

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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**May 2018
A-07-17-03224**

Office of Inspector General

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Report in Brief

Date: May 2018

Report No. A-07-17-03224

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



Why OIG Did This Review

Federal regulations require nursing and skilled nursing facilities (nursing homes) to submit correction plans to the Centers for Medicare & Medicaid Services (CMS) or to their respective State agency for certain deficiencies identified during surveys. State agencies must verify the correction of identified deficiencies by obtaining evidence of correction or through onsite reviews. This review of the State agency in Nebraska is part of an ongoing series of reviews of States' verification of correction of deficiencies.

Our objective was to determine whether Nebraska verified that nursing homes in the State corrected deficiencies identified during surveys in calendar year (CY) 2016 in accordance with Federal requirements.

How OIG Did This Review

We selected a stratified random sample of 100 deficiencies associated with 70 nursing homes and reviewed State agency documentation.

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

What OIG Found

Nebraska did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2016 in accordance with Federal requirements. We estimated that Nebraska did not obtain or maintain the nursing homes' evidence verifying correction of deficiencies for 92 percent of the deficiencies identified during surveys in CY 2016.

For the sampled deficiencies, Nebraska did not have documentation supporting that it had verified the nursing homes' correction of 83 deficiencies. Specifically, Nebraska did not obtain or maintain sufficient evidence of correction for 66 less serious deficiencies (for which correction plans verifying that corrections have been made must be submitted and approved) and for 17 other, more serious deficiencies (which require followup surveys to determine that corrections have been made). Evidence of correction that may have been on record for these more serious deficiencies was stored in electronic files that could not be opened or were missing.

What OIG Recommends and Nebraska Comments

We recommend that Nebraska revise its policies to (1) require nursing homes to include evidence of correction with all submitted correction plans for deficiencies at or above the level of seriousness designated in Federal requirements and (2) ensure that this evidence is retained by the State. We also recommend that Nebraska maintain accessibility of, and the ability to read, survey data documentation in accordance with changes in technology.

Nebraska described corrective actions that it said it had implemented. Nebraska asserted that for less serious deficiencies, acceptance of a nursing home's plan of correction constituted acceptable evidence of correction; Nebraska also pointed to an operational dysfunction in CMS's electronic system. Regarding the more serious deficiencies, Nebraska disputed that both it and we were unable to open the electronic files containing evidence of correction. Nebraska said that its staff accessed CMS's secure software and provided the information to us. We maintain that our findings and recommendations remain valid. A nursing home's submission of a plan of correction does not relieve a State of its responsibility to verify that previously identified deficiencies have been corrected. Evidence of correction that Nebraska provided was limited and generally came from only one information source, but the State agency procedures require verification from at least one additional information source.

TABLE OF CONTENTS

INTRODUCTION..... 1

 Why We Did This Review 1

 Objective 1

 Background 1

 Medicare and Medicaid Coverage of Nursing Homes 1

 Standard and Complaint Surveys of Nursing Homes..... 1

 Deficiencies and Deficiency Ratings..... 2

 Correction Plans..... 3

 Nebraska State Agency 4

 How We Conducted This Review 4

FINDINGS..... 5

 Federal Requirements..... 5

 The State Agency Did Not Obtain or Did Not Maintain Sufficient Evidence
 That Nursing Homes Corrected Less Serious Deficiencies..... 6

 The State Agency Did Not Maintain Sufficient Evidence That It Verified Nursing
 Homes’ Correction of More Serious Deficiencies During Followup Surveys 7

RECOMMENDATIONS 8

STATE AGENCY COMMENTS 9

OFFICE OF INSPECTOR GENERAL RESPONSE 9

APPENDICES

 A: Audit Scope and Methodology 12

 B: Related Office of Inspector General Reports..... 15

 C: Statistical Sampling Methodology 16

 D: Sample Results and Estimates..... 18

 E: State Agency Comments 19

INTRODUCTION

WHY WE DID THIS REVIEW

Federal regulations require skilled nursing and nursing facilities (nursing homes) that participate in Medicare and Medicaid to submit corrective action plans (correction plans) to the Centers for Medicare & Medicaid Services (CMS) or to their respective State agency for certain deficiencies identified during surveys, such as nursing homes' failure to provide necessary care and services. State agencies must verify the correction of identified deficiencies by obtaining evidence of correction or through onsite reviews. Previous Office of Inspector General (OIG) reviews found that some State agencies did not always verify that selected nursing homes had corrected identified deficiencies. This review of the State agency in Nebraska is part of an ongoing series of reviews of States' verification of correction of deficiencies. (Appendix B lists related OIG reports on nursing home compliance issues.)

