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CALIFORNIA NURSING HOMES

Care Problems Persist Despite Federal and State Oversight

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The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

Nursing homes play an important role in the health care system of the United States. Among other services, they provide skilled nursing and supportive care to older individuals who do not need the intensive medical care provided by hospitals, but for whom receiving such care at home is no longer feasible. An estimated 43 percent of Americans who passed their 65th birthday in 1990 will use a nursing home at some time in their lives. In 1997, there were more than 17,000 nursing homes in the United States with over 1.7 million beds. The federal government, through the Medicare and Medicaid programs, paid these homes nearly $28 billion in 1997.

In 1997, a lawyer and an investigator raised allegations to your Committee that 3,113 residents died in 971 California nursing homes in 1993 as a result of malnutrition, dehydration, and other serious conditions for which they did not receive acceptable care. Poor nutrition, dehydration, and improper care of incontinent and immobile residents can result in bedsores (pressure sores) or urinary tract infections, which, if not properly treated, can lead to more serious infection and death. The federal government, through the Health Care Financing Administration (HCFA), and the state of California, through its Department of Health Services (DHS), share oversight responsibilities for California nursing homes that participate in the Medicare and Medicaid programs. To assess compliance with federal standards, DHS relies primarily on a yearly standard survey conducted by nurses or other staff with medical or social service backgrounds who review the care and services provided by the homes. California has more than 1,400 nursing homes, with over 141,000 resident beds. The Medicare and Medicaid programs paid these homes approximately $2 billion in 1997.

Concerned about the life-threatening potential of these conditions, you asked us to (1) examine, through a medical record review, whether these allegations had merit and whether serious care problems currently exist; (2) review the adequacy of federal and state efforts in monitoring nursing home care through annual surveys; and (3) assess the effectiveness of

federal and state efforts to enforce sustained compliance with federal nursing home requirements.

To address the allegations pertaining to the acceptability of care in 1993, two registered nurses, one with a doctoral degree in gerontological nursing and the other with a master's degree in the same field, and both with clinical expertise in nursing home care and data abstraction, conducted a clinical review of the medical records for a sample of residents included in the allegations. Using clinical practice guidelines, published research, and professional judgment concerning acceptable nursing home care, the nurses determined whether residents received acceptable or unacceptable care. Their work was further reviewed by another registered nurse on our staff with experience working in nursing homes and judging whether care met acceptable clinical standards. This second review focused specifically on a critical examination of all cases in which the first team of registered nurses identified residents as having had unacceptable care. Our registered nurse also discussed some of the cases with physicians and additional registered nurses specializing in geriatric care to further clarify whether care was acceptable or unacceptable. From this second review, we excluded all questionable cases from the final unacceptable care group. Because of our sampling method, the results of this analysis of medical records pertaining to deaths in 1993 cannot be generalized to the universe of all residents in California nursing homes operating then or now.

To assess the adequacy of federal and state efforts in monitoring nursing home care, we (1) reviewed federal and state data that showed the results of surveys, complaint investigations, and enforcement actions taken from 1995 to 1998; (2) accompanied state surveyors during their regularly scheduled annual survey of two nursing homes and, with the help of a second team of registered nurses experienced in assessing nursing home care, conducted a concurrent survey of care at these two homes; and (3) interviewed officials from nursing homes, DHS, HCFA, nursing home industry associations, and advocacy groups. Before releasing the draft for official comment, we consulted with a number of noted clinical experts,[1]

[1]They included Sydney Katz, M.D., Professor Emeritus of Geriatric Medicine, Columbia University, who had led the Institute of Medicine study that influenced the Omnibus Budget Reconciliation Act of 1987 nursing home reforms; Mathy Mezey, Ed.D., R.N., FAAN, Independence Foundation Professor of Nursing Education, New York University, and Director of the Hartford Institute for Geriatric Nursing; John W. Rowe, M.D., President of Mount Sinai Medical Center and School of Medicine; and T. Franklin Williams, M.D., Professor of Medicine Emeritus and Department of Veterans Affairs Distinguished Physician, University of Rochester School of Medicine and Dentistry, and Director, National Institute on Aging, National Institutes of Health (1983 through 1991).

who reviewed our findings and found the report well supported and balanced.

We conducted our work between October 1997 and July 1998 in accordance with generally accepted government auditing standards. (See app. I for a detailed description of our scope and methodology.) In addition to this report, we are currently conducting, for you and other requesters, a broader-based review that addresses nursing home enforcement nationwide. We expect to issue that report early in 1999.

Results in Brief

Overall, despite the federal and state oversight infrastructure currently in place, certain California nursing homes have not been and currently are not sufficiently monitored to guarantee the safety and welfare of their residents. We reached this conclusion primarily by using data from federal surveys and state complaint investigations conducted by California's DHS on 1,370 California homes, supplemented with our more in-depth analysis of certain homes and certain residents' care. We also found that surveyors can miss problems that affect the safety and health of nursing home residents and that even when such problems are identified, enforcement actions do not ensure that they are corrected and do not recur.

With regard to allegations made about avoidable deaths in 1993, our expert nurses' review of the 62 resident cases sampled[2] found that residents in 34 cases received care that was unacceptable and that sometimes endangered their health and safety. Our team found such care problems as inadequate intervention by the nursing home to prevent dramatic, unplanned weight loss and failure to properly treat pressure sores that became infected and toxic. However, in the absence of autopsy information that establishes the cause of death, we cannot be conclusive about the extent to which this unacceptable care may have contributed directly to individual deaths.

Unacceptable care continues to be a problem in many homes. For example, our analysis of federal survey and state complaint investigations found that nearly 1 in 3, or 407, of 1,370 California nursing homes were cited by state surveyors for having serious or potentially life-threatening care problems.[3]

[2]Our criteria for inclusion in the sample were that a case came from a home with at least 5 of the allegedly avoidable deaths and at least 5 such deaths per 100 beds; 72 nursing homes met these criteria. The 62 cases were drawn randomly and came from 15 of those nursing homes.

[3]The 1,370 homes represent 95 percent of Medicare- and Medicaid-certified homes in California in operation at some time between July 1, 1995, and February 26, 1998.

Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. We found that homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations. In addition, we found instances of irregularities in the homes' documentation of the care provided to their residents, such as missing pages of clinical notes needed to explain a resident's injury later identified through physician observation. These types of irregularities could shield from surveyor scrutiny such problems as inadequate staffing or avoidable injuries. Finally, in visiting homes selected by California DHS officials themselves, our team found multiple cases in which DHS surveyors did not identify certain serious care problems—including unaddressed dramatic weight loss and related nutritional problems. Surveyors missed these and other care problems, in part, because federal guidance on conducting surveys does not include sampling methods that can enhance the spotting of potential problems and help establish their prevalence.

Even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. For example, California state surveyors had cited about 1 in 11 homes in our analysis—accounting for over 17,000 resident beds—for violations in both of their last two surveys that resulted in harm to residents. Nevertheless, HCFA generally took a lenient stance toward many of these homes. California's DHS, consistent with HCFA's guidance on imposing sanctions, grants all noncompliant homes—except for the few homes that qualify as posing the greatest danger to residents—a 30- to 45-day grace period. During this period, these homes may correct deficiencies without penalty, regardless of their past performance. In addition, a substantial number of California's homes that have been terminated and later reinstated have soon thereafter been cited again for serious deficiencies when reviewed in subsequent surveys. Recognizing its enforcement shortcomings, California's DHS launched a pilot program this month intended to target for increased vigilance certain of the state's nursing homes with the worst performance records.

Although our report focuses on nursing homes in California, the problems we identified are indicative of systemic survey and enforcement weaknesses. Our recommendations therefore target federal guidance in general so that improvements are available to any state experiencing problems with seriously noncompliant homes. Thus, through HCFA's leadership, federal and state oversight of nursing homes can be

strengthened nationally and residents nationwide can enjoy increased protection.

Background

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) introduced major reforms in the federal regulation of nursing homes that responded to growing concerns about the quality of care that residents received. Among other things, these reforms revised care requirements that facilities must meet to participate in the Medicare or Medicaid programs, modified the survey process for certifying a home's compliance with federal standards, and introduced additional sanctions and decertification procedures for homes that fail to meet federal standards.

Oversight Is Shared Federal and State Responsibility

The federal responsibility for overseeing nursing facilities belongs to HCFA, an agency of the Department of Health and Human Services (HHS). Among other tasks, HCFA defines federal requirements for nursing home participation in Medicare and Medicaid and imposes sanctions against homes failing to meet these requirements. The law requires HCFA to contract with state agencies to survey nursing homes participating in Medicare and Medicaid. In California, DHS performs nursing home oversight, and its authority is specifically defined in state and federal laws and regulations. As part of this role, DHS (1) licenses nursing homes to do business in California; (2) certifies to the federal government, by conducting reviews of nursing homes, that the homes are eligible for Medicare and Medicaid payment; and (3) investigates complaints about care provided in the licensed homes.

To assess nursing home compliance with federal and state laws and regulations, DHS relies on two types of reviews—the standard survey and the complaint investigation. The standard survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review of care and services with regard to meeting the assessed needs of the residents.[4] The complaint investigation entails conducting a targeted review with regard to a specific complaint filed against a home. California state law mandates that a complaint must be investigated within 2 to 10 days, depending on the seriousness of the infraction being alleged. HCFA requires that any complaint involving immediate jeopardy to a resident's health or safety be investigated within 48 hours.

[4]The standard survey is used not only to meet HCFA's requirement to certify homes for Medicare and Medicaid participation but also to ensure that a home is continuing to meet its state licensing requirements.

Separate Federal and State Enforcement Systems

The state and HCFA each has its own enforcement system for classifying deficiencies that determines which remedies, sanctions, or other actions should be taken against a noncompliant home. During standard surveys, California's DHS typically cites deficiencies using HCFA's classification and sanctioning scheme; for complaint investigations, it generally uses the state's classification and penalty scheme, which allows the imposition of penalties and other actions under state enforcement criteria.

Table 1 shows HCFA's classification of deficiencies and their accompanying levels of severity and compliance status.

Table 1: HCFA's Deficiency Classification System

HCFA deficiency category	Level of severity	Compliance status of home cited for this deficiency
Immediate jeopardy to resident health or safety	Most serious	Noncompliant
Actual harm that does not put resident in immediate jeopardy	Serious	Noncompliant
No actual harm, with potential for more than minimal harm	Less serious	Noncompliant
No actual harm, with potential for minimal harm	Minimal	Substantially compliant

HCFA guidance also classifies deficiencies by their scope, or extent, as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern, defined as affecting more than a limited number of residents; and (3) widespread, defined as affecting all or almost all residents. HCFA guidance on citing a deficiency's scope as "widespread" states that "'the universe' [of residents required for determining 'widespread'] is the entire facility," not just those who, by their condition, would have been affected by the deficiency cited. The example provided explains that if a facility was deficient in appropriately treating all of a facility's tube-fed residents—but the number of tube-fed residents was less than the facility's total number of residents—surveyors must cite the deficiency's scope as "pattern" and not widespread.

Whether a deficiency is judged by surveyors to be isolated, a pattern, or widespread has implications for enforcement. For example, under HCFA regulations, a home is to be cited for "substandard quality of care" when it has certain deficiencies exceeding a particular severity and scope level. Receiving a substandard rating is significant because, depending on a

home's past performance, such a rating can prompt stronger enforcement actions than are typically taken under HCFA policy.

