

December 2005

# NURSING HOMES

## Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety





Highlights of [GAO-06-117](#), a report to congressional requesters

## Why GAO Did This Study

Since 1998, GAO has issued numerous reports on nursing home quality and safety that identified significant weaknesses in federal and state oversight. Under contract with the Centers for Medicare & Medicaid Services (CMS), states conduct annual nursing home inspections, known as surveys, to assess compliance with federal quality and safety requirements. States also investigate complaints filed by family members or others in between annual surveys. When state surveys find serious deficiencies, CMS may impose sanctions to encourage compliance with federal requirements.

GAO was asked to assess CMS's progress since 1998 in addressing oversight weaknesses. GAO (1) reviewed the trends in nursing home quality from 1999 through January 2005, (2) evaluated the extent to which CMS's initiatives have addressed survey and oversight problems identified by GAO and CMS, and (3) identified key challenges to continued progress in ensuring resident health and safety.

GAO reviewed federal data on the results of state nursing home surveys and federal surveys assessing state performance; conducted additional analyses in five states with large numbers of nursing homes; reviewed the status of its prior recommendations; and identified key workforce and workload issues confronting CMS and states.

[www.gao.gov/cgi-bin/getrpt?GAO-06-117](http://www.gao.gov/cgi-bin/getrpt?GAO-06-117).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen, (202) 512-7118, [allenk@gao.gov](mailto:allenk@gao.gov).

## NURSING HOMES

# Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety

## What GAO Found

CMS's nursing home survey data show a significant decline in the proportion of nursing homes with serious quality problems since 1999, but this trend masks two important and continuing issues: inconsistency in how states conduct surveys and understatement of serious quality problems. Inconsistency in states' surveys is demonstrated by wide interstate variability in the proportion of homes found to have serious deficiencies—for example, about 6 percent in one state and about 54 percent in another. Continued understatement of serious deficiencies is shown by the increase in discrepancies between federal and state surveys of the same homes from 2002 through 2004, despite an overall decline in such discrepancies from October 1998 through December 2004. In five large states that had a significant decline in serious deficiencies, federal surveyors concluded that from 8 percent to 33 percent of the comparative surveys identified serious deficiencies that state surveyors had missed. This finding is consistent with earlier GAO work showing that state surveyors missed serious care problems. These two issues underscore the importance of CMS initiatives to improve the consistency and rigor of nursing home surveys.

CMS has addressed many survey and oversight shortcomings, but it is still developing or has not yet implemented several key initiatives, particularly those intended to improve the consistency of the survey process. Key steps CMS has taken include (1) revising the survey methodology, (2) issuing states additional guidance to strengthen complaint investigations, (3) implementing immediate sanctions for homes cited for repeat serious violations, and (4) strengthening oversight by conducting assessments of state survey activities. Some CMS initiatives, however, either have shortcomings impairing their effectiveness or have not effectively targeted problems GAO and CMS identified. For example, CMS has not fully addressed issues with the accuracy and reliability of the data underlying consumer information published on its Web site.

The key challenges CMS, states, and nursing homes face in their efforts to further improve nursing home quality and safety include (1) the cost to older homes to be retrofit with automatic sprinklers to help reduce the loss of life in the event of a fire, (2) continuing problems with hiring and retaining qualified surveyors, and (3) an expanded workload due to increased oversight, identification of additional initiatives that compete for staff and financial resources, and growth in the number of Medicare and Medicaid providers. Despite CMS's increased nursing home oversight, its continued attention and commitment are warranted in order to maintain the momentum of its efforts to date and to better ensure high-quality care and safety for nursing home residents.

CMS generally concurred with the report's findings. CMS noted several areas of progress in nursing home quality and identified remaining challenges to conducting nursing home survey and oversight activities.

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## **Abbreviations**

AHFSA	Association of Health Facility Survey Agencies
ASPEN	Automated Survey Processing Environment
AST	ASPEN Scheduling and Tracking
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
MDS	minimum data set
MFCU	Medicaid Fraud Control Unit
NFPA	National Fire Protection Association
OSCAR	On-Line Survey, Certification, and Reporting system
QIO	Quality Improvement Organization
QIS	Quality Indicator Survey
RN	registered nurse

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United States Government Accountability Office  
Washington, DC 20548

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December 28, 2005

The Honorable Charles E. Grassley  
Chairman  
Committee on Finance  
United States Senate

The Honorable Herb Kohl  
Ranking Minority Member  
Special Committee on Aging  
United States Senate

Numerous congressional hearings since July 1998 have focused attention on the need to improve the care and safety of the nation's 1.5 million nursing home residents, a highly vulnerable population of elderly and disabled individuals for whom remaining at home is no longer feasible. Many nursing home residents require help with feeding, toileting, grooming, or other routine activities of daily living; are cognitively impaired; or have chronic health care conditions such as heart disease. Some individuals with chronic conditions are long-term residents of nursing homes, while others enter nursing homes for a short period, such as after a hospitalization. With the aging of the baby boom generation, the number of individuals needing nursing home care is expected to increase in size dramatically. Combined Medicare and Medicaid payments for nursing home services were about \$65 billion in 2003, including a federal share of about \$43 billion.<sup>1</sup>

In a series of reports, we have identified significant weaknesses in federal and state activities designed to detect and correct quality and safety problems at nursing homes.<sup>2</sup> Our key findings included the following:

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<sup>1</sup>Medicare is the federal health care program for elderly and disabled people. In addition to other health and long-term care services, Medicare covers up to 100 days of nursing home care following a hospital stay. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. Medicaid also pays for long-term care services, including nursing home care. Data for 2003 are the most recent data available.

<sup>2</sup>See Related GAO Products at the end of this report.

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- A small but unacceptable proportion of nursing homes repeatedly caused actual harm to residents, such as worsening pressure sores or untreated weight loss, or placed residents at risk of death or serious injury.
  - The results of state inspections, known as surveys, understated the extent of serious quality-of-care and fire safety problems, reflecting weaknesses in the survey methodology and an inconsistent application of federal standards.
  - Serious complaints by residents, family members, or staff alleging harm to residents remained uninvestigated for weeks or months, and delays in the reporting of abuse allegations compromised the quality of available evidence, hindering investigations.
  - When serious deficiencies were identified, federal and state enforcement policies did not ensure that the deficiencies were addressed and remained corrected.
  - Federal mechanisms for overseeing state monitoring of nursing home quality and safety were limited in their scope and effectiveness.

The Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for managing the Medicare and Medicaid programs, as well as overseeing compliance with federal nursing home standards—announced a set of initiatives intended to address many of the weaknesses we identified in July 1998 as well as needed improvements CMS identified in its own self-assessment.<sup>3</sup> Over time, CMS has refined and expanded these initiatives, including launching a Web site—Nursing Home Compare—that has progressively increased the data available to the public about the care provided by nursing homes.<sup>4</sup> You asked us to review the progress made by CMS since 1998 in addressing quality and safety problems in the nation’s nursing homes. In response to your request, we (1) reviewed the trends in nursing home quality by analyzing nursing home survey results, (2) evaluated the extent to which CMS’s initiatives have addressed survey and oversight shortcomings identified by us and CMS, and (3) identified key remaining challenges to continued progress in ensuring resident health and safety.

To assess trends in nursing home quality, we analyzed data from the federal On-Line Survey, Certification, and Reporting system (OSCAR), which compiles the results of state nursing home surveys; we focused on

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<sup>3</sup>Prior to July 2001, CMS was known as the Health Care Financing Administration. Throughout this report, we refer to the agency as CMS, even when describing initiatives taken prior to its name change.

<sup>4</sup><http://www.medicare.gov/NHCompare/home.asp>.

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trend data since CMS announced its nursing home initiatives. We have used OSCAR data since 1997 to track trends in the proportion of homes found to have harmed residents or placed them at risk of immediate jeopardy. To better understand the trends identified through our OSCAR analysis, we evaluated the results of federal comparative surveys for all states for the period March 2002 through December 2004 and compared the results for two other time periods—October 1998 through May 2000 and June 2000 through February 2002. Federal comparative surveys are conducted at nursing homes recently surveyed by the state to assess the adequacy of the state surveys. We judgmentally selected five large states—California, Florida, New York, Ohio, and Texas—for additional analysis based on the change in the proportion of homes cited with serious deficiencies, geographic representation, and the number of nursing homes. These five states account for almost 30 percent of the nation’s nursing homes.<sup>5</sup> CMS officials generally recognize OSCAR data to be reliable. We have used OSCAR data in prior work to examine nursing home quality issues and we updated certain data for this report. Throughout the course of our work, we discussed our analysis of OSCAR data with CMS officials at both the central office and the regional offices to ensure that the data accurately reflected state nursing home survey activities. We determined that these data were accurate for our purposes.

To evaluate the extent to which survey and oversight shortcomings we identified had been addressed by CMS’s initiatives, we reviewed the status of our recommendations, and updated our understanding of the initiatives by analyzing relevant documentation and discussing their implementation status with CMS officials (see app. D). We also discussed with CMS officials the initiatives implemented as a result of CMS’s self-assessment of needed improvements. We focused on four areas: surveys, complaints, enforcement, and oversight. We discussed the preliminary findings from our OSCAR data trend analysis with CMS and state survey agency officials. To assess the remaining challenges to continued improvement of nursing home oversight, we identified through interviews with CMS and state survey agency officials key workforce and workload issues that confront states and CMS in protecting the health and safety of nursing home residents. We also contacted officials at the Association of Health Facility Survey Agencies (AHFSA) to update information on surveyor turnover and retention issues. We conducted our review from May through December

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<sup>5</sup>In this report, we use the term “states” to include the 50 states and the District of Columbia.



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2005 in accordance with generally accepted government auditing standards.

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## Results in Brief

CMS's nursing home survey data show a significant decrease in the proportion of nursing homes with serious quality problems, from about 29 percent in 1999 to about 16 percent by January 2005, but this trend masks two important and continuing issues: inconsistency among state surveyors in conducting surveys and understatement by state surveyors of serious deficiencies. Inconsistency in states' surveys is demonstrated by CMS data that reveal continued wide interstate variability in the proportion of homes found to have serious deficiencies. For example, in the most recent time period, one state found such deficiencies in about 6 percent of homes, whereas another state found them in about 54 percent of homes. We previously reported that confusion about the definition of actual harm contributed to inconsistency and understatement in state surveys. In addition, state surveyors continue to understate serious deficiencies, as shown by the larger number of serious deficiencies identified in federal comparative surveys than in state surveys of the same homes. Although federal comparative surveys since October 1998 show an overall decline in the proportion that identify serious deficiencies not identified by state surveys, data for the two most recent periods show an increase in such discrepancies, from 22 percent to 28 percent of comparative surveys. In the five large states we reviewed, federal surveyors concluded that the state surveyors had missed serious deficiencies in from 8 percent to 33 percent of comparative surveys—that is, these deficiencies existed and should have been identified at the time of the state survey. The federal surveyors' assessment is consistent with our July 2003 findings: a sample of deficiencies demonstrated considerable understatement of quality-of-care problems such as serious, avoidable pressure sores. The continuing evidence of inconsistency in survey results among states and understated deficiencies underscores the importance of CMS's initiatives to improve the consistency and rigor of nursing home surveys.

CMS has addressed many of the shortcomings we identified in nursing home survey and oversight activities, but several important initiatives have not yet been implemented, such as those intended to make state surveys more consistent across states and to reduce the understatement of deficiencies. Important steps CMS has taken include (1) revising the survey methodology, (2) issuing states additional guidance to strengthen complaint investigations, (3) implementing immediate sanctions for homes cited for repeat serious violations, and (4) strengthening oversight by

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conducting assessments of state survey activities. In addition, CMS has undertaken initiatives of its own. For example, it has made important information available to the public on nursing home quality through its Nursing Home Compare Web site and has contracted with independent quality organizations to work with nursing homes to improve quality. Although CMS has addressed many weaknesses in survey and oversight processes, other initiatives either have not effectively targeted the problems identified or have shortcomings that impair their effectiveness. For example, CMS has not fully addressed issues with the accuracy and reliability of the data underlying consumer information published on its Web site.

CMS, states, and nursing homes face a number of key resource and workload challenges in their efforts to further improve nursing home quality and safety. CMS is moving to require older nursing homes to install sprinkler systems, a proven life-saving device, but implementation could be delayed because of concerns about the cost of the retrofit to these homes. CMS indicated that it plans to ask for public comment about the length of the phase-in period rather than proposing one itself. States are continuing to experience problems in hiring and retaining qualified surveyors, a factor that survey agency officials believe contributes to inconsistency and understatement in the citation of serious deficiencies. State survey agencies attributed high turnover and recruiting difficulties to the lack of competitive salaries for registered nurses (RN), who are a major component of states' surveyor workforce, and intense competition from hospitals and other providers because of the RN shortage. Increased nursing home oversight has strained both CMS and state survey agency resources, resulting in delays for some key initiatives. For example, CMS has undertaken time-consuming state survey agency performance reviews and significantly increased the number of federal comparative surveys performed. In addition, state survey agency workloads have grown as a result of initiatives that require the prompt investigation of complaints alleging resident harm and the need to conduct on-site revisits at nursing homes to ensure that serious problems actually have been corrected. However, the increased number of quality and safety initiatives has required CMS to establish priorities, with some initiatives taking precedence over others. For example, CMS attached a high priority to including quality indicator data on its public Web site and implemented this initiative promptly, while the revision of the survey process has encountered delays due to higher priorities. Continued attention and commitment to improving nursing home oversight are essential to maintaining the momentum built by CMS's accomplishments to date and thus better ensuring quality care and safety for nursing home residents.

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In commenting on a draft of this report, CMS generally concurred with our findings, describing the progress it has made in several areas and agreeing that challenges remain. CMS also indicated that while it remained concerned about understatement, it did not believe that understatement was worsening. CMS described the ongoing challenges it faces and the steps it will take to address them. In commenting on the section of the draft report focused on trends in nursing home quality, the states we reviewed commented on the actions they have taken to improve nursing home survey quality and the challenges they face in conducting nursing home survey and oversight activities.

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## Background

Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. A range of statutorily defined sanctions is available to CMS and the states to help ensure that homes maintain compliance with federal quality requirements. CMS also is responsible for monitoring the adequacy of state survey activities.<sup>6</sup>

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## Standard Surveys and Complaint Investigations

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.<sup>7</sup> During a standard survey, separate teams of surveyors conduct a comprehensive assessment of federal quality-of-care and fire safety requirements. In contrast, complaint investigations generally focus on a specific allegation regarding resident care or safety.