OBJECTIVE

Our objective was to determine whether the Nebraska Department of Health and Human Services, Division of Public Health (State agency), verified that nursing homes in Nebraska corrected deficiencies identified during surveys in calendar year (CY) 2016 in accordance with Federal requirements.

BACKGROUND

Medicare and Medicaid Coverage of Nursing Homes

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

Standard and Complaint Surveys of Nursing Homes

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

agency to determine whether nursing homes meet the participation requirements in the State Medicaid plan (the Act § 1902(a)(33)).

Under an agreement with the Secretary, the State agency must conduct standard surveys to determine whether nursing homes are in compliance with Federal participation requirements (42 CFR § 488.305(a) and § 7200 of CMS's *State Operations Manual* (the Manual), Pub. No. 100-07). The State agency certifies compliance or noncompliance with Federal participation requirements for non-State-operated nursing facilities (42 CFR §§ 488.330(a)(1)(A) and (C)).¹ A certification of compliance constitutes a determination that a facility is in substantial compliance and is eligible to participate in the Medicare program, the Medicaid program, or both (42 CFR § 488.330(b)(1)).

A standard survey is a periodic nursing home inspection, using procedures specified in the Manual, that focuses on a sample of residents selected by the State agency to gather information about the quality of resident care furnished to Medicare or Medicaid beneficiaries in a nursing home. A standard survey must be conducted at least once every 15 months (42 CFR § 488.308(a)).

The State agency must review all nursing home complaint allegations (42 CFR § 488.308(e)(2)).² Depending on the outcome of the review, the State agency may conduct a standard survey or an abbreviated standard survey (complaint survey) to investigate noncompliance with Federal participation requirements.

Deficiencies and Deficiency Ratings

A nursing home's noncompliance with a Federal participation requirement is defined as a deficiency (42 CFR § 488.301). Examples of deficiencies include a nursing home's failure to adhere to proper infection control measures or failure to provide necessary care and services.

The State agency must report each deficiency identified during a survey on the appropriate CMS form³ and provide the form to the nursing home and CMS. These forms include (1) a statement describing the deficiency, (2) a citation of the specific Federal participation requirement that was not met, and (3) a rating for the seriousness of the deficiency (deficiency rating).

¹ CMS certifies the compliance or noncompliance of State-operated facilities (42 CFR § 488.330(a)(1)(B)).

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

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

The State agency must determine the deficiency rating using severity and scope components (42 CFR § 488.404(b)). Each deficiency is given a letter rating of A through L, which corresponds to a severity and scope level. (A-rated deficiencies are the least serious, and L-rated deficiencies are the most serious.) Severity is the degree of or potential for resident harm and has four levels, beginning with the most severe: (1) immediate jeopardy to resident health or safety, (2) actual harm that is not immediate jeopardy, (3) no actual harm with potential for more than minimal harm but not immediate jeopardy, and (4) no actual harm with potential for minimal harm. Scope is the number of residents affected or pervasiveness of the deficiency in the nursing home and has three levels: (1) isolated, (2) pattern, and (3) widespread. The Manual provides information on the severity and scope levels used to determine the deficiency rating (§ 7400.5.1). Table 1 below shows the letter for each deficiency rating and its severity and scope levels.

Table 1: Severity and Scope Levels for Deficiency Ratings

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

Correction Plans

Nursing homes must submit for approval correction plans to the State agency or CMS for all deficiencies except A-rated deficiencies (with the severity level of no actual harm with potential for minimal harm and the scope level of isolated) (42 CFR § 488.402(d)).⁴ An acceptable correction plan must specify exactly how the nursing home corrected or plans to correct each deficiency (the Manual § 2728B and § 7304.4).

