

MEMORANDUM

Department of Aging and Disability Services Regulatory Services Policy * Internal Memorandum

TO: Regulatory Services
Regional Directors and State Office Managers

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Regulatory Services

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Consumer Rights and Services

SUBJECT: **IM 07-12** – Revised Regulatory Services Guidelines Regarding Complaint/Incident Management for Triage and Prioritization (Replaces IM 06-35)

APPLIES TO: All Regulatory Services Provider Types

DATE: September 25, 2007

This IM replaces previous operational guidance to Regulatory Services staff regarding prioritization of complaints and provider self-reported incidents. Changes are highlighted on the attached document with ***bold italicized*** text.

BACKGROUND

In July 1998, the US General Accounting Office (GAO) was asked to assess progress made in improving the quality of care provided by nursing homes to elderly and disabled individuals and identify significant weaknesses in federal and state oversight. The GAO study found that weaknesses persisted in state survey, complaint, and enforcement activities.¹ In October 2000, the Centers for Medicare & Medicaid Services (CMS) implemented new, annual performance reviews to measure state performance in the timeliness of surveys and complaint investigations and the proper documentation of survey findings. In 2003, the Long Term Care-Regulatory Complaint and Intake Management Unit convened a workgroup to assess prioritization of complaints and provider self-reported incidents of all providers licensed by Regulatory Services. (The workgroup's goal was to align prioritization across program types as allowed by statute.) In November 2003, CMS provided direction to state survey agencies via S&C-04-09

¹ *Nursing Home Quality, Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight.* United States General Accounting Office Report to Congressional Requestors, July 2003.

Guidelines to Support Management of Complaints and Incidents and the National Implementation of the ASPEN Complaints/Incidents Tracking System (ACTS).

PURPOSE

The intent of this memorandum is to attempt to ensure that DADS' management of complaints and provider self-reported incidents:

- achieves predictability and consistency of intake data collection;
- ensures appropriate determination of priority assignment;
- aligns intake prioritization for all provider types licensed by Regulatory Services as allowed by statute; and
- ensures that triage and prioritization of complaints and incidents adheres to CMS' S&C-04-09.

The Consumer Rights and Services Complaint Intake Unit retains discretion to make a priority assignment outside of the direction provided herein, as long as the logic and rationale utilized in the triage and prioritization of the allegation for investigation maximizes the protection of consumer and resident health and safety.

If you have questions regarding the attached guidelines, please contact Consumer Rights and Services, Complaint Intake, at 512-438-2408.

Attachment

INTAKE PROCESS

Complaints regarding care, treatment, and services provided to consumers of long-term care services come from a variety of sources and in several formats. A complaint allegation (*an assertion that a requirement of licensure or certification has been violated*) can come directly from consumers or residents, family members, health care providers, advocates, law enforcement, or other state agencies. Report sources may be oral or written.

A self-reported incident is an official notification to the state survey and licensing agency from a Regulatory Services provider that the physical or mental health or welfare of a consumer or resident has been, or may be, adversely affected by mistreatment, neglect, or abuse. These reports also include injuries of unknown source and exploitation or misappropriation of consumer or resident property.

The information recorded in the complaint or provider self-reported incident intake reflects information furnished by the person reporting at the time of the intake concerning the nature of the alleged noncompliance and the extent of any alleged threat or potential threat to the health, safety, and well-being of consumers or residents.

TRIAGE PROCESS

Intake triage begins when the Consumer Rights and Services Complaint Intake Unit receives a complaint(s) or a provider self-reports an incident as required by DADS rules.

Intake triage ends when:

- The Complaint Intake Unit receives or has collected enough comprehensive information to make a prioritization decision; and
- The intake has been reviewed by a Complaint Intake quality monitor program specialist and sent to the Regulatory Services Compliance, Assessment, Regulatory Enforcement System (CARES) or the Home and Community Support Services Agency Information Technology (HCSSA IT) complaint and incident tracking system to schedule an on-site investigation.

The end of triage date is counted as day zero when calculating the “date to be investigated by.”

When Complaint Intake receives voice mail or written complaints, subsequent oral or written communication from the complainant may be necessary to obtain comprehensive information to complete the intake triage and prioritization. **Unless extenuating circumstances impede the collection of relevant information, the intake triage process is completed no more than two working days from Consumer Rights and Services Complaint Intake’s receipt of the complaint or incident. Should intake triage exceed two working days, the intake program specialist will document the rationale or circumstances for the delay in completing triage in the CARES or HCSSA IT intake general notes.**

INFORMATION TO BE COLLECTED FROM COMPLAINANTS

(If the complainant requests anonymity, an intake program specialist will explain confidentiality and document in the intake general notes that the complainant wished to remain anonymous despite an explanation of confidentiality.)