The quality-of-care component of a survey focuses on determining whether (1) the care and services provided meet the assessed needs of the

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<sup>6</sup>In addition to nursing homes, CMS and state survey agencies are responsible for oversight of other Medicare and Medicaid providers such as home health agencies, intermediate care facilities for the mentally retarded, accredited and nonaccredited hospitals, end-stage renal dialysis facilities, ambulatory surgical centers, rural health clinics, outpatient physical therapy centers, hospices, portable x-ray suppliers, comprehensive outpatient rehabilitation facilities, and Community Mental Health Centers.

<sup>7</sup>CMS generally interprets these requirements to permit a statewide average interval of 12.9 months and a maximum interval of 15.9 months for each home.

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residents and (2) the home is providing adequate quality care, including preventing avoidable pressure sores, weight loss, and accidents. Nursing homes that participate in Medicare and Medicaid are required to periodically assess residents' care needs in 17 areas, such as mood and behavior, physical functioning, and skin conditions, in order to develop an appropriate plan of care. Such resident assessment data are known as the minimum data set (MDS). To assess the care provided by a nursing home, surveyors select a sample of residents and (1) review data derived from the residents' MDS assessments and medical records; (2) interview nursing home staff, residents, and family members; and (3) observe care provided to residents during the course of the survey. CMS establishes specific investigative protocols for state survey teams—generally consisting of RNs, social workers, dietitians, and other specialists—to use in conducting surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states.

The fire safety component of a survey focuses on a home's compliance with federal standards for health care facilities.<sup>8</sup> The fire safety standards cover 18 categories ranging from building construction to furnishings. Examples of specific requirements include the use of fire- or smoke-resistant construction materials, the installation and testing of fire alarms and smoke detectors, and the development and routine testing of a fire emergency plan. Most states use fire safety specialists within the same department as the state survey agency to conduct fire safety inspections, but about one-third of states contract with their state fire marshal's office.

Complaint investigations provide an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Complaints may be filed against a home by a resident, the resident's family, or a nursing home employee either verbally, via a complaint hotline, or in writing. Surveyors generally follow state procedures when investigating complaints but must comply with certain federal guidelines and time frames. In cases involving resident abuse, such as pushing, slapping, beating, or otherwise assaulting a resident by individuals to whom their care has been entrusted, state survey agencies may notify state or local law enforcement agencies that can initiate criminal investigations. States must maintain a registry of qualified nurse aides, the primary

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<sup>8</sup>CMS requires nursing homes to meet applicable provisions of the fire safety standards developed by the National Fire Protection Association (NFPA), of which CMS is a member. NFPA is a nonprofit membership organization that develops and advocates scientifically based consensus standards on fire, building, and electrical safety.

caregivers in nursing homes, that includes any findings that an aide has been responsible for abuse, neglect, or theft of a resident's property. The inclusion of such a finding constitutes a ban on nursing home employment.

Deficiencies identified during either standard surveys or complaint investigations are classified in 1 of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). States are required to enter information about surveys and complaint investigations, including the scope and severity of deficiencies identified, in CMS's OSCAR database.

**Table 1: Scope and Severity of Deficiencies Identified During Nursing Home Surveys**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy <sup>a</sup>	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm <sup>b</sup>	A	B	C

Source: CMS.

<sup>a</sup>Actual or potential for death/serious injury.

<sup>b</sup>Nursing home is considered to be in "substantial compliance."

## Enforcement Policy

Ensuring that documented deficiencies are corrected is a shared federal-state responsibility. CMS imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification on the basis of state referrals. CMS normally accepts a state's recommendation for sanctions but can modify it. The scope and severity of a deficiency determine the applicable sanctions, which can involve, among other things, requiring training for staff providing care to residents, imposing money fines, denying the home Medicare and Medicaid payments for new admissions, and terminating the home from participation in these programs. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of homes. They may use the federal sanctions or rely on their own state licensure authority and nursing home sanctions.

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## Oversight

CMS is responsible for overseeing each state survey agency's performance in ensuring quality of care in nursing homes participating in Medicare or Medicaid. Its primary oversight tools are statutorily required federal monitoring surveys conducted annually in at least 5 percent of the state-surveyed Medicare and Medicaid nursing homes in each state and annual state performance reviews. Federal monitoring surveys can be either comparative or observational. A comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing home to observe the team's performance. Roughly 81 percent of the approximately 800 federal monitoring surveys are observational. Performance reviews examine state survey agency compliance with seven standards: (1) timeliness of the survey, (2) documentation of survey results, (3) quality of state agency investigations and decision making, (4) timeliness of adverse action procedures, (5) budget analysis, (6) timeliness and quality of complaint investigations, and (7) timeliness and accuracy of data entry.

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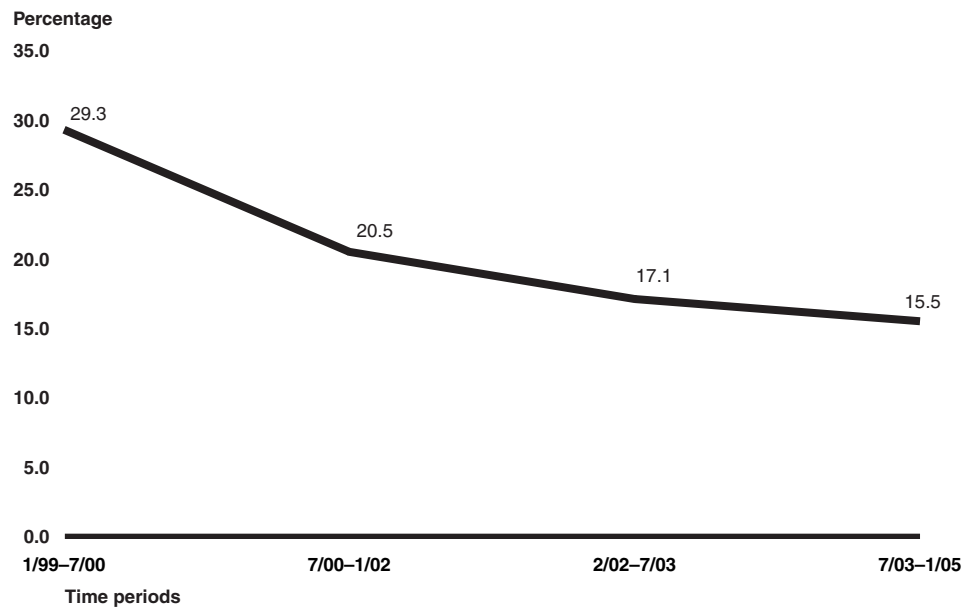
## Available Data Show Significant Overall Decrease in Serious Quality Problems but Indicate Continued Inconsistency and Understatement in State Findings

CMS's nursing home survey data show a significant decrease in serious quality problems in recent years, but other information indicates that this trend masks two important and continuing issues: inconsistency in how states conduct surveys and understatement of serious quality problems. OSCAR data continue to show wide interstate variability in the proportion of homes found to have serious deficiencies, suggesting inconsistency in states' interpretation and application of federal regulations. We previously reported that confusion about the definition of actual harm contributed to inconsistency and understatement in state surveys. Moreover, although federal comparative surveys conducted from October 1998 through December 2004 showed a decline in the proportion of serious deficiencies that were not identified by state surveys, this overall trend masks a more recent increase from 2002 through 2004 in federally identified understatement of serious deficiencies. In five large states we examined with a significant decline in the proportion of homes found to have harmed residents, federal comparative surveys found that a significant proportion of state surveys had missed serious deficiencies, that is, state surveyors either failed to cite the deficiencies altogether or cited them at too low a level of scope and severity.

From January 1999 through January 2005, the proportion of nursing homes nationwide with actual harm or immediate jeopardy deficiencies declined

from about 29 percent to about 16 percent. Figure 1 shows the proportion of homes nationwide with these deficiencies for four consecutive time periods from January 1999 through January 2005.<sup>9</sup> During the 6-year time period, 41 states had a decline in serious deficiencies ranging from about 5 to about 36 percentage points (see app. II).

**Figure 1: Percentage of Nursing Homes Nationwide with Serious Deficiencies, January 1999 through January 2005**



Source: GAO analysis of OSCAR data.

The nationwide data show a decline in nursing homes cited for serious deficiencies; however, the data obscure the continued significant interstate variation in the proportion of homes with serious deficiencies, which suggests inconsistency in how states conduct surveys. Table 2

<sup>9</sup>In the time period prior to CMS's implementation of its quality initiatives (January 1, 1997, through June 30, 1998), the proportion of homes nationwide with actual harm or higher-level deficiencies was 27.7 percent. However, this report focuses on trend data following CMS's July 1998 announcement of the initiatives. In our September 2000 report on CMS's quality initiatives, we compared trends in nursing home deficiency citations for two time periods—one before (January 1, 1997, through June 30, 1998) and one after (January 1, 1999, through July 10, 2000) the implementation of the nursing home initiatives. Since our 2000 report, we have updated this trend analysis for three time periods: July 11, 2000, through January 31, 2002; February 1, 2002, through July 10, 2003; and July 11, 2003, through January 31, 2005.

shows that while 10 states identified serious deficiencies in less than 10 percent of the homes surveyed, 15 states found similar deficiencies in more than 20 percent of homes surveyed from July 2003 through January 2005. For example, during that period California identified actual harm and immediate jeopardy deficiencies in about 6 percent of the state's nursing homes, while Connecticut found such deficiencies in approximately 54 percent of its facilities. Since January 1999, the proportion of homes with serious deficiencies had declined nearly 23 percentage points in California but increased by about 6 percentage points in Connecticut.

**Table 2: Percentage of Nursing Homes Identified as Having Serious Deficiencies during State Nursing Home Surveys, July 2003 through January 2005**

Percentage of homes with serious deficiencies	Number of states
More than 20 percent	15
10 percent to 20 percent	26
Less than 10 percent	10

Source: GAO analysis of OSCAR data.

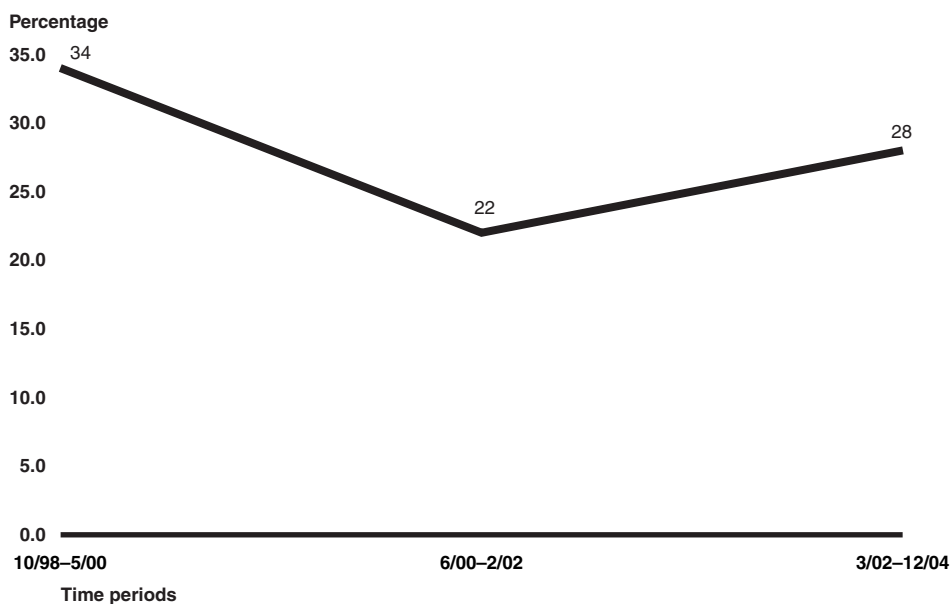
We discussed the decline in serious deficiencies in the five large states we examined with state survey agency officials and officials from the responsible CMS regional offices. Officials in four of the five states believed that there had been some improvement in nursing home quality. CMS regional office officials, however, were concerned about the magnitude of the decline in serious deficiencies in two states—Texas and California. The Texas state survey agency noted both some improvement in quality as well as a significant number of inexperienced surveyors who it believed were hesitant in citing actual harm. The San Francisco regional office and state survey agency officials acknowledged that confusion by state surveyors as to what constituted actual harm had contributed to the decline in California. The regional office staff discussed this issue with California survey agency officials and believed that training combined with the CMS inquiries might have contributed to a recent increase in actual harm deficiency citations.

The overall decline in the proportion of federal comparative surveys nationwide that noted serious deficiencies not identified by state surveyors across the three time periods we examined masks a reversal of this trend in the most recent time period analyzed, suggesting ongoing understatement of deficiencies. The time periods analyzed were October 1998 through May 2000, June 2000 through February 2002, and March 2002



through December 2004. From October 1998 through February 2002, the proportion of federal comparative surveys nationwide that noted serious deficiencies that were not identified by state surveyors declined from 34 percent to 22 percent (see fig. 2). However, federal surveys conducted from March 2002 through December 2004 that found serious deficiencies not identified by state surveyors increased from 22 percent to 28 percent. In addition, our work in the five states we examined demonstrates continued understatement by state surveyors of serious deficiencies that cause actual harm or immediate jeopardy.

**Figure 2: Percentage of Federal Comparative Surveys That Noted Serious Deficiencies Not Identified in State Surveys**



Source: GAO analysis of federal comparative surveys.

Because some serious deficiencies found by federal, but not state, surveyors may not have existed at the time of the state survey,<sup>10</sup> CMS requires its regional offices to specifically identify on worksheets which deficiencies state surveyors had missed during the state survey. We

<sup>10</sup>For example, a deficiency noted in a federal survey could involve a resident who was not in the nursing home at the time of the state survey but was admitted between the state and the federal surveys.

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analyzed CMS regional office worksheets for 73 comparative surveys in five large states—California, Florida, New York, Ohio, and Texas—with a significant decline in serious deficiencies from January 1999 through January 2005.<sup>11</sup> Overall, 18 percent of these federal comparative surveys identified at least one serious deficiency missed by state surveyors, ranging from a low of 8 percent in Ohio to a high of 33 percent in Florida (see table 3). Table 3 also shows that in comparative surveys noting serious deficiencies that state surveyors missed, from one to seven serious deficiencies were missed. Federal surveyors' findings of understatement of serious deficiencies are consistent with our own work. Our July 2003 report analyzed state surveys of homes with a history of harming residents but whose most current survey identified quality-of-care problems at below the level of harm; we concluded that about 40 percent of the 76 homes we analyzed had harmed residents, including instances of severe weight loss; multiple falls resulting in broken bones and other injuries; and serious, avoidable pressure sores. Similarly, our November 2004 report on Arkansas nursing home deaths found numerous instances of serious, understated quality-of-care problems.

