred about one-quarter of their Medicare beneficiary residents to hospitals for inpatient admissions. Medicare spent $14.3 billion on these hospitalizations. Some nursing homes had much higher hospitalization rates than others, suggesting that some hospitalizations may have been avoidable through better nursing home care. Louisiana nursing homes had the highest hospitalization rates of any State. One of the most frequent reasons for those hospitalizations was a urinary tract infection (UTI), which is a clinically detectable condition occurring when disease-causing microorganisms invade some part of the urinary tract.

A Centers for Medicare & Medicaid Services (CMS)-sponsored study identified conditions, including UTIs, that are associated with potentially avoidable hospitalizations of nursing home residents. The study found that a UTI is a condition that is generally preventable and manageable in the nursing home setting.

We selected for review West Carroll Care Center (the Nursing Home) because about 75 percent of resident hospitalizations during the period October 1, 2011, through May 14, 2013, occurred because of conditions the CMS-sponsored study found to be associated with potentially avoidable hospitalizations. A UTI was the most frequent reason for the hospitalizations.

The objective of this review was to determine whether the Nursing Home provided services to its residents in accordance with their care plans, as required by Federal regulations, before the residents were hospitalized with UTIs.

BACKGROUND

Federal regulations require that nursing home services be provided in accordance with each resident's written care plan, which nursing homes develop based on comprehensive resident assessments. Individual services included in care plans are known as care plan approaches.

Dehydration can increase the risk for contracting a UTI, which may cause a change in a resident's physical or mental condition or a change in urine appearance. Care plan approaches that may prevent or detect a UTI may include (1) monitoring and documenting a resident's hydration status; (2) monitoring and documenting a resident's physical or mental condition; or (3) observing and documenting a resident's urine appearance, or a combination of these.

HOW WE CONDUCTED THIS REVIEW

We reviewed Nursing Home records for 17 Medicare- and Medicaid-eligible residents who were hospitalized 23 times with a UTI during the period October 1, 2011, through May 14, 2013. Our review covered each resident's Nursing Home records for up to 60 days before each hospitalization. Therefore, our audit period was August 1, 2011, through May 14, 2013.

We reviewed the Nursing Home's care records to determine whether the Nursing Home followed certain care plan approaches that can prevent or detect UTIs. Additionally, we contracted with an independent medical review contractor to review the records supporting the 23 hospital claims.

WHAT WE FOUND

The Nursing Home did not always provide services to its residents in accordance with their care plans, as required by Federal regulations, before they were hospitalized with UTIs. Specifically, the Nursing Home staff did not monitor and document residents' hydration status, monitor and document residents' conditions, or document residents' urine appearances as their care plans required.

All 23 nursing home stays that we reviewed involved residents with 1 or more care plan approaches that can prevent or detect a UTI. The Nursing Home staff did not follow the residents' care plans for 22 of the 23 stays. In many cases, there were significant lapses in providing these services.

These deficiencies occurred because the Nursing Home did not have policies and procedures to ensure that its staff provided services in accordance with its residents' care plans. As a result, the residents were at increased risk for contracting infections and becoming hospitalized.

During our audit, the Nursing Home developed policies and procedures requiring that the director of nursing or a designee conduct reviews to ensure that the nursing staff follows residents' care plans.

WHAT WE RECOMMEND

We recommend that the Nursing Home implement its newly developed policies and procedures requiring that:

- its nursing staff follow residents' care plans and
- the director of nursing or a designee conduct reviews to ensure that the nursing staff follows residents' care plans.

NURSING HOME COMMENTS

In written comments on our draft report, the Nursing Home agreed with our findings and stated that it has implemented corrective actions, including new and revised policies, staff education, and continued audits to ensure staff compliance with policies and procedures.

