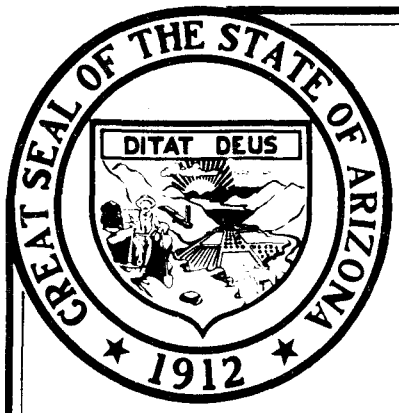

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

HEALTH CARE FACILITIES FUNCTION

Report to the Arizona Legislature
By the Auditor General
July 1988
88-5

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July 13, 1988

Members of the Arizona Legislature
The Honorable Rose Mofford, Governor
Mr. Theodore E. Williams, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Health Services, health facilities licensing function. This report is in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee.

The report addresses the need for stronger enforcement of agency regulations. Weak enforcement by DHS threatens residents in nursing homes and supervisory care homes. Lax enforcement by DHS also jeopardizes the health and safety of children in day care. In addition, the lack of an efficient tracking system may impair DHS's ability to handle day care complaints in a timely manner.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, health facilities licensing function, in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

This is the first in a series of reports to be issued on the Arizona Department of Health Services (DHS). The report focuses on the functions of health care facilities offices under the Division of Emergency Medical Services/Health Care Facilities.

Ineffective Enforcement By The Department Of Health Services Threatens The Health And Safety Of Residents In Long-Term Care Facilities (see pages 9 through 18).

Weak enforcement by the DHS threatens residents in nursing homes and supervisory care homes. Though the Department has closed some facilities where care endangered patients, many others with serious deficiencies continue to operate undeterred. Our Office found extensive, and often repeated, noncompliance with important health and safety related regulations. One nursing home repeated 45 serious deficiencies during a 32-month period. Some of the violations this facility was cited for include:

- psychological and physical abuse of patients
- inadequate medical and nursing care of patients
- improper use of restraints
- deficient food and nutrition services

Despite widespread noncompliance among long-term care facilities, our review shows that enforcement action by the Department is rare, particularly use of formal intermediate sanctions.

DHS needs a stronger commitment to enforcement, and should consider requesting statutory changes to upgrade its enforcement capabilities, such as a provision to more quickly assess civil penalties. As a guide, DHS could use the intermediate sanctions recently adopted by the Federal government for nursing homes in the Medicare/Medicaid programs.

Weak Enforcement Action By The Department Of Health Services Threatens The Health And Safety Of Children In Day Care (see pages 19 through 30).

Lax enforcement by DHS also jeopardizes the health and safety of children in day care. As in the long-term care program, our sample of day care files revealed serious, and often repeated, violations of rules and regulations, yet little enforcement action by DHS. For example, between 1985 and 1987 one center had 100 citations for violating regulations most likely to affect a child's health and safety including failure to adequately supervise children, use of unqualified and underaged staff, unlocked cleaning supplies, poisonous plants on the playground and algae covered bathroom faucets. Sexual abuse of children was also alleged on three occasions. DHS responded to these problems by holding an "enforcement meeting" and placing the center on a provisional license. However, DHS took no further action when the center later violated the terms of the enforcement meeting. In fact, DHS issued the center a regular three-year license, despite citing it for 11 additional serious violations.

One explanation for DHS's weak enforcement is its lack of an aggressive enforcement philosophy. The agency's philosophy is to "work with centers" rather than take strong enforcement actions against them. Also, DHS has no guidelines mandating when enforcement actions should be taken.

In addition to a stronger enforcement policy, DHS should develop additional sanctions to improve compliance. Civil penalties, bans on admissions and postings of inspection results are sanctions that have been used in other states and could be considered by DHS.

The Department of Health Services Should Improve Its Day Care Complaint Handling Procedures (see pages 31 through 34).

DHS does not follow its established policies and procedures regarding tracking complaints or timeliness of complaint investigations. The policies specify a timeframe for investigating complaints that ranges from 24 hours to 20 working days, depending on the severity of the allegation and the location of the center.

To ensure that all day care complaints are investigated in a timely manner, DHS's policies and procedures call for the use of both a manual and computerized system to track complaints. The Day Care Office does not keep its manual log up-to-date, and has not implemented a computerized tracking system.

DHS's lack of an efficient tracking system may impair its ability to handle complaints in a timely manner. For example, based on a sample file review, DHS did not investigate 29 percent of its day care complaints within the timeframe specified in its policies and procedures. Further, some DHS day care licensing specialists were unaware of specific timeframes established for complaint investigations.

TABLE OF CONTENTS

APPENDIX

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Health Services, health facilities licensing function, in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

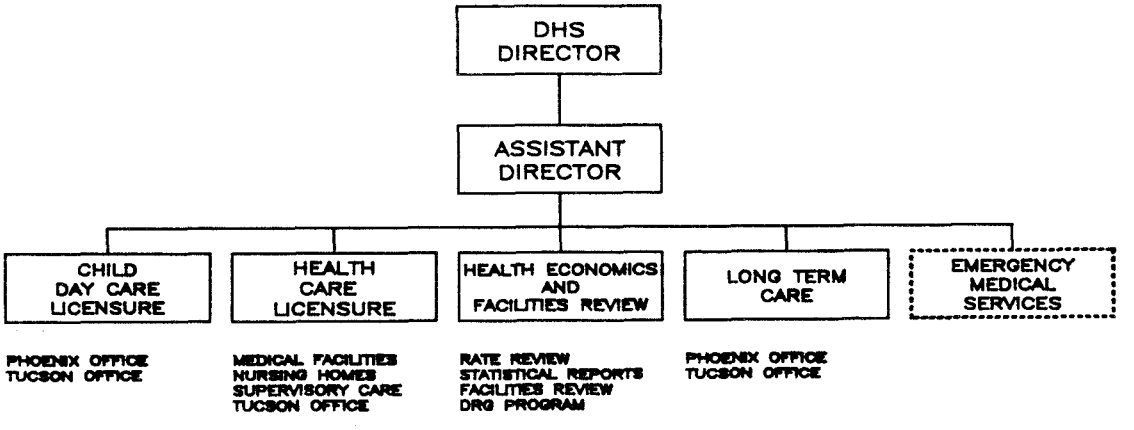
This is the first in a series of reports to be issued on the Arizona Department of Health Services (DHS). The report focuses on the functions of health care facilities offices under the Division of Emergency Medical Services/Health Care Facilities.

Functions and Organization

The Division of Emergency Medical Services/Health Care Facilities has two primary functions: (1) to regulate emergency medical services, and (2) to regulate health care and child day care institutions. Four of the Division's five offices are focused on the regulation of health care and day care institutions. These four offices - Child Day Care Licensure, Health Care Licensure, Health Economics and Facilities Review, and Long Term Care - are the subject of this report. The fifth office, Emergency Medical Services, will be covered in a separate audit. The four Health Care Facility Offices follow Federal and Arizona statutes and rules which govern the licensing and monitoring of health care facilities and child day care centers.

FIGURE I

DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES/HEALTH CARE FACILITIES



Source: Department of Health Services Organization Chart

The Division is also responsible for rate review of hospitals and nursing homes, and consultation services to long-term care facilities.

Child Day Care Licensure - The goal of the Child Day Care Licensure Office is to protect the health and safety of children enrolled in child day care centers. A December 1985 report states that more than 54,000 children are cared for in licensed Arizona day care centers. Based on statutes and rules and regulations, DHS regulates centers to ensure that a safe, clean and healthy physical environment is maintained, adequate supervision is provided, nutritious food is served, and appropriate care and activity is provided.

The Office's principal program function is licensing and inspecting centers. The number of licensed child day care centers has more than doubled in the past 12 years. In 1976 DHS licensed 443 child day care facilities. Today there are more than 900 licensed centers in the state.[1] DHS issues a regular license for a three-year period, although A.R.S. §36-885.B requires at least one unannounced inspection per center annually. Each licensing specialist is currently responsible for licensing and inspecting approximately 130 centers. DHS also investigates more than 900 complaints against licensed and unlicensed centers annually.

Health Care Licensure - This Office is responsible for licensing health care facilities throughout the state, and is organized into two sections. The Medical Facilities Section licenses hospitals, home health agencies, outpatient surgery facilities, infirmaries, and health maintenance organizations. The Long-Term Care Section licenses nursing homes and supervisory care facilities.

Long-term care facilities in Arizona care for approximately 10,000 residents. Although the elderly constitute the majority of long-term care

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(1) A.R.S. §36-881.3 defines a day care center as any facility that regularly receives compensation for the care of five or more children not related to the proprietor.

care residents, facilities also care for the developmentally disabled, the chronically mentally ill and the severely physically disabled of any age group. The level of care required of residents may range from general supervision as found in supervisory care homes to continuous nursing care as provided in nursing care institutions.[1]

To ensure that residents receive appropriate care, the Long-Term Care Section inspects and licenses facilities. In this regard, the section has two major functions: medicare certification surveys and state licensing inspections. For long-term care facilities to receive Medicare monies, they must comply with Federal standards and be certified. The Federal government establishes the certification criteria but delegates surveying to the state.[2] As of February 1988, 57 percent of nursing homes in Arizona had medicare certified beds. None of the supervisory care homes are medicare certified.

In addition to medicare surveys, the Office performs state licensing inspections. Staff inspect more than 240 nursing homes and 180 supervisory care facilities to determine compliance with licensure requirements. Licensing surveys are conducted annually, and usually in conjunction with the medicare certification survey. DHS may grant a provisional license (up to one year) to facilities with deficiencies that are readily correctable.

Complaint investigation is another duty of the section. Staff annually investigate approximately 800 nursing home complaints and 200 supervisory care home complaints. Staff also investigate reports of unlicensed facilities.

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(1) A.R.S. §§36-401.A.30 and 31 define a supervisory care home as a residential care facility in which residents receive accommodation, board and general supervision, including assistance in the self-administration of medications. A.R.S. §§36-401.A.21 and 22 define a nursing care institution as a health care institution for individuals who need nursing services on a continuing basis but do not require hospital care. The nursing services are performed under the direction of a physician or registered nurse.

(2) Arizona receives Federal monies for performing Medicare certification activities.

Long-Term Care - The Long-Term Care Office (LTCO) is separate from the Long-Term Care Section, which licenses facilities. LTCO provides technical assistance, related support services and information to individuals, families and long-term health care providers. It serves as a consulting group to nursing homes and supervisory care homes. Staff provide information on nursing care, social services, nutrition and health education to providers desiring assistance. The Office also prepares an annual directory to long-term care facilities and a guide to selecting long term care.

Health Economics And Facilities Review - This Office has three sections: Facilities Review, Health Economics And Rate Review, and Hospital Discharge Data. The Facilities Review Section reviews architectural/construction drawings for health care institutions and day care centers to ensure that national safety codes, building standards and other construction regulations are followed. These reviews are part of the statutory permit process. According to the Department, the section performs approximately 310 on-site inspections each year to determine construction compliance.

The Health Economics and Rate Review Section collects and analyzes rate review and uniform financial information for hospitals and nursing homes. This information is compiled semiannually in a public report, and compares room rate and ancillary service cost data from 73 hospitals and 130 nursing homes. The Section also reviews and makes recommendations on proposed rate increases for hospitals and nursing homes.

The Hospital Discharge Data Section collects and analyzes data regarding the number of procedures performed and the associated costs. This is compiled annually in the Comparative Hospital Cost Report, and is available to consumers statewide. The Section also prepares a more extensive analysis which is used mainly by providers and other government agencies.