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<sup>11</sup>The decline in serious deficiencies ranged from a low of 14.3 percentage points in Texas to a high of 23 percentage points in California and New York (see app. II).

**Table 3: Federal Comparative Surveys in Five States that Identified Serious Deficiencies Missed by State Surveys and the Number of Missed Deficiencies, March 2002 through December 2004**

State	Number of federal comparative surveys conducted	Federal comparative surveys that found missed serious deficiencies		Total number of serious deficiencies missed
		Number	Percentage	
California	23	4	17	6 <sup>b</sup>
Florida	12	4	33	7 <sup>b</sup>
New York	11	2 <sup>a</sup>	18 <sup>a</sup>	6 <sup>b</sup>
Ohio	12	1	8	1
Texas	15	2	13	5
<b>Total</b>	<b>73</b>	<b>13</b>	<b>18</b>	<b>25</b>

Source: GAO analysis of federal comparative surveys conducted from March 2002 through December 2004.

<sup>a</sup>On one comparative survey, federal surveyors did not provide information on whether any of the deficiencies they identified existed at the time of the state survey; therefore, this number may be understated.

<sup>b</sup>The number of serious missed deficiencies could be higher because federal surveyors sometimes did not indicate whether they believed that a serious deficiency they cited had existed at the time of the state survey and therefore was missed by state surveyors.

Our prior reports identified five factors that we believe contribute to inconsistency and the understatement of deficiencies by state surveyors: (1) weaknesses in CMS's survey methodology; (2) confusion about the definition of actual harm; (3) predictability of surveys, which allows homes to conceal problems if they so desire; (4) inadequate quality assurance processes at the state level to help detect understatement in the scope and severity of deficiencies; and (5) inexperienced state surveyors due to retention problems. CMS has initiatives under way to revise the survey methodology and address the confusion about what constitutes harm, and it has taken some steps to reduce survey predictability. However, CMS did not implement the recommendation in our July 2003 report to strengthen the ability of state quality assurance processes to detect understatement. While it agreed with the intent of our recommendation, CMS indicated that its state performance standards initiative already incorporated this concept. The status of these initiatives and state workforce issues are discussed in the following section.

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## CMS Has Addressed Many Shortcomings in Survey and Oversight Activities, but Work Continues on Some Key Initiatives

CMS has addressed many shortcomings in nursing home survey and oversight activities both in response to our recommendations and as a result of its own assessment of needed improvements, but it is still working on key initiatives that have not yet been implemented.<sup>12</sup> Appendix I provides a complete listing of our previous recommendations and the implementation status of CMS initiatives taken in response. Examples of CMS's initiatives to address shortcomings include (1) revising the survey methodology, (2) issuing states additional guidance to strengthen complaint investigations, (3) implementing immediate sanctions for homes cited for repeat serious violations, and (4) strengthening oversight by conducting assessments of state survey activities. CMS also has published information on its Web site about nursing home quality and has engaged independent quality organizations to work with nursing homes to improve quality.<sup>13</sup> Despite CMS's initiatives in four distinct areas—surveys, complaints, enforcement, and oversight—some initiatives either have not effectively targeted the problems we identified or have shortcomings that impair their effectiveness.

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## Surveys: Key Initiatives Are under Development, but Most Have Not Yet Been Implemented

Several CMS initiatives are intended to address shortcomings in the survey process, but most of these initiatives are in the developmental stage and have not yet been implemented. In addition, despite CMS's efforts to make scheduling of surveys less predictable, many remain predictable. (See table 4).

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<sup>12</sup>CMS has independently identified shortcomings in areas such as survey processes and consumer information and has developed initiatives to address these problems.

<sup>13</sup>Under contract with CMS, 39 Quality Improvement Organizations (QIO) (formerly known as Peer Review Organizations) help to ensure the quality of care delivered to Medicare beneficiaries in each state. Prior to 2002, QIO's work focused on care delivered in acute care settings such as hospitals.

**Table 4: Nursing Home Surveys: CMS Initiatives and Implementation Status**

<b>Initiative</b>	<b>Status</b>
Survey methodology: Revise to ensure that surveyors do not miss significant care problems.	In process
Investigative protocols: Strengthen to ensure greater rigor in surveyors' on-site investigations of specific areas.	In process
Definitions of actual harm and immediate jeopardy: Revise to promote increased interstate consistency in deficiency citations.	In process
Additional survey initiatives: Implement initiatives to give surveyors a way to voice concerns and explore the use of photographic evidence to improve the survey process.	In process
Survey predictability: Reduce to prevent nursing homes from potentially masking certain deficiencies if they so choose.	Selected initiatives implemented

Source: GAO analysis of CMS initiatives.

## Survey Methodology

In response to our 1998 recommendation to improve the rigor of the survey methodology to help ensure that surveyors do not miss significant care problems, CMS took some interim steps and launched a longer-term initiative. As interim steps, CMS instructed state survey agencies in 1999 to (1) increase the sample of residents reviewed during surveys and (2) review available quality indicator information on the care provided to a home's residents before actually visiting the home. By using the quality indicators, which are essentially numeric warning signs of the prevalence of care problems, to select a preliminary sample of residents before the on-site review, surveyors are better prepared to target their surveys and to identify potential care problems.<sup>14</sup> Surveyors augment the preliminary sample with additional resident cases once they arrive in the home.

For the longer term, CMS awarded a contract in 1998 to revise the methodology used to survey nursing homes, and the agency plans to pilot this new methodology in the fall 2005. Under development for 7 years, the proposed two-stage, data-driven Quality Indicator Survey (QIS) is intended to systematically target potential problems at nursing homes. Its expanded sample should help surveyors better assess the scope of any deficiencies identified. In stage 1, a large resident sample will be drawn and relevant

<sup>14</sup>Quality indicators, the result of a CMS-funded contract, are based on nursing home resident assessment information—MDS—which is data on each resident that homes are required to report periodically to CMS. Quality indicators are derived from nursing homes' assessments of residents and are used to rank a facility in 24 areas compared with other nursing homes in the state.

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data from on- and off-site sources will be analyzed to develop a set of quality-of-care indicators, which will be compared to national benchmarks.<sup>15</sup> Stage 2 will systematically investigate potential quality-of-care concerns identified in stage 1. In June 2005, CMS selected five states to pilot test the new survey methodology.<sup>16</sup> The QIS pilot test will begin during the fall 2005, with a final evaluation of the pilot due in the fall 2006. The evaluation will examine the QIS's cost-effectiveness, focusing on the time and surveyor team size required under QIS compared to the current survey methodology, and on the QIS's impact on deficiency citations. In developing the QIS, CMS has attempted to prevent increases in the time required to complete surveys. Depending on evaluation findings and any subsequent streamlining of the QIS, national implementation could begin in mid-2007.

## Investigative Protocols

Since 2001, CMS has been developing surveyor investigative protocols to ensure greater rigor in on-site investigations of specific quality-of-care areas. We recommended in July 2003 that CMS finalize the development of these important protocols; however, CMS is still working on this initiative. In 2001, CMS hired a contractor to facilitate the convening of expert panels for the development and review of these protocols.<sup>17</sup> In November 2004, more than 1 year later than scheduled, CMS implemented a protocol on pressure sores. Since then, CMS has implemented protocols in two other areas—incontinence and medical director qualifications and responsibilities. The protocols provide detailed interpretive guidelines and severity guidance. Protocols in seven more areas are under development, with an issuance target of fall 2005.<sup>18</sup>

## Definitions of Actual Harm and Immediate Jeopardy

To promote increased consistency among states in deficiency citations, a work group of CMS central office, regional office, and state survey agency staff was convened in early 2005 to clarify the definitions of actual harm and immediate jeopardy. Our July 2003 report noted that confusion about the definitions contributed to the understatement of serious deficiencies.

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<sup>15</sup>On-site sources include observations, interviews, and records review. An example of an off-site data source is the MDS.

<sup>16</sup>The pilot states are California, Connecticut, Kansas, Louisiana, and Ohio.

<sup>17</sup>Prior to this contract, surveyor protocols were developed by CMS, with comments from stakeholder groups, but the development process did not include an expert panel.

<sup>18</sup>Investigative protocols are being developed for accidents and supervision, quality assurance, resident activities programs, psychosocial severity, safe food handling/nutrition, pharmacy services/unnecessary drugs, and end-of-life/pain management issues.

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According to CMS, the 2005 draft revised definition of actual harm attempts to clarify the existing definition by eliminating confusing language and identifying indicators and examples of actual harm.<sup>19</sup> The draft revised definition of immediate jeopardy is intended to provide additional guidance on documenting whether deficiencies are at the immediate jeopardy severity level, including criteria for identifying whether immediate jeopardy exists, and updates examples of immediate jeopardy. A CMS official indicated that the draft revised definition of immediate jeopardy stresses that action must be taken at once to prevent harm. As of August 2005, CMS had no target issuance date for the revised definitions.

#### Additional Survey Initiatives

CMS is implementing two additional survey initiatives—developing guidance to ensure surveyors are able to report concerns to CMS regional offices and studying surveyors’ use of photographic evidence.

- To address anecdotal reports that surveyors are sometimes asked to overlook or downgrade survey findings, CMS has issued and is obtaining state comments on draft guidance to ensure that surveyors can cite survey findings without such inappropriate pressure. Currently, surveyors report concerns to the state survey agency. CMS officials indicated that the draft guidance tries to (1) establish a nonthreatening option for voicing concerns to CMS regional office staff without overburdening the regional offices with additional investigations and (2) give CMS a way to identify any patterns of problems. Implementation of this effort is anticipated in late 2005.
- CMS also contracted for a study of the use of photographic evidence by surveyors to support survey findings. In our 2004 report on Arkansas nursing home deaths, we reported that photographs taken by coroners provided key evidence supporting neglect of nursing home residents and the existence of serious, avoidable care problems. The goal of CMS’s study is to identify issues and develop training materials related to surveyors’ use of photographic evidence. This study began in the summer 2005, with final training materials to be issued in the summer 2006.

#### Survey Predictability

In 1998, we reported that nursing homes could mask certain deficiencies if they chose to because of survey predictability. CMS responded by

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<sup>19</sup>For example, a CMS official informed us that the language, “limited consequences to the resident,” which is used in the current definition of actual harm, confused states because it was vague and that states formed their own interpretations of the language. The draft revised definition eliminates this language.

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directing states to (1) avoid scheduling a home's survey for the same month of the year as the home's previous standard survey and (2) begin at least 10 percent of standard surveys outside the normal workday (either on weekends, early in the morning, or late in the evening).<sup>20</sup> However, our current analysis showed that a significant proportion of state nursing home surveys remain predictable. We consider surveys to be predictable if they are conducted within 15 days of the anniversary of a home's prior survey.<sup>21</sup> From 2002 to 2005, the proportion of predictable surveys increased from 13 percent to 14.5 percent (see app. III). Overall, 29 states had an increase in survey predictability. As shown in table 5, as of July 2005, from 10 percent to over 50 percent of current nursing home surveys in 35 states were conducted within 15 days of the anniversary of a home's last standard survey. CMS officials stated that avoiding surveys close to the 12-month anniversary of a home's prior survey, while meeting the requirements that surveys occur not less than once every 15 months and maintaining a statewide average interval of 12 months, could require increased funding because more surveys would need to be accomplished within the first 9 months after a survey.<sup>22</sup> However, CMS noted that states are not currently funded to conduct surveys within the first 9 months after the previous survey. CMS officials also told us that CMS had introduced the ASPEN Scheduling and Tracking (AST) module for its central and regional offices and the states in February 2004 as a tool to reduce survey predictability; however, state officials we spoke with about AST were unfamiliar with its survey predictability features.<sup>23</sup>

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<sup>20</sup>CMS disagreed with a portion of our predictability recommendation that suggested segmenting the standard survey into more than one review to provide more opportunities for surveyors to observe problematic homes. CMS disagreed because of concerns that segmenting the survey would reduce the effectiveness and increase the cost of surveys.

<sup>21</sup>CMS instructed the states to avoid, if possible, scheduling a home's survey for the same month as the one in which the home's previous standard survey was conducted.

<sup>22</sup>According to CMS, states consider 9 months to 15 months from the last standard survey as the window for completing standard surveys because it yields a 12-month average. CMS and states acknowledged that states sometimes fall behind in conducting surveys and homes are not surveyed until near or after the 15-month time frame. Thus, to maintain an average survey interval of 12 months, more surveys would need to occur within 9 months of the last standard survey.

<sup>23</sup>ASPEN stands for the Automated Survey Processing Environment. ASPEN is used by CMS central office, regional offices, and state survey agencies for tracking surveys and survey findings. ASPEN comprises multiple modules such as the ASPEN Enforcement Manager and the ASPEN Complaints and Incidents Tracking System.



**Table 5: Percentage of Predictable Current Nursing Home Surveys, as of April 2002 and July 2005**

Percentage of predictable surveys	Number of states	
	April 2002	July 2005
More than 50 percent	0	1
25 percent to 50 percent	5	7
10 percent to 24 percent	26	27
Less than 10 percent	20	16

Source: GAO analysis of OSCAR data.

Notes: "Predictable surveys" are defined as surveys conducted within 15 days of the anniversary of homes' prior surveys.

## Complaint Investigations: CMS Has Strengthened State Guidance and Oversight and Is Continuing to Address Problems Involving Allegations of Abuse

CMS has completed certain initiatives to ensure that quality problems found during complaint investigations are promptly addressed and has taken steps to address weaknesses in the notification and investigation of abuse in nursing homes. CMS is continuing work on (1) ensuring state compliance with federal nurse aide registry requirements and (2) assessing the effectiveness of conducting employee background checks. (See table 6).

**Table 6: Complaint Investigations: CMS Initiatives and Implementation Status**

Initiative	Status
Complaint guidance: Issue additional guidance to states to strengthen complaint investigations, including allegations of abuse.	Selected initiatives implemented
Complaint oversight: Enhance federal oversight of state complaint investigations, including allegations of abuse.	In process

Source: GAO analysis of CMS initiatives.

## Complaint Guidance

CMS guidance issued since 1999 has helped to strengthen state procedures for investigating complaints. In 1999, we reported that complaints alleging that nursing home residents were being harmed were not being investigated for weeks or months in several states and recommended that CMS develop additional standards for the prompt investigation of serious complaints alleging situations that may harm residents but are categorized as less than immediate jeopardy. CMS promptly instructed states to investigate complaints alleging harm to a resident within 10 workdays of

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receiving the complaint and later specified that investigations of these complaints be conducted on-site at the nursing home.<sup>24</sup> During 1999, CMS developed and issued guidance intended to help states identify complaints that allege harm to residents. Also in 1999, CMS hired a contractor to study and recommend improvements to state complaint practices. CMS used the findings of this study to develop more detailed guidance for states to help improve the effectiveness of complaint investigations. In 2004, CMS issued this guidance to states, which further clarified the 1999 instructions on identifying actual harm.