The deficiencies that can warrant a substandard rating involve federal requirements related to quality of care, quality of life, and resident behavior and facility practices. Any of these types of deficiencies involving immediate jeopardy to resident health and safety results in a substandard rating. In addition, these types of deficiencies lead to a substandard rating if they are of the following severity and scope combinations: a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Serious Care Problems Found in Many Nursing Homes Reviewed

The work of our expert nurses indicates that some of California's nursing home residents who died in 1993 received unacceptable care that, in certain cases, endangered their health and safety. We also found evidence that serious care problems exist today in California nursing homes. Data from standard and complaint surveys indicate that nearly a third of California's nursing homes experience serious care problems.

Review of 1993 Medical Records Uncovered Serious Care Problems

We examined medical records of residents who died in 1993 from such causes as malnutrition, dehydration, pressure sores, and urinary tract infections with sepsis (the presence of bacteria and toxins in the blood or tissue). Their deaths were alleged to have been caused by unacceptable nursing home care. The 3,113 cases of alleged unacceptable care were distributed across nearly three-fourths of California's nursing homes in 1993. However, to avoid selecting isolated instances of such deaths, our cases were drawn from about 5 percent of California's homes that had at least five of the allegedly avoidable deaths. Our review suggests that 34 residents—more than half of the 62 cases reviewed—received unacceptable care.[5] Our expert nurses concluded that, in some of these cases, unacceptable care endangered residents' health and safety. Care problems included dramatic, unplanned weight loss, failure to properly treat pressure sores, and failure to manage pain. The examples in figure 1 illustrate the nature of the care problems we identified.

[5]Care was considered unacceptable based on the clinical judgment of our nurse reviewers—using practice guidelines to help them reach their judgment—and supplemented with additional review. The unacceptable care they identified led to outcomes that caused serious harm to some residents. Care given in 1993 was not analyzed as to whether the homes would have been considered compliant using HCFA's 1995 enforcement requirements.

Figure 1: Examples of Quality-of-Care Problems Found in Review of 1993 Medical Records

Quality-of-Care Problems

- A resident lost 59 pounds—about one-third of his weight—over a 7-week period. Only a small share of the weight loss was attributable to fluid loss. Until 2 days before the resident's death, the nursing home staff had not recorded his weight since the day he was admitted to the home or notified the physician of the resident's condition. According to the medical record, the resident was in severe pain during his 7-week stay at the home as a result of infected pressure sores that worsened from stage II to stage IV (most severe). Although his physician had ordered pain medication, his medical record indicated that the nursing home staff gave him pain medication for only 3 of the 7 weeks.

- A resident was admitted to a nursing home with five pressure sores, four of which exposed the bone. Although the physician ordered pain medication during treatments that removed the blackened dead tissue from her sores, the resident's medical record indicated that she received pain medication only three times during 5 weeks of daily treatments. The resident, who was not in a condition to verbalize her needs, was reported in the nursing notes to moan whenever this procedure was done without prescribed pain medication.

- Before she entered a nursing home as a result of a stroke, a resident had lived independently. Upon admission, she received physical and speech therapy for 2 months and regained her ability to walk with assistance and more than 90 percent of her ability to swallow. However, during her 18-month stay in the home, she lost nearly one-half of her total weight, dropping from 100 to 54 pounds. The medical records gave no indication of the reason for the weight loss. Her death certificate indicated that the wasting away of her body (cachexia), as well as a gangrenous foot, caused her death.

In other cases we reviewed from 1993, the care documented in the medical record was acceptable. For example, when nursing home staff recognized that a resident was having difficulty swallowing food, they changed her diet to pureed food and placed the resident in a restorative feeding program, where she received additional help in eating. Although the resident later refused all food and liquid and eventually died of dehydration, our expert reviewers concluded that the nursing home staff provided acceptable care during the resident's 4-month stay in the home. The cause of death listed on her death certificate might raise questions about the care she received, but only medical record review could determine whether the care was acceptable.

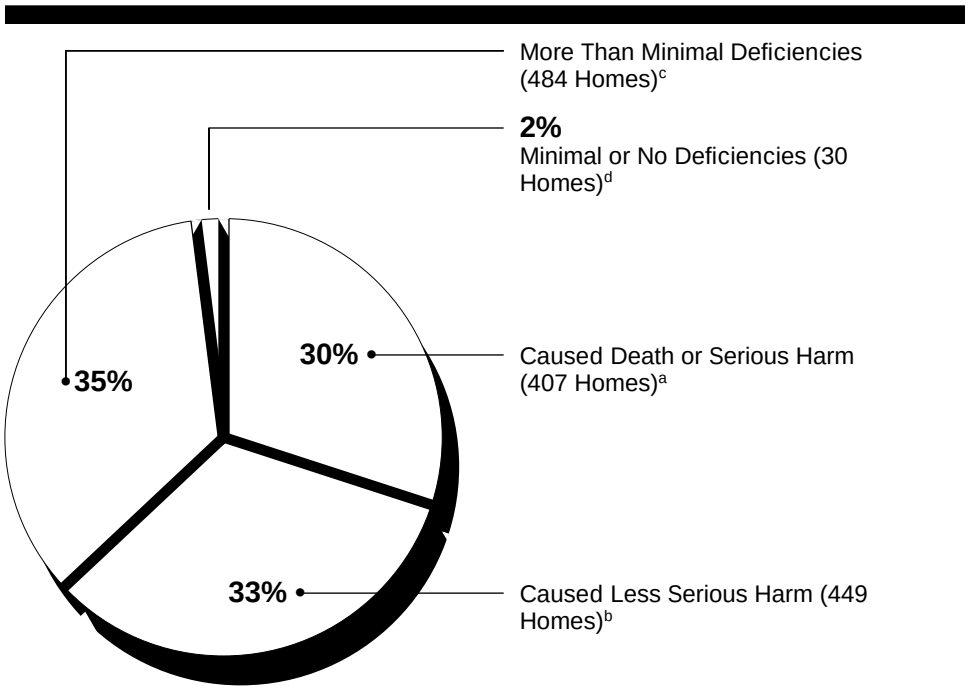
State's Quality Reviews Show Substantial Care Problems Occurring Today

DHS surveyors identified a substantial number of homes with serious care problems through their annual standard surveys of nursing homes and through ad hoc complaint investigations. Through examining the most recent two surveys from homes that had at least two standard surveys conducted between July 1995 and February 1998, and that may have had

complaint investigations in 1996 or 1997, we found that surveyors cited 407 homes—nearly a third of the 1,370 homes included in our analysis—for serious violations classified under the federal deficiency categories, the state's categories, or both. These homes were cited for violations that caused death, seriously jeopardized residents' health and safety, or were considered by state surveyors to have constituted substandard care.

Figure 2 shows the distribution of the nursing homes included in our analysis by the seriousness of the federal and state violations cited.

Figure 2: Distribution of 1,370 California Nursing Homes by Seriousness of Federal and State Violations Cited, 1995-98



Note: Violations can be federal deficiencies cited in either of a home's two most recent surveys or state deficiencies cited for 1996 or 1997.

[a]Federal and state violations in this category include (1) improper care leading to death and (2) life-threatening harm or other serious injury—federal violations classified as immediate and serious jeopardy and state violations cited as class AA or A. Federal violations also include a specified set of 49 deficiencies of severity and scope that constitute substandard care. State violations additionally include intentional falsification of medical records or material omission in medical records.

[b]Federal and state violations in this category include harm to a resident that regulators judged to be less than life-threatening—federal violations classified as causing residents actual harm that do not put a resident in immediate jeopardy and are not classified as substandard care. State violations included in this category are those cited as class B, which have a direct or immediate relationship to the health, safety, or security of a resident.

[c]Federal violations in this category include deficiencies that have not caused actual harm but could cause more than minimal harm to residents if not corrected. California has no directly equivalent state citation for this category.

[d]Homes in this category either were cited for no violations or for federal violations that did not cause harm to residents but could result in minimal harm if not corrected. California has no directly equivalent state citation for this category.

The four wedges in figure 2 correspond to federal deficiency categories shown in table 1 and include comparable-level deficiencies cited using the state's separate classification scheme, as follows:

- "Caused death or serious harm" represents any federal deficiency that surveyors classified as constituting immediate jeopardy or substandard care and California deficiencies of improper care leading to death, imminent danger or probability of death, intentional falsification of medical records, or material omission in medical records.
- "Caused less serious harm" represents federal violations constituting actual harm but not immediate jeopardy or substandard care and California violations that have a direct or immediate relationship to the health, safety, or security of a resident.
- "More than minimal deficiencies" represents federal violations that could cause more than minimal harm to residents if not corrected.
- "Minimal or no deficiencies" represents either no violations or federal violations that could have resulted in minimal harm to residents if not corrected.

Figure 3 shows the distribution of types of deficiencies in the category called "caused death or serious harm" and gives examples of each type. The category "improper care leading to death" does not include all residents who died in homes cited for violations related to residents' care, because the category "life-threatening harm" can also include such violations and associated deaths.

Figure 3: Examples of Deficiencies DHS Cited Between 1995 and 1998 That Correspond to the "Caused Death or Serious Harm" Category in Figure 2

"Caused Death or Serious Harm"

- **Improper Care Leading to Death**[a] (26 homes cited): A resident admitted to a home for physical therapy rehabilitation following hip surgery died 5 days later from septic shock caused by a urinary tract infection. The home's staff failed to monitor fluid intake and urine output while the resident was catheterized and afterward. Nursing home staff failed to notify a physician as the resident's condition deteriorated. When his family visited and found him unresponsive, they informed the staff, and his physician was contacted. The physician ordered intravenous antibiotics, but staff were not able to get the intravenous line in place and continuously functioning until 8 hours had passed. The resident died 3 hours later.

- **Life-Threatening Harm**[b] (259 homes cited): Because a home lacked sufficient licensed nursing staff on duty, residents did not receive treatments, medications, or food supplements as ordered. One resident's medical record indicated that, although a licensed nurse had noted the individual's deteriorating physical condition a half hour before she died, there was no evidence that the nurse continued to assess the resident's vital signs, administered oxygen as prescribed by a physician's order, or notified the attending physician and family about the resident's deteriorating condition.

- **Other Serious Improper Care**[c] (111 homes cited): Violations included failure to provide multiple residents with sufficient fluids, maintain an environment free of accident hazards, administer proper care for pressure sores, or maintain clean bed and bath linens.

- **Falsification of, or Key Omissions From, Medical Records**[d] (11 homes cited): A home's treatment records named a staff member as having provided two residents with range-of-motion exercises nine separate times. It was later determined that the staff member was not working at the home when the treatments were reportedly provided.

[a]State violations cited as class AA.

[b]Federal violations classified as "immediate and serious jeopardy" and state violations cited as class A. This category includes some violations causing harm that were associated with a resident's death.

[c]Federal violations are classified as "substandard quality of care" if (1) the deficiencies are in one of three requirement categories—quality of care, quality of life, and resident behavior and facility practices and (2) their prevalence is widespread and has a potential for harming residents, or they have harmed more than a limited number of residents or put the health and safety of one or more residents in immediate jeopardy. Substandard quality-of-care violations that put residents in immediate jeopardy are included in "life-threatening harm" in this figure.

[d]State violations classified as "intentional falsification of medical records" or "material omission in medical records." Three other homes were cited for falsification of or key omissions from medical records, but because they were also cited for other serious care violations, they were included in the "other serious improper care" group.

We also found examples of poor care that were ranked by state surveyors as causing less serious harm under the federal and state classification systems. For example, the cases described in figure 4 were not classified in the group of "most serious" violations.

Figure 4: Examples of Deficiencies DHS Cited Between 1995 and 1998 That Correspond to the "Caused Less Serious Harm" Category in Figure 2

"Caused Less Serious Harm"

- A family member noticed that a resident's feet were purple and swollen and that her speech was slurred. The nursing home's medical records indicated that the home's staff had not noted or evaluated these conditions. The resident died the next day.