Budget and Staff

The Health Care Facilities offices are principally funded through General Fund appropriations.[1] The Offices' budget for fiscal years 1985-86 through 1987-88 are presented in Table 1. Table 2 shows the number of authorized staff by Office for fiscal years 1985-86 through 1987-88.

TABLE 1

DEPARTMENT OF HEALTH SERVICES - HEALTH CARE FACILITIES OFFICES
BUDGET FOR FISCAL YEARS 1985-86 THROUGH 1987-88

	1985-86	1986-87	1987-88
Child Day Care Licensure	$ 392,089	$ 495,614	$ 518,198
Health Care Licensure	513,523	580,905	573,068
Long-Term Care Services	402,543	418,225	448,110
Health Economics And Facilities Review Division Total	$2,053,701	$2,267,351	$2,290,583

Source: Department of Health Services Budget Office.

(1) As mentioned, the State also receives Federal monies for administering medicare certifications.

TABLE 2

DEPARTMENT OF HEALTH SERVICES - HEALTH CARE FACILITIES OFFICES
AUTHORIZED STAFF FOR FISCAL YEARS 1985-86 THROUGH 1987-88

	1985-86	1986-87	1987-88
Child Day Care Licensure	15	18	19
Health Care Licensure	19.75	19.5	18.5
Long Term Care Services	11.5	11	11
Health Economics and Facilities Review	18	20	20

Source: Department of Health Services Budget Office

Audit Scope And Purpose

This audit was conducted to evaluate the adequacy of regulation by the Department of Health Services, Health Care Facilities, focusing on these specific areas.

- The adequacy of the Health Care Licensure Office's enforcement of statutes and rules and regulations governing licensed long-term care facilities.

- The adequacy of the Child Day Care Licensure Office's enforcement of statutes and rules and regulations governing licensed child day care centers.

- The Child Day Care Licensure Office's compliance with complaint handling policies and procedures.

This report also contains Other Pertinent Information regarding deregulation and its effects on the hospital and nursing homes industry.

The section Area For Further Audit Work addresses an issue we identified during the course of our audit but were unable to research due to time constraints.

The methodological design and sampling procedures used to develop this report are described in the Appendix.

This audit was conducted in accordance with generally accepted governmental auditing standards.

The Auditor General and staff express appreciation to the Director and staff of the Department of Health Services, and specifically the staff of the Division of Emergency Medical Services/Health Care Facilities, for their cooperation and assistance during the course of our audit.

FINDING I

INEFFECTIVE ENFORCEMENT BY THE DEPARTMENT OF HEALTH SERVICES THREATENS THE HEALTH AND SAFETY OF RESIDENTS IN LONG-TERM CARE FACILITIES

Weak enforcement by the Department of Health Services (DHS) threatens residents in nursing homes and supervisory care homes. Patient health, safety and welfare is in danger because DHS permits poor patient care at long-term care facilities. To increase institutional compliance, greater reliance on enforcement action is needed.

Poor Patient Care Permitted By The Department

DHS risks patient health, safety and welfare by permitting poor health care at nursing homes and supervisory care homes. Although the Department has closed some facilities where poor care endangered patients, many others with serious deficiencies continue to operate undeterred. Consequently, repeated noncompliance with important regulations is widespread.

Closed facilities - The Department has closed several facilities where inadequate care placed patient lives in imminent danger. According to records, the Department either denied or revoked nursing home licenses four times in fiscal year 1985, five times in fiscal year 1986, and five times again in fiscal year 1987. Likewise, DHS was responsible for closing three supervisory care homes in fiscal year 1985, five in fiscal year 1986, and five in fiscal year 1987.

Institutions with serious health problems operate undeterred - DHS enforcement is generally weak, however, and intermediate actions are rarely taken against institutions whose care endangers patients. The following case examples illustrate this:

- CASE 1

  During a 31 month period, from late April 1985 through mid December 1987, this nursing home was surveyed eleven times. Numerous com-

plaints were made against this facility and it was cited for 130 violations of regulations most likely to affect a patient's health and safety. A summary of the facility's problems and DHS's activities during this period are listed below.

April 26, 1985 - During a licensing inspection conducted at this facility, a DHS survey team found numerous maintenance and housekeeping deficiencies. There were holes in walls and ceilings, and the patient call system was out for an entire wing. The team also reported that not all incontinent patients were bathed often enough to prevent body odor. The survey team leader recommended that a follow-up survey be completed before issuing a license to this facility.

A six-month provisional license was issued without any follow-up, based only on the facility's plan of correction.

June 25,1985 - The Department investigated a complaint alleging that the facility was understaffed. This allegation was partially substantiated.

September 6, 1985 - Care at this facility was deteriorating and DHS concluded there was "potential . . . endangerment [to the] health, safety, and welfare of the patients." Patients examined by surveyors were wet and unchanged. Dried brown fecal matter was on the floors of at least five patient rooms and bathrooms.

One patient was found hanging through the side rails of her bed. A body restraint had slid up around her neck.

Other serious deficiencies were cited during this visit. For example, medical techniques important for preventing the spread of infection were not being followed by all personnel.(1) The facility also admitted 30 patients at a time when it was experiencing severe staffing problems.

DHS scheduled an enforcement meeting with the facility because of the serious deficiencies found. The facility was allowed to retain its provisional status.

December 6, 1985 - A second follow-up survey, three months later, revealed continued noncompliance. Staffing was inadequate and the facility was still in need of repair. DHS scheduled a second enforcement meeting with the facility and issued a second six-month provisional license.

January 13, 1986 - According to the health care licensure bureau chief, the facility agreed to a ninety day freeze on admissions following the enforcement meeting with the department. This action was apparently an informal action, however, as there is no record of the action or any departmental follow-up in the files.

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(1) Infection can be particularly dangerous among the elderly.

February 20, 1986 - DHS investigated a complaint alleging that the facility was short staffed and had poor all-round patient care. DHS was unable to substantiate the allegations, but found other deficiencies.(1) Floors in two rooms were soiled with feces. In one case, surveyors found no evidence that a patient received a complete neurological exam ordered by a doctor. In another case, a patient's care plan did not reflect a 15-pound weight loss.

The facility retained its provisional status.

June 12, 1986 - DHS received another complaint alleging understaffing and poor patient care. Although DHS was unable to substantiate many of the allegations, serious violations were again found. Six patients received equal portions of food and the same menu - regardless of their dietary orders. No evaluations for weight and dietary needs had been done for four other patients. In addition, dinner did not appear to be well balanced and well prepared. The facility was undergoing a change in ownership, and consequently, maintained its provisional status after this survey.(2)

June 19, 1986 - A licensing inspection again found previously cited deficiencies. On 21 separate occasions staffing was below minimum standards in various units, infection control problems were noted, and maintenance and housekeeping practices were deficient. Floors in several rooms were soiled with feces and other sticky material.

The new owners were not held responsible for repeating violations cited under the previous ownership, and DHS issued a six-month regular license.

August 28, 1986 - Responding to a complaint, DHS reported six more instances of staffing below standards.

October 30, 1986 - A follow-up survey revealed that problems with food service and dietary care, first observed in February and June 1986, had resurfaced. Surveyors were concerned that patient weights were fluctuating significantly. Surveyors reported "there is disorganization in serving the patients' meals, and no one is monitoring food intake of confused patients."

Staffing and infection control problems were again cited.

The facility maintained its licensing status.

November 6, 1986 - According to the health care licensure bureau chief, a third enforcement meeting was held, and the facility's owner

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(1) DHS's inability to substantiate a complaint does not necessarily indicate a failure on the agency's part to conduct a proper and complete investigation. Investigations may be hampered by inconclusive evidence, incomplete information, unavailable witnesses, etc.

(2) According to the office's Attorney General representative, a prior owner's license history cannot be transferred to the new owner. However, a new owner is expected to address deficiencies cited previously and bring the facility into compliance with stated regulations.

agreed to limit admissions to two per week until its next licensing survey. Again, this was an informal agreement with no record of the agreement, or departmental follow-up, in the agency's files.

December 31, 1986 - The second licensing survey in six months revealed more serious noncompliance. Deficiencies related to infection control were again cited. Problems in this area were worse than on previous occasions. In several cases, proper precautions were not taken to prevent the spread of infection. In addition, the facility wasn't determining whether patients received adequate nutrition, or if patients were maintaining ideal weight ranges (due to a faulty scale.) Maintenance services and staffing were again deficient. DHS concluded that patients were not receiving adequate and appropriate medical, nursing and personal care.

The facility was issued a one-year regular license after this survey. It agreed to be surveyed again in six months, but no follow-up was conducted by DHS.

December 11, 1987 - One year later, the facility exhibited the same type of problems as before: inadequate infection control, understaffing and maintenance deficiencies. Patient meals weren't strictly conforming to doctor's orders, and ten of 15 patients observed had been losing weight over a period of one year. Surveyors considered deficiencies to be life threatening.

The facility was placed on a six-month provisional license.

Comment: The Department took no significant action to curb the repeated noncompliance exhibited by this facility. This facility repeated at least 34 serious violations during the period reviewed. It violated the same four regulations on five or more separate occasions. Provisional licenses and enforcement meetings were not an effective deterrent. For example, the facility repeated 11 violations while operating under provisional licenses.

- **CASE 2**

During a 37 month period from mid October 1984 through mid November 1987, this nursing home was surveyed eleven times. This long term care institution was cited for 182 serious violations, many of them repeated violations. A summary of DHS's findings and actions are listed below.

April 19, 1985 - Operating less than a month with a provisional license, the facility was resurveyed due to a change of owners. A survey team found incomplete assessments of the nutritional status and needs of patients. Staffing was below minimum standards for seven out of 21 days reviewed. Infection control problems were noted.

The facility was granted a one-year regular license based on an acceptable plan of correction.

April 3, 1986 - During a licensing survey, DHS found substantial evidence of poor patient care. Food and nutrition services, cited during the last survey, had apparently worsened. Two of five patients reviewed had been served meals different from what their doctors had ordered. The nutritional status and needs of patients had not been assessed, and one patient was found to be 29 pounds underweight. In addition, although five patients had doctors' orders for increased fluid intake, there was no evidence that these orders were being followed. Finally, infection control problems had worsened since the last survey.

Despite the inadequate care observed, DHS issued this facility a one-year regular license.

April 23, 1986 - A complaint alleged that a patient: 1) sustained a rib injury due to rough handling; and 2) was left unattended and unrestrained in the bathroom, fell as a result, and received lacerations on the forehead and nose. While DHS could not substantiate the first allegation, the second complaint was substantiated. Additionally, this patient was found to be dehydrated and suffering from a urinary tract infection. The Department attributed both conditions to poor medical and nursing care.

February 27, 1987 - DHS promptly responded to several complaints alleging substandard care. Most allegations were substantiated, and the facility was cited for psychological and physical abuse of patients. For example, in one case, the facility delayed four hours before notifying the attending physician of a patient in distress. This patient was later diagnosed as having a broken hip. In another case, the attending physician was not notified of a drastic change in a patient's condition. The patient died five hours later.

DHS amended the facility's status to provisional for the remaining three months of the licensure period.

March 17, 1987 - Responding to complaints, DHS found psychological and physical abuse of patients for the second time in less than a month. This time the abuse charges were the result of the following violations: improper administration of nursing treatments, improper care to prevent and treat bed sores, improper use of restraints, inadequate care of incontinence, and improper medical care.

June 12, 1987 - A licensing inspection found that the institution was still not administering adequate nursing, medical and personal care. For example, in many cases the institution was not taking precautions to prevent infection from spreading. Likewise, surveyors found changes in a patient's condition were not reported to the attending physician. Food services were again poor. No steps were taken to ensure that patients were receiving enough fluids to maintain hydration.

The Department issued the facility a third provisional license, this one for six months.