In March 2002, we recommended that CMS ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units (MFCU) of allegations or confirmed complaints of abuse.<sup>25</sup> In response, CMS issued a March 2002 letter to CMS regional offices and state survey agencies clarifying its policies on abuse reporting time frames, requirements for reporting to local law enforcement and/or the MFCU, displaying complaint telephone numbers, and citing abuse on surveys. CMS issued additional guidance in December 2004 clarifying nursing home reporting requirements and definitions for alleged violations, including mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property. CMS has not, however, implemented our March 2002 recommendation to accelerate the agency's campaign to increase public awareness of nursing home abuse through the development and distribution of posters that are to be prominently displayed in nursing homes, and other materials.<sup>26</sup>

## Complaint Oversight

CMS has taken three important steps to improve its oversight of state complaint investigations, including allegations of abuse. First, it required in its annual state performance review, which was established in fiscal year 2001 and fully implemented in fiscal year 2002, that federal surveyors

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<sup>24</sup>Prior to this new requirement, federal guidelines required only that complaints alleging immediate jeopardy to residents be investigated within 2 workdays. For all other complaints, states could establish their own investigative time frame.

<sup>25</sup>MFCUs have authority to investigate the physical and sexual abuse of nursing home residents, in addition to investigating fraud and abuse in the Medicaid program. Typically, MFCUs are an investigative component of the state's Office of the Attorney General but may be located in other agencies, such as the state police, instead. Forty-eight states have a MFCU.

<sup>26</sup>In 2002, CMS informed us that the posters were developed, but have not yet been printed or distributed. According to a CMS official, the agency's focus on higher-priority activities has contributed to the delay.

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review a sample of complaints in each state to determine whether states properly categorize complaints (i.e., determine how quickly they should be investigated), investigate complaints within the time specified, and properly include the results of investigations in CMS's database. Our March 1999 report on complaints had recommended that CMS strengthen its oversight in these areas. During its 2004 review of state performance, CMS identified 5 states that did not meet the standard for properly categorizing complaints and 13 states that did not conduct timely investigations of all complaints alleging immediate jeopardy to residents; however, 11 of the 13 states missed the requirement by a small margin.<sup>27</sup> States failing state performance review standards are asked to submit a corrective action plan to CMS.

Second, in January 2004, CMS implemented a new national automated complaint tracking system, the ASPEN Complaints and Incidents Tracking System. Our March 1999 report on enforcement noted that the lack of a national complaint reporting system hindered CMS's and states' ability to adequately track the status of complaint investigations as well as CMS's ability to maintain a full compliance history on each nursing home. To address these concerns, we recommended the development of a better management information system. One goal of CMS's new management information system is to standardize reported complaints so that analysis can be conducted across all states. This system is intended to provide CMS with an effective tool for overseeing and managing state complaint investigations.<sup>28</sup>

Third, in November 2004, CMS requested state survey agency directors to self-assess their states' compliance with federal requirements for maintaining and operating nurse aide registries, to which states are required to report substantiated findings of abuse, neglect, or theft of nursing home residents' property by nurse aides. CMS has not issued a formal report of findings from the state self-assessment, but CMS officials noted that as a result of resource constraints some states reported having difficulty maintaining compliance with certain federal requirements, such as (1) timely entry by state survey staff of information in nurse aide registries and (2) state notification to nursing homes employing nurse aides found guilty of abuse at another facility. In our March 2002 report, we recommended that CMS shorten the state survey agencies' time frames

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<sup>27</sup>Results for 2005 were not available at the time we conducted our work for this report.

<sup>28</sup>We did not evaluate the effectiveness of the complaint tracking system.

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for determining whether to include findings of abuse in the nurse aide registry. Annotations to nurse aide registries are made after final determinations that abuse occurred, which entail completion of the state's investigation as well as adjudication of any appeals.<sup>29</sup> Until the final determination, residents may continue to be exposed to aides who are allegedly abusive. CMS noted that while most of the time frames are defined in regulation, it can review the time frames when regulatory changes are considered. No changes to the regulations had been made as of August 2005.

As part of its third effort, CMS also is conducting a Background Check Pilot Program. Our March 2002 report recommended an assessment of state policies and practices for complying with federal requirements prohibiting employment of individuals convicted of abusing nursing home residents. The pilot program will test the effectiveness of state and national fingerprint-based background checks on employees of long-term care facilities, including nursing homes.<sup>30</sup> Pilot programs in seven states—Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin—will be phased in from fall 2005 through September 2007. An independent evaluation is planned.

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### Enforcement: CMS Has Strengthened the Potential Deterrent Effect of Sanctions and Has Other Initiatives Under Way

CMS significantly strengthened the potential deterrent effect of enforcement actions by requiring immediate sanctions for homes found to have a pattern of harming residents. Moreover, CMS continues to develop new policies and to clarify existing ones in order to strengthen enforcement activities and encourage nursing home compliance with federal requirements. (See table 7).

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<sup>29</sup>CMS requires state survey agencies to investigate allegations of nursing home resident abuse, which can be submitted by residents, family members, friends, physicians, and nursing home staff, within 2 days of learning of the allegation, but does not impose a deadline for completing the investigation. After the state survey agency has made an initial determination, the nurse aide may request an appeal within 30 days. Hearings may not be held for several months, and decisions are not always immediate.

<sup>30</sup>The Background Check Pilot Program was mandated by Section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173, 117 Stat. 2066, 2257.). CMS issued grant solicitation letters to states in July 2004 and made grants in January 2005.

**Table 7: Enforcement: CMS Initiatives and Implementation Status**

<b>Initiative</b>	<b>Status</b>
Immediate sanctions policy: Eliminate grace periods for homes cited for repeat serious violations.	Fully implemented
Additional enforcement policy issues: Address weaknesses in policies, the appeals process, and enforcement tracking.	Selected initiatives implemented
Special Focus Facility Program: Revise to include the most poorly performing homes and to strengthen enforcement.	Fully implemented
Civil money penalties: Improve tracking and collection to make them a more effective enforcement tool.	In process
Past noncompliance policy: Revise by clarifying key terms, increasing homes' accountability for past quality-of-care problems, and posting on the CMS Web site specific information about homes' past noncompliance.	In process

Source: GAO analysis of CMS initiatives.

## Immediate Sanctions Policy

Responding to our July 1998 recommendation to eliminate grace periods for homes cited for repeat serious violations, CMS began a two-stage phase-in of a new enforcement policy. In the first stage, effective September 1998, CMS required states to refer for immediate sanction homes found to have a pattern of harming residents or of exposing them to actual harm or potential death or serious injury (H-level deficiencies and above on CMS's scope and severity grid). Effective January 2000, CMS expanded this policy, requiring referral of homes found to have harmed one or a small number of residents (G-level deficiencies) on successive standard surveys.<sup>31</sup> In response to our 2003 finding that states failed to refer a substantial number of homes that met the criteria for the immediate sanctions, CMS initiated oversight of state compliance with this policy. To conduct this oversight, CMS analyzed deficiency data for 2000 through 2003 to identify potential instances of homes that should have been but were not referred for immediate sanctions. In ongoing work, we are assessing the impact and implementation of the immediate sanctions policy.

## Additional Enforcement Policy Issues

Based on recommendations in our July 1998 report and our March 1999 report on enforcement, CMS has addressed weaknesses in its policies in

<sup>31</sup>States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G through L on CMS's scope and severity grid) in each of two successive surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

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three areas: nursing homes' correction of deficiencies, the nursing home appeals process, and the enforcement data tracking system.

- CMS now requires on-site follow-up, referred to as a revisit, of homes with substandard quality of care or actual harm or higher-level deficiencies until the state verifies correction of each deficiency cited.<sup>32</sup> Our 1998 report found that CMS's policy of allowing nursing homes to self-report resumed compliance was sometimes inappropriately applied to homes with deficiencies in the immediate jeopardy category or that were found to have substandard quality of care. We recommended that CMS require that for homes with recurring serious violations, state surveyors substantiate resumed compliance by means of an on-site revisit. CMS also has issued additional guidance on the "reasonable assurance period" during which terminated homes must demonstrate that they have corrected the deficiencies that led to their terminations.<sup>33</sup> This guidance provided additional examples of reasonable assurance decisions.
- CMS and the Department of Health and Human Services (HHS) requested and received funding and staffing increases for the HHS Departmental Appeals Board in fiscal years 1999 and 2000 to address our March 1999 finding that the growing backlog of appeals hampered the effectiveness of civil money penalties by delaying their collection. The Board is responsible for adjudicating the appeals. By August 2003, the backlog of appeals of civil money penalties had been significantly reduced.
- CMS implemented the automated ASPEN Enforcement Manager on October 1, 2004, to facilitate tracking of enforcement actions. Prior to implementing this system, CMS had no centralized system for tracking or managing federal and state enforcement actions.<sup>34</sup> The ASPEN Enforcement Manager is intended to provide real-time entry and tracking of enforcement actions, issue monitoring alerts, generate enforcement letters, and facilitate analysis of enforcement patterns. CMS expects that ASPEN Enforcement Manager data will enable states, CMS regional offices, and the CMS central office to more easily track and evaluate

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<sup>32</sup>Substandard quality of care is defined as deficiencies cited at the F level of scope and severity in certain care areas—quality of life, quality of care, and resident behavior and facility practices.

<sup>33</sup>Before readmitting a terminated nursing home to Medicare, CMS requires the home to address the situation that led to termination and provide reasonable assurance that it will not recur. To give this assurance, a home is required to have two surveys not more than 6 months apart, each of which shows the problem to be corrected. The reasonable assurance period is the time between these two surveys.

<sup>34</sup>From 2000 to 2004, CMS used a nationwide summary of the 10 regional office enforcement databases known as the Long Term Care Enforcement Tracking System.

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nursing home performance and compliance status as well as respond to emerging issues. In ongoing work, we are assessing whether data from the ASPEN Enforcement Manager can be used to analyze nursing homes' deficiency and enforcement histories.<sup>35</sup>

### Special Focus Facility Program

In December 2004, CMS revised the method for selecting nursing homes for the Special Focus Facility Program to ensure that the most poorly performing homes were included in the program and to strengthen enforcement for those nursing homes with an ongoing pattern of substandard care.<sup>36</sup> For this program, first initiated in January 1999, states were directed to select two nursing homes to be special focus facilities, conduct two standard surveys each year in the special focus facilities, and submit monthly status reports on the selected homes. The revised guidance directs states to select, from an expanded list of facilities, a minimum of up to six nursing homes, depending on the number of nursing homes in the state; the revised guidance gives states the option to select more than the minimum.<sup>37</sup> States are also given the flexibility to remove from the list homes that have made significant improvements. Enforcement authority over special focus facilities has been strengthened so that while homes are in the Special Focus Facility Program, immediate sanctions must be imposed if homes fail to significantly improve performance from one survey to the next; termination from participation in Medicare and Medicaid is required for homes with no significant improvement in 18 months and three surveys.

### Civil Money Penalties

In April 2004, CMS launched a Civil Money Penalty Improvement Project to improve its ability to track and collect civil money penalties in an effort to make them a more effective enforcement tool. CMS mapped out the current process for tracking and collecting civil money penalties to identify weaknesses and developed draft guidance with detailed policies and procedures for addressing areas identified as needing improvement, with a target release date of fall 2005. Also planned are enhancements to the Civil Money Penalty Tracking System, CMS's information system for

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<sup>35</sup>We did not evaluate the performance of the ASPEN Enforcement Manager for this report.

<sup>36</sup>In the Special Focus Facility Program, state survey agencies conduct enhanced monitoring of nursing homes with histories of providing poor care.

<sup>37</sup>The revised special focus facility selection methodology addressed criticisms about the original state selection process from state survey agencies, including that the process did not account for state size or number of nursing homes, and used insufficient performance data in selecting homes. Alaska is not required to select special focus facilities.

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civil money penalties. The enhancements are intended to streamline the system, improve its reporting capabilities, and improve its compatibility with the enforcement monitoring system. The system's changes are planned to occur through 2005 and 2006.

Also in 2004, CMS, in conjunction with various state survey agencies, began developing a civil money penalty grid—an optional guideline for use by states and CMS regional offices to help ensure greater consistency across states in the amounts of civil money penalties recommended. The grid is expected to provide ranges for minimum civil money penalties for deficiencies, while allowing for flexibility to adjust the penalties on the basis of factors such as the severity of an identified deficiency, the care areas in which deficiencies were cited, and past history of noncompliance.<sup>38</sup> The target issuance date for a draft grid was August 2005.

#### Past Noncompliance Policy

In October 2005, CMS issued a revised past noncompliance policy that (1) clarifies how to address recently identified past deficiencies, (2) further defines “past noncompliance,” (3) eliminates the use of the term “egregious,” and (4) clarifies the methods for determining whether past noncompliance has been corrected. Past noncompliance occurs when a current survey reveals no deficiencies but determines that an egregious violation of federal standards occurred in the past and was not identified during an earlier survey.<sup>39</sup> In November 2004, we reported that CMS's past noncompliance policy was ambiguous. The policy did not define what constituted an egregious violation or relate egregious violations to its scope and severity grid. Moreover, the policy did not hold homes accountable for negligence associated with resident deaths unless current residents are experiencing the same quality-of-care problems and it obscures the nature of care problems. CMS's revised policy responds to our recommendation and holds homes accountable for all past noncompliance resulting in harm to residents. We also recommended that past noncompliance citations identify the specific nature of the care problem in the OSCAR database and on the Nursing Home Compare Web site. In 2007, CMS plans to enhance the information on the Nursing Home Compare Web site to include the specific nature of the past

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<sup>38</sup>CMS's guidance to states describes the factors to be considered when determining the amount of a civil money penalty.

<sup>39</sup>The assumption is that the nursing home identified and corrected this earlier care problem.



noncompliance. According to CMS officials, the delay is related to the implementation of higher priority initiatives by the agency. Currently, the Web site only indicates whether there were instances of past noncompliance and does not identify the nature of the care deficiency.

**Oversight: Intensity and Scope of Federal Efforts Has Increased Significantly, but Work Remains**

CMS has significantly improved the intensity and scope of its oversight activities and has made significant improvements both in its data systems and in its analysis and use of the data it collects on survey activities. The effectiveness of several of these oversight initiatives, however, is uneven, and more work remains to be done. (See table 8).