- Upon admission, a resident was evaluated by nursing home staff as a low risk for developing pressure sores. One month later, the resident was admitted to the hospital with pressure sores on her buttock, thigh, calf, and foot. The hospital physician could not perform surgery on the most serious sores because of the resident's deteriorated skin condition. This deterioration was caused by severe dehydration and infected pressure sores. The resident died 2 days later from infected pressure sores, sepsis, dehydration, and septic shock.

- Several nursing care interventions were identified for one home's resident who had chronic obstructive pulmonary disease, chronic arthritis, dementia, and several serious pressure sores, including a stage IV sore on her coccyx. The resident's plan of care identified the need for (1) a special mattress to prevent pressure and promote healing, (2) assistance with eating and participation in a feeding program, and (3) turning and repositioning every 2 hours. Observation by surveyors for 10 hours over 2 days revealed that the resident was left in a wheelchair without a pressure-relieving device for her coccyx and without being repositioned and that she ate in her room without assistance, encouragement, or participation in a feeding program.

Deficiencies classified as "potential for more than minimal harm"—corresponding to the "more than minimal deficiencies" category in figure 2—can also include problems more serious than their classification implies, as figure 5 shows.

Figure 5: Examples of Deficiencies DHS Cited Between 1995 and 1998 That Correspond to the "More Than Minimal Deficiencies" Category in Figure 2

"More Than Minimal Deficiencies"

- For 2 consecutive days, while conducting an on-site review, surveyors witnessed a resident choking and coughing while trying to eat. The resident's medical record indicated that nursing home staff were supposed to make sure the resident's mouth was cleared after meals to prevent him from aspirating (that is, introducing food or liquids into the lungs). Following the surveyors' second observation of the nursing assistant's failure to clear the resident's mouth, a chest X ray was taken. It showed that the resident was suffering from pneumonia, which the surveyor noted may have resulted from aspiration of food and liquids.

- Surveyors documented that, for five residents with pressure sores, the home had not assessed the sores or developed a plan of treatment that was followed by staff. In one case, a resident had a less serious pressure sore that developed into a more serious sore with blackened, dead tissue. The resident was observed with a dressing on the sore that had not been changed for almost 2 weeks, even though the physician's order called for treatments, with dressing changes, twice a day. Surveyors had previously cited this home for improper treatment of pressure sores.

- At one home, several residents fell, which surveyors attributed to the home's failure to prevent accidents. One resident was dropped by a nursing assistant while being moved to a wheelchair, even though family members who were present requested that the nursing assistant seek additional help before moving the resident.

Homes with deficiencies classified as having "potential for minimal harm"—corresponding to the "minimal or no deficiencies" category in figure 2—are considered by HCFA to be in substantial compliance, as shown in table 1. However, figure 6 shows examples of deficiencies that California surveyors classified in this category in which the harm could be considered by some to be greater than minimal.

Figure 6: Examples of Deficiencies DHS Cited Between 1995 and 1998 That Correspond to the "Minimal or No Deficiencies" Category in Figure 2

"Minimal or No Deficiencies"

- Surveyors found dirt and grime on floors where clean linen was stored; paper towels, toilet paper, and used gloves on resident bathroom floors; and a foul odor emanating from a resident's room where excrement was tracked across the floor. Forty minutes after the initial observation of the excrement, the home's housekeeper mopped only beside a resident's bed, missing the majority of the excrement.
- Surveyors found several residents in urine-soaked clothing because they were not helped to the bathroom, despite the residents' calls for help. The home was cited for not having enough staff to provide sufficient nursing care.
- Surveyors spoke with several residents who fell or were dropped by staff while being moved. According to one resident, he was dropped while being moved from his bed to a chair, bumping his amputation incision. Resident records showed no evidence of the falls.

Predictability of Surveys, Questionable Records, and Survey Limitations Hinder Efforts to Identify Care Problems

The deficiencies that state surveyors identified and documented very likely capture part but not the full extent of care problems in California's homes, for several reasons. Some homes can mask problems because they are able to predict the timing of annual reviews or because medical records sometimes contain inaccurate information that overstates the care provided, given the resident's observed condition. In addition, state surveyors can miss identifying deficiencies because of limitations on the methods used in the annual review—methods established in HCFA guidance on conducting surveys—to identify potential areas of unacceptable care.

Surveys' Predictable Timing Likely Conceals Additional Care Problems

The extent of care problems is likely to be masked because of the predictability of homes' standard surveys. The law requires that a standard survey be unannounced, that it begin no later than 15 months after the last day of the previous standard survey, and that the statewide average interval between standard surveys not exceed 12 months. Because many California homes were reviewed in the same month—sometimes almost the same week—year after year, homes could often predict the timing of their next survey and, if inclined, prepare to cover up problems that may normally exist at other times. For example, a home that may routinely operate with too few staff could temporarily augment its staff during the period of the survey in order to mask an otherwise serious deficiency in staffing levels. Advocates and residents' family members told us they believe that such staffing adjustments are common, given their own observations in homes they visited.

At two homes we visited, we saw that the homes' officials had made advance preparations—such as making a room ready for survey officials—indicating that they knew the approximate date and time of their upcoming oversight review. When we discussed these observations with California DHS officials, they acknowledged that a review of survey scheduling showed that the timing of some homes' surveys had not varied by more than a week or so for several cycles. DHS officials have since instructed district office managers to schedule surveys in a way that reduces their predictability.

The issue of the predictable timing of surveys is long-standing. In the mid-1980s, the Institute of Medicine recommended adjusting the timing of surveys to make them less predictable and maximize the element of surprise. It suggested that standard surveys be conducted between 9 and 15 months after the previous standard survey.[6] In OBRA 87, the Congress established a civil monetary penalty to be levied against an individual who notifies a nursing home about the time or date of an impending survey. In 1995, HCFA issued guidance to states to keep the timing of the standard survey unpredictable by ensuring that all surveys are unannounced. However, the guidance is silent on varying the survey cycle as a way to reduce the predictability of these reviews.

Since the guidance was issued, two studies have found that regular timing of surveys is still a problem. The National State Auditors Association found that in nine states it studied, the timing of inspections in some states was around the same date every year, which allowed nursing homes to predict when their survey would occur.[7] Similarly, nursing home advocates in 41 states and the District of Columbia polled by HCFA noted that the predictability of surveys was a continuing problem.[8] One state's advocate noted that a home's care, food, and environment change dramatically as the time of the home's standard survey nears.

[6]The Institute of Medicine, Improving the Quality of Care in Nursing Homes (Washington, D.C.: Institute of Medicine, 1986), pp. 32-33.

[7]National State Auditors Association, National State Auditors Association Joint Performance Audit: Long-Term Care (Baton Rouge, La.: Performance Audit Division, Louisiana Office of the Legislative Auditor, 1998).

[8]HCFA conducted a telephone survey of state nursing home ombudsmen to determine whether the ombudsmen had observed changes in nursing homes since the 1995 implementation of the revised survey and enforcement processes. Ombudsmen are members of the local community who are trained and certified to assist in resolving problems raised by nursing home residents, their families, and others.

Questionable Records Suggest That Some Amount of Poor Care Escapes Detection in Record Reviews

Another reason quality problems in nursing homes escape detection is the questionable accuracy of some resident medical records. When conducting on-site reviews, surveyors screen residents' medical records for indicators of improper care; if information in the records is misleading or omitted, surveyors may fail to identify care deficiencies.

Studies of nursing home quality cite questionable accuracy of resident medical records as a problem. For example, one study found that nursing home staff often incorrectly record the amount of food consumed by residents, thus calling into question the information maintained on the adequacy of residents' nutrition.[9] Another study examined records on the use of restraints compared with actual restraint use. In this study, although nursing home records showed that staff had removed residents' restraints every 2 hours as required, researcher observation revealed that, in fact, 56 percent of the residents had been continuously restrained for 3 hours or longer.[10]

In the course of reviewing the 1993 medical records, we also found inaccuracies and otherwise misleading information. The examples in figure 7, abstracted from the 1993 California records we reviewed, illustrate the implausibility or suspicious omissions of information contained in some residents' records. We found discrepancies in about 29 percent of the 1993 California records we reviewed.

[9]Jeanie Kayser-Jones and others, "Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents," Nursing Home Medicine, Vol. 5, No. 3 (Mar. 1997), pp. 69-76.

[10]John F. Schnelle, Joseph G. Ouslander, and Patrice A. Cruise, "Policy Without Technology: A Barrier to Improving Nursing Home Care," The Gerontologist, Vol. 37, No. 4 (1997), pp. 527-32.

Figure 7: Examples of Questionable Medical Records in 1993

Questionable Medical Records

- During the hospital stay of a nursing home resident, doctors discovered that the resident was suffering from a fractured leg and that the fracture had occurred at least 3 weeks before the hospitalization. The nursing home's records were missing the clinical notes for the same 3-week period preceding the resident's hospital stay, thus omitting any indication that an injury had occurred, how it might have occurred, or how it might have been treated.

- Although a resident's medical record showed that each day she consumed 100 percent of three high-caloric meals and drank four high-protein supplements, the resident lost 7 pounds–10 percent of her total weight–in less than a month.[a] The implausibility of the resident's weight loss under these conditions raises major questions about the accuracy of the medical records regarding nutritional intake.

[a]According to medical experts, a 5-percent weight loss in 1 month is significant.

Recent Serious Care Problems Missed in Comprehensive Standard Surveys

Through medical record reviews as well as direct observation at two homes, we found that the standard surveys at these facilities failed to identify a number of serious care problems.[11] In our visits to two facilities during their annual surveys, we arranged for our team of registered nurses to accompany the state surveyors and conduct concurrent surveys designed specifically to identify quality-of-care problems.[12] Our survey methodology differed from the methodology specified by HCFA guidance and used by state surveyors in three major ways: (1) we selected a stratified, random sample of a much larger number of cases to review, including vulnerable populations such as new admissions and those at risk for pressure sores; (2) we collected uniform information on those cases using a structured protocol for observations, chart review, and staff interviews; and (3) we compared the results from those cases at each facility with data collected under the same sampling method at more than 60 other nursing homes nationwide, and then targeted our case review in areas where we identified a facilitywide pattern that could denote poor care. Using this methodology, we were able to spot cases in which the homes had not intervened appropriately for residents experiencing weight loss, dehydration, pressure sores, and incontinence—cases the state surveyors either missed or identified as affecting fewer residents.

[11]At a third home, we gathered information on survey procedures but did not conduct a concurrent review of residents' records or facility care.

[12]The scope of our team's survey was limited to quality-of-care issues, whereas the state surveyors had a broader scope of review that included requirements in 14 other areas, such as administration and dietary services.

At the two homes where our nurses conducted their quality-of-care surveys, the findings of our team and those of DHS surveyors were similar in some respects and different in others. For example, state surveyors cited one of the homes (home A) for a high medication error rate that was not found by our surveyors. However, problems state surveyors missed included unaddressed nutrition and weight loss, failure to prevent pressure sores, and poor management of resident incontinence—cases in which the homes had not intervened appropriately. (See fig. 8 for examples of such problems in home A.)

Figure 8: Examples of Problems Our Surveyors Found That DHS Surveyors Missed in On-Site Review, Home A

Unaddressed Nutrition and Weight-Loss Problems

- Through reviews of residents' medical records, our surveyors identified four individuals who were not receiving food supplements even though they were underweight; one person who was tube-fed, rapidly lost weight, and later died; and one person who was alive but lost weight while being tube-fed.[a] Our surveyors concluded that the home's failure to address these weight-related symptoms constituted a pattern of poor care that resulted in actual harm.