November 18, 1987 - Five months later, the Department resurveyed the facility as the expiration date of its provisional license approached. The survey team again found serious deficiencies: doctors orders were not being implemented, and doctors had not been notified of changes in patient conditions and treatments. In addition, food and nutrition service was deficient. Finally, a 24 percent error rate in administering patient medication was observed.

The Department issued the facility a one-year regular license following this inspection.

Granting this facility a regular license violated A.R.S. §36-425, which mandates that a facility operating under a provisional license should be relicensed only if all conditions "constituting failure to comply with requirements" are corrected.

Comment: As in the previous case, DHS took no significant action to deter continued noncompliance. Consequently, the facility repeated 45 violations during the course of our review. Provisional licenses were again not an effective deterrent - the facility repeated 26 violations under its provisional license.

Further, an analysis of closed facilities showed little difference between negligence exhibited by facilities closed by DHS and that exhibited by the facilities in the cases cited above. The Department has broad discretion in determining when and what actions to take. The program's informal policy is to escalate enforcement for a facility when there is an imminent threat to patients health and safety that is not readily correctable.

Institutional noncompliance is widespread - These cases are not isolated examples. Institutional noncompliance with regulations important to patient health and safety is widespread. Our Office found extensive, and often repeated, noncompliance through a statistical review of Department files.[1] We reviewed violations most likely to threaten a patient's health and safety and found:

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(1) For the purposes of our review, each regulation was assigned a specific severity level. Regulations with a three, four or five rating were considered to be those most likely to affect a patient's health and safety if violated. They were the only levels analyzed. These severity levels were applied to each documented violation, although the actual seriousness of the violation itself could vary depending on the situation. See Appendix for further explanation of the methodology employed to select the sample and assess the severity of violations.

- Ninety-four percent of all nursing homes and 68 percent of all supervisory care homes examined violated the same regulation at least once during consecutive licensing surveys.

- Forty-seven percent of all nursing homes in our sample and 36 percent of all supervisory homes violated the same regulation at least once during three consecutive licensing surveys.

- Thirty-four percent of the nursing homes surveyed violated the same regulation at least once during four consecutive licensing surveys.

- Sixteen percent of all nursing homes reviewed violated the same regulation during five or more surveys.

- Seventy-six percent of all nursing homes with provisional licenses violated the same regulation at least once during their next licensing inspection.

Despite these widespread problems, our review shows that enforcement action by the Department is inadequate. It seldom takes intermediate action to deter noncompliance.

Federal evaluators found similar problems in a nationwide study. In July 1987 the United States General Accounting Office (GAO) issued a report indicating that negligence among nursing homes is a national problem.

Using a methodology similar to the one our Office used, the GAO analyzed nursing home compliance with Federal requirements for Medicare participation.[1] The GAO found that:

> Over one third of the nursing homes participating in Medicare and/or Medicaid . . . failed to meet one or more of the nursing home requirements considered by nursing home experts to be most likely to affect residents' health and safety in three or more consecutive inspections.

Greater Reliance on Enforcement Is Needed To Reduce Institutional Negligence

Greater attention to enforcement is needed to discourage institutional

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(1) Medicare is a Federal insurance program that assists elderly citizens in financing health care costs. State health departments administer the Medicare program under the Federal supervision of the Health Care Financing Administration. DHS inspects and certifies institutions wishing to participate in the program, for a fee that covers much of the Department's expense for long-term care.

noncompliance. The Department must make enforcement a top priority, and then request statutory changes necessary to upgrade its enforcement capabilities.

Enforcement must be made a higher priority - DHS has not made enforcement a high priority. DHS generally does not act against a facility until conditions are severe enough to warrant closing the facility. The Department rarely uses intermediate sanctions permitted by law, such as civil penalties. In a random sample of files, our Office found the Department never assessed civil fines for noncompliance, and only once restricted the admissions of an institution.[1] Both sanctions are allowed by law.

The Long-Term Care program's top priorities are conducting Federal and Arizona State surveys, follow-ups, and complaint investigations. The Department devotes much of its staff time to Medicare activities because of the Federal government's major financial investment (see footnote). Most remaining staff hours go to state licensing surveys and complaint investigations, the program's other priority areas.

Since the Department estimates it needs over 20 more full-time employees to efficiently perform these program priorities,[2] enforcement - which requires additional staff time for hearing preparation, hearings, etc. - is largely ignored. However, DHS must start considering enforcement a priority. As our review shows, surveys and complaint investigations are of little or no value if no enforcement action is taken and problems are not corrected.

Statutory changes needed - Once a stronger commitment to enforcement is made, the Department should consider ways to upgrade its authority to take intermediate actions. The Federal government recognized that such sanctions could reduce institutional noncompliance, and recently acted to increase sanctions available for the Medicare/Medicaid program. Though DHS has some enforcement powers, its current statutes are weak in comparison to other states.

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(1) According to the program bureau chief, DHS informally restricts the admissions of approximately 30 to 40 institutions a year.

(2) DHS has not analyzed additional staff time needed for enforcement.

In response to the widespread noncompliance it found during its study, the GAO recommended that Congress enact legislation giving states new alternatives for enforcing compliance with Federal requirements. The GAO presented a list of possible intermediate sanctions for states to use.

- Civil fines for each day a facility remains in noncompliance
- Initiating bans on admission
- On-site monitoring by an agency responsible for conducting certification surveys
- Withholding or reducing payments to the facility

This listing parallels recommendations made in 1986 by the National Academy of Sciences' Institute of Medicine (IOM). For example, in its report the IOM endorsed both civil penalties and bans on admission.

> Civil penalties are a useful enforcement tool because they can be applied to less serious violations early and often, thus discouraging more serious violations. Penalties can also be applied to serious but isolated violations. The IOM emphasized, however, that administrative and legal delays need to be avoided for civil penalties to be effective.
>
> The advantage of admissions bans is that "the resulting loss of income provides a continuing incentive to facilities to achieve compliance." The IOM recommended that agencies be authorized to apply the ban prior to any hearings and appeals.

Recently enacted Federal law implements many of the recommendations made by the GAO and IOM, and requires that state agencies develop a series of intermediate sanctions, including civil penalties.

Though DHS has intermediate sanctions it can use against facilities, its current authority is weak in comparison to other states. For example, although the Department can assess civil penalties, the Department must prepare for and conduct an administrative hearing before it can assess a fine. Other states have no such requirement. They can assess a fine

directly, and must only conduct a hearing if the facility appeals the fine. The IOM warned that administrative delays could undermine a penalty system.

Moreover, the maximum penalty assessment is conservative in comparison with other states. The Department may assess a maximum fine of up to $300 a day per violation. Other states, in contrast, can assess maximum penalties ranging from $1,000 to $25,000 a day per violation.

Several states have provisions the Department could use to improve its enforcement capabilities. The state laws of Wisconsin, Washington and Illinois, for example, each contain provisions worth considering by the Department.

- In Illinois, the health department may place a qualified person at a long-term care institution to monitor the patient care if a facility's noncompliance is serious enough. The monitor advises a facility on how to comply with state regulations, and reports on its compliance.
- In Wisconsin and Washington, the health departments can direct fines they have assessed to be spent by the cited facility to improve services.

RECOMMENDATIONS

1. The Department should reevaluate its staffing needs,[1] identify enforcement as a Department priority, and request the necessary appropriation. The Legislature should review the proposal and consider funding the request.

2. The Legislature should consider amending existing statutes to strengthen the Department's ability to take intermediate enforcement actions.

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(1) New Federal legislation and possible Medicare-Medicaid rule changes should also be considered.

FINDING II

WEAK ENFORCEMENT ACTION BY THE DEPARTMENT OF HEALTH SERVICES THREATENS THE HEALTH AND SAFETY OF CHILDREN IN DAY CARE

Lax enforcement actions by the Department of Health Services (DHS) jeopardize the health and safety of children in day care. DHS does not take effective enforcement action against centers that repeatedly violate standards. DHS does not use available enforcement options due to its lenient enforcement philosophy, limited number of staff, and lack of guidelines. In addition to a stronger enforcement philosophy, DHS should develop additional sanctions to improve compliance.

DHS's Enforcement Actions Fail To Bring Day Care Centers Into Compliance

Although DHS has a variety of enforcement options available, they are rarely used. Results of a review of day care center files[1] illustrates that the current actions taken by DHS do not bring centers into compliance with day care rules and regulations.

DHS does not take sufficient enforcement actions against centers that do not comply with day care rules and regulations. DHS has the statutory power to revoke or suspend a license, assess civil penalties, or issue a provisional license when deficiencies are noted. In addition, DHS can hold informal enforcement meetings with center administrators to discuss methods for maintaining compliance. However, these enforcement actions are rarely used. DHS did not revoke or suspend any licenses in 1986 or 1987.[2] In addition, DHS has never applied a civil penalty, although

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(1) Auditor General Staff reviewed 188 day care files. See Appendix for details.

(2) According to DHS staff, the fact that DHS did not technically suspend or revoke any licenses does not mean that no action was taken. DHS staff contend that an increase in the number of inspections, enforcement meetings, and the threat of legal action causes some centers to either close voluntarily or sell to new owners.

this option has been available since August 1985. As a result, violations are widespread and are often repeated. (DHS, between 1985 and 1987, cited 97 percent of the centers in our sample for violating at least one regulation considered to be most likely to affect a child's health and safety.)[1]

The following case examples illustrate DHS's lack of effective enforcement actions.

- **CASE 1**

  During a 29-month period, from May 1985 through September 1987, a center was inspected 17 times. The center received several complaints and was cited 100 times for violating regulations most likely to affect a child's health and safety, many of them repeat instances. A summary of DHS's findings and enforcement actions are listed below.

  June 1985 - DHS received a complaint alleging that a 21-year-old employee engaged a 4-year-old girl in inappropriate sexual contact. DHS's investigation discovered that the center, which had a regular 3-year license, had not maintained complete personnel records, had not conducted adequate background checks on all employees, and had not been adequately supervising children. Due to conflicting testimony, DHS was unable to conclusively substantiate that sexual misconduct had in fact occurred. However, DHS later learned that the alleged perpetrator, for whom the center had no personnel file or background check, had prior police contact in another state relating to sexual offenses.

  November 1985 - While investigating a complaint, DHS found that the center was placing children in a dark unsupervised room for disciplinary purposes, an act DHS had previously cited. In addition, DHS cited the center for four additional violations, including one staff member supervising two rooms of sleeping children, and a staff/child ratio of 1:20 instead of 1:15 for 3-year-olds.

  April 1986 - DHS conducted an annual inspection. Seven violations were cited, including failure to register and fingerprint all employees.

  August 1986 - DHS received a second sexual abuse complaint alleging that the victim, a 7-year-old boy, was forced by an 11-year-old boy to perform oral sex. During the ensuing inspection, DHS staff

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(1) We used the same approach in reviewing day care violations that we did in reviewing nursing homes. Each regulation was assigned a specific severity level. Regulations with a four or five rating were considered to be those most likely to affect a child's health or safety if violated. These were the only levels analyzed. These severity levels were applied to each documented violation, although the actual seriousness of the violation itself could vary depending on the situation.

observed several unsupervised children wandering throughout the basement of the building and confirmed that children had been unsupervised in the small dark room where the alleged molestation occurred. The guardian of the alleged perpetrator said the 11-year-old-boy denied the charge but would not permit DHS staff to interview him. Although the younger boy's description of the act was vivid, due to conflicting testimony and a lack of witnesses, DHS was again unable to conclusively substantiate the complaint.

However, DHS cited the center for 22 violations, including failure to adequately supervise school age children, failure to register and fingerprint personnel, and using underage employees. DHS noted that 15 teenage employees were not registered, had no references, and had not had tuberculosis tests. Ages available for eight of the 15 showed that at least five of them were under 16.(1)

January 1987 - After issuing a provisional license for a new director in September, DHS conducted a follow-up provisional inspection and cited the center for algae covered bathroom faucets and drinking fountain, a broken and open utility box, a clogged toilet, and uncovered electrical outlets.