To the extent possible, the intake program specialist will collect the following information from the complainant:

- Complainant's name, address, and two means of telephone contact; the best time to contact the complainant; and the complainant's e-mail address. If the complainant provided one telephone number, the intake general notes will include documentation to reflect that the complainant provided only one means of telephone contact.
- Relationship of the complainant to the consumer or resident.
- Name and address of the facility or agency.
- How the complainant became aware of the problem(s): whether the complainant was present and witnessed the facility or agency alleged noncompliance or if the complainant heard about it from someone else.
- How many consumers or residents were involved and how they were affected by the provider's alleged noncompliance. The consumer's or resident's expected level of care or service needs; date of birth; Social Security number; payment source; unit, room, or floor number; significant medical history; decision-making capacity; cognitive status; special needs; and supervision level.
- Narrative specifics of the complainant's allegations; the date, time, and location of the allegation; and names of witnesses, alleged perpetrator(s), and anyone else the complainant believes may have information to share about their concerns.
- Adverse consequences or negative impact to the consumer's or resident's mental, physical, or psychosocial well-being or functional status; injuries; and any medical treatment required or provided and the location where the treatment was provided.
- The complainant's belief about the pervasiveness of the alleged noncompliance; how or why the complainant believes the noncompliance occurred (e.g., lack of staff, proficiency of staff, etc.); whether the complainant knew if any other consumer or resident might have had the same or similar problems.
- Any action taken by the complainant to date, such as reporting or discussing concerns with the provider or other individuals (e.g., police, ombudsman). If yes, what have they done and with whom have they spoken?
- The complainant's expectation or desire for resolution or remedy.

INFORMATION THAT IS PROVIDED TO THE COMPLAINANT

The intake specialist is responsible for providing the following information to the complainant:

1. Regulatory authority to investigate;
2. The anticipated time frame for Regulatory Services to investigate; and
3. Information and referral to other appropriate agencies that could provide assistance, including the name and telephone number of a contact person, if available.

ACKNOWLEDGMENT OF COMPLAINTS

- Complaints left on voice mail are monitored by Complaint Intake program specialists and returned the day received or within 24 hours. When the intake program specialist returns the voice mail, the date and time the complainant was contacted will be annotated in the CARES or HCSSA IT intake general notes.
- The intake program specialist will acknowledge and document in the CARES or HCSSA IT intake general notes that the complainant was informed that his/her complaint would be investigated.¹
- The Complaint Intake quality monitor program specialist will acknowledge complaints received by *mail, fax, or referral* by letter and will annotate the acknowledgment on the CARES or HCSSA IT intake general notes. (If the complainant is a consumer or resident who still resides in the facility, a complaint acknowledgement letter **is not** sent to the consumer or resident at the facility address.)
- The Complaint Intake quality monitor program specialist will acknowledge complaints received via *e-mail* and will annotate the electronic acknowledgement in the CARES or HCSSA IT intake general notes.

PROVIDER SELF-REPORTED INCIDENTS

The following information will be obtained for provider self-reported incidents:

- Reporting person's name and title;
- Facility or agency name, address, and telephone number; HCSSA license number or provider number;
- Name of the individual who reported the allegation to the facility or agency (e.g., resident, staff, family member);
- Date and time the provider first became aware of the reportable incident;
- Date, time, and location of the incident;

¹ Complaints against home health and hospice providers will be acknowledged by letter regardless of how the complaint was received. [40 TAC § 97.502]

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- Consumer(s) or resident(s) involved. Consumer's or resident's expected level of care and service needs; date of birth; Social Security number; payment source; unit, room, or floor number; significant medical history; decision-making capacity; cognitive status; special needs; and level of supervision;
- Narrative specifics of the incident;
- Name(s) of witness(es), alleged perpetrator(s), or anyone else the individual who reported the incident believes may have information to share about the incident;
- Adverse consequences or negative impact to the consumer's or resident's mental, physical, or psychosocial well-being or functional status; injuries; and any medical treatment required or provided and the location where the treatment was provided;
- The provider's immediate action(s) to date to protect the health and safety of the consumer or resident and prevent further reoccurrence (e.g., suspension or termination of employee, specific in-service training or retraining, change in consumer's or resident's care or service plan, change in consumer's or resident's level of supervision); and
- Anyone else the provider notified of the incident (e.g., police, ombudsman, other state agency).

PRIORITY DEFINITIONS

On-or-before 24 hours² (applies to all provider types except HCSSA):

Immediate response by Regulatory Services is warranted because a provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure or certification has failed to protect consumers/residents from abuse, neglect, or mistreatment or has caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer or resident.

On-or-before 2 working days (applies to HCSSA only):

Immediate response by Regulatory Services is warranted because a HCSSA provider allegedly created or allowed a present and ongoing situation in which the provider's noncompliance with one or more requirements of licensure or certification has failed to protect consumers or has caused, or is likely to cause, serious injury, harm, impairment, or death to a consumer.