**Table 8: Oversight: CMS Initiatives and Implementation Status**

<b>Initiatives</b>	<b>Status</b>
Federal comparative surveys: Increase number to intensify oversight.	Fully implemented
Smoke detectors: Require them in nursing homes without sprinklers to strengthen fire safety.	Fully implemented
Assessments of state survey activities: Review state survey agencies' compliance with federal standards.	Selected initiatives implemented
Data systems and analysis: Upgrade to improve tracking and oversight of state survey activities.	In process
Sharing data: Share quality data with the public to help drive quality improvement.	Selected initiatives implemented
Quality Improvement Organizations: Use Quality Improvement Organizations to help nursing homes improve the quality of care.	In process
Coordination and dissemination of best practices: Initiate activities to improve nursing home oversight.	In process

Source: GAO analysis of CMS initiatives.

**Federal Comparative Surveys**

In response to recommendations in our November 1999 and July 2004 reports, CMS has (1) significantly increased the number of federal comparative surveys both for quality of care and fire safety and (2) decreased the time between the end of the state survey and the start of the federal survey for quality-of-care comparative surveys, allowing CMS to better distinguish between serious problems missed by state surveyors and changes in a home that occurred after the state survey. We found earlier that CMS was making negligible use of comparative surveys, its most effective tool for assessing a state survey agency's ability to identify serious quality-of-care and fire safety deficiencies in a nursing home, to

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fulfill its 5 percent monitoring mandate.<sup>40</sup> Only 21 quality-of-care comparative surveys were conducted from November 1996 through October 1998. Our 2004 fire safety report found that CMS had conducted only 40 fire safety comparative surveys in fiscal year 2003, ranging from 4 in some states to none in others.

Since 2001, CMS has required its regional offices to complete at least two quality-of-care comparative surveys per state per year, but federal surveyors have been exceeding this minimum threshold.<sup>41</sup> During the period March 1, 2002, through December 31, 2004, CMS completed 424 comparative surveys, about 140 per year. In addition, the average elapsed time between state and comparative surveys has decreased from 33 calendar days for the 64 comparative surveys we reviewed in 1999 to 26 calendar days for the 424 surveys completed through 2004.

CMS planned to further increase the number of comparative surveys by contracting in the fall of 2003 for 170 quality-of-care comparative surveys in addition to those conducted by federal surveyors. However, an increase in the number of quality-of-care comparative surveys is unlikely because of delays in contractor readiness and the addition of fire safety comparative surveys to the contract. CMS had expected to have a sufficient number of contract surveyors trained and available to start surveys by the winter of 2005, but it took longer than anticipated to train the new surveyors. In addition, CMS modified the contract to include fire safety comparative surveys. In fiscal year 2005, the contractor conducted 34 quality-of-care comparative surveys and 250 fire safety comparative surveys. Together, the contractor and CMS regional offices conducted a total of 859 fire safety comparative surveys in fiscal year 2005. CMS also is using the contract surveyors to augment federal survey teams. According to CMS, it will use contract funds carried over from earlier years to conduct quality-of-care comparative surveys during fiscal year 2006, and

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<sup>40</sup>CMS is statutorily required to conduct federal monitoring surveys in at least 5 percent of the surveyed nursing homes in each state each year, with a minimum of 5 facilities in each state. As of January 2005, there were 16,146 nursing homes, which would require 807 federal monitoring surveys. Until 1992, all federal monitoring surveys were comparative. In part because comparative surveys were resource intensive, CMS began to rely more heavily on observational surveys, which require a smaller number of federal surveyors.

<sup>41</sup>During fiscal years 1999 and 2000, CMS required a minimum of one comparative survey to be completed yearly in the 20 states having fewer than 200 nursing homes, two in the 24 states that had from 200 to 599 homes, and three in the 7 states that had 600 or more homes.

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will only use fiscal year 2006 funds to conduct fire safety comparative surveys.

### Smoke Detectors in Homes without Sprinklers

In response to a recommendation in our July 2004 report to strengthen fire safety standards, CMS published an interim final rule in March 2005 requiring nonsprinklered nursing homes to install battery-powered smoke detectors in resident rooms and common areas, including resident dining, activity, and meeting rooms. Previously, federal standards required smoke detectors in (1) corridors or resident rooms only in homes built after 1981 and (2) nonsprinklered resident rooms containing furniture brought from the resident's home. We reported that the lack of smoke detectors in resident rooms may delay staff response and fire department notification, which in turn may increase the number of nursing home fire-related fatalities. CMS will begin surveying nursing homes' compliance with the new requirement in May 2006.

### Assessments of State Survey Activities

In October 2000, CMS regional offices began conducting on-site state performance reviews to assess compliance with federal standards.<sup>42</sup> Previously, CMS permitted states to evaluate and report on their own performance against a number of standards, a technique that essentially allowed states to write their own report cards because CMS did not independently validate information provided by the states. In fiscal year 2005, CMS began to tie funding increases for state survey agencies to one of the seven performance standards—the timely conduct of standard surveys—time frames that are established in federal statute.

Nevertheless, in our current analysis of the standard that is intended to measure the supportability of survey findings, we found that three key issues we identified in July 2003 still exist. First, distinctions in state performance were hard to identify because, while some states have consistently met the standard for documentation of deficiencies, federal comparative surveys completed during essentially the same time frame found that surveyors in these states frequently missed serious deficiencies. Second, CMS regional offices were inconsistent in conducting state performance reviews. For fiscal year 2004, five states nationwide did not meet this standard, but three of the five states were in one CMS region. Third, the standard for assessing the supportability of deficiencies is

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<sup>42</sup>Since fiscal year 2001, CMS has expanded the scope of state performance reviews to include seven additional Medicare and Medicaid providers, such as hospitals and renal dialysis facilities, in addition to nursing homes.

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composed of 11 elements that mix major and minor issues.<sup>43</sup> Although CMS has simplified the standard for assessing the supportability of deficiencies, we believe that many of the elements reviewed remain essentially administrative in nature rather than substantive.<sup>44</sup> Of the elements that make up the standard, only 2 assess the appropriateness of the cited scope and severity; the remaining elements assess such issues as how the deficiency is written, including avoiding the use of the passive voice. We do not believe that this standard is sufficiently focused on identifying understatement.

CMS did not implement our July 2003 recommendation that it require states to review a sample of deficiencies cited at or below the level of actual harm in order to detect understatement because, according to CMS, the state performance review of the supportability of deficiencies already accomplished this objective. In discussing our current findings regarding the standard intended to measure the supportability of survey findings, CMS officials agreed that (1) measuring the quality of state surveys, one goal of reviewing the supportability of deficiencies, was particularly challenging because there is no one agreed-upon way to measure quality; and (2) some standards are complex, contributing to consistency problems.

In developing this report, we also noted two additional problems with the state performance reviews that were not previously reported. First, in its fiscal year 2004 review, CMS began combining state performance review

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<sup>43</sup>The 11 elements are (1) the citation has the full regulatory reference; (2) evidence supports determination of noncompliance at the cited regulation; (3) each deficient practice statement clearly summarizes the provider/supplier failure(s) and quantifies a relevant extent; (4) the scope accurately reflects the evidence and the residents who are, or may be, affected by the deficient practice; (5) the severity rating in nursing homes or the condition, standard, or element level cited reflects the evidence and the actual and/or potential outcomes to beneficiaries; (6) each person referred to is uniquely identified; (7) the observations, interviews, and record reviews support the deficient practice statement and illustrate the entity's noncompliance; (8) descriptions of observation of provider/supplier practice include date, time, duration, and location; (9) descriptions of interviews include dates and times and who was interviewed; (10) record review includes date of entry and exact title of record, and verifies lack of additional records with a knowledgeable person; and (11) evidence is written in plain language that is clear, concise, and easily understood.

<sup>44</sup>CMS was unable to score the standard in fiscal year 2001 because the standard was too complicated. The standard consisted of 33 elements in fiscal year 2001 but was reduced to 7 elements for the subsequent 2 fiscal years. In fiscal year 2004, the number of elements was increased to 11.

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results across the different provider types, such as nursing homes and home health agencies, for which states have oversight responsibility. For example, CMS calculates one overall state score on the supportability of deficiencies across provider types, rather than issuing provider-specific scores. One CMS region suggested that because nursing homes are generally surveyed by a unique pool of surveyors, combining results in this manner limits the usefulness of the feedback to state survey agencies. Second, CMS provides feedback to states regarding their performance each year, but it does not publicly report the results. Doing so would appear to be consistent with CMS's stated philosophy of sharing information with the public to help improve nursing home quality.

## Data Systems and Analysis

CMS has pursued important upgrades in the system used to track the results of state survey activities and has increased its analysis of OSCAR and other data to improve oversight by CMS central and regional offices and state survey agencies. Examples include the following:

- In 2000, CMS began to produce 19 periodic reports to monitor both state and regional office performance.<sup>45</sup> Some reports, such as survey timeliness, are used during state performance reviews, while others are intended to help identify problems or inconsistencies in state survey activities and the need for intervention.
- In 2001, 2002, and 2005 CMS published a "Nursing Home Data Compendium," which includes detailed tables and figures on nursing homes, resident demographics, resident clinical characteristics, and survey results.
- In 2004, CMS commissioned a series of "White Papers" on topics ranging from enforcement to resource issues. The goal was to stimulate discussion among key stakeholders and generate ideas for "next steps" to help mitigate problems. The reports, authored by CMS and state survey agency staff, relied on data analysis from OSCAR and other CMS databases.
- In 2004, CMS prepared an internal study on enforcement trends since the imposition of the immediate sanctions policy using data from the Enforcement Tracking System.
- In 2005, CMS unveiled a Web site for use by regional offices and state survey agencies that generates a series of standard reports through a software program called Providing Data Quickly; this software permits easier access to the data contained in OSCAR. One such report identifies

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<sup>45</sup>Examples include reports on pending nursing home terminations (weekly), data entry timeliness (quarterly), tallies of state surveys that find homes deficiency-free (semiannually), and analyses of the most frequently cited deficiencies by states (annually).

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homes that have repeatedly harmed residents and meet the criteria for imposition of immediate sanctions.

CMS indicated that it is continuing to make progress in redesigning the OSCAR system. In our March 1999 report on enforcement, we recommended that the agency develop an improved management information system that would help it to track the status and history of deficiencies, integrate the results of complaint investigations, and monitor enforcement actions. Although the target implementation date for the redesigned system has slipped from 2005 to 2008, depending on competing priorities and available funding, CMS has implemented two key components of the redesigned system—a complaint tracking system and a system to track the status of enforcement actions. Both systems are intended to provide CMS with critical management capabilities that it previously lacked.

## Sharing Data with the Public

Using market forces to help drive quality improvement is an important CMS objective behind sharing data with the public on nursing home quality. Since CMS launched Nursing Home Compare in 1998, the agency has progressively expanded the information available on this Web site. In addition to data on the deficiencies identified during standard surveys, the Web site now includes data on the results of complaint investigations, information on nursing home staffing levels, and quality indicators, such as the percentage of residents with pressure sores. However, CMS continues to address ongoing problems with the accuracy and reliability of the underlying data, such as the MDS, quality indicators, and nurse staffing levels.

In February 2002, we concluded that CMS efforts to ensure the accuracy of the underlying MDS data<sup>46</sup> used to calculate the quality indicators (1) relied too much on off-site review activities by its contractor and (2) anticipated on-site reviews in only 10 percent of its data accuracy assessments, representing fewer than 200 of the nation's nursing homes.<sup>47</sup> CMS did not

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<sup>46</sup>The MDS, which is prepared periodically for each nursing home resident, contributes to multiple functions, including establishing patient care plans, assisting with quality oversight, and setting nursing home payments that account for variation in resident care needs.

<sup>47</sup>This limited on-site presence was also inconsistent with a recommendation in a 2001 report CMS commissioned regarding the benefits of on-site reviews in detecting MDS accuracy problems and with the view of 9 of the 10 states with separate MDS review programs that an on-site presence at a significant number of their nursing homes is central to their review efforts.

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concur with our recommendation that it reorient its review program to complement ongoing state MDS accuracy efforts as a more effective and efficient way to ensure MDS data accuracy.<sup>48</sup> CMS commented that its efforts already provided adequate oversight of state activities and complemented state efforts. In April 2005, CMS ended work under its data assessment and verification contract because of cost concerns, but signed a new contract in September 2005 that focuses on on-site reviews of MDS accuracy.<sup>49</sup> According to CMS officials, the on-site reviews were more effective in identifying discrepancies because the reviewers were able to find more information on-site that conflicted with the nursing homes' assessments.<sup>50</sup>

In November 2002, CMS began reporting on its Web site quality indicator data for each nursing home nationwide that participates in Medicare and Medicaid, even though our October 2002 report concluded that such reporting was premature given serious questions about the sufficiency of CMS efforts to validate the quality indicators and improve the accuracy of the underlying data.<sup>51</sup> CMS disagreed with our recommendation to postpone its scheduled November 2002 public reporting of the data until

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<sup>48</sup>Such a shift in focus would include (1) taking full advantage of the periodic on-site visits already conducted at every nursing home nationwide through its routine survey process; (2) ensuring that the federal MDS review process is designed and sufficient to consistently assess the performance of all states' reviews for MDS accuracy; and (3) providing additional guidance, training, and other technical assistance to states as needed to facilitate their efforts.

<sup>49</sup>Although the focus of the prior data assessment and verification contract was MDS accuracy reviews, the contract also included an examination of issues of interest to other CMS components that sponsored the contract. For example, the contractor examined facility assessment data on Medicare beneficiaries who received home health services.

<sup>50</sup>While on-site, the contractor had access to a broader range of information gleaned from observation, interviews with residents and staff, and reassessments of residents. During the 3-1/2 years of the data assessment and verification contract, 69 on-site reviews were completed, less than the 200 anticipated in 2001 and less than the revised goal of 100 on-site reviews. According to the contractor's report, the highest discrepancy rates identified during the 69 on-site reviews of 617 assessments included the number of medications (50 percent discrepancy rate) and pain management (10 percent discrepancy rate).

<sup>51</sup>The November 2002 roll-out of quality indicator data included a combined total of 10 chronic care and post-acute-care quality indicators. Chronic care quality indicators included decline in activities of daily living, pressure sores (with facility-level adjustment), pressure sores (without facility-level adjustment), inadequate pain management, physical restraints used daily, and infections. Post-acute-care quality indicators included failure to improve and manage delirium (with facility-level adjustment), failure to improve and manage delirium (without facility-level adjustment), inadequate pain management, improvement in walking, and rehospitalizations.