After a nursing home submits a correction plan, the State agency or CMS must certify whether the nursing home is in substantial compliance with Federal participation requirements (the Manual § 7317.1).⁵ A nursing home is in substantial compliance when identified deficiencies have ratings that represent no greater risk than potential for minimal harm to resident health and safety (A, B, or C) (42 CFR § 488.301). The State agency must determine whether there is substantial compliance by verifying correction of the identified deficiencies through obtaining

⁴ Nursing homes use Form CMS-2567, Statement of Deficiencies and Plan of Correction, to submit correction plans.

⁵ The State agency provides the certification information to CMS on Form CMS-1539, Medicare/Medicaid Certification and Transmittal (the Manual § 2762).

evidence of correction⁶ or conducting an onsite review (followup survey).⁷ The deficiency rating guides which verification method the State agency uses. For less serious deficiencies (with the ratings *D* or *E*, or *F* without substandard quality of care⁸), the State agency may accept the nursing home's evidence of correction in lieu of conducting a followup survey to determine substantial compliance. For more serious deficiencies (with the ratings *G* through *L*, or *F* with substandard quality of care), the State agency must conduct a followup survey to determine substantial compliance.

Nebraska State Agency

In Nebraska, the State agency determines whether nursing homes meet Federal participation requirements and recommends to CMS whether nursing homes should be certified for participation in the Medicare and Medicaid programs. For purposes of administering its nursing home survey program, the State agency is divided into eight territories throughout the State; each territory conducts surveys within its designated area. During CY 2016, the State agency was responsible for conducting surveys of 212 nursing homes that participated in the Federal Medicaid or Medicare program or both.

HOW WE CONDUCTED THIS REVIEW

According to CMS's deficiency data, the State agency identified 1,371 deficiencies that required a correction plan during CY 2016. We excluded from our review 433 deficiencies that (1) were not directly related to resident health services, (2) had the ratings *B* or *C*, which did not require verification of correction, or (3) were duplicates. The remaining 938 deficiencies (from a total of 184 nursing homes) had ratings that required the State agency to verify correction by either obtaining evidence of correction (890 deficiencies) or conducting a followup survey (48 deficiencies). We selected a stratified random sample of 100 deficiencies (which between them were associated with a total of 70 nursing homes, and which consisted of 70 less serious deficiencies in stratum 1 and 30 more serious deficiencies in stratum 2) and reviewed State agency documentation to determine whether the State agency had verified the nursing homes'

⁶ Examples of evidence of correction include, but are not limited to, invoices or receipts verifying purchases or repairs, sign-in sheets of those attending inservice training, and interviews with training participants.

⁷ The State agency is not required to verify the correction of deficiencies with the ratings *B* or *C*; however, correction plans are still required for deficiencies with those ratings.

⁸ The Manual, § 7001, defines "substandard quality of care" with reference to the lettered ratings discussed in this paragraph. CMS has elaborating information that cites to 42 CFR § 483. Subparagraphs of this regulation identify "Federal Regulatory Groups" and itemize, within each group, specific coded listings of possible issues. For instance, the Federal Regulatory Group identified as "Quality of Care" includes coded issue F327: "Sufficient Fluid to Maintain Hydration" and cites to 42 CFR § 483.25. Accordingly, a less serious deficiency can have a rating of *F* without substandard quality of care only if that deficiency (1) meets the severity and scope criteria as depicted in Table 1 and (2) does not feature any of the coded listings of possible issues for any of the Federal Regulatory Groups.

correction of the sampled deficiencies. We also interviewed State agency officials and employees regarding survey operations, quality assurance, and training.

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

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

FINDINGS

The State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2016 in accordance with Federal requirements. For the 100 sampled deficiencies, the State agency verified the nursing homes' correction of 17 deficiencies but did not have documentation supporting that it had verified the nursing homes' correction of the remaining 83 deficiencies. Specifically, the State agency did not obtain or maintain sufficient evidence of correction for 66 of the less serious deficiencies that had ratings of *D* or *E*, or *F* (without substandard quality of care) and for 17 other, more serious deficiencies that had ratings of *F* (with substandard quality of care) or higher.

The State agency's practice, in cases of less serious deficiencies that did not require followup surveys, was to accept the nursing homes' plans of correction without requiring any additional documentation. For more serious deficiencies that did require followup surveys, the State agency did not maintain sufficient documentation to show that it had verified the correction of these deficiencies.