On-or-before 14 calendar days (applies to all provider types except HCSSA):

The present or ongoing threat of continued abuse, neglect, or mistreatment has been removed. Consumer(s)/resident(s) is no longer in imminent danger; however, the provider's alleged noncompliance with one or more requirements of licensure or certification may have or has a high potential to cause harm that impacts a consumer's/resident's mental, physical, or psychosocial status and is of such consequence that a rapid response by Regulatory Services is indicated. There is

² The investigation must be initiated no later than midnight of the next calendar day following completion of triage and prioritization and the routing of the intake to the region via CARES or HIT.

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evidence or suspicion that system(s) failure contributed to or brought on the threat. Usually, specific rather than general information (e.g., descriptive identifiers, individual names, date/time/location of occurrence, description of harm) will factor into the assignment of this level of priority.

10 working days (applies to HCSSA only):

Alleged provider noncompliance may have or has a high potential to cause harm that affects a consumer's mental, physical, or psychosocial well-being and is of such consequence that a rapid response by Regulatory Services is indicated. Complaint allegation(s) may assert that one or more of the following occurred:

- Nursing care was not delivered as planned to a consumer with present and ongoing need for nursing care;
- There was a break in service for skilled services for Community Care for the Aged and Disabled-Community Based Alternatives (CCAD-CBA), Community Living Assistance and Support Services (CLASS), or Deaf Blind/Multiple Disability (DBMD) waiver consumers;
- Agency personnel were not available to consumers during normal operating hours;
- The consumer sustained harm due to improper or inadequate care or service;
- Immediate threat to health and safety has been removed, but the situation poses a continued threat to the consumer and other consumers.

On-or-before 30 calendar days (applies to all provider types except HCSSA):

A provider's alleged noncompliance with one or more requirements of licensure or certification has caused or may cause harm that is of limited consequence and does not significantly impair the consumer's/resident's mental, physical, or psychosocial status.

On-or-before 45 calendar days (applies to all provider types except ADC, and applies to HCSSA Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP) deemed agencies with CMS regional office authorization):

A provider's alleged noncompliance with one or more requirements of licensure or certification has a low potential for more than minimal harm or may result in physical, mental, or psychosocial harm that would not directly impact consumer/resident health and safety and functional status; this priority may also be assigned for alleged violations of regulations that do not directly impact consumer/resident health and safety.

45 working days (applies to HCSSA only):

Allegation(s) against HCSSA provider may assert that one or more of the following exist:

- Alleged noncompliance with one or more requirements of licensure or certification that has a low potential for more than minimal harm or may result in physical,

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mental, or psychosocial harm that would not directly impact consumer health and safety;

- Financial insolvency without alleged impact on consumers; or
- Inaccurate clinical records.

90 working days (applies to HCSSA only):

Complaint allegation(s) may assert that an agency is providing home health services (hiring and sending out nurses to provide skilled nursing services or hiring and sending out aides to provide personal assistance services) without a license.

Next On-site (applies to HCSSA only):

Complaint allegation(s) against HCSSA provider may assert that one or more of the following occurred:

- Discharge without proper notice;
- Illegal remuneration (solicitation – kickbacks);
- Billing irregularities;
- Personal Assistance Services not being provided when the situation does not pose a serious threat to the consumer's health and safety; or
- Consumer rights violations.

Professional Review (applies to all provider types except HCSSA):

A provider who has cause to believe that the physical or mental health or welfare of a consumer(s)/resident(s) has been, or may be, adversely affected by mistreatment, neglect, or abuse must self-report the incident to the state survey agency immediately on learning of the alleged conduct or conditions. This report could include injuries of unknown source and exploitation/misappropriation of consumer/resident property.

Complaint Intake Unit staff assign a Professional Review priority³ when a provider self-reports an incident to Regulatory Services, and the provider's oral report indicates that the provider's immediate corrective action is reasonably likely to ensure that abuse, neglect, mistreatment, or injury to a consumer(s)/resident(s) will not occur again, or at least not while the provider conducts its investigation and the provider's written investigation report is received and reviewed by a Complaint Intake program specialist.

A review of the Provider Investigation Report by a Complaint Intake nurse specialist will include an assessment of the provider's description of the incident, the provider's summary and analysis of the investigation procedures, the provider's conclusion whether the allegation is supported by the provider's professional judgment, and the recommendation(s) or the corrective action(s) taken by the provider as a result of the investigation findings.

³ Regulatory Service staff can review provider self-reported incidents prioritized Professional Review by creating an ad hoc report through CARES Intake Custom Report module.

Based on review of the facility investigation report, if further investigation is warranted to assess whether the provider's abuse prohibition policies ensure compliance with regulatory requirements, the Complaint Intake Unit will send the intake to the region's CARES compliance review bin to schedule an on-site investigation.