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these problems were addressed. Since 2002, however, CMS has taken steps to address the questions we raised about the validity of quality indicators. For example, CMS dropped certain quality indicators that it found were not sufficiently reliable for public reporting, such as the facility-adjusted profile prevalence of pressure sores. In addition, CMS worked with the National Quality Forum to address measurement problems with the pressure sore quality indicator by developing separate indicators for short- and long-term nursing home residents; these new indicators were added to the Web site in January 2004.<sup>52</sup> A weight loss quality indicator also was developed and added to the Web site in November 2004. Our October 2002 report had noted the potential for consumer confusion in interpreting and using quality indicator data. CMS conducted consumer testing of new language and displays on Nursing Home Compare during the summer of 2004.

Although nursing home staffing data have been available on the Nursing Home Compare Web site since June 2000, a CMS official told us that the agency has been aware of problems with these self-reported data since the late 1990s.<sup>53</sup> This official stressed that, despite problems, they were the only available data on nursing home staffing. Examples of erroneously reported data include facilities with no nurse staffing hours or hours equal to thousands of residents per day. In addition, the staffing data do not address important issues such as turnover or retention.<sup>54</sup> As a temporary fix, CMS developed edits that examine staffing ratios to determine whether any facility falls above or below certain thresholds and, effective July 2005, temporarily excluded the questionable staffing data from Nursing Home Compare until they can be corrected or confirmed. To address this issue, CMS is considering a proposal for a new system that relies on nursing home payroll data. If approved, such a system could take 3 to 4 years to implement because of the need to solicit and consider public comment and to develop software to transmit the staffing data.

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<sup>52</sup>The National Quality Forum is a nonprofit organization created to develop and implement a national strategy for health care quality measurement and reporting. It has broad participation from government and private entities as well as all sectors of the health care industry.

<sup>53</sup>The Web site reports the nursing staff hours per resident per day and certified nurse aides per resident per day.

<sup>54</sup>The National Quality Forum has discussed expanding staffing data to include these and other issues such as use of nonnursing staff to provide care, use of part-time and contract nurses, and the tenure of the director of nursing and the administrator.



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## Quality Improvement Organizations

CMS's initiative to include quality indicator data on its Nursing Home Compare Web site also established a new role for Quality Improvement Organizations (QIO) with regard to nursing homes. From 2002 through 2005, QIOs worked intensively with at least 10 percent of nursing homes in each state to improve quality.<sup>55</sup> Although we have not evaluated QIO nursing home quality improvement activities, CMS's preliminary analyses indicate that the QIO program has helped to reduce the use of daily physical restraints, increased management and treatment of pain, and reduced the incidence of delirium among post-acute-care residents. However, less progress has been made in decreasing the prevalence of pressure sores, according to CMS's analyses. In August 2004, the QIO and state survey agency in 18 states launched a new pilot program. Working together, they identified from one to five nursing homes per state that had significant quality problems. The QIO then worked with these homes to help them redesign their clinical practices. According to CMS, the results of this pilot indicated that these historically "troubled" nursing homes had dramatically improved their clinical quality and decreased their quality-of-care survey deficiencies.<sup>56</sup> In 2005, the QIOs' role with nursing homes was extended for an additional 3 years, and QIOs will continue to focus on statewide improvement in four areas—pressure sores, physical restraints, pain management, and depression. In addition, QIOs will help nursing homes set individual targets for quality improvement, implement and document process-related clinical care, and assist in the development of a more resident-focused care model. QIO expenditures on nursing home quality improvement for the period of August 2002 through July 2008 are expected to total about \$216 million.

## Coordination and Dissemination of Best Practices

CMS has taken certain actions to maximize the experience and resources of state survey agencies as well as the CMS central and regional offices to improve nursing home oversight. Specifically, in 2004, CMS convened an internal Long-Term Care Task Force and charged it with providing guidance on and coordinating long-term care efforts within CMS and included representation across the agency's divisions and the regional offices. Also in 2004, CMS began an effort to collect and disseminate nursing home survey and certification best practices developed by

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<sup>55</sup>In smaller states, QIOs worked with at least 10 nursing homes.

<sup>56</sup>An evaluation of the pilot program reported on the results of the pilot program; however, the evaluation was conducted by the same QIO responsible for facilitating the pilot program.

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professional associations, universities, and federal agencies.<sup>57</sup> Through the best practices effort, CMS plans to share successful strategies used by states and regional offices in a broad range of issues affecting survey and certification of nursing homes, such as surveyor recruitment and complaint intake. A contractor will identify, research, and document best practices, which CMS plans to post on its Web site. One of the issues the best practices effort will address is surveyor recruitment initiatives underway in states. As of August 2005, these best practices had not been published on the CMS Web site.

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## Resource and Workload Issues Pose Key Challenges to Further Improving Nursing Home Quality and Safety

CMS, states, and nursing homes face a number of key challenges in their efforts to further improve nursing home quality and safety, including (1) the cost of retrofitting older nursing homes with automatic sprinklers, a potentially costly requirement that has a demonstrated ability to prevent deaths in the event of a fire; (2) continuing problems in hiring and retaining qualified surveyors, a factor that states indicated can contribute to variability in the citation of serious deficiencies; and (3) an increasing federal and state survey workload due to increased oversight, the identification over time of additional initiatives, and growth in the number of Medicare and Medicaid providers that must be surveyed, including expected growth in nursing homes. The increased workload has created competition for both staff and financial resources and required the establishment of priorities, which may have contributed to delays in developing and implementing several key quality initiatives, such as the implementation of a more rigorous survey methodology.

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## Cost Could Delay Retrofitting of Older Nursing Homes with Sprinklers

Although the substantial loss of life in two 2003 nursing home fires could have been reduced or eliminated by the presence of properly functioning automatic sprinkler systems, cost has been an impediment to CMS's requiring them for all homes nationwide. Newly constructed homes must incorporate sprinkler systems; however, older homes constructed with noncombustible materials that have a certain minimum ability to resist fire

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<sup>57</sup> Best practices have been collected from organizations including the American Medical Directors Association, University of Iowa Geriatric Nursing Center, Association of Rehabilitation Nurses, American Diabetes Association, National Kidney and Urologic Diseases Information Clearinghouse, Feinberg School of Medicine (Northwestern University), American Academy of Neurology, American Society of Consultant Pharmacists, United Ostomy Association, and the Centers for Disease Control and Prevention.

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are not required to install sprinklers. We previously reported that cost has been a barrier to requiring sprinklers for all older nursing homes. In July 2005, the National Fire Protection Association (NFPA) voted to require retrofitting of older homes with sprinklers, a requirement that will become a part of the 2006 edition of the NFPA code. Anticipating this action, CMS indicated that it has been developing a notice of proposed rule making, the first step in adopting the NFPA requirement for all homes that serve Medicare and Medicaid beneficiaries. A CMS official stated that the agency plans to issue the notice in March 2006 and after reviewing public comments, it will publish a final version of the rule and stipulate an effective date for homes to come into compliance.<sup>58</sup>

One issue that remains unresolved is how much time older homes will be given to install sprinklers. As we reported in 2004, industry officials believe that a transition period must be considered for homes to come into compliance and to determine how to pay for the cost of installing sprinklers.<sup>59</sup> Rather than proposing a phase-in period, the proposed rule will request input on how much time homes should be given to come into compliance with the requirement. According to CMS, a longer phase-in period could help alleviate concerns about the cost of retrofitting homes with sprinklers. Based on our recommendation, CMS collected data on the sprinkler status of homes nationwide and found that about 21 percent of nursing homes are unsprinklered or partially sprinklered.<sup>60</sup> Although CMS has not completed its cost analysis, the agency believes that the costs associated with the retrofit will be less than the industry's \$1 billion estimate.

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<sup>58</sup>To update federal fire safety standards, CMS issues notice and solicits comments on the proposed new standards in the *Federal Register*, reviews public comments, and publishes a final version of the standards with an effective date. This process of adopting NFPA's 2000 standards in 2003 took CMS about 16 months.

<sup>59</sup>After the 2003 nursing home fire in Hartford, Connecticut, the state passed a law requiring all nursing homes to install sprinklers not later than July 1, 2005 (Conn. Spec. Acts 03-3, §92.). In 2005, the state extended the effective date to July 31, 2006 (Conn. Pub. Acts 05-187.). Florida enacted a law in June 2005 that requires nursing homes in the state to be protected with automatic sprinklers by December 31, 2010. A loan guarantee program would be available in Florida because of concern about the cost impact of retrofitting on homes (Fla. Laws Ch. 2005-234).

<sup>60</sup>This includes about 1 percent of homes whose sprinkler status is unknown.

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## States Continue to Have Problems in Hiring and Retaining Surveyors

The hiring and retention of surveyors, particularly RNs, remains a major, frequently discussed issue among state survey agency directors, according to an AHFSA official, the association that represents state survey agency directors. In July 2003, we reported that the limited experience level of state surveyors because of a high turnover rate was a contributing factor to (1) variability in citing actual harm or higher-level deficiencies and (2) understatement of such deficiencies. In more than half of the 42 states that responded to our inquiry, from 30 percent to more than 50 percent of surveyors had 2 years' experience or less, as of July 2002. Twenty-five states responded to our request for updated information on surveyor workforce issues as of July 2005.

Of 23 states that provided data in both 2002 and 2005, 13 reported an improvement in 2005 (i.e., a decline in the proportion of inexperienced surveyors); 9 indicated that the situation had worsened (e.g., an increase in the proportion of inexperienced surveyors); and 1 state reported no change (see app. IV). As of July 2005, however, 20 percent or more of surveyors in 20 of the 25 states had 2 years' experience or less (see table 9). Surveyor vacancy rates in the 25 states ranged from about 3 percent in Tennessee to 31 percent in Alabama and Florida; overall, 15 states had double-digit vacancy rates. Officials in 18 states believed that inexperienced surveyors contributed to interstate variability in the citation of serious deficiencies. One state survey agency indicated that staff attrition resulted in a workforce of less experienced surveyors who demonstrated a hesitance to cite actual harm and contributed to understatement. State survey agency officials in several states, however, suggested that the problem for less-experienced surveyors was not identifying harm but rather investigating and documenting the circumstances that led to the harm, including facility culpability, a skill that surveyors develop as they gain more experience.<sup>61</sup>

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<sup>61</sup>According to CMS and state officials, the first year for a new surveyor is essentially a training period with low productivity. It takes as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well.

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**Table 9: Percentage of Surveyors with 2 Years' Experience or Less, as of July 2005**

Percentage of surveyors with 2 years' experience or less	Number of states
More than 50 percent	5
More than 30 percent to 50 percent	5
20 percent to 30 percent	10
10 percent to less than 20 percent	5

Source: AHFSA data from 25 states.

Because state survey agency salaries are rarely competitive with the private sector, state survey agencies told us that it is difficult to retain surveyors and to fill vacancies. RNs, a major component of states' surveyor workforce, are in high demand and short supply, according to AHFSA. Furthermore, 9 states responding to our July 2005 inquiry indicated that state civil service requirements can make it more difficult to fill vacancies. Several of the 9 states characterized the hiring process as either cumbersome or time-consuming, or both, and 1 state noted that the process takes close to 9 months. Two states reported that they had to select candidates to interview from a certified list. One of the states indicated that the certified list often contained unqualified applicants, while the other state noted that some of the applicants were not the "best fit." Of the 25 states, 21 indicated that they had implemented initiatives to help retain surveyors. The most popular retention strategies were to increase starting salaries and to implement flexible surveyor work schedules. For example, New York instituted a locality pay differential for New York City. While 5 of the 25 states indicated that they had a state-imposed hiring freeze, 1 state reported that budget pressures prevented it from taking steps to improve retention rates.<sup>62</sup> A continuing problem cited by AHFSA is that federal funds are distributed late in the fiscal year, which does not tie into state budget cycles for approving additional positions. This problem may be particularly acute in the 5 states that reported having a hiring freeze.

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<sup>62</sup>As a result of the recession that began in 2001, states experienced growing budget pressures and experienced significant budget shortfalls from fiscal years 2003 through 2005. Although budget pressures diminished at the end of fiscal year 2004, many states projected budget shortfalls in fiscal year 2005.

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## Workload Issues and Competing Priorities Pose Challenges for CMS and States

CMS and states have experienced increased survey workloads due to the greater intensity of nursing home oversight, the increasing number of initiatives, and growth in the number of Medicare and Medicaid providers requiring oversight. This workload growth required the prioritization of initiatives that, in some cases, has resulted in implementation delays for some key initiatives. The consensus-building process necessary to bring initiatives to fruition also has contributed to some delays. The initiatives likely will continue to compete for priority with other CMS programs, posing a challenge for efforts to further improve nursing home quality and safety.

## Increased Workload Has Contributed to Delays

Greater nursing home oversight has increased demand on both CMS and state survey agency resources, causing delays for some key initiatives. CMS's increased workload is evident in the labor-intensive state performance reviews. Since their introduction in October 2000, the reviews have been gradually expanded from nursing homes to several other Medicare and Medicaid providers, such as home health agencies and hospitals. CMS also has significantly increased the number of federal quality-of-care and fire safety comparative surveys. Such surveys are more labor-intensive than the alternative type of federal monitoring surveys, known as observational surveys, because they require an entire federal survey team rather than a smaller number of federal surveyors. The agency also has committed considerable resources to developing new data systems for complaints and enforcement actions while simultaneously increasing its use of available data to further improve federal and state oversight. Despite the increased workload, CMS implemented survey staff reductions of 5 percent in regional offices and 3 percent in its central office in January 2004. As of August 2005, these staff reductions have remained in effect.

As state survey agency workloads grew with the implementation of the initiatives, they also experienced resource pressures. States are now required to conduct on-site revisits to ensure serious deficiencies have been corrected, investigate complaints alleging actual harm on-site and do so more promptly, and initiate off-hour standard surveys. Thus, surveyors' presence in nursing homes has increased and surveyors' work hours have effectively been expanded to weekends, evenings, and early mornings. The requirement to impose immediate sanctions on homes that repeatedly harm residents also has had a workload impact because in the past a grace period allowed homes to correct deficiencies before the sanctions went into effect. The imposition of immediate sanctions requires states to track, which some states do manually, the homes that must be referred for immediate sanctions and requires CMS and states to act to impose

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recommended sanctions that in the past would have been rescinded because the homes could have corrected the deficiencies during a grace period. While states' budget pressures appear to be easing, many state survey agencies reported hiring freezes, staff vacancies, or high turnover as of July 2002 when all of these initiatives had already been fully implemented.

The number of initiatives that CMS has implemented on its own has grown, further increasing its workload. For example, CMS added quality indicator data to its Nursing Home Compare Web site and has involved QIOs in helping nursing homes to improve quality of care. In addition, CMS created a task force to develop guidance intended to improve consistency across states in the imposition of civil money penalties.