On the basis of our sample results, we estimated that the State agency did not obtain or maintain the nursing homes' evidence verifying correction of deficiencies in accordance with Federal requirements for 866 (92 percent) of the 938 deficiencies identified during surveys in CY 2016.

FEDERAL REQUIREMENTS

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

Section 7317.1 of the Manual states: “While the plan of correction serves as the facility’s allegation of compliance in non-immediate jeopardy cases, substantial compliance cannot be certified and any remedies imposed cannot be lifted until facility compliance has been verified. . . . Also, it should be noted that this guidance applies to prospective, as well as currently participating, facilities.”

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

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

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

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

THE STATE AGENCY DID NOT OBTAIN OR DID NOT MAINTAIN SUFFICIENT EVIDENCE THAT NURSING HOMES CORRECTED LESS SERIOUS DEFICIENCIES

For 66 of the 70 less serious deficiencies we sampled for which the State agency was required to obtain evidence of correction, the State agency did not have any evidence (60 deficiencies) or did not have sufficient evidence (6 deficiencies) that the nursing homes corrected these deficiencies. These 66 deficiencies had the ratings *D* or *E*, or *F* (without substandard quality of care). According to section 7300.3 of the Manual, these ratings required the State agency to obtain, at a minimum, evidence of correction from the nursing homes before certifying the homes’ substantial compliance with Federal participation requirements.

For at least some of the 60 deficiencies for which the State agency did not have any evidence of correction, nursing homes may have submitted such evidence, but if so, the State agency did not retain that evidence. Specifically, nursing homes had submitted correction plans for all 60 of these deficiencies, but neither State agency staff nor we could locate evidence of correction,

because such evidence either had not been attached to the correction plans or had not been retained.⁹

For example, on April 13, 2016, the State agency completed a nursing home survey and identified several deficiencies, including an *E*-rated deficiency (no actual harm with potential for more than minimal harm but not immediate jeopardy; scope level of “pattern”) related to infection control. The surveyor noted: “Based on observation and policy review, the facility failed to disinfect the glucometer in a manner to prevent the potential for cross contamination of blood borne pathogens for 3 residents. . . . This had the potential to affect seven residents that shared these glucometer machines.” To address this deficiency, the nursing home’s correction plan listed one corrective action that focused on the affected residents and four additional corrective actions that sought to ensure that the deficient practice would not recur.

Specifically, the first corrective action involved monitoring the vital signs of the three affected residents for any change in their conditions. The nursing home also included plans to review and update the glucometer procedure policy, to educate staff on the manufacturer’s glucometer cleaning recommendations, and to audit staff members on their understanding of the new cleaning process. However, the State agency did not obtain evidence from the nursing home to show that any of these corrective actions had actually been implemented. Instead, the State agency accepted the nursing home’s plan of correction as confirmation of substantial compliance.

The State agency’s practice for addressing less serious deficiencies did not comply with Federal requirements. Specifically, a State agency official said via email that, “if we are accepting the POC [plan of correction] as the facility’s allegation of compliance and not doing an onsite revisit, we do not need any additional documentation.”¹⁰

THE STATE AGENCY DID NOT MAINTAIN SUFFICIENT EVIDENCE THAT IT VERIFIED NURSING HOMES’ CORRECTION OF MORE SERIOUS DEFICIENCIES DURING FOLLOWUP SURVEYS

For 17 of the 30 more serious deficiencies we sampled for which the State agency was required to conduct a followup survey, the State agency did not have any evidence (2 deficiencies) or did not maintain sufficient evidence (15 deficiencies) that the nursing homes corrected these deficiencies. These 17 deficiencies had ratings of *F* (with substandard quality of care) or higher, which were more serious than the 66 deficiencies discussed in our first finding. According to section 7300.3 of the Manual, these ratings required the State agency to conduct onsite revisits

⁹ Nursing homes submitted correction plans for all 60 of these deficiencies using the Automated Survey Processing Environment (ASPEN) electronic plan of correction (ePOC) system. ASPEN enables the CMS Central Office, CMS Regional Offices, and State agency users to electronically manage and track plans of correction for ePOC-enrolled health care providers under their oversight. In the State of Nebraska, approximately 83 percent of nursing homes are enrolled in the ASPEN ePOC system.

¹⁰ However, if a nursing home had serious deficiencies in addition to the less serious deficiencies, the State agency would verify the correction of both types of deficiencies during its followup survey.