Pressure Sore Problems

- Our review of residents' medical records showed a high rate of recurring pressure sores with no evidence of an overall plan for their prevention. Our survey team also observed several bed-bound or wheelchair-bound residents remaining in the same position for hours, a condition that can foster the formation of pressure sores. Our survey team concluded that the DHS surveyors should have noted a pattern of poor care and classified this home's care for pressure sores as a condition demonstrating actual and potential harm.

Incontinence Problems

- Our survey team noted that the home had a strong odor of urine, a condition that should have prompted (but did not prompt) the state surveyors to explore the effectiveness of the home's bladder continence care. In addition, through medical record reviews and interviews, our surveyors noted that the home lacked a timed, prompted voiding schedule for residents who could not verbalize their needs. Our surveyors observed one resident who had not been changed for more than 6 hours, despite the fact that the resident's medical record called for frequent checks to ensure that the resident was clean and dry. Our surveyors concluded that, similar to the two care problems noted above, the home should have been cited for a pattern of poor care.

[a]People who receive tube feeding generally should not lose weight, according to medical experts, because the amount of caloric intake can be monitored to maintain a stable weight.

DHS surveyors classified home A's violations as posing potential for more than minimal harm to residents and, according to standard practice for deficiencies classified at this level, required the home to produce a

corrective action plan. In contrast, we determined, on the basis of the problems shown in figure 8, that this home had a pattern of poor care and classified this home's care for unaddressed nutrition and weight-loss problems, pressure sore problems, and incontinence problems as conditions demonstrating actual harm.

At home B, we noted that the state surveyors had found a considerable number of problems, including some that were similar to those we found. For example, both teams found pressure sore treatment and infection control deficiencies. The state surveyors also found problems we did not identify, including the home's failure to provide oral hygiene to residents and to appropriately administer an intravenous medication to one resident. However, the state surveyors overlooked quality-of-care problems that we detected and considered serious. Among those missed were problems in the category of "failure to provide appropriate personal and preventive care." (See fig. 9.)

Figure 9: Examples of Problems Our Surveyors Found That DHS Surveyors Missed in On-Site Review, Home B

Failure to Provide Appropriate Personal Care

- Our surveyors observed several residents in soiled clothing in the dementia unit, where the urine smell was very strong. Although the unit's nurse said that the residents were toileted every 2 hours, our surveyors could find no evidence during their extended visit of this unit that the nursing staff followed a regular toileting regime. In fact, they noted that one of the unit's residents asked repeatedly to be toileted and was ignored by staff. Our surveyors also observed several residents who were not dressed or groomed.

Failure to Provide Appropriate Preventive Care

- Our surveyors found that the home failed to provide residents with an adequate diet to meet their nutritional needs, provide protective devices for residents with contractures to prevent a worsening of the condition, protect residents from falls that ultimately resulted in fractures, and provide residents with a restorative bowel and bladder program to maintain continence.

DHS surveyors classified home B's violations as resulting in actual harm but determined that the harm was isolated rather than systemic.[13] By defining the extent of the deficiencies as isolated, DHS followed its standard practice—for a deficiency cited at this level—of requiring the home to

[13]The nursing home challenged the state's classification of the identified deficiency and succeeded in having the finding reduced from actual harm to potential for more than minimal harm.

submit a corrective action plan. In contrast, by using a larger sample, we were able to establish a frequency of cases demonstrating a pattern of actual harm.

HCFA's Survey Methodology Limits Identification of Care Problems

Several factors account for the different assessments of care between the two survey teams. First, in reviewing medical records to identify areas with potential for poor care, our surveyors took random samples of cases from several types of residents, including the most vulnerable residents. Second, the number of cases our surveyors drew was large enough to estimate how common the problems were in the homes. Third, the information our surveyors collected from medical record reviews, staff interviews, and data analyses was entered into a structured format and compared with similar information from more than 60 other homes nationwide. This allowed our surveyors to pinpoint areas where care seemed problematic and review those cases thoroughly.

HCFA policy establishes the procedures, or protocol, that state surveyors must follow in conducting a home's standard survey. Selecting cases for review is an activity that occurs early in the standard survey of a home to identify potential instances of poor care. At the beginning of a standard survey, the nursing home administrator must supply surveyors with documents that specify, among other things, a census of residents by medical condition, such as numbers of individuals with pressure sores, indwelling catheters, and physical restraints. The state surveyors use this information to select the majority of cases for particular scrutiny during the survey. They may add to the list of cases after observing residents and talking with nursing home staff.

HCFA's protocol for selecting cases does not call for taking a random sample of sufficient size, however, and relies primarily on the use of professional expertise and judgment, based on numerous criteria that HCFA offers as guidance. While professional judgment is an essential component in identifying poor care, the nonrandom nature of the sample and its insufficient size precludes the state surveyor from easily determining the prevalence of the problems identified.

The protocol our surveyors used for sampling allowed them to cast a wider net. Specifically, they took random samples of three groups of residents to target cases in which poor care would be most likely to surface. The three groups sampled were classified as "new admissions," "long stays" (residents more than 105 days into their stay), and "sentinel

events" (residents whose medical conditions put them at the greatest risk for poor outcomes). By stratifying the sample and taking a random selection of a sufficient number of each group, our surveyors could project the results of the samples to all residents in the home, thus assessing the potential prevalence of their initial review findings.[14] For each resident in the sample, the survey team collected information from observations, chart reviews, and staff interviews assessing 75 elements reflecting quality-of-care outcomes. Our surveyors then profiled these findings—that is, they compared the data from the sampled cases with data collected under the same sampling method at more than 60 nursing homes in other states.

Analyzing data collected from the cases sampled, our survey team compared a home's rate of poor outcomes against the rates determined for the homes in other states.[15] For example, they found that, at the two homes discussed, the rate of pressure sores was 27 percent and 21 percent of each home's total residents, whereas the comparison homes' average rate was roughly 8 percent. Being able to compare rates of medical conditions in a nursing home, such as the percentage of residents with pressure sores, allows the surveyor to determine whether the home is an outlier in comparison with other homes. Our surveyors then used this information to review residents' care regarding specific conditions to determine whether the poor outcome rates were due to unacceptable care or were justifiable because of other factors.

HCFA has just begun to implement a requirement for all nursing homes participating in Medicare and Medicaid to transmit electronically certain data they maintain on residents' health and functional status. Having this information in computerized form could provide surveyors better access to residents' outcome data, thus potentially enhancing surveyors' ability to select cases for review more systematically and quickly. Access to information in this form could also facilitate assessing a home's performance with regard to residents' outcomes against an established average or norm. These benefits will depend, however, on ensuring that these data are valid and reliable reflections of residents' status and care.

[14]The methodology used by our surveyors could add to the time necessary for state surveyors to complete a survey. This survey methodology examined quality-of-care outcomes only, whereas state surveyors, following federal guidance, must review 14 additional areas, such as social services, resident assessment, and transfer and discharge activities.

[15]To perform this profiling analysis, our surveyors used customized software and a laptop computer.

HCFA's Enforcement Policies Ineffective at Bringing Homes Cited Repeatedly for Serious Problems Into Compliance

Once surveyors find deficiencies through nursing home surveys, their next step is to have the homes correct their deficiencies and return to compliance with federal requirements. Despite HCFA's goal to have nursing homes sustain compliance with federal requirements over time, our work in California showed that 1 in 11 California homes—serving thousands of residents—were cited twice in a row for "actual harm" violations. Relatively few disciplinary actions were taken against such homes because of HCFA's forgiving stance on enforcement. HCFA's termination policy is likewise generous—allowing California homes terminated from the program for serious problems to be easily reinstated—even though they often have serious care violations in subsequent surveys. Recognizing these and other weaknesses in the current process, California's DHS has begun a "focused enforcement" effort and has implemented procedures to strengthen its use of available nursing home enforcement authority for facilities with the poorest past performance records.

Sustained Compliance Goal Not Met for Certain Homes Serving Thousands of Residents

OBRA 87 requires the HHS Secretary to ensure that the enforcement of federal care requirements for nursing homes is adequate to protect the health, safety, welfare, and rights of residents. In the background to its final regulations, HCFA stated that its system of requirements implementing OBRA 87 reforms "was built on the assumption that all requirements must be met and enforced" and that its enforcement actions will encourage "sustained compliance." In addition, HCFA noted that "our goal is to promote facility compliance by ensuring that all deficient providers are appropriately sanctioned."[16] However, our data suggest that current enforcement efforts in California are not reaching the stated goal to ensure that all requirements are met and deficient providers are appropriately sanctioned, and also may not fulfill the OBRA 87 promise to protect the health, safety, welfare, and rights of residents. National data indicate this problem is not limited to California.

A significant number of homes in our analysis had repeated violations in categories that HCFA classifies as "serious" or "most serious." Specifically, 122 homes—representing over 17,000 resident beds—were cited in both of their last two surveys for conditions causing actual harm or conditions that put residents in immediate jeopardy or caused death.[17] The repeated deficiencies included, among others, problems with infection control,

[16]59 FR 56116-56117.

[17]Sixty-six percent of these homes are classified in figure 2 in the category "caused death or serious harm," and 34 percent are classified as "caused less serious harm."

pressure sore treatment, and bladder continence care.[18] Preliminary analysis of national data indicates that repeating serious deficiencies is more common nationally than in California. One in nine nursing homes in the United States—representing more than 232,000 resident beds—were cited in both of their last two surveys for conditions that caused actual harm or put residents in immediate jeopardy or caused death.

Relatively few disciplinary actions have been taken against homes cited for repeated harm violations. Before OBRA 87, the only sanction available to HCFA and the states to impose against such noncompliant homes, short of termination, was to deny federal payments for new admissions. Because this sanction afforded HCFA and the states an opportunity to defer the decision to terminate, it was considered an "intermediate" sanction. OBRA 87 provided for additional intermediate sanctions, such as denial of payment for all admissions, civil monetary penalties, and on-site oversight by the state ("state monitoring").[19] Nevertheless, between July 1995 and May 1998, nearly three-quarters of those 122 homes—cited in at least 2 consecutive years for serious deficiencies—had no federal intermediate sanctions that actually took effect.

HCFA's Forgiving Enforcement Stance Helps Explain How Some Homes Can Repeatedly Harm Residents Without Facing Sanctions

Our review of federal actions taken against California's noncompliant homes indicates that HCFA's policies, as implemented by California's DHS, have not led to sustained compliance, either for some homes immediately referred for sanctioning[20] or for others given a grace period to correct their deficiencies. In addition, HCFA has reinstated California homes terminated for serious deficiencies that became problem homes soon after reinstatement.

Oversight of Homes Immediately Referred for Sanctioning Not Adequate to Ensure Sustained Compliance

HCFA guidance instructs state agencies to immediately refer for federal sanctioning homes that meet HCFA criteria for posing the greatest danger to residents. The immediate referral contrasts with the practice of first granting homes a grace period to correct cited deficiencies. To qualify for

[18]A much greater number—1,083 homes—were also out of compliance with federal nursing home requirements in both of their last two surveys; however, they were not cited in two consecutive surveys for deficiencies classified in the actual harm or immediate jeopardy categories.

[19]Other sanctions include third-party management of a home for a temporary period ("temporary management"); requirement for a home to follow a corrective action plan developed by HCFA, the survey agency, or a temporary manager—with HCFA or survey agency approval—rather than by the facility itself ("directed plan of correction"); and mandatory training of a home's staff on a particular issue ("directed in-service training").