February 1987 - DHS investigated a third sexual abuse complaint alleging that two girls, aged 3 and 4, were abducted from the center playground, at least one of them was sexually abused, and then both were returned to the center.

During the investigation, the DHS specialist noted that throughout the inspection she observed a "failure to provide a safe and healthful environment and failure to provide direct supervision." DHS learned that at the time of the alleged abduction, playground supervision duties were not clearly defined. Two staff members on the playground claimed there were not enough teachers supervising the children. A staff member said that at one point, one teacher was supervising 35 children. Although staff members supervising the playground did not remember seeing anything unusual on the day of the alleged incident, one staff person said that people walking by on the sidewalk often stop and visit with the children through the chain link fence.

Interviews with the alleged victims indicated that they had been abducted. In addition, the mothers of the children told DHS both girls were suffering from nightmares and were afraid to be away from their mothers. However, since there were no witnesses who could conclusively confirm that the abduction had taken place, DHS could not substantiate that the incident had occurred.

Based on the "pattern of serious deficiencies that had occurred at the center over time" DHS held an enforcement meeting. As a result of the meeting, DHS issued the center a provisional license for deficiencies on the condition that the center achieve and maintain

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(1) Regulations require all day care employees to be at least 16 years old. All employees under 18 must be supervised at all times.

compliance. In particular, DHS told the center that children must be supervised at all times and children must not be allowed in unlicensed areas of the building.

June 1987 - DHS visited the center three times during June. The first time, DHS substantiated a complaint that children were unsupervised on a field trip, a direct violation of the enforcement meeting agreement.

During a follow-up visit two weeks later, DHS cited the center for 13 violations, including an unlocked storage area containing cleaning supplies, a bottle of insecticide on a desk in the preschool office, bathroom faucets covered with algae, poisonous plants on the playground within reach of children, inaccessible staff files, dirty carpets, walls and floors, and allowing a 14-year-old visitor to supervise children in the bathroom. DHS also noted that the center had only four games, a few sports items and a few books for the 60 children enrolled in summer day care.

Within five days DHS received and substantiated two complaints that children were still using unlicensed areas of the center, a second violation of the enforcement agreement. In addition, DHS cited 12 violations. The center still had an unlocked storage area, poisonous plants on the playground, and dirty floors and walls, as well as water leaking from the ceiling. Despite the center's violations of the enforcement agreement, DHS took no action.

August 1987 - DHS conducted a licensing inspection and cited the center for several repeat violations, including poisonous plants on the playground, a leaking ceiling, lack of toys and equipment, a water fountain "covered with scum," and failure to register all employees.

September 1987 - DHS conducted a follow-up inspection before relicensing. DHS cited many repeat violations, including improperly documented references, water leaking from the ceiling, "thick black scum" on the water fountain, inadequate toys and equipment, a dirty bathroom, uncovered electrical outlets, and playground littered with trash. In spite of all the violations and the history of noncompliance, DHS issued the center a regular three-year license.

Comment: DHS did not take sufficient actions to enforce compliance with day care regulations. After multiple violations and several serious complaints, DHS held an enforcement meeting. Based on this meeting, the center received a provisional license for deficiencies on the condition that it comply with and maintain the day care rules. Although DHS later substantiated that these standards were not being maintained, it took no

action against the center. DHS's issuance of a regular three-year license violated its own rule[1] against issuing a regular license to centers that are not in compliance.

- CASE 2

During a 33-month period, from March 1985 through November 1987, a center was inspected ten times. The center received 12 complaints[2] and was cited for 51 violations of regulations considered most likely to affect a child's health and safety, including eight for improper staff/child ratios. A summary of DHS's findings and enforcement actions is listed below.

March 1985 - DHS conducted a relicensing inspection and cited 12 violations, including one staff person supervising two rooms with 33 napping children, unlocked toxic materials, broken toilet facilities, and playground fence falling down. DHS received verification from the center that corrections had been made. After a follow-up visit in April, DHS issued the center a regular three-year license.

March 1986 - DHS conducted an annual inspection. The center was cited for nine violations, including improper staff/child ratios, inappropriate discipline, unlocked storage area, and medications not stored in a locked container.

June 1986 - DHS verified a complaint that the center had improper staff/child ratios (including a 1:18 ratio instead of a 1:10 ratio for 2-year-olds), and that the carpet and floors were filthy. In addition, DHS cited the center for a broken fire alarm, unlocked storage area and dirty bathrooms.

July 1986 - DHS conducted a surprise visit and cited the center for improper staff/child ratios and a "filthy bathroom."

August 1986 - DHS investigated three complaints about the center and verified that it had improper staff/child ratios and was not adequately supervising children. In addition, DHS cited the center for faulty plumbing and two broken toilets.

March 1987 - After issuing a provisional license for a new director in September, DHS conducted a licensing inspection. DHS again cited the center for improper staff/child ratios, food remnants on the floor and three broken toilets. DHS issued a regular three-year license.

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(1) DHS rules and regulations state: "In order for a center to satisfactorily complete the provisional period, surveys conducted by the Department must show that all deficiencies cited in previous Departmental surveys of the center have been corrected and that the center is in complete compliance with applicable statutes and these rules." (Emphasis added)

(2) In addition to the 12 complaints, DHS referred two others to its sanitarian for investigation.

September 1987 - DHS investigated three complaints. It substantiated that the center had improper staff/child ratios, children were unsupervised, personnel were unqualified, no licensed director was working at the center, the acting director was abusive to parents, and the center was dirty.

October 1987 - DHS investigated two complaints and substantiated that children were allowed to eat snacks directly from the floor and that the center was dirty.

November 1987 - DHS investigated three complaints and substantiated that the center was not in compliance with staff/child ratios, allowed an underage employee to supervise children, had not required all employees to have a tuberculosis test, and lacked appropriate toys and equipment in good condition. In addition, DHS cited the center for holes in the walls and baseboards including two holes 24" by 9" and 36" by 10", and a broken porch support that "when pushed out allowed the roof to sag dangerously."

Comment: Although nine of the 12 complaints received for the center since June 1986 were substantiated and the number of repeat violations remained high, DHS took no action against the center. Subsequent to our file review, the center was due for relicensing. DHS threatened that it would not issue a new license if the center did not correct its many physical/structural problems.(1) According to DHS, the center made substantial improvements and a regular three-year license was issued.

- **CASE 3**

During a 20-month period, between March 1985 and November 1987, a center was visited 26 times by DHS specialists. The center was cited 53 times for violating regulations considered most likely to affect a child's health and safety, several of them repeat violations. A summary of DHS's findings and enforcement actions are listed below.

March 1985 - DHS substantiated a complaint that medications were kept on a counter in the infant room, soiled diapers were stored in open containers within reach of toddlers, and the center was dirty. The specialist noted "the center needs attention in all areas regarding cleanliness and better maintenance."

August 1985 - DHS conducted a follow-up inspection to a July annual inspection. The specialist noted that renovations were being done to improve the facility. However, she warned the center that conditions were in violation of the rules, and cited it for allowing children to climb on stacked building materials, lack of toys and equipment, and inadequate indoor space.

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(1) DHS concedes that in the past it had not required the center to invest a great deal of money and time into repairing some of the physical problems at the center because it has planned to move to a new location for the past two years. Thus, problems with plumbing and bathroom facilities continued.

September 1985 - DHS responded to a complaint and verified that children had access to rusty nails, washers and screws on the playground, and there were no planned activities for children.

December 1985 - DHS cited the center for ten violations, including unlocked medications, unlabeled baby bottles, trash on the playground and failure to register a new director.

January 1986 - DHS conducted a follow-up inspection and again cited the center for unlocked medications and a nonregistered director.

June 1986 - DHS conducted a licensing inspection, and cited the center for lack of cleanliness and failure to fingerprint all employees.

August 1986 - DHS issued a regular three-year license in July. During a follow-up inspection, DHS again cited the center for dirty bathrooms, improper staff/child ratios, and for propping bottles in cribs to feed three babies under 5 months of age.

September 1986 - A follow-up visit noted that the center still had improper ratios.

January 1987 - In response to a complaint, DHS cited the center for inappropriate discipline.

June 1987 - DHS conducted an annual inspection and cited the center for seven violations, including unsupervised children, cleaner fluid in reach of children, and failure to sanitize after each diaper change.

September 1987 - DHS substantiated a complaint that the center had improper staff/child ratios, and mixed toddlers and infants together. DHS noted that during the inspection the center had a ratio of 1:27 instead of 1:20 for 4-year-olds, and 1:14 instead of 1:10 for 2-year-olds.

November 1987 - DHS investigated two complaints that the center had improper staff/child ratios and that children were left alone on the playground. DHS did not substantiate the validity of the complaints because ratios and supervision were correct at the time of the inspection.

Comment: This center is representative of many of the day care centers in our sample. DHS cited the center for many violations, often previously cited violations. At no time did DHS take any type of enforcement action against the center.

DHS enforcement actions ineffective - Both our file review and the case examples illustrate that DHS's enforcement actions are ineffective. Our review revealed that 28 percent of the centers were cited for violating

the same regulation during at least three separate inspections, while 9 percent of the centers were cited for violating the same regulation five or more times. In most cases, DHS took no action against centers that failed to comply with the day care rules and regulations. Based on the overall number of violations cited and the number of repeat violations, simply citing a violation is not a strong enough deterrent to keep it from occurring again. Even when DHS does take some type of enforcement action, the actions are not effective. As the case examples reveal, enforcement meeting agreements are not enforced, and centers with provisional licenses for deficiencies are issued regular licenses even though they are not in compliance with the rules.

DHS Does Not Use Available Enforcement Options

DHS has enforcement options available that it does not use. DHS's current philosophy is to "work with centers" rather than taking strong enforcement actions against them. In addition, DHS may be hindered by a limited number of staff. Further, in contrast to other states, DHS has no comprehensive policies and procedures to guide its enforcement actions.

DHS enforcement philosophy is not aggressive - DHS does not have an aggressive enforcement philosophy. Although the Department does have enforcement options available, the options are rarely used. Instead, DHS employs a philosophy of "working with a center" to bring it into compliance. All levels of personnel expressed this philosophy. Personnel stated that their goal is to work with centers to bring them into compliance rather than taking strong actions against them. The case examples also illustrate this philosophy. The case examples cited showed numerous, often repeat violations, yet DHS rarely took stronger action than citing the center for noncompliance.

In addition, some state organizations representing day care centers commented that DHS does not take strong enough enforcement actions against centers that do not comply. The director of one state organization said that because DHS does not "come down harder" some centers do only what they have to do to comply and then "fall back to their old habits."

Due to its current enforcement philosophy, DHS's emphasis on meeting its statutory requirement to inspect each center annually may be in vain. Annual inspections to identify problems are not effective if centers do not achieve and remain in compliance. As the case examples show, citing a violation does not mean that it will be corrected. The fact that at least 28 percent of the centers in the sample repeated the same violation during three different inspections clearly demonstrates that these are not isolated cases. Thus, in some cases, an inspection with no enforcement action may be no more effective than no inspection at all.

DHS cites understaffing - DHS attributes its lack of aggressive enforcement to understaffing. According to DHS day care administrators, it does not have enough personnel to meet its inspection responsibilities, investigate complaints, and take escalated enforcement actions. The day care office chief says that staff shortages make it impossible to take necessary enforcement actions, which include revoking and suspending licenses, applying civil penalties, and conducting follow-up inspections against centers that are out of compliance. She says that lack of staff has prohibited the Division from writing a comprehensive policy and procedures manual. In addition, the Division Director claims the shortage of personnel prohibits DHS from dealing with potential problems because all of its resources are directed to handling current problems.