(that is, followup surveys) to the nursing homes in question to collect the evidence of correction from the facilities themselves.

For example, on January 11, 2016, the State agency completed a nursing home survey and identified a *G*-rated deficiency (actual harm that is not immediate jeopardy; scope level of “isolated”) related to quality of care. The surveyor noted: “Based on observation, record review and interview, the facility staff failed to obtain treatment orders and failed to evaluate nutritional requirements for the development of a pressure ulcer for 1 resident.” To address this deficiency, the nursing home’s correction plan listed one corrective action that focused on obtaining wound care orders and completing a nutritional evaluation for the affected resident. The correction plan listed three additional corrective actions that sought to ensure that the deficient practice would not recur and that included measures to reeducate the nursing staff on skin guidelines as well as provisions for the Director of Nursing Services to conduct audits of wound and nutritional evaluations.

However, the State agency was unable to provide us with sufficient evidence of correction to show that all of the corrective actions called for in the plan of correction for this *G*-rated deficiency had actually been implemented. The State agency was able to provide some surveyor’s notes that (1) indicated that the affected resident’s wound was improving and (2) noted that two of the three residents surveyed in the State agency’s revisit were having their wounds monitored regularly. However, although the nursing home’s correction plan included a provision for the audits of wound and nutritional evaluations, the surveyor’s notes did not document that these audits were taking place. Nor did the surveyor’s notes contain any information related to the reeducation of the nursing staff on skin guidelines, although this measure was also listed in the nursing home’s correction plan.

For these 17 deficiencies, State agency staff gave us electronic files that may have contained evidence of correction; however, these were password-protected files, and neither we nor State agency staff were able to open them. Although we were able to review some evidence of correction related to these 17 deficiencies, we found the available evidence to be insufficient to properly verify substantial compliance by the nursing homes.

RECOMMENDATIONS

We recommend that the State agency:

- revise its policies to (1) require nursing homes to include evidence of correction with all submitted correction plans for deficiencies with ratings of *D* or higher and (2) ensure that this evidence is retained by the State agency, and
- maintain accessibility of, and the ability to read, survey data documentation in accordance with changes in technology.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not directly address our recommendations but stated that it would “rebut conclusions” made in that report. The State agency also described corrective actions that it said it had implemented to address our recommendations. Specifically, the State agency said that it had conducted re-training for all nursing homes on the types of evidence that should be submitted, had procedures currently in place specifying the types of evidence that must be submitted with plans of correction, had implemented an evidence tracking system, had trained its surveyors on electronic storage, and had initiated bi-monthly reviews to ensure that electronic files are saved appropriately and contain the required information.

The State agency disputed our interpretation of guidance in the Manual¹¹ and referred to a chart in that Manual that, it said, addresses onsite revisits (that is, followup surveys) but not offsite revisits. The State agency added that in its view, acceptance of a nursing home’s plan of correction constituted acceptable evidence of correction of deficiencies “to confirm substantial compliance, in lieu of an onsite follow-up visit.”

In addition, the State agency said that an “operational dysfunction . . . a malfunction and systematic design error” in CMS’s ePOC process (footnote 9) prevented the State agency from saving attachments that had been included with facility plans of correction.

The State agency’s comments also addressed one of the examples we cited earlier in “The State Agency Did Not Maintain Sufficient Evidence That It Verified Nursing Homes’ Correction of More Serious Deficiencies During Followup Surveys”—the G-rated deficiency involving care of a pressure ulcer. The State agency acknowledged that the surveyor’s notes did not document that audits or staff re-education (both of which were specified in the nursing home’s correction plan) were conducted, but added that “re-education was in fact identified” in the nursing home’s plan of correction.

In the context of our second finding and our second recommendation, the State agency disputed that neither we nor the State agency were able to open the password-protected electronic files containing evidence of correction. The State agency said that its staff accessed CMS’s secure software and provided the information to us.

The State agency’s comments appear in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency’s comments, we maintain that our findings and recommendations remain valid. Although the State agency did not directly address our

¹¹ Section 7317.2 of the Manual.

recommendations, we note that the corrective actions it described, when fully implemented, should adequately fulfill our recommendations.