[20]OBRA 87 and HCFA's implementing regulations refer to certain actions as "remedies" that HCFA has also called intermediate sanctions, such as civil monetary penalties, denial of payment for new or for all admissions, and temporary management. In this report, we use the term "sanction."

immediate referral, homes must be cited for violations in the immediate jeopardy category or be rated as a "poor performer." HCFA's definition of poor performer itself is circumscribed such that the definition applies to relatively few homes. A home must have been cited on its current standard survey for substandard quality of care and have been cited in one of its two previous standard surveys for substandard quality of care or immediate jeopardy violations. Homes cited for cases of actual harm to residents—if assessed at the isolated level—do not satisfy HCFA's criteria for the substandard quality-of-care classification. Since July 1995, when the federal enforcement scheme established in OBRA 87 took effect, about 25 California homes have been designated as poor performers and 59 homes have been cited for immediate jeopardy deficiencies. HCFA guidance permits the state to broaden the definition of poor performer, but California has chosen not to do so.[21]

Even homes immediately referred for sanctioning do not necessarily receive sanctions that take effect. Among California homes HCFA considers to have the most serious deficiencies that immediately jeopardize resident health and safety, only about half had any sanctions that actually took effect. If homes come into substantial compliance before sanctioning is scheduled to take effect, HCFA rescinds the sanction.

In principle, sanctions imposed against a home remain in effect until the home corrects the deficiencies cited and until state surveyors find, after an on-site review (called a "revisit") that the home has resumed substantial compliance status. HCFA's guidance on revisits allows states to forgo an on-site visit and accept a home's report of resumed compliance status if the home's deficiencies are not more serious than the "potential for harm" range and do not constitute substandard care. HCFA officials told us this policy was put into place because of resource constraints. In California, however, this policy has been applied even to some of the immediate referral homes that continue to have deficiencies that put them out of substantial compliance upon revisit. Thus, our review of certain enforcement cases showed that HCFA failed to ensure that homes with a record of posing the greatest danger to residents had, in fact, resumed substantial compliance.

[21]For example, California could include in the poor performer definition a home's record of violations cited in the course of complaint investigations. Unlike standard surveys, complaint investigations are generally unexpected and provide surveyors a unique opportunity to gauge care issues in a home's everyday environment. Because these investigations can uncover serious quality-of-care problems, regulators would get a more complete picture of a home's compliance history if the results of complaint investigations were included in the "poor performer" determination.

For example, in the case of one home immediately referred for sanctioning, DHS surveyors made a few on-site reviews, but HCFA twice accepted the home's self-reported statement of compliance without requesting DHS to revisit and independently verify that the home had fully corrected its deficiencies.[22] Specifically, in an October 1996 survey, DHS cited the home for immediate jeopardy and actual harm violations, including improper pressure sore treatment, medication errors, insufficient nursing staff, and an inadequate infection control program. By early November 1996, however, surveyors had found in an on-site review that the problems had abated but had not fully ceased. A week later, the home reported itself to HCFA as resuming substantial compliance. HCFA accepted this report without further on-site review.

About 6 months later (May 1997), in the home's next standard survey, DHS found violations that warranted designating the home a poor performer. On a revisit to check compliance in July 1997, surveyors found new but less serious deficiencies. In August 1997, however, when the home reported itself in compliance, HCFA accepted the report without further verification. Between October 1996 and August 1997, HCFA imposed several sanctions but lifted them each time it accepted the home's unverified report of resumed compliance.[23]

Widely Granted Grace Periods Lead to Amnesty for Serious Violators

According to HCFA guidance, noncompliant homes that are not classified in the immediate jeopardy or poor performer categories do not meet HCFA's criteria for immediate referral for sanctioning, even though residents may have suffered actual harm. Following this guidance, California's DHS first notifies these homes of the sanctions it will recommend imposing unless the home resumes compliance. DHS revisits the homes where residents have suffered actual harm or worse to ensure that compliance has been achieved. In practice, on the basis of HCFA's guidance, the state will forward notification of the recommended sanctions to HCFA only if the home fails to correct the deficiencies cited within a 30- to 45-day grace period allowed by HCFA. Although California's DHS regulators have the option of referring the home immediately for disciplinary action, the

[22]A home reports itself to HCFA as being in compliance by sending HCFA a letter called a "credible allegation of compliance."

[23]In the October 1996 survey, HCFA imposed a civil monetary penalty that went into effect October 3 and was stopped from further accrual on November 8 when HCFA determined federal requirements had been met, based on the survey that had found lower-level deficiencies. In the May 1997 standard survey, HCFA imposed a civil monetary penalty to take effect in May 1997 and a denial of payment for new admissions sanction to take effect in July 1997, both of which HCFA stopped in August 1997 when the home reported that it was in compliance.

accepted practice under HCFA's guidance is to first allow the home to return to compliance status within the specified grace period.

HCFA policy permits granting a grace period to this group of noncompliant homes, regardless of their past performance. Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes[24] a grace period to correct deficiencies. For nearly the same period (July 1995 to April 1998), the rate of noncompliant homes receiving a grace period nationwide was 99 percent, indicating that the practice of granting a grace period to nearly all noncompliant homes is common across all states.

Moreover, data we analyzed on actions taken against California homes cited repeatedly for harming residents suggest that DHS does not take into account a home's compliance history when determining whether to impose intermediate sanctions. Of the 122 homes in our analysis cited repeatedly for harming residents, 73 percent were not federally sanctioned. In the case of such homes—cited in consecutive surveys for actual harm or immediate jeopardy violations—granting a grace period with no further disciplinary action appears to be a highly questionable practice. Table 2 illustrates a home with the same violations cited 4 years in a row—thus not sustaining compliance from one standard survey to the next—and still receiving a grace period to correct its deficiencies after each survey.

[24]Table 1 shows HCFA's deficiency classification system and associated compliance status.

Table 2: Example of Home Awarded Grace Periods Year After Year, Despite Repeated Noncompliance

Date	Selected deficiencies cited	Action taken
August 1994 standard survey	Pressure sores: A resident was admitted following the surgical repair of a broken hip in an acute-care institution. While in the nursing home, she developed a pressure sore at the incision site on her hip. It progressed to a stage IV (most severe) pressure sore. At the time of the survey, she was being treated for the probability of bone infection (osteomyelitis) of that hip caused by the pressure sore. Later, another lesion developed on the opposite extremity. The home did not provide care to prevent either the development or progression of the sore. This second pressure sore also progressed to a bone infection.	Home submits corrective action plan and is subsequently found in substantial compliance.[a]
September 1995 standard survey	Pressure sores: In the case of several residents, the home failed to assess skin conditions as potential pressure sores, thus failing to implement appropriate pressure sore treatment. Personnel also failed to properly treat sores once they were identified. In one case, for example, the home did not properly treat a resident during a 6-month period for a pressure sore that developed from clear skin into an open area on the resident's knee and quickly worsened to a larger, more severe sore.	Home submits corrective action plan and is subsequently found in substantial compliance.
October 1996 standard survey	Pressure sores: Nurses were found to have neglected treating pressure sores for 16 percent of residents sampled. The nurses did not follow the plans established for treating the sores and did not clean the sores in a clean, safe way.	Home submits corrective action plan and is subsequently found in substantial compliance.
December 1997 standard survey	Pressure sores: An incontinent resident at risk for pressure sores was found lying in urine-soaked linens nine separate times during a 4-day survey. Another resident was admitted to the home with clear skin, except for a sore on his left heel. The sore worsened over a 3-month period, but the home did not intervene. Ultimately, because of the sore's severity, the physician recommended that the leg be amputated below the knee. Twenty percent of sampled residents without pressure sores when admitted did not receive appropriate preventive care. An additional 10 percent of residents sampled were not given proper treatment of existing sores or care to prevent new ones.	Home submits corrective action plan and is subsequently found in substantial compliance.

[a]This enforcement action was taken before the implementation of OBRA 87 enforcement provisions.

HCFA Reinstates Most Terminated Homes

Although HCFA has the authority to terminate homes from participation in Medicare and Medicaid if they fail to resume compliance, termination rarely occurs and is not as final as the term implies. In the recent past, California's terminated homes have rarely closed for good. Of the 16 homes terminated in the 1995 to 1998 time period, 14 have been reinstated. Eleven have been reinstated under the same ownership they had before termination. Of the 14 reinstated homes, at least six have been cited since

their reinstatement with new deficiencies that harmed residents, such as failure to prevent avoidable accidents, failure to prevent avoidable weight loss, and improper treatment of pressure sores.

A home that reapplies for participation is required to have two consecutive on-site reviews—called reasonable assurance surveys—within 6 months to determine whether it is in substantial compliance with federal regulations before its eligibility to bill federal programs can be reinstated. However, HCFA has not always ensured that homes are in substantial compliance before reinstatement. For example, one home terminated on April 15, 1997, had two reasonable assurance surveys on April 25 and May 28, 1997. Although the nursing home was not in substantial compliance at the time of the second survey, HCFA considered the deficiencies minor enough to reinstate the home on June 5, 1997. The consequence of termination—stopping reimbursement for the home's Medicare and Medicaid beneficiaries—was in effect for no longer than 3 weeks.[25]

About 3 months after reinstatement, however, the home was cited for harming residents. DHS surveyors investigating a complaint found immediate jeopardy violations as a result of a dangerously low number of nursing home staff. In addition, surveyors cited the facility for providing substandard care. Residents who could not move independently, some with pressure sores, were left sitting in urine and feces for long periods of time; some residents were not getting proper care for urinary tract infections; and surveyors cited the home's infection control program as inadequate.

California DHS Pilots Alternative Enforcement Procedures Targeting a Small Group of Most Seriously Deficient Homes

By 1997, California DHS officials recognized that the state, in combination with HCFA's regional office, had not dealt effectively with persistently and seriously noncompliant nursing homes using the OBRA 87 enforcement process. The process discouraged immediate application of enforcement actions. It allowed nursing homes to come back into compliance for a short period of time, escaping enforcement action altogether. In many instances, though, homes did not sustain compliance for a significant period of time. Therefore, in July 1998 and with HCFA's agreement, DHS began a "focused enforcement" process that combines state and federal authority and action, targeting providers with the worst compliance records for special attention.

[25]Under Medicare and Medicaid rules, terminated nursing homes may be paid for care of residents in the home from the date of termination up to 30 days after the termination takes effect.

As a start, DHS has identified about 34 homes with the worst compliance histories—generally two in each of its districts. Officials intend to conduct standard surveys of these homes about every 6 months rather than every 9 to 15 months. In addition, DHS intends to conduct more complete on-site reviews of facilities for all complaints received about these homes. DHS and HCFA told us that they do not intend to accept such homes' self-reports of compliance without a revisit. DHS officials told us that the agency is developing procedures—consistent with HCFA regulations implementing OBRA 87 reforms—to ensure that, where appropriate, the state will immediately recommend and HCFA will impose civil monetary penalties and other strong sanctions to bring such homes into compliance and keep them compliant. For focused enforcement homes unable to sustain compliance, state officials plan to revoke their state licenses and recommend termination from the Medicare and Medicaid programs. In addition, DHS plans to screen the compliance history of facilities by owner—both in California and nationally—before granting new licenses to operate nursing homes in the state. State officials told us that they will require all facilities with the same owner to be in substantial compliance before any new licenses are granted.

Conclusions

The responsibility to protect nursing home residents, among the most vulnerable members of our society, rests with nursing homes and with HCFA and the states. In a number of cases, this responsibility has not been met in California. We and state surveyors found cases in which residents who needed help were not provided basic care—not helped to eat or drink; not kept dry and clean; not repositioned to prevent pressure sores; not monitored for the development of urinary tract infections; and not given pain medication when needed. When such basic care is not provided, residents may suffer unnecessarily.