Although additional staff in itself would not strengthen DHS's enforcement actions, our review does indicate that the Child Day Care Licensure Office may be understaffed. The recommended caseload for a day care licensing specialist ranges from 1:40 to 1:75. [1] According to

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(1) Auditor General staff contacted many states and several national associations in an attempt to identify an acceptable caseload for day care licensing specialists. We found that caseloads vary dramatically among states because of the different duties performed. In addition, we identified only two national associations that have taken a position regarding caseloads. The Child Welfare League of America recommends a caseload of 1:40, while the National Association for the Education of Young Children recommends a caseload of 1:50 with a maximum of 1:75. These ratios are recommendations but are not accepted as industry standards.

DHS, the current caseload in Arizona is 1:130. Based on these figures, the Office could be understaffed by seven to 20 licensing specialist positions. DHS has requested funding for three to five additional licensing specialists for each of the last three years, but only three positions have been approved.

DHS lacks enforcement guidelines - Another factor hindering enforcement is that DHS has no guidelines mandating when enforcement actions should be taken against a center. Although DHS can revoke and suspend licenses, assess civil penalties, and issue provisional licenses for deficiencies, the current statutes do not specify when these actions should be invoked. Further, DHS lacks comprehensive policies and procedures on when to apply each option. Thus, licensing specialists initially use their own discretion to determine if and when a sanction should be applied.

According to some Arizona child care professionals, DHS's broad discretion has led to inequity in types of violations cited and in enforcement actions taken. One organization spokesperson said a day care licensing specialist told a center to do some costly remodeling. Later, another specialist said the remodeling had not been necessary. In addition, our review indicates that provisional licenses for deficiencies are not issued consistently. We found instances where DHS issued a center a provisional license for one particular violation yet other centers cited for the same violation were not issued a provisional license.

Other states have developed comprehensive policy and procedures manuals that mandate enforcement actions under specific circumstances. For example, the Texas day care licensing division has developed a step by step guide to licensing, citing violations, applying corrective sanctions, investigating complaints, etc. According to the Director of the Texas program, the manual has promoted consistency and uniformity throughout the licensing program. In addition, he said the manual is available to all day care centers so they can better understand the licensing process.

In Conjunction With a Stronger Enforcement Policy, DHS Should Develop Additional Sanctions to Improve Compliance

DHS enforcement could also be strengthened if the Department had additional enforcement options. Other states have developed various intermediate sanctions, including the use of civil penalties, bans on admissions and postings of inspection results.

One alternative is to use civil penalties to punish centers that violate the rules and regulations. Although DHS has the statutory authority to apply civil penalties, it has not used them. DHS staff claim the current process is too time-consuming. Current statutes require DHS to hold a hearing before assessing each civil penalty. In addition, DHS can only impose the penalty for each day the violation is documented by a Department on-site visit, and DHS must issue a provisional license to any center assessed a civil penalty.

California has a civil penalty statute that appears to have avoided these problems. At the time of the inspection, the specialist assigns each violation a date for correction and a penalty for noncompliance after that date. Within ten days of the correction date, the specialist conducts a follow-up inspection. A civil penalty is assessed, without a hearing, for any previously cited violation that has not been corrected. The penalty is accrued daily from the deadline set for correction. The penalty stops accruing when the center notifies the day care division that it is in compliance. A specialist may then conduct a follow-up inspection to verify compliance. The California statute includes an appeals process. However, according to a California spokesperson, fines are rarely appealed. California collected $339,159 in fines in fiscal year 1986-87.

A second alternative, used in Texas and being considered by Massachusetts, is a ban on admissions. Rather than applying a direct monetary fine to centers that fail to comply with rules and regulations, the state bans admissions until the center demonstrates that it can maintain compliance. The potential loss of income provides an incentive to achieve compliance. Massachusetts is also considering reducing the capacity of centers that fail to follow staff/child ratios.

A third alternative, also used in the Texas day care system, requires centers to post the results of inspections. This permits parents to see the violations that were cited. Since most parents spend a very short time in the center each day, it is highly possible that they are unaware of some problems that exist. Posting inspection results would give parents the opportunity to see the problems identified within each center and to decide if they want their children exposed to them.

RECOMMENDATIONS

1. DHS should develop a stronger enforcement philosophy in regulating day care centers.

2. DHS should document its staffing needs and request funding to achieve adequate staffing levels.

3. DHS should compile a comprehensive policy and procedures manual for the Day Care Licensing Office. The manual should include guidelines governing enforcement.

4. The Legislature should consider amending A.R.S. §36-891 to facilitate issuing civil penalties.

5. The Legislature should consider providing DHS with additional intermediate sanctions, such as bans on admissions, mandatory capacity reductions and postings of inspection results.

FINDING III

THE DEPARTMENT OF HEALTH SERVICES SHOULD IMPROVE ITS CHILD DAY CARE COMPLAINT HANDLING PROCEDURES

DHS does not follow its established policies and procedures regarding tracking of child day care complaints or timeliness of complaint investigations. Tracking of complaint investigations is inadequate and may lead to untimely complaint investigations.

Current complaint policies - Policies and procedures state that DHS will investigate all written and verbal child day care complaints.[1] The policies specify a timeframe for investigation of complaints that ranges from 24 hours to 20 working days, depending on the severity of the allegation and the location of the center. DHS must investigate all allegations of abuse or situations that could pose immediate danger to the health and safety of children within 24 hours; all complaints for centers within Maricopa or Pima counties must be investigated within ten working days or sooner.

To ensure that all child day care complaints are investigated in a timely manner, DHS's policies and procedures[2] call for the use of both a manual and computerized system to track complaints. The manual system consists of a master list of complaints which includes the date the complaint was received and the date it was investigated. The computerized system should maintain information on complaints for statistical and administrative purposes, and operate so that pending or completed complaint investigations can be tracked at any time.

Tracking Of Complaint Investigations Is Inadequate

DHS has not adhered to its policies and procedures regarding complaint tracking. Although the Child Day Care Office does maintain a manual log

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(1) DHS received 1,000 child day care complaints in 1987.
(2) Effective July 23, 1986.

of complaints, it is not kept up to date. In addition, the computerized tracking system has not been fully developed.

The Child Day Care Office keeps a manual log that identifies when a complaint was received and when it was investigated. However, this log is not always current. According to the Phoenix team leader, the last time she reviewed the log many complaint investigations that had been completed were not noted. The Office reviews the log quarterly, so it is possible that a complaint could be misplaced or forgotten for up to three months before being noticed.

In addition to not maintaining a complete manual log, DHS has not implemented a computerized tracking system. When the current policies and procedures were written, a computerized tracking system was envisioned. Child Day Care staff designed a form and have been collecting complaint information for computer input since January 1987. However, according to the Child Day Care Office, DHS has not considered the system a high priority and has not provided a computer consultant to write the necessary program. Thus, the computerized tracking system cannot be implemented.

One licensing specialist pointed out that the inability to track complaints causes confusion when caseloads are changed.[1] She said when a specialist receives a complaint, it is usually placed in the center's working file.[2] If a different specialist is assigned to the center before the complaint is investigated, the complaint could go undetected for a long period since the specialists normally only review a file before a required inspection.

DHS does not handle all child day care complaints in a timely manner - DHS's lack of an efficient tracking system may impair its ability to handle complaints in a timely manner. Based on the sample in our file

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(1) Specialists transfer their caseloads annually.

(2) In addition to the public file for each center, a working file contains the most recent inspection information for each center. Specialists use the working file during investigations and for follow-up work.

review [1], DHS did not investigate 29 percent of its child day care complaints within the timeframe specified in the policies and procedures.[2]

For example:

- DHS received a complaint that a day care center in Maricopa county had improper staff/child ratios and that personnel were not qualified. According to the complaint policy, DHS should have investigated the complaint within ten working days. However, the complaint was not investigated for 28 working days (almost six weeks). At the time of the investigation, DHS confirmed that the center had improper staff/child ratios and employees were not qualified to supervise children.

DHS established policies and procedures for complaints to ensure that all complaints are investigated in a timely manner. Failure to meet these guidelines may allow problems to continue.

Since complaint investigation timeliness is not closely monitored, it does not appear that the complaint policies are enforced. In fact, not all of the child day care licensing specialists were familiar with the complaint handling policies. Interviews with some specialists revealed that they were unaware of specific timeframes for complaint investigations and did not feel that the policies were enforced.

RECOMMENDATIONS

1. DHS should adhere to its policies and procedures regarding timeliness of complaint investigations.

2. DHS administrators should train staff members on the policies and procedures for investigating complaints.

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(1) See Appendix for discussion of sampling procedures.

(2) According to DHS, some complaints are not investigated in accordance with the timeframe because the nature of the complaint is not serious and either: 1) the specialist has been to the center within 30 days prior to receiving the complaint, or 2) the center is located outside of Maricopa and Pima counties. Taking this into account, 21 percent of the complaints still were not investigated in a timely manner.

3. DHS administrators should monitor compliance with the complaint policies and procedures by implementing the computerized tracking system.

4. DHS should provide the Child Day Care Office with the necessary consultation so a computer program can be written to automate the complaint tracking process.

OTHER PERTINENT INFORMATION

Changes have occurred in the regulation of hospitals and nursing homes in Arizona. In the early and mid-1980s regulatory methods were amended or allowed to sunset. Inpatient bed space and costs have continued to increase after deregulation. However, the impact of deregulation on capacity and price is unclear.

Arizona's Regulatory System Has Undergone Change

Arizona has reduced regulatory control over hospitals and nursing homes. The two methods used to control supply and rates were sunset or were statutorily amended in the early and mid-1980s.

Arizona oversaw hospital and nursing home supply, services and rates with two regulatory methods: certificate of need (CON) and rate review. Both regulatory methods required providers to submit to State review.

The CON process required providers to obtain approval from the Department of Health Services (DHS) before changing services offered or expending over a specified dollar amount for construction or expansion of facilities. Providers were to substantiate the community's need for the proposed facility or service changes.

The other regulatory method used was rate review. Providers wishing to increase their rates were required to submit a rate proposal for DHS review and to undergo public hearings. However, providers could implement rate increases regardless of DHS recommendations.

The regulatory methods were changed in response to concerns over their effectiveness. During the early 1980s, providers complained that the CON and rate review processes were expensive and time-consuming. They also felt that the processes were arbitrarily and inconsistently applied. The general public also expressed concern by voting down health care cost containment propositions in a 1984 election. According to hospital industry representatives, the Legislature felt that this indicated the public did not support regulation. The Legislature allowed nursing homes

to be excluded from the CON process in 1982, and it terminated the process in 1985 for hospitals. Also in 1982, legislation passed that eliminated public hearings for hospital rate proposals. Further, the legislation required public hearings for nursing home rate reviews only when proposed increases exceeded the health care consumer price index. These changes further moved the state toward a deregulated environment.

Capacity And Prices Continue To Increase

Since deregulation, Arizona's inpatient bed space and prices have continued to increase. Hospital and long-term care bed capacity has steadily risen. In addition, the prices charged for hospital stays continue to increase but at a slower pace than when regulated.

Excess bed space continues to increase - The number of excess hospital and nursing home beds is increasing. Bed space capacity continues to grow while occupancy rates are falling. These trends are generating excess bed space and may be costing consumers millions of dollars annually. In addition, the number of facilities offering high cost procedures has also increased.

The number of hospital beds has increased modestly both before and after deregulation. The number of non-Federal hospital beds increased by 934 beds between 1982 and 1986. Before deregulation, hospital bed capacity grew .3 percent in 1983 and 5 percent in 1984. After deregulation, the increase in capacity was 1 percent for both 1985 and 1986. During the same period, occupancy rates fell from 65 percent to 58 percent.