The number of nursing home initiatives simultaneously under development or being implemented as well as other CMS responsibilities, such as preparing to implement the new Medicare prescription drug benefit in January 2006, have necessitated the establishment of priorities and led to delays and queues.<sup>63</sup> CMS assigned some initiatives, such as the development and public reporting of quality indicators, a high priority and implemented them swiftly despite issues related to their validity and the quality of the underlying data—problems that CMS is still working to address. In contrast, the revision of the survey process has encountered delays because of funding shortfalls and has been in process for 7 years. For example, initial testing of the new methodology in 2002 and 2003 was limited, even though CMS had already invested \$4.7 million in its development from initiation in 1999 through September 2003. A pilot test of the new methodology is scheduled to begin in the fall 2005; depending on the results of the testing, implementation could begin in mid-2007. Although CMS attaches a high priority to enhancing the information available to the public on nursing home quality and safety, adding information on past noncompliance and the fire safety status of nursing homes are in a queue behind the programming required to implement higher-priority projects. There is also a regulatory queue, with other,

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<sup>63</sup>The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created the new Medicare prescription drug benefit, which will offer Medicare beneficiaries outpatient prescription drug coverage (Pub. L. No. 108-173, §101, 117 Stat. 2066, 2071-2152 (adding §§ 1860D-1-1860D-42 to the Social Security Act, codified at 42 U.S.C. §§ 1395w-101-1395w-152)). On January 28, 2005, CMS issued the final regulations implementing the Medicare prescription drug benefit.

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higher-priority regulations ahead of the notice of proposed rule making to require retrofitting of nursing homes with automatic sprinklers.

Delays in implementing the nursing home initiatives are also attributable to CMS's need to be responsive to stakeholder input. Appropriately, CMS seeks input from various stakeholders such as states, regional offices, the nursing home industry, and resident advocates. For example, CMS sought input from experts in developing investigative protocols for surveyors. Due to this lengthy consultative process, combined with the prolonged delays stemming from internal disagreement over the structure of the process during the initial stages, CMS has only implemented two investigative protocols since 2001. Likewise, implementation of the ASPEN Complaint Tracking System was delayed because during the system's pilot test, several states indicated their belief that their existing systems were superior and opposed the idea of either abandoning these systems or maintaining separate systems.

#### Number of Providers Subject to Surveys Is Growing

Both the overall growth in providers and the anticipated growth in nursing homes pose additional workload challenges for CMS and states. In addition to nursing homes, CMS and states are responsible for surveys of other Medicare and Medicaid providers, such as home health agencies and hospitals. The number of these providers grew from 39,651 in October 2000 to 45,375 in January 2005, approximately 14 percent.<sup>64</sup> While the number of nursing homes has decreased slightly during the same period, from 17,012 to 16,146, the rate of decline has slowed; and as the baby boom generation ages, increasing the number of elderly needing long-term care services, the number of nursing homes is expected to grow to meet the demand. In 2000, 35.1 million people were aged 65 or older. This number is expected to grow to about 54.7 million by 2020.

Nursing home survey activities consume the majority of state survey budgets and resources. Nursing homes make up about 31 percent of Medicare and Medicaid providers, but account for 73 percent of the federal budget for oversight of such providers.<sup>65</sup> The funding for nursing home surveys is disproportionate because the time frames for standard

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<sup>64</sup>This increase includes a substantial increase in the number of end-stage renal disease facilities and ambulatory surgical centers.

<sup>65</sup>The federal government funds 100 percent of costs associated with certifying that nursing homes meet Medicare requirements and 75 percent of the costs associated with Medicaid standards.



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nursing home surveys are statutory. For those survey requirements not in statute, CMS determines the survey time frames; these surveys are therefore a lower priority.<sup>66</sup> Even among nursing home survey activities, however, annual standard surveys are considered a higher priority than complaint surveys or initial surveys for which the statute does not dictate specific time frames.<sup>67</sup> CMS and state survey agency officials recognize that CMS may have shifted its focus and resources to nursing homes at the expense of adequate oversight of other providers serving Medicare and Medicaid beneficiaries, and some states contend that the focus on nursing home standard surveys has hampered their ability to investigate nursing home complaints within mandated time frames. For example, according to a California state survey agency official, California law mandates that all nursing home resident complaints, not just complaints alleging actual harm, be investigated within 10 days. Likewise, an official from the Pennsylvania state survey agency stated that in Pennsylvania, all complaints must be investigated within 48 hours. California survey agency officials have told us that a complaint alleging a care problem deserves a higher priority than a standard survey, which may or may not identify deficiencies.

### Key Nursing Home Initiatives Continue to Compete for Priority

According to CMS officials, key nursing home initiatives continue to compete for priority with other CMS projects. Examples of nursing home initiatives that have been affected include revision and testing of the new survey methodology, continued development of the investigative protocols that surveyors use to investigate care problems, and an increase in the number of quality-of-care comparative surveys.

- **Revised survey methodology.** CMS officials have indicated that nationwide implementation of the revised survey methodology could be affected if its use requires additional survey time or a greater number of surveyors to conduct each survey. The pilot test of the new methodology, scheduled for 2005 and 2006, includes an examination of steps to streamline the revised process, if necessary. Cost considerations limited the pilot of the new methodology to fewer states than the 20 that volunteered.

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<sup>66</sup>The time frames for home health agency surveys are also established by statute.

<sup>67</sup>CMS has identified four priority tiers for ranking state workload. CMS's guidance to states for formulating budgets puts standard surveys in Tier I, the highest tier, and puts complaints and initial surveys in Tiers II and III, respectively.

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- **Investigative protocols for quality-of-care problems.** Only three sets of investigative protocols had been implemented as of November 2005, and it is unclear whether the contractor's assessment of the protocols' effectiveness can be completed before the contract ends in 2006. Furthermore, unless the contract for the investigative protocols is re-bid, CMS expects to return to the traditional revision process even though agency staff believe that the expert panel process used under the contract produced a high-quality product.
  - **Federal comparative surveys.** CMS hired a contractor in 2003 to further increase the number of federal quality-of-care comparative surveys, but dropped funding for quality-of-care comparative surveys from the fiscal year 2006 contract.<sup>68</sup> The agency reallocated the funds to help state survey agencies meet the increased survey workload resulting from growth in the number of other Medicare providers.

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## Concluding Observations

CMS has focused considerable attention since 1998 on addressing weaknesses in state and federal oversight activities in order to better care for and protect nursing home residents. The agency has implemented many important improvements in the areas of surveys, complaints, enforcement, and oversight, such as taking steps to address survey predictability, issuing additional guidance to ensure timely on-site investigations of complaints alleging harm to residents, implementing an immediate sanctions policy to eliminate grace periods for homes cited for repeat serious violations, and strengthening oversight by conducting assessments of state survey activities. However, some key activities are still in process. For example, CMS's effort to revise the survey methodology has been underway for 7 years. Given the pivotal role played by surveys in helping to ensure that nursing home residents receive high-quality care, the development and implementation of a more rigorous survey methodology is one of the most important contributions CMS can make to addressing oversight weaknesses. Certain other initiatives, such as sharing data with the public in an effort to use market forces to drive quality improvement, also remain in process. Since launching Nursing Home Compare in 1998, CMS has been aware of accuracy and reliability issues with the underlying data and began changing its approach to data integrity in 2005. The agency is working to address issues concerning data on nursing home staffing that compelled it to temporarily exclude questionable data from its Web site in July 2005 until its accuracy can be

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<sup>68</sup>As stated earlier, CMS set aside some fiscal year 2006 funds for conducting fire safety comparative surveys.

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verified. Because consumers use these data to make decisions about nursing home care, ensuring the accuracy, reliability, and timeliness of nursing home quality data is critical. Even with CMS's increased efforts to improve nursing home quality, the agency's continued attention and commitment to these efforts is essential in order to maintain and build upon the momentum of its accomplishments to date.

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## Agency and State Comments and Our Evaluation

We provided CMS a draft of this report for review. CMS generally concurred with our findings, noting that progress has been made in many areas such as surveys and complaint investigations, oversight activities, and citation of serious deficiencies, but that challenges remain. (CMS's comments are reproduced in app. V.) CMS also provided technical comments, which we included in the report as appropriate. We also provided the five states we contacted an opportunity to review the portion of the draft focused on trends in nursing home quality. California, Florida, Ohio, New York, and Texas provided written comments. California's comments focused on clarifying its experience seeking CMS guidance on the definition of actual harm, but did not state whether it agreed with our findings. Ohio commented that our report's findings related to continued inconsistency and understatement of serious deficiencies by state surveyors did not apply to its state survey agency. New York stated that including a more detailed description of states' efforts to improve nursing home quality would provide a more balanced view of the reasons for the decline in serious deficiencies. Florida and Texas generally concurred, but Texas did not provide specific comments. CMS and states' specific comments focused primarily on four issues: understatement of serious deficiencies, the definition of actual harm, data availability, and challenges to conducting nursing home survey and oversight activities.

CMS commented that it remains concerned about the possible understatement or omission of serious deficiencies, but that it did not believe that understatement caused the decline in serious nursing home deficiencies or that understatement was worsening. CMS noted its efforts to work with states that fail to improve their ability to identify deficiencies such as withholding funding increases until corrective action plans are developed. Florida, New York, and Ohio similarly commented that efforts such as their states' quality improvement initiatives, regulatory changes to improve nursing home operations, and engagement of the provider community have contributed to the decline.

CMS suggested that including the results of observational surveys in our analysis of the percentage of federal surveys that found serious

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deficiencies missed by states would show that the percentage remained relatively constant from 2002 to 2004 rather than increasing. As we noted in our 1999 report, however, comparative surveys are more effective than observational surveys in identifying serious deficiencies missed by state surveyors because they are the only oversight tool that provides an independent federal survey where results can be compared to those of the state. Observational surveys can serve as an effective training tool for state surveyors but, in our view, they do not accurately represent typical state surveyor performance due to the likelihood that state surveyors modify their performance when they are aware that they are being observed by federal surveyors.

Florida and Ohio noted that in addition to comparative surveys, CMS conducted many observational surveys during the time period studied. Ohio disagreed that our analysis of federal comparative surveys suggests that nursing home surveyors in Ohio missed serious deficiencies, citing its combined performance ratings for observational and comparative surveys. New York commented that federal comparative surveys often do not include the same resident sample used in the state survey and that only looking at comparative surveys provides a narrow analysis of state survey quality. New York suggested a more detailed analysis of comparative survey data and consideration of state performance review results. We note that, in 2002, CMS directed federal surveyors to include at least 50 percent of the residents included in the state survey sample. We also acknowledge that CMS is conducting state performance reviews as part of its oversight of state survey activities, but note that the reviews have shortcomings as described in our July 2003 report. Florida noted that our analysis of federal comparative surveys that identified missed serious deficiencies is based on limited data. We acknowledge that our analysis is based on a small number of surveys, but note that it includes the full universe of comparative surveys conducted from March 2002 through December 2004 in the five states we reviewed.

The range of comments from states reinforces the need for CMS to clarify the definition of actual harm, as it plans to do. California noted that while some of its state surveyors were confused about the definition of actual harm, after discussions with CMS from 1998 through 2004, the survey agency and CMS are now in agreement on the definition of actual harm. New York stated that confusion about the definition of actual harm has been reduced. Ohio noted that its state surveyors are not confused by the definition of actual harm, but that states have not received clear and specific guidance from CMS. Florida agreed that clearer guidance would be useful.

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CMS indicated that it is taking steps to improve the reliability and accuracy of publicly reported data by identifying suspect data and posting more detailed information about past noncompliance. As we state in our report, we believe that consumers should have timely and accurate data to inform their decisions regarding nursing home care.

CMS commented that the workload issues described in this report present challenges beyond those we have previously reported. CMS stated that continued constraint of resources could “likely cause some erosion of the gains already made” in the survey and oversight activities to date. To address the challenges it faces, CMS plans to increase efforts to improve productivity, determine the cost and value of policies, focus state performance standards on substantive issues, prioritize survey activities, coordinate with stakeholders, address increasing fuel costs, and enhance emergency preparedness. California, Florida, New York, and Ohio reiterated the staffing challenges they have experienced and the steps they have taken to address them, some of which are described in this report. Despite these efforts, California indicated that its staffing challenges have negatively impacted the investigative process. While we recognize the challenges CMS and states face, we continue to believe that maintaining the momentum developed over the last several years on key CMS initiatives, such as the development of the revised survey methodology (i.e., Quality Indicator Survey), is critical to addressing nursing home survey and oversight weaknesses.

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As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services and appropriate congressional committees. We also will make copies available at no charge on the GAO Web site at <http://www.gao.gov>.

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If you or your staff have any questions about this report, please contact me at (202) 512-7118 or [allenk@gao.gov](mailto:allenk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.

*Kathryn G. Allen*

Kathryn G. Allen  
Director, Health Care

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# Appendix I: Prior GAO Recommendations, Related CMS Initiatives, and Implementation Status

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Table 10 summarizes our recommendations from 14 reports on nursing home quality and safety, issued from July 1998 through November 2004; CMS's actions to address weaknesses we identified; and the implementation status of CMS's initiatives. The recommendations are grouped into four categories—surveys, complaints, enforcement, and oversight. If a report contained recommendations related to more than one category, the report appears more than once in the table. For each report, the first two numbers identify the year in which the report was issued. For example, HEHS-98-202 was released in 1998. The Related GAO Products section at the end of this report contains the full citation for each report. Of our 36 recommendations, CMS has fully implemented 13, implemented only parts of 3, is taking steps to implement 13, and declined to implement 7.