Regarding the State agency's assertion that acceptance of a nursing home's plan of correction constituted acceptable evidence of correction of less serious deficiencies, the State agency relied exclusively on section 7317.2 of the Manual, which pertains only to onsite revisits (followup surveys) and not to offsite revisits. However, section 7317.1 states that substantial compliance cannot be certified and any remedies imposed cannot be lifted until facility compliance has been verified. The section 7317.1 criterion supports our view that a nursing home's submission of a plan of correction does not relieve the State agency of its responsibility to verify that previously identified deficiencies have been corrected; such verification is required in order for the State agency to confirm substantial compliance. These requirements apply both to less serious and more serious deficiencies.

The State agency's reference to our example of the G-rated deficiency involving care of a pressure ulcer illustrates this flaw in the notion that acceptance of a nursing home's plan of correction constitutes acceptable evidence of correction of deficiencies. The State agency's comments acknowledged the same shortcomings in the surveyor's notes that our finding describes. Those notes indicated that the followup survey at this nursing home evaluated the care of pressure ulcers for some specific residents but did not support that the surveyor had evaluated all of the actions listed in the correction plan. A followup survey whose notes were so limited in their scope cannot be said to have verified substantial compliance.

Moreover, we note that if CMS's ePOC process did not permit the State agency to save attachments that facilities had included with their plans of correction, nothing prevented the State agency from requiring these facilities to send these attachments by U.S. Mail or by one of a number of other methods.

Finally, the State agency's comments regarding the inability to access password-protected electronic files are not entirely accurate. As stated earlier, during our fieldwork we asked State agency staff to provide us with detailed evidence of correction that we needed to verify substantial compliance with Federal requirements. The staff referred us to password-protected files that neither we nor they could open. As a workaround, State agency staff was able to access, and provide us with, *some* evidence of correction from a single information source—the surveyor's notes—for 15 of the 17 more serious deficiencies that we identified. The State agency's inability to provide us with the more detailed evidence of correction, however, meant that the State agency was deviating from its own procedures. The Surveyor Notes Worksheets used by State agency surveyors for both standard and complaint surveys specify that findings must be verified with at least one additional information source (that is, at least one source in addition to the surveyor's notes).¹² The limited evidence-of-correction data, obtained from one

¹² The Worksheet for standard surveys includes the following statement: "Remember to verify findings with at least one other information source." The Worksheet for complaint surveys includes the following statement: "Remember to verify findings with at least two information source" (*sic*).

source, that the State agency provided to us in these cases, did not include sufficient detail for us to be able to conclude that surveyors had obtained adequate evidence to verify that the facilities in question (1) had corrected deficiencies and (2) were now in substantial compliance with Federal requirements.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

According to CMS's deficiency data, the State agency identified 1,371 deficiencies that required a correction plan during CY 2016. We excluded from our review 433 deficiencies that (1) were not directly related to resident health services, (2) had the ratings *B* or *C*, which did not require verification of correction, or (3) were duplicates. The remaining 938 deficiencies (from a total of 184 nursing homes) had ratings that required the State agency to verify correction by either obtaining evidence of correction (890 deficiencies) or conducting a followup survey (48 deficiencies). We selected for review a stratified random sample of 100 deficiencies, which between them were associated with a total of 70 nursing homes.

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

We conducted our audit, which included fieldwork at the State agency's office in Lincoln, Nebraska, from May to December 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed CMS officials to gain an understanding of the State agency's oversight responsibilities for nursing homes and CMS's guidance to the State agency regarding verification of corrections of deficiencies identified during nursing home surveys;
- interviewed State agency officials and employees regarding survey operations, quality assurance, and training;
- obtained from CMS a database containing 1,371 deficiencies¹³ that required a correction plan and were identified during standard and complaint surveys of Nebraska nursing homes in CY 2016;

¹³ This figure does not include *A*-rated deficiencies.