Administrative Review/Off-site Investigation (applies to HCSSA only):

A complaint that does not warrant an on-site investigation may be given an off-site administrative review (e.g., written/verbal communication or documentation) to determine if further action is necessary. The State Agency may review the information at the next on-site survey.

Desk Review (applies to HCSSA only):

Effective October 1, 2004, desk reviews are used for off-site investigation of HCSSA self-reported incidents. If further investigation is warranted to ensure compliance with federal, state, or local laws, an on-site investigation is scheduled at the request of regional staff. Whether investigation is by desk review or on-site, it must be completed on or before 120 working days.

Financial (applies to Medicaid-certified NFs):

Complaints against a Medicaid-certified nursing facility are referred to Provider Services for investigation when one of the following may exist:

- The facility has failed to properly manage a resident's trust fund; or
- The facility has failed to reimburse pro-rata monies due a resident when a resident is admitted to a Medicare bed or has been discharged.

Withdrawn (applies to all provider types):

This category details complaint allegations withdrawn in accordance with S&CC Memo 03-08.

Not Required/Not Applicable (applies to all provider types):

Regulatory Services determines it has no jurisdiction to investigate a complaint or a referral, or a report to another agency, board, or entity is required.

REGULATORY SERVICES PRIORITIZATION TIME FRAMES BY PROVIDER TYPE

Nursing Facility

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 24 hours
Non-Immediate Threat (High) – 10 working days (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 14 calendar days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 30 calendar days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 <i>Rev. 18, 03-17-06</i>)	On-or-before 45 calendar days
Desk Review/Off-site Investigation	Professional Review
Referral – Immediate/Other	Financial
No Action Necessary	Withdrawn
No Action Necessary	Not Required

Assisted Living

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
NA	On-or-before 24 hours
NA	On-or-before 14 calendar days
NA	On-or-before 30 calendar days
NA	On-or-before 45 calendar days
NA	Professional Review
NA	Withdrawn
NA	Not Required

Adult Day Care

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
NA	On-or-before 24 hours
NA	On-or-before 14 calendar days
NA	On-or -before 30 calendar days Health & Safety Code Section 103.008 (b)
NA	Professional Review
NA	Withdrawn
NA	Not Required

**Intermediate Care Facilities for Persons with Mental Retardation
or Related Conditions**

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 24 hours
Non-Immediate Threat (High) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 14 calendar days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 14 calendar days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 calendar days
Desk Review/Off-site Investigation	Professional Review
No Action Necessary	Withdrawn
No Action Necessary	Not Required

Home Health and Hospice

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Immediate Threat – 2 working days (CMS S&C- 04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 2 working days
Non-Immediate Threat (High) 10 working days (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 10 working days
Non-Immediate Threat (Medium) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 working days
NA	On-or-before 90 working days
Non-Immediate Threat (Low) (CMS S&C-04-09 and SOM Chapter 5 Rev. 18, 03-17-06)	On-or-before 45 calendar days (deemed providers only) ⁴

⁴ Complaints against providers with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP) deemed status require CMS Regional Office (RO) approval and cannot be prioritized in excess of 45 calendar days (SOM 3262).

Time Frames Related to Federal Guidelines	Regulatory Services Prioritization Time Frame
Administrative Review/Off-site Investigation (SOM Chapter 5 Rev. 18, 03-17-06)	Next On-site ⁵ ⁶
Desk Review /Off-site Investigation	Desk Review
No Action Necessary	Withdrawn
No Action Necessary	Not Applicable/Not Warranted

ADDITIONAL ISSUES TO CONSIDER WHEN TRIAGING & PRIORITIZING INTAKES

Harm level:

1. Did harm or injury occur? How significant was it? Did it impair the consumer's or resident's functioning?
2. Did the consumer(s) or resident(s) require treatment?
3. Did the consumer(s) or resident(s) experience physical or psychological discomfort without significant change in their physical or psychosocial well-being?
4. Did the provider exercise reasonable judgment in assessing and minimizing the threat to consumer or resident health and safety?

Quality and completeness of the information provided:

1. How much first-hand knowledge did the complainant have?
2. Is the information vague or specific?
3. Has there been a pattern of similar complaints?

Time frame of the allegation:

1. How recently did the allegation(s) occur?
2. Has there been a previous allegation(s) or provider self-reported incident(s) investigated regarding the same consumer(s) or resident(s)?
3. Is there a pattern of outstanding complaints or provider self-reported incidents regarding the same concerns or involving the same consumer(s) or resident(s)?

⁵ Allegations of Abuse/Neglect/Exploitation are referred to Department of Family and Protective Services (DFPS) in accordance with Memorandum of Understanding (MOU)-05/20/02.

⁶ *Next on-site is defined as the very next time a survey is conducted at the agency that the complaint is against.*