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INTRODUCTION

WHY WE DID THIS REVIEW

An Office of Inspector General (OIG) study found that in Federal fiscal year (FY) 2011, nursing homes transferred about one-quarter of their Medicare residents to hospitals for inpatient admissions.[1] Medicare spent $14.3 billion on those hospitalizations. Some nursing homes had much higher hospitalization rates than others, suggesting that some hospitalizations may have been avoidable through better nursing home care. Louisiana nursing homes had the highest hospitalization rates of any State, transferring 38 percent of their Medicare residents to hospitals for inpatient admissions. One of the most frequent reasons for those hospitalizations was a urinary tract infection (UTI).

A CMS-sponsored study identified conditions, including UTIs, that are associated with potentially avoidable hospitalizations of nursing home residents.[2] The study found that a UTI is a condition that is generally preventable and manageable in the nursing home setting.

We selected for review West Carroll Care Center (the Nursing Home) because about 75 percent of the resident hospitalizations during the period October 1, 2011, through May 14, 2013, occurred because of conditions the CMS-sponsored study found to be associated with potentially avoidable hospitalizations. A UTI was the most frequent reason for the Nursing Home's resident hospitalizations, accounting for 18 percent of all hospitalizations.

OBJECTIVE

Our objective was to determine whether the Nursing Home provided services to its residents in accordance with their care plans, as required by Federal regulations, before the residents were hospitalized with UTIs.

BACKGROUND

Federal Requirements

Sections 1819 and 1919 of the Social Security Act provide that nursing homes participating in the Medicare and Medicaid programs, respectively, must meet certain specified requirements. These requirements are contained in Federal regulations at 42 CFR part 483, subpart B, which state that nursing homes must:

- conduct comprehensive assessments of each resident's functional capacity and

[1] *Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring* (OEI-06-11-00040), November 2013.

[2] *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations From Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs*, RTI International, August 2010.

- develop and follow a comprehensive care plan addressing each resident's care needs.

Regulations also state that the services provided or arranged by the facility must be provided in accordance with each resident's written plan of care (42 CFR, subpart B, § 483.20(k)(3)(ii)). Individual services included in care plans are known as care plan approaches.

Urinary Tract Infections

A UTI is a clinically detectable condition associated with invasion by disease-causing microorganisms of some part of the urinary tract. Dehydration can increase the risk for developing a UTI. UTI symptoms may include a change in a resident's physical or mental condition (e.g., confusion, decreased activity) or a change in the resident's urine appearance (e.g., onset of bloody urine, amount of sediment).

Accordingly, care plan approaches that can prevent or detect a UTI may include:

- monitoring and documenting a resident's hydration status (prevention),
- monitoring and documenting a resident's condition (detection), and/or
- observing and documenting a resident's urine appearance (detection).

West Carroll Care Center

The Nursing Home is an 80-bed facility in Oak Grove, Louisiana, that provides skilled care, short-term rehabilitation, and long-term-care services.

HOW WE CONDUCTED THIS REVIEW

We reviewed Nursing Home records for 17 Medicare- and Medicaid-eligible residents who were hospitalized 23 times with a UTI during the period October 1, 2011, through May 14, 2013. Our review covered each resident's Nursing Home records for up to 60 days before each hospitalization.[3] Therefore, our audit period was August 1, 2011, through May 14, 2013.

We reviewed the Nursing Home's care records for the 17 residents to determine whether the care plans contained 1 or more of the following care plan approaches that can prevent or detect a UTI:

- monitoring and documenting the resident's hydration status,
- monitoring and documenting the resident's condition, and
- observing and documenting the resident's urine appearance.

[3] We refer to this time period as the "nursing home stay."

If a care plan contained one or more of these care plan approaches, we determined whether the Nursing Home staff followed the approach and whether they did so at the frequency specified within the care plan.

Additionally, we used an independent medical review contractor to review the records supporting the 23 hospital claims.

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.

See Appendix A for the details of our audit scope and methodology and Appendix B for the sample results on the Nursing Home's compliance with care plan approaches.

FINDINGS

The Nursing Home did not always provide services to its residents in accordance with their care plans, as required by Federal regulations, before the residents were hospitalized with UTIs. Specifically, the Nursing Home staff did not monitor and document residents' hydration status, monitor and document residents' conditions, and document residents' urine appearances as their care plans required.