- removed 433 deficiencies that:
 - were not directly related to resident health services,¹⁴
 - had the ratings *B* or *C* (not requiring verification of correction), or
 - were duplicates;
- developed a stratified random sample from the remaining 938 deficiencies (from a total of 184 nursing homes) by creating 2 strata, representing deficiencies that:
 - were less serious and required the State agency to obtain, at a minimum, evidence of correction (footnote 10) (stratum 1), and
 - were more serious and required the State agency to conduct a followup survey (stratum 2),

by selecting a total of 100 sample units, consisting of 70 sample units from stratum 1 and 30 sample units from stratum 2;

- reviewed State agency documentation for each sampled deficiency to determine whether the State agency had verified the nursing home's correction of the deficiency;¹⁵
- estimated the number and percentage of deficiencies in the sampling frame for which the State agency did not verify the nursing homes' correction in accordance with Federal requirements;
- reviewed consecutive standard surveys for each nursing home associated with the deficiencies in our stratified random sample to determine the time interval between the standard survey conducted in CY 2016 (if one had been conducted) and the last day of that nursing home's previous standard survey;
- where necessary, accessed and reviewed the State agency's records for CY 2017 to obtain dates of completion of standard surveys conducted in that year of nursing homes not surveyed in CY 2016; and
- discussed the results of our review with State agency officials on December 20, 2017.

¹⁴ We excluded deficiencies that were related to physical environment; residents' rights; admission, transfer, and discharge rights; dietary services; quality of life; and administration.

¹⁵ Documentation included surveyor notes, training sign-in sheets, and invoices verifying purchase and repairs, if available.

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Florida Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-04-17-08052</u>	4/27/18
<i>North Carolina Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-04-17-02500</u>	1/04/18
<i>New York Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-02-15-01024</u>	10/19/17
<i>Kansas Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-07-17-03218</u>	9/06/17
<i>Missouri Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes</i>	<u>A-07-16-03217</u>	3/17/17
<i>Arizona Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-09-16-02013</u>	10/20/16
<i>Oregon Properly Verified Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-09-16-02007</u>	3/14/16
<i>Washington State Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid</i>	<u>A-09-13-02039</u>	7/09/15
<i>Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect</i>	<u>OEI-07-13-00010</u>	8/15/14
<i>CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries</i>	<u>A-09-12-02037</u>	6/04/14
<i>Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries</i>	<u>OEI-06-11-00370</u>	2/27/14
<i>Skilled Nursing Facilities Often Fail To Meet Care Planning and Discharge Planning Requirements</i>	<u>OEI-02-09-00201</u>	2/27/13
<i>Federal Survey Requirements Not Always Met for Three California Nursing Homes Participating in the Medicare and Medicaid Programs</i>	<u>A-09-11-02019</u>	2/27/12
<i>Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs</i>	<u>A-09-09-00114</u>	9/21/11

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of all health deficiencies identified during nursing home surveys conducted by the State agency in CY 2016 and that required the State agency to verify the correction of deficiencies.

SAMPLING FRAME

We obtained from CMS a Microsoft Excel spreadsheet containing 1,371 deficiencies that required a correction plan and were identified during standard and complaint surveys of Nebraska nursing homes in CY 2016. CMS extracted the data from the Certification and Survey Provider Enhanced Reporting system. We then removed 433 deficiencies as shown in Table 2 below.

Table 2: Deficiencies Removed

Reason for Removing Deficiencies	No. of Deficiencies Removed
Not directly related to resident health services	421
Had the ratings <i>B</i> or <i>C</i> (not requiring verification of correction)	10
Duplicates	2
Total	433

After we removed these deficiencies, the sampling frame consisted of 938 deficiencies.

SAMPLE UNIT

The sample unit was a health deficiency that was identified during a nursing home survey in CY 2016 and that required both a plan of correction and the State agency to verify the correction of the deficiency.

SAMPLE DESIGN

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

Table 3: Number of Deficiencies in Each Stratum

Stratum	Description	No. of Deficiencies
1	Deficiencies with ratings of <i>D</i> or <i>E</i> , or <i>F</i> without substandard quality of care	890
2	Deficiencies with ratings of <i>G</i> through <i>L</i> , or <i>F</i> with substandard quality of care	48
Total		938

SAMPLE SIZE

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

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

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

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Results

Stratum	No. of Deficiencies	Sample Size	No. of Deficiencies Not Verified by the State Agency
1	890	70	66
2	48	30	17
Total	938	100	83

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

	No. of Deficiencies Not Verified	Percentage of Deficiencies Not Verified
Point estimate	866	92%
Lower limit	827	88%
Upper limit	906	97%



Pete Ricketts, Governor

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

April 13, 2018

Mr. Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Report Number: A-07-17-03224

Dear Mr. Cogley:

The Nebraska State Agency (NESA) has reviewed the draft report of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) results entitled “Nebraska Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid.” Please allow this letter to rebut conclusions made in the OIG report and to submit NESA’s Action Plan to address recommendations outlined by OIG.