The trend of increased capacity coupled with a decreasing occupancy rate is even more evident in nursing homes. Although comparisons cannot be made between pre- and post-regulation years because data is not available, it appears there has been a large increase in bed space since deregulation. Between 1982 and 1986 the number of non-Federal nursing home beds grew by 5,878 beds, an average annual increase of 14 percent. During the same period, occupancy rates fell from 91 percent to 71 percent.

Growing capacity combined with falling occupancy rates gives Arizona a bed space surplus that may be costly to the consumer. Based on data collected by DHS,[1] we estimated that Arizona had approximately 3,400 excess hospital beds and the same number of excess long-term care beds at the end of 1986. Estimates developed for the Arizona State Health Plan 1985-1990 suggest that a hospital bed accrues at least $80,000 per year in fixed costs. If this is accurate, Arizona's excess hospital bed space cost approximately $270 million in 1986.[2] Estimates for the fixed cost of a long-term care bed were unavailable.

In addition to excess capacity, the number of facilities offering high cost services since deregulation is rapidly increasing, and may have harmful effects. Services in this category include open-heart surgery, megavoltage radiation therapy, and computed tomographic scanners.

The only service for which accurate and easily accessible information exists is open-heart surgery. Before deregulation in 1985, seven facilities offered this procedure. By 1987 the number had grown to 16 facilities. Standards[3] suggest that each facility offering open-heart surgery should perform at least 200 operations annually to maintain its proficiency and prevent unnecessary duplication of expensive equipment. By mid-1987 only nine facilities met this standard. A Phoenix Gazette special investigation reported hospitals performing a lower volume of open-heart surgeries had death rates nearly twice as high as those hospitals performing the suggested minimum.

Hospital rates in Arizona are rising - The cost of a hospital stay in Arizona continues to increase. From 1980 to 1986 hospital costs have risen faster than in most other states. In addition, the number of facilities implementing rate increases against DHS' recommendations has increased since mandatory public hearings were eliminated.

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(1) Published in Arizona Hospital Statistics, 1974 through 1986.

(2) Figures are based on the number of beds at the end of 1986.

(3) The standards were published in National Guidelines for Health Planning by the Department of Health, Education and Welfare, and were developed in the late 1970s for the health planning program. Although rules and regulations for this program were later repealed, the standards are still generally accepted as minimum standards for proficiency.

Arizona hospital costs continue to increase, but at a slower pace since deregulation. Cost per inpatient day in Arizona's hospitals rose from $377 in fiscal year 1981 (a 21 percent increase from the previous year) to $799 in fiscal year 1986 (a 10 percent increase from the previous year). Arizona currently ranks fifth highest in per day charges for hospital stays, compared with a rank of tenth in fiscal year 1980. Arizona has been ranked fifth since 1983.

The number of rate increases in Arizona have also increased. Since the elimination of mandatory public hearings, the number of facilities implementing rate increases against DHS' recommendation have risen. From 1978 through 1985 an average of 4.1 facilities per year implemented rate increases against the recommendations of DHS, with an associated dollar cost of $3.6 million per year. In 1986, four years after public hearings on proposed rate increases were abolished and one year after the CON process was eliminated, 28 facilities implemented rate increases against DHS recommendations, with an associated dollar cost of $60 million.

Impact Of Deregulation Unclear

Although capacity, services and prices have continued to increase since deregulation, it is not clear that these increases are the direct result of deregulation. It is difficult to isolate the effects of deregulation from the effects of other changes occurring in the health care industry.

It may be too soon to determine the impact of deregulation. We contacted officials and representatives of the insurance, nursing home and hospital industries. They indicated that the health care industry has not had sufficient time to adjust to the new operating environment. An insurance industry official also claimed that the excess capacity resulted from a rise in construction that was an initial reaction to the termination of CON. They anticipate it will take several years before the market stabilizes enough to allow an accurate assessment of deregulation's effects.

It is also difficult to separate the effects of deregulation from other changes currently taking place in the health care industry. Outpatient

care has increased in recent years, and changes in Medicare reimbursement policies have resulted in shorter inpatient stays. In addition, insurance and hospital officials noted that insurance companies and health maintenance organizations are negotiating rates and developing new methods to help contain health care costs. These factors also contribute to changing trends in the industry.

AREA FOR FURTHER AUDIT WORK

Should The Long-Term Care Office Be Abolished?

Arizona Revised Statutes §36-447.18 established the Long-Term Care Office (LTCO). LTCO is responsible for developing, implementing, and providing technical assistance and support services to licensed nursing care facilities in the areas of nursing care, nutrition, social services and health education. It also provides consumer information regarding cost and location of long-term care facilities. Its estimated operating budget for fiscal year 1988 is $448,000. LTCO has 11 authorized full-time employee positions: one administrator, six consultants and four clerical staff.

However, it appears that the demand and need for LTCO's services may not be sufficient to justify its continuation. According to representatives of the nursing home industry, most facilities choose to hire private consultants when technical assistance is needed. In fact, medicare certified facilities must contract with professionals for dietetic services, specialized rehabilitation, social services, etc., if a facility does not employ such personnel. In Arizona, as of February, 1988, 57 percent of licensed nursing homes are medicare certified and have consultant services available. It is anticipated that beginning in January 1989, most nursing homes will be certified and have professional/consultant contracts in order to qualify for AHCCCS monies available for long-term care.

Further audit work, including a review of the Office's work load and a survey of long-term care institutions, is needed to determine whether there is a need for the Office.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Director

ROSE MOFFORD, GOVERNOR
TED WILLIAMS, DIRECTOR

July 7, 1988

Mr. Douglas R. Norton
Auditor General
Office of the Auditor General
2700 North Central Avenue, Suite 700
Phoenix, Arizona 85004

Dear Mr. Norton:

Attached please find the Department of Health Services' response to the performance audit of the Health Care Facilities portion of the Division of Emergency Medical Services and Health Care Facilities.

Many of our concerns as raised in the response to your earlier draft remain unchanged. As a result, our response is essentially the same. Though the response is 17 pages long, we trust you will print it in its entirety.

Realizing that this is the first of a series of audits to be conducted at the Department of Health Services, we hope that our concerns are taken as the constructive criticism they are meant to be. We look forward to working with your staff in the future and appreciate the role an audit function should, and must, play in the governmental structure.

Sincerely,

Glyn R. Caldwell, MD for

Ted Williams
Director

TW/sd

enclosures

ARIZONA DEPARTMENT OF HEALTH SERVICES

ROSE MOFFORD, GOVERNOR
~~EVAN MECHAM, GOVERNOR~~
TED WILLIAMS, DIRECTOR

DIVISION OF EMERGENCY MEDICAL SERVICES
AND HEALTH CARE FACILITIES
701 East Jefferson Street - 4th Floor
Phoenix, Arizona 85034

July 7, 1988

Overview

In general, the Department agrees with the report's conclusions and recommendations; however, the Department is disturbed by the inaccurate assessment of the severity of repeated violations. In addition, the report did not acknowledge the personnel shortages in both the Office of Health Care Licensure and the Office of Child Day Care Licensure which limited rigorous enforcement. When serious conditions existed, both Offices took appropriate action, allowing for the effects sudden transfer has on elderly, ill nursing home residents and the inadequate number of day care centers in Arizona. Between these two Offices, 1858 separate complaints were investigated in 1987 resulting in closure of 5 supervisory care homes, revocation of 2 nursing home licenses, 50 specific legal actions and issuance of 288 provisional child day care center licenses. Although this may not be an enviable record, we think it demonstrates a reasonable response in spite of inadequate resources.

Causes of "Inadequate" Enforcement

Resource Constraints - Part of the explanation for enforcement activities which are less than "should be" are resource constraints under which the Offices operate. The Offices of Health Care Licensure and Child Day Care Licensure have both experienced a dramatic growth in the number of facilities they oversee; unfortunately, this growth has not been matched by an increase in staff.

The number of nursing home facilities in the State nearly doubled during the last four years. The number of other types of facilities which the Office of Health Care Licensure must regulate has more than tripled. Since 1980, the Office of Health Care Licensure has been given only five new State positions. Of these, two were designated for behavioral health licensure. The overall increase in staff in the Office of Health Care Licensure has been paid from Federal funding sources and these positions can only be used for Medicare activities.

The Office of Child Day Care Licensure has received only 1.5 FTEs since 1974 while the number of facilities has increased from 443 to 947. Case loads per surveyor have increased from 74 to 126. Since 1984, the number of day care facilities which the Office of Child Day Care Licensure regulates has increased by approximately 225 without a commensurate increase in staff.

In response to the increasing case loads, the Offices have requested additional staff during every budgeting cycle. In the past, these needs have been prioritized below many other policy considerations.

With limited staff, the Department has been forced to concentrate on the most efficient means for ensuring the actual, versus potential, safety of the populations served. Enforcement actions consume a great deal of time. As an example, a summary suspension in which the Office of Health Care Licensure is currently involved has already consumed 640 hours, not including the time which will be spent in hearing. The Department estimates it will require another 300 hours before this issue is settled. Under the terms of the contract with the Health Care Financing Administration, these State actions can only be funded by the State.

Without sufficient resources to undertake formal enforcement proceedings against facilities, the Department chose to use informal enforcement mechanisms. In the Office of Health Care Licensure, these informal mechanisms include voluntary restrictions on admitting new patients, coordination with the counties to restrict the number of county patients admitted to the facilities and voluntary relocation of patients at risk. In addition, the Office of Health Care Licensure uses the threat of Medicare termination to informally enforce State regulations. These activities are funded through Federal funds and apply pressure to comply with both State and Federal regulations.

The Office of Child Day Care Licensure has used similar informal enforcement mechanisms to compensate for chronic understaffing. The Office has issued amended licenses which state the reasons a facility was given a provisional license. The Office also has denied applications for approval as Director of a center when history indicates that the applicant has been unable to maintain a facility in compliance with licensing regulations.

Other Factors Inhibiting Enforcement - Other factors have prevented the Department from using formal enforcement mechanisms. Fines levied against offending facilities are often paid from operating revenues, reducing the amount of money available for improving the conditions which lead to noncompliance in the first place. Closure of nursing homes is possible because the State enjoys a surplus of beds. However, even though relocation of nursing home residents is possible, it may not be advisable because studies indicate that sudden transfer of such patients increases the mortality rate 300%.

Areas of General Concern

By and large the individual facts cited in the report are accurate, though specific errors were noted in the sections dealing with the individual findings. However, the Department is concerned about two aspects of this report: a tone of condemnation throughout the report and an inaccurate assessment of the severity of repeated violations.

Choice of Report's Tone - The Department is concerned about the tone in which this report is written for several reasons. First, after reading the report on the performance audit of the State Fire Marshal's Office, the Department was somewhat surprised by the tone in which the Office of the Auditor General chose to write the report on the Health Care Licensing function. The Fire Marshal is charged with the same type of regulatory responsibility as the Division of EMS and Health Care Facilities, i.e. ensuring the safety of the users of all of the state's public buildings. That report stated that the State Fire Marshal's Office inspects only 3% of the facilities it should and conducts only 5% of the follow-up inspections required.

Nonetheless, that report does not address the "threat to health and safety" posed by the Fire Marshal's poor performance. Instead, it addresses the potential liability facing the State from the State Fire Marshal's performance of its duties and the need for increased enforcement efforts. In contrast, numerous places in this report state that people's health, safety and welfare are in jeopardy because of poor enforcement of rules, even though the Offices involved rigorously inspect all facilities annually and conduct numerous follow-up inspections. The first six pages of the first finding contain the phrase "threatens health and safety" five times. What circumstances cause one agency's poor performance to be more egregious than another's?