All 23 nursing home stays that we reviewed involved residents with 1 or more care plan approaches that can prevent or detect a UTI:

- monitoring and documenting the resident's hydration status (20 stays),
- monitoring and documenting the resident's condition (10 stays), and
- monitoring and documenting the resident's urine appearance (8 stays).

The Nursing Home staff did not follow the residents' care plans for 22 of the 23 stays. Because one care plan did not state the frequency with which the care plan approaches were to be performed, we could not determine whether the Nursing Home staff adequately followed it.

In many cases, there were significant lapses in providing these services as required. (See Appendix B.) For the nursing home stays we reviewed, the Nursing Home staff did not:

- monitor and document residents' hydration status 95 percent of the time,
- monitor and document the residents' condition 68 percent of the time, and
- monitor and document the residents' urine appearance 50 percent of the time.

These deficiencies occurred because the Nursing Home did not have policies and procedures to ensure that its staff provided services in accordance with its residents' care plans. As a result, the residents were at increased risk for contracting infections and becoming hospitalized.

THE NURSING HOME DID NOT ALWAYS PROVIDE SERVICES TO ITS RESIDENTS IN ACCORDANCE WITH THEIR CARE PLANS

Inadequate Monitoring of Residents' Hydration Status

Of the 23 nursing home stays that we reviewed, 20 stays involved residents with care plans requiring that the Nursing Home staff check the residents for signs of dehydration, as evidenced by, for example, poor skin elasticity or dry mouth, and document their findings.

In all 20 cases, the Nursing Home did not meet this requirement before the residents were hospitalized with a UTI. Overall, the Nursing Home staff did not document that it had monitored the residents' hydration status at the frequencies the care plans required on 95 percent of the days we reviewed.

For example, the resident care plan for sampled Nursing Home stay number 6 (Appendix B) required that the Nursing Home staff monitor the resident for dehydration and document the findings at least every shift. However, during the 60 days before the resident was hospitalized with a UTI:

- The staff documented monitoring the resident for dehydration every shift on only 1 day.
- On 2 days, the staff documented monitoring the resident for dehydration on only one shift each day.
- For the remaining 57 days, the staff did not document monitoring the resident for dehydration at all.

For this sampled stay, the staff did not document that it had monitored the resident's hydration status at the frequency the care plan required on 98 percent of the days we reviewed.

Inadequate Monitoring of Residents' Conditions

Of the 23 nursing home stays that we reviewed, 10 stays involved residents with care plans requiring that the Nursing Home staff monitor and document the residents' conditions.

In all 10 cases, the Nursing Home did not meet this requirement before the residents were hospitalized with a UTI. Overall, the Nursing Home staff did not document that it had monitored the residents' conditions at the frequencies the care plans required on 68 percent of the days we reviewed.

For example, the resident care plan for sampled Nursing Home stay number 13 required that the Nursing Home staff monitor and document the resident's condition at least every shift.

However, during the 60 days before the resident was hospitalized with a UTI:

- The staff documented monitoring the resident's condition every shift on only 1 day.
- On 10 days, the staff documented monitoring the resident's condition on only one shift each day.
- For the remaining 49 days, the staff did not document monitoring the resident's condition at all.

For this sampled stay, the staff did not document that it had monitored the resident's condition at the frequency the care plan required on 98 percent of the days we reviewed.

Inadequate Documentation of Residents' Urine Appearance

Of the 23 nursing home stays that we reviewed, 8 stays involved residents with care plans requiring that the Nursing Home staff observe and document the residents' urine appearance.

In all eight cases, the Nursing Home did not meet this requirement before the residents were hospitalized with a UTI. Overall, the Nursing Home staff did not document the residents' urine appearance at the frequencies the care plans required on 50 percent of the days we reviewed.

For example, the resident care plan for sampled Nursing Home stay number 20 required that the Nursing Home staff observe and document the resident's urine appearance every shift. However, during the 60 days before the resident was hospitalized with a UTI:

- The staff documented the resident's urine appearance every shift on only 15 days.
- On 29 days, the staff documented the resident's urine appearance on only one shift each day.
- For the remaining 16 days, the staff did not document the resident's urine appearance at all.