As serious as the identified care problems are, weaknesses in federal and state oversight of nursing homes raise the possibility that many care problems escape the scrutiny of surveyors. Homes can prepare for surveyors' annual visits because of the visits' predictable timing. Homes can also adjust resident records to improve the overall impression of the home's care. In addition, DHS surveyors may overlook significant findings because the federal survey protocol they follow does not rely on an adequate sample for detecting potential problems and their prevalence. Together, these factors can mask significant care problems from the view of federal and state regulators.

Furthermore, HCFA needs to reconsider its enforcement approach toward homes with serious, recurring violations. Federal policies allowing a grace period to correct deficiencies and to accept a home's report of compliance without an on-site review can be useful policies, given resource constraints, when applied to homes with less serious problems. However, even with resource constraints, HCFA and DHS need to ensure that their enforcement efforts are directed to homes with serious and recurring violations and that policies developed for homes with less serious problems are not applied to them.

Under current policies and practices, noncompliant homes that DHS identifies as having harmed or put residents in immediate danger have little incentive to sustain compliance, once achieved, because they may face no consequences for their next episode of noncompliance. Our findings regarding homes that repeatedly harmed residents or were reinstated after termination suggest that the goal of sustained compliance has not been met. Failure to bring such homes into compliance limits the ability of federal and state regulators to protect the welfare and safety of residents.

Recommendations

In order to better protect the health, safety, welfare, and rights of nursing home residents and ensure that nursing homes sustain compliance with federal requirements, we recommend that the HCFA Administrator revise federal guidance and ensure state agency compliance through taking the following actions:

- Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyors' visits; the variation could include segmenting the standard survey into more than one review throughout the 12- to 15-month period, which would provide more opportunities for surveyors to observe problematic homes and initiate broader reviews when warranted.
- Revise federal survey procedures to instruct surveyors to take stratified random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.
- Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.
- Require that for problem homes with recurring serious violations, state surveyors substantiate, by means of an on-site review, every report to HCFA of a home's resumed compliance status.

Agency Comments and Our Response

We sought comments on a draft of this report from HCFA and DHS (whose written comments are reproduced in appendixes II and III), experts on nursing home care, and representatives from the nursing home industry. The reviewers generally agreed that the findings were troubling and that improvements were needed in the federal survey and enforcement process to better protect residents' health and safety. Reviewers also suggested technical changes, which we included in the report as appropriate.

HCFA officials informed us that they are planning to make significant modifications in their survey and enforcement processes, which they believe will address our recommendations. HCFA concurred with the recommendation to eliminate the grace period for homes with repeated serious violations and agreed that having a more scientifically selected and larger case review sample would improve the ability of surveyors to detect poor care in nursing homes. HCFA also agreed to change its revisit policy for homes that are seriously noncompliant.

HCFA agreed in principle that quality of care needs to be monitored outside the bounds of an annual, standard survey and acknowledged that certain factors can affect the predictability of surveys. These factors include the time of day and day of week the survey begins as well as the timing of surveys for homes in a given locale. Based on its analysis of certain OSCAR data, however, HCFA disagreed that states are not varying their survey schedules. We believe that basing a conclusion about the predictability of the annual survey primarily on analysis of OSCAR data is problematic, given weaknesses we identified in the classification of surveys entered into the database. Given these questions we raised, HCFA agreed to review the validity of the OSCAR data. HCFA also raised concerns—as did DHS—that segmenting the survey into two or more reviews would make it less effective and more expensive. We believe that segmenting the survey could largely eliminate concern about predictability and, by increasing the frequency of surveyors' visits to homes, could provide more opportunity to observe problematic homes and initiate broader reviews when warranted. These advantages should be evaluated relative to the potential disadvantages that concern HCFA.

DHS officials generally agreed with our findings and recommendations. They attributed many of the problems in the current survey and enforcement process to federal policy directives that, they maintain, have weakened states' ability to oversee quality of care and quality of life in nursing homes. In its comments, DHS has also suggested a number of additional changes it believes would improve the federal survey and

enforcement process. These include adding a waiting period before homes terminated from Medicare and Medicaid could be reinstated in the programs, changing HCFA's definitions of scope of violations and of substandard care to more realistically reflect the seriousness of poor care, changing HCFA's revisit policy for homes that are not in substantial compliance, developing a peer review of survey and enforcement practices in different regions, improving the database used for enforcement tracking, and more fully funding survey and enforcement activities for the state.

Some reviewers questioned whether the scope of our clinical review of 1993 records and concurrent review of nursing homes was sufficient to permit drawing conclusions about the current condition of all California nursing homes. These aspects of our methodology—while important—were not the primary basis for reaching our conclusions. The most comprehensive and compelling evidence we analyzed was recent standard survey reports of California's own surveyors, the statewide database DHS maintains on complaint investigations, and the nationwide database HCFA maintains on nursing home deficiencies. In response to these comments, we modified the report to better clarify our methodology and the primary basis for our findings.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until July 28, 1998. At that time, we will make copies of this report available to interested parties upon request.

Please contact me or Kathryn Allen, Associate Director, at (202) 512-7114 if you or your staff have any further questions. This report was prepared by Jack Brennan, Scott Berger, Mary Ann Curran, C. Robert DeRoy, Gloria Eldridge, and Hannah Fein, under the direction of Sheila Avruch.

William J. Scanlon
Director, Health Financing
and Systems Issues

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Abbreviations

ACLAIMS	Automated Certification and Licensing Administrative Information Management System
DHS	Department of Health Services
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA 87	Omnibus Budget Reconciliation Act of 1987
OSCAR	On-Line Survey, Certification, and Reporting
UTI	urinary tract infection

Objectives, Scope, and Methodology

Concerned about the life-threatening potential of the recent allegations, you asked us to determine whether the allegations had any merit and whether the monitoring of California's nursing homes has been adequate to protect residents. More specifically, we assessed (1) whether, as alleged, residents who died in 1993 from certain causes had received unacceptable care that could have endangered their health and safety, and whether serious care problems currently exist; (2) the adequacy of federal and state efforts in monitoring nursing home care through annual surveys; and (3) the effectiveness of federal and state efforts to enforce sustained compliance with federal nursing home requirements.

We reviewed the medical records of a sample of the 3,113 residents alleged to have died avoidable deaths in 1993 in 971 California nursing homes from malnutrition, dehydration, urinary tract infection (UTI), bowel obstruction, or bedsores (pressure sores). We met with those making the allegations, and from them we obtained copies of the death certificates of the 3,113 residents. To select our sample, we eliminated residents with UTI who did not also suffer from septicemia (the presence of bacteria and toxins in the blood), because if these conditions are not present, UTI is generally not lethal. We assumed that if care was a problem in a home, more than one resident would have been affected. We therefore excluded death certificates for residents of homes with (1) fewer than five such deaths and (2) for such deaths, a deaths-to-total-beds ratio of less than 5 percent. That left a universe of 546 residents at 72 homes. In addition, we eliminated residents who died in counties having few nursing homes. After these exclusions, our universe became 446 residents at 59 homes, from which we selected a preliminary sample of 75 residents from 15 homes. Fourteen of these homes were freestanding and one was a hospital-based nursing home. Because we selected from residents of homes with five or more such deaths in certain counties, our results cannot be generalized to the universe of all residents in California nursing homes who died of the same causes in 1993.

To review the medical records, we used two registered nurses with advanced degrees in gerontological nursing and with expertise in clinical nursing home care and data abstraction. To guide them, another registered nurse on our staff developed a detailed structured data collection instrument.[26] The nurses' work was reviewed by the registered nurse on our staff, who has experience working in nursing homes and judging

[26]The protocol was developed primarily from two documents—American Health Care Association, The Long Term Care Survey (no date); and Andrew M. Kramer and others, Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles (Sept. 1995). The protocol was then refined through consultation with experts and a GAO methodologist and pretested using an initial chart review.

whether care met acceptable clinical standards. This second review focused on a critical examination of all cases where the first team of registered nurses identified residents as having unacceptable care, in order to exclude any cases that might be questionable rather than unacceptable. The registered nurse on our staff also discussed some of the cases with physicians and additional registered nurses specializing in geriatric care to further clarify whether care was acceptable. We excluded all questionable cases from the unacceptable care group. Because of the time needed to thoroughly review each resident's complete clinical history (some were more than 600 pages), the nurses reviewed 62 of the 75 records initially selected from 1993.

To determine the extent of deficiencies identified by state surveyors in California nursing homes since July 1995, and to identify enforcement actions taken in response to the deficiencies, we used two databases. The first, HCFA's On-Line Survey, Certification, and Reporting (OSCAR) System, contains information about violations of federal requirements that a home has received in its last four surveys. The second, the Automated Certification and Licensing Administrative Information Management System (ACLAIMS) database, is maintained by California's DHS and contains information on each home's violations of state requirements. In addition, we used data that HCFA's San Francisco regional office maintains separately from OSCAR on federal sanctions imposed.

In OSCAR, we identified 1,445 California homes that had survey data after July 1, 1995—the date the new OBRA 87 scope and severity system went into effect. If a nursing home at a particular address had more than one provider number, we included in our analysis only one of the provider numbers to represent that home. Of the 1,445 California homes, 1,370 of those homes (95 percent) had at least two surveys entered into the OSCAR database since July 1995. Information in the OSCAR database is constantly being updated. We downloaded OSCAR data on February 26, 1998, to get a fixed database for our analysis of 1,370 homes. We also continued to work with OSCAR on-line as necessary, for example, to download survey reports on particular homes. The nursing homes we analyzed included Medicare and Medicaid dually certified facilities, Medicare-only facilities, Medicaid-only facilities, and both freestanding and hospital-based facilities. To develop information shown in figures 2 and 3, we combined information from both the OSCAR and ACLAIMS databases.

We did not conduct a thorough assessment of the validity or reliability of either OSCAR or ACLAIMS. We did determine, however, that OSCAR excludes

data that could be useful in obtaining a complete picture of a nursing home's history of deficiencies. For example, serious violations of state requirements discovered during complaint investigations are not routinely shown as federal deficiencies in OSCAR. Other information, such as the seriousness and extent of identified deficiencies, were missing from OSCAR in some cases. We found instances of missing information in 282 of the 1,370 homes in our analysis. The effect of these omissions from the database, we believe, is an understatement of documented deficiencies in OSCAR.

To assess the effectiveness of the survey process, we accompanied California state surveyors on annual standard surveys conducted at two homes. To do this, we arranged for a team of registered nurses to accompany the DHS surveyors and conduct concurrent surveys using a protocol developed under a HCFA research contract designed specifically to identify quality-of-care problems. These nurses work with Andrew M. Kramer, M.D., of the University of Colorado's Center on Aging Research Section of the Health Sciences Center, who developed the survey protocol for HCFA. Before conducting the concurrent surveys at these homes, we accompanied a state survey team to a third home to gather information on survey procedures.

To better understand survey deficiencies, complaints, and enforcement, we reviewed selected records. We determined the types of problems being identified by surveyors by obtaining and analyzing annual standard surveys for 18 homes we visited. We also obtained and analyzed information about the number and type of complaints investigated by two district offices. To better understand enforcement efforts, we reviewed selected enforcement files and enforcement data kept by HCFA.