In the last two years the Office of Health Care Licensure initiated almost fifty terminations. Most facilities corrected their deficiencies before the termination took affect. In fact, a study of Medicare certification activities conducted by Brown University on ten states found that Arizona was the most stringent in interpreting Medicare standards. It also found Arizona to be the most aggressive in initating Medicare termination actions.

Finally, in presenting the case examples of repeat non-compliance, the audit team seems to insinuate that the Department either prefers

not to substantiate complaints or is incompetent of doing so. Nothing could be further from the truth. Unfortunately, substantiating complaints is extremely difficult. Even the trained investigators in the various police departments have great difficulty substantiating some of the complaints.

Assessment of Severity - The report over-estimates the severity of the repeated violations. For the last two years, a national task force has tried to define violations which constitute serious and immediate threat. As yet, it has been unable to reach a consensus on the definition. Preliminary reports of its progress stress the need for professional judgment to gauge the severity in each particular circumstance.

In preparing its review of the Division's files, the staff from the Auditor General's Office asked staff from the Offices of Health Care Licensure and Child Day Care Licensure to give a single severity rating, from 1 (least serious) to 5 (most serious), for violation of each regulation number. Department staff repeatedly pointed out the shortcomings of this technique, but we note that it was applied anyway. Though the discussion of the actual violations that were classified as "serious" has been removed from this final version of your report, we do note that you mentioned some of our concerns in footnotes. We will include our comments on the previous version for the reader's benefit.

- Although every regulation number can be violated in numerous ways, some violations are of minimal severity and others are more grave, the audit team forced violations of almost every regulation number to be of one severity rating.

- The severity of each violation noted in the sampled institutions was determined by the severity assigned to the regulation number, not the circumstance of that particular violation.

- The severity rating, as applied by the audit team, did not distinguish between violations which noted a single incident and violations which constituted widespread occurrences in a facility.

- Because a given regulation can be violated in numerous ways, many of the "repeat deficiencies" noted in the report are not actually occurrences of the same specific violation. For example, there are over five hundred particular circumstances which can be cited as violations of R9-10-921.A.2. (infection

control, nursing standards of care and dietary). Alleging that repeated violations of R9-10-921.A.2. are repeats of the same deficiency is inappropriate. Further examples of this over-simplification are drawn from the regulations the report highlights in its Audit Methodology section.

Nursing Home Regulations

Auditor General Example 1: "Failure to Report Changes in the Condition of a Patient to the Attending Physician - may result in inappropriate treatment."

ADHS Comment: A.R.S. 36-447.05.E. states, "Changes in the medical condition of a patient shall be reported to the patient's attending physician."

Because there are varying degrees by which a medical condition can change, violation of this statute does not necessarily constitute an imminent threat to the patient's health. For example, though a small skin tear should be reported to the attending physician, lack of notification would not present a serious risk to a patient.

Auditor General Example 2: "Failure to Investigate and Prevent Infections in the Facility - may allow infections to spread."

ADHS Comment: R9-10-921.A.2.a. states, "Investigation, control and prevention of infections in the facility."

Because of the way in which this regulation is written, the Department is forced to cite inadequate "surveillance" as a violation of this regulation. "Surveillance" is defined as close observation and, in this instance, means written documentation of treatment of infections. A violation of this regulation does not necessarily mean that infection is inadequately treated in the facility.

Auditor General Example 3: "Failure to Prevent Medical, Psychological and/or Physical Abuse of Patients - can result from inadequate care, inappropriate supervision, etc."

ADHS Comment: A.R.S. 36-447.17.A.6. states "Each patient shall be free from medical, psychological or physical abuse."

The Department usually cites this regulation when nursing care problems occur (such as inadequate turning, inadequate restorative programs, inadequate notification of physicians or improperly following doctors orders). The Department seldom identifies instances of actual psychological or physical abuse. In cases of substantiated psychological or physical abuse, the Department has aggressively enforced the regulations. Where isolated staff members were involved, the facilities themselves often discharged the offending staff member. Where professional nurses are involved, the Department notifies the Board of Nursing to initiate its enforcement proceedings.

In cases of unsubstantiated charges of abuse, the Department closely monitors the facility. At least five of the enforcement proceedings on licenses involved suspected abuse. In each of these cases, the Department acted swiftly to identify and relocate the residents at risk.

Supervisory Care Regulations

Auditor General Example 1: "Inadequate Supervision - includes no staff on duty at night and/or no staff on duty with first aid training."

ADHS Comment: R9-10-616.B. states, "Sufficient personnel shall be employed to ensure the well-being of the residents and to provide effective food service, housekeeping and maintenance service." R9-10-616.C. states, "At all times when residents are present, at least one employee on duty on the premises shall have satisfactorily completed eight hours of basic first aid training. Written verification of this training shall be available at the facility."

Over the past three year period, the Department identified several facilities where the staff did not stay awake at night. The Department cited the facilities for violation of R9-10-616.B. The facilities challenged this interpretation of the regulation and the Department asked for an official Attorney General's opinion. The Department

thought it unreasonable to undertake enforcement actions for violations of this regulation during the months spent waiting for the opinion.

The first aid requirement includes availability of documentation of appropriately trained staff. A lack of documentation does not necessarily mean that patients are not being monitored by staff with proper training. In other instances where the Department cited facilities for violations of this regulation, the deficiency was noted because a review of staffing files indicated the possibilty of inadequate staffing.

Auditor General Example 2: "Failure to Assess Appropriate Level of Care - may result in residents who require skilled care receiving only general supervision."

ADHS Comment: R9-10-613 describes the functional level appropriate for supervisory care. R9-10-615.B. requires that residents meet admission requirements.

Patients requiring skilled nursing care are rarely found in supervisory care facilities. Approximately four years ago, the Department did note widespread problems of supervisory care facilities accepting patients requiring personal or intermediate care. The Department initiated legal actions against the offending facilities, and the patients were relocated. The Department has aggressively monitored this regulation since then. As a result, when the Department cites a violation of this regulation, it usually involves an isolated case of a patient's condition having deteriorated, either temporarily or permanently.

Because supervisory care patients are frequently immunocompromised individuals, their conditions can change rapidly. A simple cold can temporarily change the apparent level of care required. It would be unrealistic and inhumane to transfer these patients to another facility for the brief period of time required for them to recover. In cases such as this, the Department cites the facility for a violation of the above referenced regulations and returns to re-evaluate the resident. In the course of these re-evaluations, the Department often finds that the patients are in the appropriate level of care. In cases where the patient's condition has deteriorated

permanently, the resident is relocated immediately. In a few cases, the resident, the physician, the family and the facility have all resisted the relocation. This causes a delay in obtaining compliance with these regulations.

Auditor General Example 3: "Failure to Maintain Safety Standards - includes: 1) failure to install fire alarms throughout the facility, 2) no grab bars in bathrooms, and 3) inadequate space based on bed capacity."

ADHS Comment: R9-10-624.A. requires that all facilities meet State and local fire codes.

This regulation does not specifically require a fire alarm system. Some jurisdictions require fire alarms and some do not. Over the last four years, the Department has met with the State Fire Marshal's Office and local fire authorities to attempt to develop uniform fire protection requirements across the state. This has been only marginally effective. As a result, the Department will develop a checklist of fire-safety requirements for each jurisdiction in which facilities are located.

Day Care Regulations

Auditor General Example 1: "Improper staff/child ratios - can result in inadequate supervision of children and increase the chances of accidents and/or abuse."

ADHS Comment: R9-5-404 states that children shall be grouped by age, that they shall be supervised at all times and establishes minimum staff-to-child ratios.

Being out of compliance by having one too many children in a class is clearly less severe than having no supervisors in a classroom.

Auditor General Example 2: "Failure to register employees - includes failure to fingerprint employees and to conduct background checks."

ADHS Comment: A.R.S. 36-883.02 and R9-5-210.A-D. require that all employees be fingerprinted and registered with the Department within 20 days of being hired.

Many of the violations of this rule refer to inadequate documentation in personnel files rather than lack of fingerprinting or background checks.

Auditor General Example 3: "Failure to store toxic and hazardous materials in a locked storage area - may allow children access to substances and equipment that could cause them harm."

ADHS Comment: R9-5-609.B. requires that all potentially hazardous materials and equipment be stored in a locked storage area.

Violation of this regulation also varies greatly in severity. While a surveyor would cite a violation of this regulation if a hammer were sitting on the teacher's desk, it can only remotely be considered a severe threat to children's health and safety.

The above discussion points out the pitfalls of a naive ranking of the severity of violations. Unfortunately, the audit team turned down the Department's repeated offers to assess the severity of the individual violations noted in the file review. Had the audit team accepted the offer, perhaps the State would have gotten more meaningful information from the months of effort devoted to the file review. It might have been possible to develop insights to the systemic causes of non-compliance in the industry, such as increased use of pool nurses, inadequate reimbursement rates from Medicare and the counties and inadequate day care center staffing ratios.

FINDING I

The report on the performance audit of the Office of Health Care Licensure points out valid concerns about the enforcement activities undertaken by the Office. However, as mentioned previously, the Department has been hampered in its ability to use its full regulatory authority because of insufficient staff and concern for the patients. Furthermore, the report addresses only part of the entire operations of the Office, omitting investigation of the entire medical facilities regulation function. It also does not address the efforts made to improve Office operations. Finally, the report includes factual and logical errors in the case examples.

In the past four years the Office of Health Care Licensure has changed its philosophy on survey techniques and now requires that facilities should be made aware of every possible infraction of licensing regulations. As a result, violations which would not be cited by regulatory bodies in other states are often noted on inspection surveys in Arizona. In addition, the Office has implemented an outcome oriented survey process which focuses on the quality of life the patients enjoy. This type of survey has greatly increased the number of violations cited over those cited in the "paper-compliance" surveys used before. In short, the quality of the surveys conducted today is more thorough than those conducted two years ago.

The audit report overstates the number of serious repeat offenses. The case examples the report uses to illustrate the effects of repeat non-compliance are similarly flawed. The facilities used as case examples have been more closely monitored than most other facilities because of their obvious problems. The reporting on the Office's activities relating to them does not accurately state 1) the actual histories of the facilities, 2) the seriousness of the deficiencies or 3) the efforts made by the Department and facilities to improve the conditions.

The Office of Health Care Licensure has recommended to the Legislature numerous improvements to the regulation of health care providers. As discussed with audit staff, these include:

- Receivership statutes - This entails State operation of troubled facilities until they can be sold to new owners or the residents can be relocated in a responsible manner. This recommendation will require the State to establish a revolving fund for subsidizing this activity.

- Imposition of criminal penalties for owners of facilities in which patients' lives have been jeopardized.

- Designation of a probationary licensing status.

- Ability to withhold Medicaid payments from facilities which are violating Federal and State certification and licensing requirements.

- Authority and staff to place consultants approved by the Department in facilities at the facilities' expense. These consultants could continually monitor improvements and conditions at the troubled facilities.

- Simplification of the civil penalty system. The Office has also suggested allowing a portion of the fines levied under this system to be used for correction of problems and training of facilities' staff.

- Statutory revision and increased funding to improve the Office's ability to conduct background checks on the owners, administrators and staff of facilities. This should include the ability to refuse licensure of a facility owned or administered by a person who has a history of serious non-compliance in this or other states.

The following is a synopsis of considerations not summarized in the audit report's case studies:

Case Study 1

- This facility exhibits the "roller-coaster" pattern. It has serious problems, corrects them, but is unable to maintain compliance for an entire licensing period. Many of the efforts the Department undertook to improve the facility are not reflected in the public file.

- After the April 26, 1985 inspection the Department was extremely concerned with this facility's non-compliance by the owners who controlled the facility from April 1985 to June 1986.

- As a result of the June 25, 1985 inspection results, the Department gave the facility a provisional license. The Department held two enforcement meetings with the facility's owners between June 1985 and January 13, 1986.