For this sampled stay, the staff did not document the resident's urine appearance at the frequency the care plan required on 75 percent of the days we reviewed.

THE NURSING HOME DOCUMENTED SERVICES ON AN EXCEPTION-ONLY BASIS

Nursing Home officials stated that the Nursing Home's practice was to document services on a resident's chart on an exception-only basis. If there was no change in a resident's health, the staff did not document services on the resident's chart.

This method of documenting services is insufficient. The three care plan approaches we reviewed required that the Nursing Home staff document services each time they were

performed. We believe that this documentation method would have helped ensure that all Nursing Home staff treating the residents on various days and shifts had an understanding of each resident's health status and care needs.

All of the nursing home stays we reviewed involved residents at increased risk for UTIs because of their (1) potential for dehydration (20 stays), (2) histories of UTI (10 stays), and (3) utilization of indwelling catheters[4] for bladder elimination (8 stays). Because the care plan approaches we reviewed were designed to mitigate these risks, following the approaches as indicated was critical.

During our audit, Nursing Home officials agreed that the Nursing Home's documentation procedures were inadequate and revised them to require that:

- its nursing staff follow the care plan approaches at the specified frequencies and
- the director of nursing or a designee conduct reviews of all patient charts to ensure that the nursing staff follows all care plan approaches at the specified frequencies.

EFFECT OF THE NURSING HOME NOT FOLLOWING RESIDENTS' CARE PLANS

As a result of the Nursing Home not following residents' care plans, the residents were at increased risk for contracting infections and becoming hospitalized. The medical reviewers confirmed that UTI diagnoses were supported in the hospital medical records for all 23 resident hospitalizations and that all residents required hospital care. Additionally, for 5 of the 23 hospitalizations, the residents experienced UTI-related complications.

RECOMMENDATIONS

We recommend that the Nursing Home implement its newly developed policies and procedures requiring that:

- its nursing staff follow residents' care plans and
- the director of nursing or a designee conduct reviews to ensure that the nursing staff follows residents' care plans.

NURSING HOME COMMENTS

In written comments on our draft report, the Nursing Home agreed with our findings and stated that it has implemented corrective actions, including new and revised policies, staff education, and continued audits to ensure staff compliance with policies and procedures. The Nursing Home's comments appear in their entirety as Appendix C.

[4] An indwelling catheter is a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Nursing Home records for 17 Medicare- and Medicaid-eligible residents who were hospitalized 23 times with a UTI during the period October 1, 2011, through May 14, 2013. Our review of Nursing Home records covered up to 60 days before each hospitalization.[5] Therefore, our audit period was August 1, 2011, through May 14, 2013.

We reviewed each resident's care plan to determine whether the care plan contained one or more of the following care plan approaches that can prevent or detect a UTI:

- monitoring and documenting the resident's hydration status,
- monitoring and documenting the resident's condition, and
- observing and documenting the resident's urine appearance.

Additionally, we used an independent medical contractor to review the hospital records to determine the medical necessity of the hospitalizations and to verify the residents' UTI diagnoses.

We did not review the overall internal control structure of the Nursing Home. We reviewed only those internal controls that were significant to our audit objective.

We conducted our audit work, including fieldwork at the Nursing Home in Oak Grove, Louisiana, from October 8, 2014, to September 17, 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed data matches showing transfers of nursing home residents between nursing homes and hospitals during the audit period using data combined from nursing home resident assessments called the Minimum Data Set, beneficiary information from the CMS Enrollment Database, and hospital claims data from the National Claims History (NCH) file;
- reviewed hospital inpatient claims data from CMS's NCH file for sample items with service dates during the audit period;

[5] We refer to this time period as the "nursing home stay." If a resident was absent from the facility during the 60-day period, we obtained records from the time the resident was readmitted to the facility to the time of hospitalization.