We also interviewed responsible officials from HCFA headquarters in Baltimore and HCFA's San Francisco regional office. We met with officials from California DHS in Sacramento and two district offices; the California Association of Health Facilities; the American Health Care Association; the American Association of Homes and Services for the Aging; the California Association of Homes and Services for the Aging; the California Advocates for Nursing Home Reform; California's Office of Ombudsman; nursing home administrators and directors of nursing; geriatricians and registered nurses with expertise in nursing home issues; and families of nursing home residents.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUL 20 1998

FROM: Nancy-Ann Min DeParle NMD
Administrator
Health Care Financing Administration

SUBJECT: GAO Draft Report, "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight"

TO: William J. Scanlon
Director, Health Financing and Systems Issues
General Accounting Office

We appreciate the opportunity to review your draft report to Congress concerning the federal and state oversight infrastructure of California nursing homes. Our comments are attached. Should you have any questions or require any additional information, please contact Rita Reinsel of the Office of Financial Management at (410) 786-7444.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight"

Introduction

We are deeply troubled by the problems cited in this report. In recent years, we have made major strides to improve our survey and enforcement procedures for nursing homes. However, we recognize, and this report underscores, that we must do more to improve the quality of care our beneficiaries receive when they enter a nursing home.

HCFA is committed to making changes in its survey and enforcement process, and in its oversight of States' implementation of that process, to improve care to nursing home residents. In December, 1997, HCFA staff began developing a new plan of action to make additional, significant modifications to the survey and enforcement processes. All of the recommendations stated in the GAO report are addressed in this plan. Slated changes include: strengthening enforcement by expanding the definition of "poor performer" to better target nursing homes with chronically poor compliance records; asking Congress for authority to impose monetary penalties for instances, instead of days of noncompliance; strengthening federal oversight of State inspections; improving targeting of clinical care areas in need of improvement, including resident hydration and nutrition; increasing the randomness of the survey; increased surveying for facilities that perform poorly; increasing access to survey results; asking Congress for authority to require criminal background checks of nursing home employees; and supporting the ombudsman program. The Clinton Administration has set the strengthening of nursing home survey and enforcement process as a priority, a priority to which HCFA has been and remains committed

Below is our response to the four broad recommendations posed in your report.

GAO Recommendation

In order to better protect the health, safety, welfare, and rights of nursing home residents and ensure that nursing homes sustain compliance with federal requirements, we recommend that the HCFA Administrator revise federal guidance and ensure state agency compliance through taking the following actions:

-- Stagger or otherwise vary the scheduling of standard surveys to effectively reduce the predictability of surveyors' visits; the variation could include segmenting the standard survey into multiple, partial reviews throughout the 12- to 15-month period.

HCFA Comment

We agree in principle that finding ways to monitor the quality of care in nursing homes outside of the bounds of the standard survey is important, but are concerned that "segmenting" the survey will render it ineffective. The survey as it is currently designed functions best as a whole and cannot be effectively divided into smaller parts that can be conducted independently at different times.

We disagree that States are not varying survey intervals. Evidence in HCFA's Online Survey, Certification and Reporting system (OSCAR) shows that survey intervals are much less constant than commonly thought. We calculated the interval in days between the starting dates for successive standard health surveys. We examined only standard surveys, and looked at every nursing home survey conducted from January 1, 1994 through December 31, 1997 (n=64,508). The start date was calculated as the date on which the first surveyor arrived at the nursing home. This date is captured on the HCFA 670 form, which records the arrival date and amount of time spent onsite for each surveyor. These data are not accessible through standard OSCAR reports but are available on regularly-updated files maintained by HCFA's Office of Information Systems.

The GAO has raised a question about OSCAR data, suggesting that California frequently conducts abbreviated surveys when a facility changes ownership or hires a new Director of Nursing, and records them as standard surveys in OSCAR. We agree that OSCAR does not distinguish between annual recertification surveys and shorter surveys conducted, for example, after a change of ownership. We are reviewing the validity of the data captured by OSCAR. However, we would also argue that an analysis of survey intervals should reasonably include abbreviated surveys as well, since those surveys contribute to the variability of survey timing.

While the mean interval between successive surveys was about one year, the standard deviation was about two months. (For 1997, the mean interval was 344.9 days (SD=59.7 days). In California, the mean interval over the last four years was 378 days (SD=50.7 days), while in 1997 the mean interval was 367 days (SD=64.9 days). Accordingly, in California's case, the start date of the survey does not follow a precise annual schedule.

Our analysis did find, however, that surveyors are likely to begin a survey on Monday or Tuesday, and spend little time in a facility outside of daytime business hours. Over each of the last four calendar years examined, fewer than 1% of surveys began on a Saturday or Sunday and, of the approximately four million hours that surveyors spend visiting nursing homes in regular surveys each year, fewer than 18,000 (0.5%) of those hours are in the evening or at night. In California, 109 of 5,524 surveys (2.0%) conducted since January 1994 have begun on Saturday or Sunday. In these years, fewer than 1% of onsite survey hours took place between the hours of 6:00 p.m. and 8:00 a.m.

We recognize there may be other factors affecting predictability of surveys, including the time of day and day of the week. In response to this finding, HCFA will change its regulations to require States to conduct nursing home surveys on weekends or in evening or night hours. Another factor may be the geographical sequencing of surveys. HCFA will work with States and provide guidance to diminish this predictable factor.

We agree and plan to develop procedures for more frequent surveys of poor performing facilities. As another step in focusing on questionable and poor care, we recently implemented a standard Minimum Data Set (MDS) database that collects current clinical information on an ongoing basis from every resident in a Medicare- or Medicaid-certified nursing home in the country. This standard MDS database will in the future serve as a surveillance system that will be sensitive to potential problems of care. Once this system is operational, surveyors will draw on this database to alert them to possible care problems before conducting standard surveys. We will continue to conduct special onsite inspections as necessary to investigate possibly poor care. At the same time, we are issuing contracts to design effective audit systems to ensure that the data reported to the standard MDS system are valid.

GAO Recommendation

-- Revise federal survey procedures to instruct surveyors to take random samples of resident cases and review sufficient numbers and types of resident cases so that surveyors can better detect problems and assess their prevalence.

HCFA Comment

We will enhance our survey system by expanding the sample to further review cases in which clinical care is suspect, including cases with weight loss or pressure sores (treatment and at risk). We will generate from MDS data lists of residents who meet these criteria, and surveyors will conduct more intensive reviews of a sample of these residents. This change will be implemented in October 1998.

We agree that a more scientifically selected larger case review would improve the ability of State and Federal surveyors to detect poor care in nursing homes. HCFA is in the process of developing an outcome-based, data-driven system for overseeing the care nursing home residents receive. We envision a survey system that will depend on a combination of quality indicators identified by the State survey agency based on MDS information and data collected onsite to assist surveyors in conducting a more effective inspection of nursing homes.

The quality indicators will provide information on the various resident care areas that can be used for targeting potentially poor care. The process will also provide for more scientific onsite sample selection and investigation methodology. Survey agencies will be able to identify conditions where immediate onsite inspections are warranted, and can compose a survey team with the optimal skills for investigating the conditions that have been flagged. Furthermore, the survey agencies will have current information on nursing home performance to enhance their scheduling and conducting of periodic onsite visits and their investigation of complaints from the public. We believe that this process will be extremely valuable for detecting and correcting systemic care problems early. Effective June 22, 1998, nursing homes are required to electronically submit the MDS for all residents to States, which in turn submit the data to a national repository at HCFA.

Over the last few years HCFA has sponsored the work of researchers who are leaders in developing quality indicators for nursing homes, including the Universities of Wisconsin and Colorado. One of the projects was the process developed by Dr. Andrew Kramer, who conducted a review of the two nursing homes cited in the GAO report. We intend to award three contracts within the next three months to further the development of these quality indicators, to design audit processes for the MDS, and to test the integration of indicators into the survey process. During 1999, we anticipate using indicators developed through these contracts in the survey process, specifically for nutrition and pressure sore development. We expect that the full integration of these quality indicators into the survey process will require additional resources, and therefore, we expect that it will take some time to implement all the improvements resulting from these studies.

GAO Recommendation

-- Eliminate the grace period for homes cited for repeated, serious violations and impose sanctions promptly, as permitted under existing regulations.

HCFA Comment

We concur with this recommendation and will issue a policy change that sets forth the expectation that immediate sanctions will be imposed when a nursing home has been found to have caused actual harm at the current survey and was also found to have caused actual harm at its last survey (either complaint or standard).

GAO Recommendation

-- Require that for problem homes with recurring serious violations, state surveyors substantiate every report to HCFA of a home's resumed compliance status with an on-site review.

HCFA Comment

The report describes situations in which facilities having serious deficiencies were subject to multiple revisits to verify that corrections were progressing, but which were permitted to allege compliance without another revisit once the noncompliance had lessened.

HCFA's current revisit policy provides that the State may accept evidence in lieu of an onsite visit only for facilities having deficiencies classified as no actual harm and are not considered to be substandard quality of care. Thus, under HCFA's policy, an onsite revisit is required whenever there is immediate jeopardy, actual harm, or substandard quality of care.

The practice identified in the Report was permitted by HCFA's policy as outlined above. HCFA's policy did not specify that a State could not accept evidence in lieu of a on-site visit for verifying compliance once an on-site visit showed no actual harm, even if the original deficiencies were serious. We agree that the State should require an on-site visit to verify compliance in cases where the original deficiencies were serious and will change our policy accordingly.

Other Comments

1. ***Endangered Residents***

   The Report references 62 resident cases sampled by expert nurses and states that residents in 34 of those cases were found to have received unacceptable care, and that sometimes this care endangered their health and safety. The report leads readers to believe that residents received care that put them at significant risk in all 34 cases. We believe it would be helpful to have this section identify the precise number of residents whose health and safety was endangered by the care they received.

2. ***Enforcement Action***

   The Report documents very serious noncompliant situations identified by the State, but it fails to complete the account by reporting the enforcement action(s) taken in response to these findings. Even though the intent of the section is to provide examples of specific types of deficiencies cited by California between 1995-1997, when taken together with other parts of the report that allege little enforcement action, it appears that these may have been unsanctioned situations. We believe that it is important to clarify the resulting enforcement action, in addition to the survey findings themselves.

3. ***Re-entry After Termination***

The report states that HCFA allows facilities with serious deficiencies back into the program after termination. HCFA's policy about re-entry after termination is based on section 1861© of the Social Security Act which provides that a previously terminated provider may re-enter the program after meeting reasonable assurance requirements. Reasonable assurance is satisfied if the provider demonstrates that the reasons for termination have been removed and will not recur.

Comments From California's Department of Health Services

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

Mr. William J. Scanlon, Director
Health Financing and Systems Issues
United States General Accounting Office
Room 5A14
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Scanlon:

We appreciate the opportunity to submit California's written response to the General Accounting Office (GAO) report, "California Nursing Homes: Care Problems Persist despite Federal and State Oversight." California takes seriously the shared responsibility with the federal government to promote the quality of care in nursing homes and takes pride in the work we do on behalf of nursing home residents.

Generally speaking, the GAO report recognizes that the federally developed and directed survey and enforcement processes are complex. Moreover, the report validates that California has complied with the array of federal requirements. Most fundamentally, however, the GAO report highlights that certain federal policy directives have resulted in weakening the state's ability to adequately oversee the quality of care and quality of life in the nation's nursing homes. California supports a review of the federal standards, process and all related Health Care Financing Administration (HCFA) policy. In that regard, California stands ready to work with HCFA, Congress and all interested parties to ensure the appropriate degree of nursing home oversight.