- At the meeting held after the January 13, 1986 inspection, the Department informed the owners that unless the facility made significant progress toward maintaining compliance, it would not be licensed. In addition, the facility agreed to a freeze on private-pay admissions, and the county agreed not to place new patients in the facility. Throughout the period of the provisional

license, a county quality assurance team visited the facility almost weekly and informed the Office of the facility's progress.

- In May 1986 the Chief of the Office met with the owners and stated that unless the facility corrected its deficiencies, it would not be relicensed at the end of its provisional license. The original owner then said that he had sold the facility to a minority partner. Since State law does not allow the transfer of a prior owner's licensing history to a new owner, the Department issued a six-month license, conditioned upon an acceptable plan of correction for meeting licensing standards. The Department felt certain that patients were not at risk in the facility.

- During the June 19, 1986 survey, Office staff determined that the facility's staffing was below the required 2.5 nursing hours per patient day for only 3 days in a four-month period. The staffing of individual units appeared to be out of compliance on 18 days, but this was a problem of poor record-keeping rather than an actual shortage of staff. The surveyors determined that staffing was adequate to give acceptable nursing care. While the facility was in full compliance with requirements for reporting changes in patients' medical conditions, <u>one</u> doctor's order had not been followed since the past inspection. The infection control deficiency cited involved <u>one</u> instance where an irrigation syringe was re-used. Office surveyors felt that the facility was in substantial compliance at the time of this inspection.

- In August 28, 1986 survey, staff again identified staffing deficiencies. The patient care deficiency could in no way be construed as life-threatening.

- During the October 30, 1986 inspection, survey staff again noted staffing deficiencies at this facility. The Office Chief called for an enforcement meeting with the facility's owner and they developed a plan for correcting the deficiencies. In addition, the plan called for major renovations to the facility including: a new roof, ceiling repairs, a new alarm system, painting the facility and new floor covering. The owner also agreed to limit admissions to two per week.

- Comments presented in the case study for the December 31, 1986 inspection are somewhat distorted.

  The case example states, "In many cases, proper precautions were not taken to prevent the spread of infection." A thorough review of the survey report shows that of the 109 patients in the facility, two with draining wounds were not placed under wound and skin precautions. Another two patients exhibited signs of poor technique during dressing changing. Surveyors noted only one other break in aseptic technique involving a patient. The facility was storing contaminated waste improperly, but this did not present a significant danger to the patients.

  The case example states, "...the facility wasn't determining patients' ideal weight ranges or whether patients received adequate nutrition." The plan of correction shows that the facility was acting properly, but its scale was not properly calibrated. Only two residents' records indicated that there were nutritional problems.

  The case example correctly states that the facility had maintenance, housekeeping and staffing deficiencies, but none of these constituted risks for the patients.

  The facility agreed to hire a new, qualified director of nursing as part of their plan of correction for these deficiencies. At that time, the Department was involved in two summary suspensions and contingency planning for relocation of the residents of 17 facilities which were near bankruptcy. Given the limited resources available to the Department, it felt the plan of correction constituted a reasonable assurance that the patients' safety was secure.

- The audit report indicates that no follow-up was made to the December 31, 1986 inspection, but the Office conducted a dual follow-up/complaint inspection on April 17, 1987. Although six allegations were made in the complaint, none were substantiated.

- The December 1987 survey revealed recurring problems. The Department issued a provisional license and staff met with the facility's owners. The owners agreed to freeze admissions. During the provisional license period, the Department worked closely with County Long Term Care personnel and the facility has been on bed-hold (restricted admissions status) for most of the period. Documentation provided by the county indicates that the facility has made significant progress. In addition, a provisional license survey in May 1988 verified the county's conclusions but also noted some continuing problems.

- The Department is currently considering legal action against this facility.

Case Study 2

- During the inspection conducted for the change of ownership on April 19, 1985, the survey team noted that this facility was in very poor condition. Department representatives met with the new owner to develop a plan of correction, including major renovations to the entire facility. Based on the owner's willingness to correct the problems in full and the thoroughness of the plan of correction, the Department issued this facility a regular license. The nutritional and staffing deficiencies mentioned in the audit report were not serious and are more representative of the unavailability of trained nursing staff in Yuma rather than poor procedures on the part of this facility.

- The April 23, 1987 inspection report did not attribute the conditions cited in the audit report to poor medical or nursing care.

- The complaint investigation conducted on February 27, 1987 revealed serious deficiencies. The Department immediately initiated a Medicare termination process and met with the owners. As a result of the the Department's actions, the owners initiated a bed-hold and hired a team of nursing consultants to correct the problems. The Department reverted the facility's license to provisional status and revoked its quality rating.

- Responding to a complaint, the Department again noted deficiencies during its March 17, 1987 inspection.

- On March 26, 1987 the Department conducted a Medicare follow-up inspection. The facility had corrected all of the Medicare violations which would have necessitated Medicare decertification. In addition, the facility had corrected most of the serious violations of State regulations.

- The violations found during the June 12, 1987 inspection were not life threatening. As a result, the Department issued a six-month provisional license, unlike the three-month provisional license issued in February 1987. Issuance of this license was allowable under State law.

- Admittedly, the Department should have conducted a follow up inspection before issuing the regular license on November 18, 1987.

FINDINGS II AND III

The report on the performance of the Office of Child Day Care Licensing makes some valid comments on the enforcement activities undertaken by the Office. The Office, as mentioned above, is extremely understaffed for its responsibilities which make it less effective at regulating the day care industry than it could be. However, the Department feels that the report is inaccurate in its assessment of the Office's aggressiveness in ensuring the health and safety of children in day care. Finally, the Department is concerned about the analysis of the Office's complaint handling procedures.

Enforcement Aggressiveness

The report states that the Department takes little enforcement action against numerous "substandard" facilities. In 1985 the Office Chief prepared a list of 78 facilities which were in chronic noncompliance. This list was identified as the Department's "hit list" and caused adverse public and media attention. Regardless of this reaction, within one year, 6 of the 78 centers had closed, and 56 were in full compliance with licensing standards. During this period, the Department conducted 357 surveys and 31 consultations with these providers. By 1988, the final accounting of enforcement

actions against these facilities is: 10 legal actions, 16 closures, 17 changes of ownership, 4 comprehensive renovations and 31 facilities in full compliance.

Though the Department recognizes the need for day care centers to meet minimum standards for health and safety, the Office of Child Day Care Licensure is hampered in taking strong regulatory action against day care facilities because of the inadequate supply of these services in the State and the effect of fines on the services provided. As the Governor's Council on Children, Youth and Families stated in its report, "The Status of Child Care in Arizona, 1986", only 15.6% of the children needing day care were in licensed facilities. Children in unlicensed facilities and those staying at home alone are probably in as great, or more, danger as those in the facilities labeled "substandard" in the audit report.

Fines may also be counter-productive. It is quite possible that fines will be paid from the centers' operating revenues, probably at the expense of needed physical plant repairs. If they are not paid for in that way, centers will probably raise rates to pay the fines. This could force some parents to refrain from placing their children in day care. Like other financial barriers, this will impact the low-income households more than others.

Complaint Handling Procedures

The audit report also addresses the timeliness with which the Office handles complaints. Although the audit report states that the Office does not address complaints against licensed facilities in a timely manner, it did not assess the Office's performance regarding the more than 250 complaints concerning unlicensed facilities which the Office handles annually. Furthermore, the Office does have a formal complaint handling procedure in place, and performance regarding this procedure is part of each surveyor's performance evaluation. Finally, the Office learned in late 1987 that for at least two years the typist had been dating complaint investigation reports as resolved on the date she typed the report, not the date the complaint was investigated. Possibly if the audit team had investigated these areas they may have reached a different conclusion on the Office's complaint handling procedures.

CONCLUSION

As mentioned above, the Department, while questioning the tone in which this report was written and the method used for assessing the severity of repeated non-compliance, agrees with many of the recommendations made. Both Offices addressed in this report need more effective means for applying intermediate sanctions, including fines, posting of the results of inspections and bans on admissions. In addition, the Offices need to develop and implement policies and procedures manuals which delineate standard operating procedures. Finally, both Offices must devise more effective and efficient ways to train new staff. All of these efforts require administrative resources for completion.

While its attempt is described as inadequate in this audit report, the Office of Child Day Care Licensure attempted to implement at least one of this report's recommendations prior to the audit. Its computerized complaint tracking system was intended to alleviate some of the problems mentioned in the audit report. Unfortunately, the Office was never given the financial and personnel resources necessary to fully implement the system.

The Department's and Division's current administration has made fulfillment of statutory mandates, which includes a policy of vigorous enforcement, a high priority. At the same time the Department recognizes the need for a responsible attitude concerning the possible deleterious effects on the people involved when it contemplates closing a nursing home or day care center.

Within the constraints of the budget process, the Department is attempting to provide these Offices the resources necessary to adequately perform their missions. For example, staffing in the Office of Child Day Care Licensure will increase by 4 in fiscal year 88-89, and the Office has requested 12 new positions for fiscal year 89-90. The Office is also attempting to secure a grant to complete work on the automated complaint tracking system.

APPENDIX

This appendix describes the methodological design and procedures used to select the sample for our file review and to develop the severity ratings presented in this report.

METHODOLOGY

Auditor General staff conducted a review of the Department of Health Services Nursing Home, Supervisory Care and Child Day Care Licensure Offices files. We collected information regarding inspections, complaints and violations documented in the Department's active licensing files. A sample of 244 files was selected based on the number of licensed facilities in each of the three Offices and the percentage of licensed facilities receiving complaints. A sample of this size has a statistical reliability of + or - 5 percent with a .95 confidence level.

The sample population was separated by license type (nursing home, supervisory care or day care). The number of files selected for each license category was proportionate to the total file population. Thus, 78 percent of the files reviewed were day care centers, 13 percent were nursing homes and 9 percent were supervisory care facilities.[1] All files were randomly selected.

To determine the extent and seriousness of noncompliance, we asked experienced staff in each of the three Offices to rate the possible threat to health and safety when individual rules and regulations are violated under normal circumstances. Although we recognize that all violations have the potential to cause serious harm, we wanted to identify the usual threat when a specific regulation is violated. All staff participants were instructed to use a five-point scale to rate the regulations, with five representing the "most serious threat to health and safety," three representing a "significant threat to health and safety," and one representing the "least serious threat to health and safety."

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(1) As of November 1987 Arizona had 820 licensed child day care centers, 134 licensed nursing homes and 96 licensed supervisory care facilities.

Using the mode to reconcile differences among participants, we selected the ratings chosen most often by staff. To resolve any remaining discrepancies and to ensure that the final ratings met with Department approval, we asked the bureau chief of each Office to rate the violations for which there was no firm consensus, and to review and approve those rankings selected by staff through consensus.

Based on the final results, we classified all supervisory care and nursing home violations with a three, four or five rating as "serious" violations, and all child day care violations with a four or five rating as "serious" violations. These severity ratings were applied to each documented violation, although the actual seriousness of the violation itself could vary depending on the situation. For example, one extra child in a room would not pose as serious a threat to health and safety as a room full of children with no adult supervision. Likewise, a nurse dealing with one extra patient would not pose as serious a threat to health and safety as ten patients with no nurse at all. To determine the actual severity would require a detailed review of each violation.

For the purpose of our study, we elected to classify regulations according to the normal situations surveyors encounter during inspections and the likelihood of a violation to affect a child or resident's health and safety. This approach to rating severity levels for analysis is comparable to the one used by the General Accounting Office during its audit of the Medicare-Medicaid program.[1]

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(1) GAO report: Medicare and Medicaid - Stronger Enforcement of Nursing Home Requirements Needed, July 1987 (GAO/HRO-87-113).