OIG cites “For deficiencies rated D or E, or F not involving substandard quality of care, the State agency has the option to accept evidence to confirm substantial compliance in lieu of conducting a follow-up survey (i.e., an onsite review).” OIG contends that NESA did not obtain or maintain sufficient evidence of correction for these lower level ratings. OIG references the SOM, Chapter 7, 7317.2, which includes a chart with examples of acceptable evidence that may be used to verify correction. OIG also contends that NESA did not retain evidence that had been attached to correction plans.

Chapter 7 Guidance

NESA respectfully disputes OIG’s interpretation of the State Operations Manual (SOM), Chapter 7 guidance. The chart referenced by OIG only references onsite re-visits (follow-up surveys) and does not address offsite re-visits. NESA contends that acceptance of the facility Plan of Correction (POC) and Allegation of Compliance was acceptable evidence of correction to confirm substantial compliance, in lieu of an onsite follow-up visit. In addition, Centers for Medicare and Medicaid Services (CMS), implemented an electronic Plan of Correction process that functionally **did not permit** NESA to save attachments included with the facility Plan of Correction.

The CMS operational dysfunction, preventing the ability to save attachments, was a malfunction and systematic design error within the CMS electronic system used for POCs. Since the date(s) of the OIG review, CMS has corrected its systematic inability to save POC attachments and now permits electronic capture of POC attachments. NESA should not be penalized for the systematic operational failure in the prior CMS functional design.

Password Protected Files

OIG reports that NESA's electronic files containing evidence of correction for more serious deficiencies were password protected and that OIG and NESA were unable to open these files at the time of the OIG review. NESA respectfully disputes this finding. The CMS software program used while conducting onsite nursing home re-visits is ***an encrypted system*** and therefore cannot be accessed without utilizing the CMS software. At the time of the review, NESA accessed the secure software and printed investigative information from the software program to provide the investigative information to OIG.

Retention of Evidence

OIG also reported that NESA did not have sufficient evidence to show nursing home correction of a G-rated deficiency. OIG's report acknowledged that NESA had evidence to show the affected resident's wound was improving and the wounds were monitored regularly. However, the nursing home's POC included a provision that audits would be performed to show that the wound and nutritional evaluations were being completed. While surveyor notes did not document that these audits were conducted, or that staff was re-educated on skin guidelines, re-education was in fact identified in the nursing home's POC.

NESA contends that an onsite revisit is performed to confirm that the facility is in compliance with CMS nursing home regulatory requirements, and that NESA produced investigative evidence demonstrating that the subject facility had brought itself into compliance with CMS nursing home regulations. NESA's evidence demonstrated affirmatively that the subject facility corrected and was in compliance with CMS nursing home regulations.

NESA has implemented the following action plans to satisfy OIG concerns:

1. On August 16, 2017, NESA's Program Manager of the Office of Long Term Care Facilities conducted re-training for all nursing homes on the types of evidence that should be submitted to demonstrate compliance with correction plans.
2. Current NESA procedures include the CMS 2567 and a cover letter identifying the requirements for an acceptable POC together with specification of the types of evidence for which proof must be submitted to NESA before a facility will be placed in compliance.
3. NESA implemented a tracking system to track and ensure that NESA has received evidence to prove compliance with the facility's POC before a facility is placed back in compliance utilizing an offsite revisit. If NESA has not received evidence showing compliance with the POC, NESA has created a follow-up letter requesting the required evidence and informing the facility that the facility will not be placed back into compliance until NESA receives and accepts the required evidence.
4. NESA trained its surveyors on methodology to appropriately save electronic files in electronic storage as well as the qualities of evidence that will be sufficient to demonstrate facility compliance in the onsite revisit.

5. NESAs initiated bi-monthly investigation packet reviews, to ensure that electronic files are saved appropriately and contain the required information.

Thank you for allowing NESAs the opportunity to respond to the OIG report.

Please advise if you have any follow-up questions.

Respectfully submitted,

/Courtney N. Phillips/

Courtney N. Phillips, PhD

Chief Executive Officer

Department of Health and Human Services