While California generally agrees with the findings and the four recommendations contained in this report regarding the effectiveness of the federal framework for oversight of the nation's nursing homes, California has additional comments and recommendations in the following areas:

- Nursing home oversight is rigidly prescribed federally and therefore limits states' flexibility to change or improve the processes or strengthen requirements;
- The federal survey and enforcement process, in some instances, has compromised the objective of providing the maximum protection of nursing home residents;
- Specific steps can be taken by Congress and HCFA which will improve the federal survey and enforcement process;
- California has initiated independent state reforms to address inadequacies in the federal process; and
- The report methodology and sample size is deficient and thus limits the applicability of the report's findings to current California practices and to the state as a whole.

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1) Nursing Home Oversight is Prescribed by Federal Law and HCFA Policy

Nursing home oversight reflects a regulatory oversight structure that is prescribed by federal law and HCFA policy direction. While the report appears critical of California's oversight in some instances, California's activities, in fact, reflect federal law and processes. All states, including California, are under contract with the HCFA to follow the statutes, regulations, and policy directives issued by the HCFA.

The GAO report validates California's full implementation of the OBRA 1987 survey and enforcement process, as well as subsequent policy directives prescribed by HCFA. Had this report compared California's performance with other states, the GAO would have determined that California has been one of the most aggressive states in implementing the process, based on the quality of surveys, training of staff, number of deficiencies written and remedies imposed. For example, California recommended and HCFA imposed $2.1 million in federal civil money penalties between February 1996 and April 1998. When requested to review proposed HCFA policy or changes to the survey or enforcement processes, California has always responded with recommendations on how the federal system can be strengthened and improved.

We acknowledge that all states have a role and responsibility as an agent of the federal government to protect nursing home residents. California shares the outrage that citizens and state and federal public officials rightly express whenever neglect or improper care comes to light. All nursing home residents deserve care that preserves individual dignity, promotes personal choice, and assures quality health care. An improved federal process would allow California and all other states the ability to better protect nursing home residents.

2) Federal Law and Policy is Not Consistent with Ensuring Quality of Care

As the GAO report concludes, the federal survey and enforcement process, as contained in OBRA 1987 and as implemented through HCFA policy, has not been effective in ensuring substantial and sustained compliance with federal requirements in all nursing homes. While nursing home reform made substantial improvements in federal standards and authority, it has not fully achieved the intended goals. In fact, some HCFA policy decisions have had the unfortunate effect of diluting requirements and preventing appropriate oversight by the states.

Emphasis on Quantity of Surveys, not Quality

HCFA's funding methodologies are at odds with the objective of assuring quality oversight and monitoring. HCFA has emphasized survey productivity and has de-emphasized the quality of the surveys conducted. Toward that end, HCFA's funding methodologies for states have been developed on the basis of the cost of conducting a survey, on average, without consideration of survey quality. States are not funded to produce the highest quality, most thorough or most

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effective survey. States are also not fully funded to spend the additional time necessary to take enforcement actions and monitor compliance in problem facilities.

New Definitions Reduced Enforcement Authority

Another significant problem for states has been HCFA's change in definitions of deficient practices which are to be considered "widespread, pattern or isolated". These definitions directly affect the scope and severity assigned to a practice which, in turn, dictates the state's ability to enforce federal requirements. This change has had the effect of prohibiting the imposition of penalties in many instances where the state believed they were warranted as well as "downgrading" the severity of enforcement actions against non-compliant facilities.

Revisit Policy Reduced State Monitoring

HCFA's policy to accept a facility's written declaration of compliance, in lieu of a revisit, has halted the state's ability to verify that a facility has corrected identified problems. Nursing homes know that they will likely not be revisited and therefore, have less incentive to come into compliance and to maintain compliance.

Enforcement System Not Effective for Single Incidents

The federal enforcement system does not allow for the imposition of enforcement actions in single instances of harm to residents, no matter how egregious the violation, or how severe the harm to the resident. The emphasis in the federal system is on patterns and facility-wide practices. States are left with little or no authority under federal law to penalize facilities in these instances, no matter how great their culpability.

No Federal Penalty for Medical Record Falsification/Omissions

Federal law and regulations do not clearly prohibit nursing homes from falsifying nursing home residents' medical records or omitting critical information. The GAO report noted the records reviewed appeared to include incorrect medical information or were missing vital information. However, states have no specific federal authority in this regard, nor is there a specified penalty for a facility's failure to maintain a complete record.

Recertification of Terminated Facilities

Providers who are terminated from Medicare and Medicaid can be immediately reinstated. This allows providers who have been terminated for poor care to be recertified to receive Medicare and Medicaid by merely meeting the requirements on a specific date. There is no "disqualifying" time period required prior to reapplication, no probationary period upon their return and no significant time period for which they must demonstrate their ability to remain in

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compliance. This has the effect of allowing providers who have previously provided substandard care to continue to care for nursing home residents.

3) Recommendations to Improve the Federal Survey and Enforcement Process

California supports the preservation of the many positive aspects of OBRA 1987 and its implementation by HCFA. The majority of OBRA 1987 can and should be maintained. However, Congress and HCFA have it within their power and authority to strengthen the effectiveness of nursing home oversight and thus improve the quality of care and quality of life in nursing homes in all states:

- **Congress must give HCFA the authority to prohibit a provider from becoming re-certified for a specified period of time after being terminated from the program.** Providers whose Medicare and Medicaid certification is terminated may be re-certified because they are able to meet requirements by a certain point in time. Poor performers should not be allowed to apply for re-certification for a specified period of time.

- **HCFA should address the predictability of surveys assured by current process.** OBRA 1987 was crafted to monitor facilities with poor compliance records more adequately and to reduce the predictability of surveys. HCFA has insufficiently funded and constricted the state's federal funding so that predictability of the survey is nearly guaranteed.

- **HCFA should restore the original definitions of "isolated, pattern, and widespread" to realistically reflect the seriousness of poor care.** The current definitions have the effect of lowering the severity of a deficiency and as a result, the enforcement consequences have been lowered or eliminated for some violations. These terms should be redefined to make the requirements for nursing homes more stringent.

- **Congress should add federal penalties for falsification and omission of medical record information.** California requires facilities to keep accurate and complete records of care. As pointed out in this report, there are serious problems with accurate information in medical records, yet there is no federal penalty that can be applied. We believe that the California requirement should be implemented federally so that it can be part of the federal oversight process.

- **HCFA should not accept a facility's written assurance of compliance in lieu of a revisit or imposition of remedies**. Facilities that are found not in compliance should always receive a revisit to verify that all deficient practices have been fully corrected.

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The decision to allow facilities to submit a written "credible allegation of compliance" -- in lieu of a revisit and/or imposition of remedies -- appears to be budget-driven and does not constitute effective regulation. There is little incentive for facilities to maintain substantial compliance when they are aware that HCFA has directed the state not to revisit them.

- **HCFA should recognize that actual harm may equate to substandard quality of care.** HCFA should consider an option to enable states to declare substandard quality of care for actual harm, even though it may be an "isolated" incident. Incidents that cause harm to residents are no less egregious because they may have happened to only one individual.

- **HCFA should revise its state funding methodology to fully fund quality surveys.** We recommend that HCFA devote resources to determining the cost of a quality survey, not the "average" survey. Increasing the number of residents reviewed will increase state costs for conducting federal surveys, but will also increase identification of life-threatening deficiencies in care practices.

- **Congress should provide funding for decreasing predictability of surveys.** California agrees that the standard survey frequency be one time per year with more frequent surveys in poor performing facilities. Without the additional funding required, visiting nursing homes more often is not possible, which means that decreasing predictability is difficult. California attempts to vary the survey cycles, but the HCFA contract and the limited budget does not allow for the necessary variation in scheduling or the additional surveys that must be conducted annually to fully implement an unpredictable cycle.

- **HCFA should examine the differences in survey and enforcement implementation between regions.** We recommend that a "peer review" approach be considered to permit an exchange of state survey teams between federal regions and states to better understand the variances in survey data and why California and other western states surpass other states in the number of deficiencies reported. It would also facilitate state survey "best practices" that can be shared and replicated by other states.

- **HCFA should revise the methodology for calculating states' budgets to acknowledge the need to conduct abbreviated surveys for all complaints.** California places the highest priority on investigating complaints. California has continued to investigate complaints within 10 days of receipt (within 48 hours of receipt for complaints alleging jeopardy to a resident's health and safety), which exceeds federal requirements. There has been no federal funding to conduct

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abbreviated surveys independent of the standard survey process.

- **HCFA should revise the federal database to provide vital enforcement data.** Currently, it is impossible for states to extract needed information from the HCFA database that is used to track certification and survey data. The states cannot obtain vital information on survey results, deficiencies, enforcement remedies recommended or enforcement remedies imposed. This results in an essentially manual system for conducting any meaningful enforcement tracking and analysis by states.

4) California Reform Efforts Represent A Model for the Nation

Within the constraints states face in operating according to federal parameters established in statute and policy, California has sought to innovate and improve the oversight of nursing homes. This focus on innovation and improvement is consistent with California's tradition as a national leader in nursing home reform throughout the last three decades. Indeed, many of the provisions of OBRA 1987 were based on innovative, precedent-setting reforms enacted in California. Since implementing OBRA, California has sought to improve the quality of care and quality of life for nursing home residents in a number of ways:

- **Focused Enforcement** development, in cooperation with HCFA, Region IX, of an alternative enforcement: In 1997, California took notice of the same problems discussed in this report and began the process focused on the poorest providers. We believe that this process will result in facilities either coming into substantial compliance and sustaining compliance, or being removed from the program with their state license revoked. This process was implemented on July 1, 1998. The new Focused Enforcement process:
  - **Identifies providers with a record of poor care**
  - **Places these facilities on a six-month survey cycle**
  - **Requires that all complaint investigations be abbreviated surveys**
  - **Requires immediate imposition of remedies**
  - **Permits no "grace period"**
  - **Requires revisits to verify correction**
  - **Triggers license revocation for chronic non-compliance**

- **Improved Complaint Investigation Process:** California has revised its complaint investigation protocol to be a more comprehensive process to better detect systemic problems in facilities. This process was implemented on June 1, 1998. This protocol specifies the process for prioritizing complaint investigations, for developing an appropriate sample and for uncovering care issues that may be affecting additional residents. It also results in most complaints being investigated more timely than currently provided for in the HCFA process.

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Further, the report focused, in part, on deaths that occurred in nursing homes in 1993. If the focus of this report is on the standards and effectiveness of the OBRA 1987 process, then the review should have focused on deaths that have occurred subsequent to the full implementation of OBRA in 1995 which would including the enforcement process. This disconnection between the GAO's focus -- the effectiveness of nursing home oversight in the context of OBRA 1987 -- and the data used in part, calls into question the appropriateness of applying the report's findings to the current OBRA process, especially in 1998.

Summary and Conclusion

In conclusion, it is important to reiterate the issues that may not be apparent from the GAO report, but are critical to understanding oversight of nursing homes:

Nursing home oversight is a rigidly prescribed federal process and therefore limits states' flexibility to change or improve the federal processes and to strengthen federal requirements;

- **The federal survey and enforcement process, in some instances, has compromised the objective of providing the maximum protection of nursing home residents;**
- **Specific steps must be taken by Congress and HCFA to improve the federal survey and enforcement process;**
- **California has independently initiated state reforms to address federal process deficiencies; and**
- **The report methodology and sample size is deficient and thus limits the applicability of the report's findings to current California practices and to the state as a whole.**

California looks forward to a productive discussion of these and other vitally important issues. We sincerely hope that future dialogue will emphasize the strengths of the existing

Mr. William J. Scanlon
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processes and continue to build on their integrity. Should the discussion surrounding these issues begin to prey on the fears of the public and particularly of family members with loved ones in facilities, the participants would be guilty of yet another type of elder abuse.

Sincerely,

S. Kimberly Belshé

S. Kimberly Belshé
Director

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