- selected the Nursing Home for review based on our analysis of the data;

- determined that 18 of the Nursing Home's FY 2012 residents were hospitalized 24 times for a UTI during our audit period;

- excluded 1 hospitalization of 1 resident from our review because the Medicare Recovery Audit Contractor[6] had already selected the hospital claim for medical review;

- used an independent medical review contractor to determine whether the hospital claims were medically necessary and to verify the residents' UTI diagnoses;

- reviewed each resident's care plan to determine whether it included 1 or more of the care plan approaches included in our audit scope;

- reviewed the Nursing Home's records to determine whether the Nursing Home staff followed the care plan approaches at the specified frequencies;

- interviewed Nursing Home personnel to obtain an understanding of the internal controls related to ensuring that care plan approaches are followed; and

- discussed our findings with Nursing Home personnel to determine the underlying causes of noncompliance.

[6] CMS contracts with Medicare Recovery Audit contractors to identify and correct Medicare improper payments.

APPENDIX B: THE NURSING HOME'S COMPLIANCE WITH CARE PLAN APPROACHES

	Monitoring of Residents' Hydration Status				
Sample Number	**Care Plan Services Provided**		**Total Days Reviewed**	**Days Not in Compliance**	**Percent of Days Not in Compliance**
1		No	57	54	95%
2		No	19	19	100
3		No	60	55	92
4		No	60	57	95
5	N/A				
6		No	60	59	98
7		No	32	32	100
8		No	60	56	93
9		No	60	58	97
10		No	60	55	92
11		No	60	55	92
12		No	13	11	85
13		No	60	57	95
14		No	60	57	95
15		No	60	59	98
16	N/A				
17		No	60	56	93
18		No	3	3	100
19		No	39	36	92
20	N/A				
21		No	60	56	93
22		No	48	44	92
23		No	60	58	97
Total		**20**	**991**	**937**	**95%**

	Monitoring of Residents' Conditions				
Sample Number	**Care Plan Services Provided**		**Total Days Reviewed**	**Days Not in Compliance**	**Percent of Days Not in Compliance**
1		No	57	44	77%
2		No	19	4	21
3	N/A				
4	N/A				
5		No	60	57	95
6	N/A				
7		No	18	3	17
8		No	60	20	33
9	N/A				
10	N/A				
11	N/A				
12		No	13	2	15
13		No	60	59	98
14	N/A				
15	N/A				
16	N/A				
17	N/A				
18		No	3	1	33
19		No	39	29	74
20	N/A				
21	N/A				
22		No	48	38	79
23	N/A				
Total		**10**	**377**	**257**	**68%**

	Documentation of Residents' Urine Appearance				
Sample Number	**Care Plan Services Provided**		**Total Days Reviewed**	**Days Not in Compliance**	**Percent of Days Not in Compliance**
1		No	28	15	54%
2		No	19	6	32
3	N/A				
4	N/A				
5	N/A				
6	N/A				
7	N/A				
8		No	60	25	42
9	N/A				
10		No	46	18	39
11	N/A				
12		No	13	5	38
13	N/A				
14	N/A				
15	N/A				
16	N/A				
17	N/A				
18		No	3	2	67
19	N/A				
20		No	60	45	75
21	N/A				
22		No	13	6	46
23	N/A				
Total		**8**	**242**	**122**	**50%**

APPENDIX C: NURSING HOME COMMENTS

West Carroll Care Center

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April 28, 2016

Report Number: A-06-14-00073

Mr. Paul Garcia
Audit Manager
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, Texas 75242

Dear Mr. Garcia,

We have received the draft report from the audit period August 1, 2011 through May 4, 2013 conducted at West Carroll Care Center.

After review of the draft report West Carroll Care Center concurs with the reported findings. Corrective actions and measures have been implemented including establishing new policies and revisions of existing policies, staff in-service and continuing education, and continued audits to ensure staff compliance of policies and procedures.

Thank you to you and your staff for the assistance offered to improve the quality of care provided to the residents of West Carroll Care Center.

Please contact me at [redacted] if additional information is needed.

Sincerely,

Dewana Little
Administrator

OIG Note: We redacted the phone numbers because they were personally identifiable information.