**Appendix I: Prior GAO Recommendations,  
Related CMS Initiatives, and Implementation  
Status**

**Table 10: Implementation Status of CMS's Initiatives Responding to GAO's Nursing Home Quality and Safety Recommendations, July 1998 through November 2004**

GAO report number	GAO recommendation	CMS initiative	Implementation status
<b>Surveys</b>			
<a href="#">GAO/HEHS-98-202</a>	<p>1. 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.</p>	<p>CMS took several steps to reduce survey predictability, but some state surveys remain predictable.</p> <ul style="list-style-type: none"> <li>In 1999, CMS instructed state survey agencies to (1) conduct 10 percent of surveys on evenings and weekends, (2) vary the sequencing of surveys in a geographical area to avoid alerting other homes that the surveyors are in the area, (3) vary the scheduling of surveys by day of the week, and (4) avoid scheduling surveys for the same month as a home's prior survey.</li> <li>In 2004, CMS provided states with an automated scheduling and tracking system (AST) to assist in scheduling surveys. CMS officials told us that AST can be used to address survey predictability. States appeared to be unaware of this feature and use of AST is optional.</li> <li>CMS disagreed with and did not implement the recommendation to segment the standard survey into more than one review throughout the 12- to 15-month period.</li> </ul>	●
	<p>2. 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.</p>	<p>CMS has been developing a revised survey methodology since 1998. A pilot test of the new methodology is scheduled to begin in the fall of 2005. Implementation could begin in mid-2007.</p>	○
<a href="#">GAO-03-561</a>	<p>3. Finalize the development, testing, and implementation of a more rigorous survey methodology, including investigative protocols that provide guidance to surveyors in documenting deficiencies at the appropriate scope and severity level.</p>	<p>See CMS action in response to recommendation to revise federal survey procedures (recommendation #2 above).</p> <p>CMS began revising surveyors' investigative protocols in October 2000. Three protocols have been issued and several more are under development. In addition, CMS is clarifying the definitions of actual harm and immediate jeopardy.</p>	○



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Related CMS Initiatives, and Implementation  
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GAO report number	GAO recommendation	CMS initiative	Implementation status
	4. Require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	CMS has no plans to implement this recommendation, indicating that regular workload and priorities take precedence over it.	⊗
GAO-05-78	5. Hold homes accountable for all past noncompliance resulting in harm to residents, not just care problems deemed to be egregious, and develop an approach for citing such past noncompliance in a manner that clearly identifies the specific nature of the care problem both in the OSCAR database and on CMS's Nursing Home Compare Web site.	CMS revised its definition of past noncompliance. CMS plans to add the specific nature of the care problem to its Web site, but programming required for the Medicare prescription drug benefit has delayed implementation.	●
<b>Complaints</b>			
GAO/HEHS-99-80	6. Develop additional standards for the prompt investigation of serious complaints alleging situations that may harm residents but are categorized as less than immediate jeopardy. These standards should include maximum allowable time frames for investigating serious complaints and for complaints that may be deferred until the next scheduled annual survey. States may continue to set priority levels and time frames that are more stringent than these federal standards.	<p>In October 1999, CMS issued a policy letter stating that complaints alleging harm must be investigated within 10 days.</p> <p>In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes.</p> <p>In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.</p>	●
	7. Strengthen federal oversight of state complaint investigations, including monitoring states' practices regarding priority-setting, on-site investigation, and timely reporting of serious health and safety complaints.	In 2000, CMS began requiring its regional offices to perform yearly assessments of states' complaint investigations as part of annual state performance reviews.	●
GAO-03-561	8. Finalize the development of guidance to states for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to residents; the handling of facility self-reported incidents; and the use of appropriate complaint investigation practices.	<p>In January 2004, CMS provided detailed direction and guidance to states for managing complaint investigations for numerous types of providers, including nursing homes.</p> <p>In June 2004, CMS made available updated guidance on the Internet that consolidates complaint investigation procedures for numerous types of providers.</p>	●

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GAO report number	GAO recommendation	CMS initiative	Implementation status
GAO-02-312	9. Ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.	<p>In 2002, CMS issued a memo to the regional offices and state survey agencies emphasizing its policy for preventing abuse in nursing homes and for promptly reporting it to the appropriate agencies when it occurs.</p> <p>In 2004, CMS informed GAO that it continues to hold discussions with the Department of Justice and with the HHS Office of General Counsel about CMS's authority to require, and potential effectiveness of requiring, state survey agencies to immediately notify local law enforcement of suspected physical and sexual abuse.</p>	○
	10. Accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.	<p>CMS developed a poster, but it is not yet released, pending approval by the Secretary of HHS.</p> <p>In 2002, CMS released a memorandum to regional offices and state agencies that addresses displaying complaint telephone numbers. CMS asked all state agencies to review how their telephone number is listed in the local directory and asked them to ensure that their complaint telephone numbers are prominently listed.</p>	○
	11. Systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.	CMS is conducting a Background Check Pilot Program in several states, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The pilot is expected to run through September 2007, followed by an evaluation of the results.	○
	12. Clarify the definition of abuse and otherwise ensure that states apply that definition consistently and appropriately.	In 2002, CMS released a memorandum to its regional offices and state survey agency directors clarifying its definition of abuse and instructing them to report suspected abuse to law enforcement authorities and, if appropriate, to the state's Medicaid Fraud Control Unit. <sup>a</sup>	●
	13. Shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.	CMS informed GAO that the regulations do not specify time frames that states must follow in substantiating abuse, but agreed to review this matter when the agency considers changes to the regulations. CMS did not indicate when this would be done.	○

**Appendix I: Prior GAO Recommendations,  
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GAO report number	GAO recommendation	CMS initiative	Implementation status
<b>Enforcement</b>			
<a href="#">GAO/HEHS-98-202</a>	14. Require that for problem homes with recurring serious violations, state surveyors substantiate, by means of an on-site revisit, every report to CMS of a home's resumed compliance status.	In 1998, CMS issued guidance to regional offices and state survey agencies strengthening its revisit policy by requiring on-site revisits until all serious deficiencies are corrected. Homes are no longer permitted to self-report resumed compliance.	●
	15. Eliminate the grace period for homes cited for repeated serious violations and impose sanctions promptly, as permitted under existing regulations.	CMS phased in implementation of its "double G" policy from September 1998 through January 2000.	●
<a href="#">GAO/HEHS-99-46</a>	16. Improve the effectiveness of civil money penalties: the Administrator should continue to take those steps necessary to shorten the delay in adjudicating appeals, including monitoring progress made in reducing the backlog of appeals.	As requested by HHS, Congress approved increased funding and staffing levels for the Departmental Appeals Board in fiscal years 1999 and 2000.	●
	17. Strengthen the use and effect of termination: <ul style="list-style-type: none"> <li>• Continue Medicare and Medicaid payments beyond the termination date only if the home and state Medicaid agency are making reasonable efforts to transfer residents to other homes or alternative modes of care.</li> <li>• Ensure that reasonable assurance periods associated with reinstating terminated homes are of sufficient duration to effectively demonstrate that the reason for termination has been resolved and will not recur.</li> <li>• Strengthen the use and effect of termination: Revise existing policies so that the pretermination history of a home is considered in taking a subsequent enforcement action.</li> </ul>	<p>CMS conducted a study and concluded that it was not practical to establish rules to address this problem.</p> <p>CMS added examples to the reasonable assurance guidance in 2000, but declined to lengthen the reasonable assurance period.</p> <p>In 2000, CMS revised its guidance so that pretermination history of a home is considered in taking subsequent enforcement actions.</p>	●
	18. Improve the referral process: The Administrator should revise CMS guidance so that states refer homes to CMS for possible sanction (such as civil money penalties) if they have been cited for a deficiency that contributed to a resident's death.	In 2000, CMS revised its guidance to require states to refer homes for possible sanction if they had been cited for a deficiency that contributed to a resident's death.	●

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GAO report number	GAO recommendation	CMS initiative	Implementation status
<b>Oversight</b>			
<a href="#">GAO/HEHS-99-46</a>	19. Develop better management information systems. The Administrator should enhance OSCAR or develop some other information system that can be used by both by the states and CMS to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.	CMS has implemented new national enforcement and complaint tracking systems but does not anticipate completing its replacement of the OSCAR data system until 2008.	○
<a href="#">GAO/HEHS-99-80</a>	20. Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.	In January 2004, CMS's new ASPEN Complaint Tracking system was implemented nationwide.	●
<a href="#">GAO/HEHS-00-6</a>	21. Improve the scope and rigor of CMS's oversight process: <ul style="list-style-type: none"> <li>• Increase the proportion of federal monitoring surveys conducted as comparative surveys to ensure that a sufficient number are completed in each state to assess whether the state appropriately identifies serious deficiencies.</li> <li>• Ensure that comparative surveys are initiated closer to the time the state agency completes the home's annual standard survey.</li> <li>• Require regions to provide more timely written feedback to the states after the completion of federal monitoring surveys.</li> <li>• Improve the data system for observational surveys so that it is an effective management tool for CMS to properly assess the findings of observational surveys.</li> </ul>	<p>CMS has significantly increased the number of quality-of-care comparative surveys. In fiscal year 2006, however, the agency will no longer contract for additional quality-of-care comparative surveys because of funding constraints.</p> <p>To better ensure that conditions in a nursing home have not changed since the state survey, CMS regional offices have reduced the average time between the state survey and the initiation of a federal comparative survey from 33 days in 1999 to 26 days by 2004.</p> <p>CMS instructed the regions to report the results of federal monitoring surveys to states on a monthly basis.</p> <p>CMS developed a separate database accessible to all regional offices that includes the results of observational surveys. Beginning in fiscal year 2002, CMS added data on the results of comparative surveys.</p>	●
	22. Improve the consistency in how CMS holds state survey agencies accountable by standardizing procedures for selecting state surveys and conducting federal monitoring surveys: <ul style="list-style-type: none"> <li>• Ensure that the regions target surveys for review that will provide a comprehensive assessment of state surveyor performance.</li> </ul>	CMS did not implement our recommendation to select individual state surveys for federal review in a manner that ensures its regional offices observe as many state surveyors as possible.	●

**Appendix I: Prior GAO Recommendations,  
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GAO report number	GAO recommendation	CMS initiative	Implementation status
	<ul style="list-style-type: none"> <li>Require federal surveyors to include as many of the same residents as possible in their comparative survey sample as the state included in its sample (where CMS surveyors have determined that the state sample selection process was appropriate).</li> </ul>	In October 2002, CMS instructed federal surveyors to select at least half of those residents selected by the state surveyors for their resident sample.	
	23. Further explore the feasibility of appropriate alternative remedies or sanctions for those states that prove unable or unwilling to meet CMS's performance standards.	In December 1999, CMS adopted new state sanctions. In fiscal year 2005, CMS began to tie survey agency funding increases to the timely conduct of standard surveys, a step that we believe offers a strong incentive for improved compliance.	●
<a href="#">GAO/HEHS-02-279</a>	24. Review the adequacy of current state efforts to ensure the accuracy of minimum data set (MDS) data, and provide, where necessary, additional guidance, training, and technical assistance.	CMS disagreed with and did not implement this recommendation.	⊗
	25. Monitor the adequacy of state MDS accuracy activities on an ongoing basis, such as through the use of the established federal comparative survey process.	CMS disagreed with and did not implement this recommendation.	⊗
	26. Provide guidance to state agencies and nursing homes that sufficient evidentiary documentation to support the full MDS assessment be included in residents' medical records.	CMS disagreed with and did not implement this recommendation.	⊗
<a href="#">GAO-03-187</a>	27. Delay the implementation of nationwide reporting of quality indicators until there is greater assurance that the quality indicators are appropriate for public reporting—including the validity of the indicators selected and the use of an appropriate risk-adjustment methodology—based on input from the National Quality Forum and other experts and, if necessary, additional analysis and testing.	CMS disagreed with and did not implement this recommendation.	⊗
	28. Delay the implementation of nationwide reporting of quality indicators until a more thorough evaluation of the pilot is completed to help improve the initiative's effectiveness, including an assessment of the presentation of information on the Web site and the resources needed to assist consumers' use of the information.	CMS disagreed with and did not implement this recommendation.	⊗

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GAO report number	GAO recommendation	CMS initiative	Implementation status
GAO-03-561	29. Further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.	CMS did not implement this recommendation because it believes that the state performance standards take into account statutory and nonstatutory performance standards.	⊗
GAO-04-660	30. Ensure that CMS regional offices fully comply with the statutory requirement to conduct annual federal monitoring surveys by including an assessment of the fire safety component of states' standard surveys, with an emphasis on unsprinklered homes.	CMS's evaluation of state surveyors' performance now routinely includes fire safety as part of the statutory requirement to annually conduct federal monitoring surveys in at least 5 percent of surveyed nursing homes in each state.	●
	31. Ensure that data on sprinkler coverage in nursing homes are consistently obtained and reflected in the CMS database.	As nursing homes are surveyed, CMS is in the process of collecting consistent data on the sprinkler status of homes and entering these data into OSCAR.	○
	32. Until sprinkler coverage data are routinely available in CMS's database, work with state survey agencies to identify the extent to which each nursing home is sprinklered or not sprinklered.	CMS has contacted state survey agencies and collected data on all but about 5 percent of nursing homes. These data will be verified during each home's next annual survey.	○
	33. On an expedited basis, review all waivers and Fire Safety Evaluation System <sup>b</sup> assessments for homes that are not fully sprinklered to determine their appropriateness.	CMS expects to complete its reviews of Fire Safety Evaluation System Assessments by late 2005.	○
	34. Make information on fire safety deficiencies available to the public via the Nursing Home Compare Web site, including information on whether a home has automatic sprinklers.	This information will not be available on the Nursing Home Compare Web site until 2007.	○
	35. Work with the National Fire Protection Association to strengthen fire safety standards for unsprinklered nursing homes, such as requiring smoke detectors in resident rooms, exploring the feasibility of requiring sprinklers in all nursing homes, and developing a strategy for financing such requirements.	CMS has issued an interim final rule requiring the installation of smoke detectors by May 24, 2006. It anticipates issuing a notice of proposed rule making requiring older nursing homes to install sprinklers early in 2006 but will ask for comments on how much time homes should be given to come into compliance.	○

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Status**

GAO report number	GAO recommendation	CMS initiative	Implementation status
	36. Ensure that thorough investigations are conducted following multiple-death nursing home fires so that fire safety standards can be reevaluated and modified where appropriate.	CMS developed and issued a standardized procedure to ensure that both state survey agencies and its own staff take appropriate action to investigate fires that result in serious injury or death.	●

- Fully implemented our recommendation
- ◐ Implemented only part of our recommendation and no further steps are planned
- ◑ Taking steps to implement our recommendation
- ⊗ Did not implement our recommendation

Source: GAO analysis of CMS's responses to our recommendations.

<sup>a</sup>In 1999, CMS had required the use of an investigative protocol on abuse prohibition during every standard survey. The protocol's objective is to determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion, and misappropriation of resident property.

<sup>b</sup>As an alternative to correcting or receiving a waiver for deficiencies identified on a standard survey, a home may undergo an assessment using the Fire Safety Evaluation System. The system provides a means for nursing homes to meet the fire safety objectives of CMS's standards without necessarily being in full compliance with every standard.

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# Appendix II: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during Standard Surveys

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In order to identify trends in the proportion of nursing homes cited with actual harm or immediate jeopardy deficiencies, we analyzed data from CMS's OSCAR database for four time periods: (1) January 1, 1999, through July 10, 2000; (2) July 11, 2000, through January 31, 2002; (3) February 1, 2002, through July 10, 2003; and (4) July 11, 2003, through January 31, 2005. Because surveys are conducted at least every 15 months (with a required 12-month statewide average), it is possible that a home was surveyed twice in any time period. To avoid double counting of homes, we included only homes' most recent survey from each time period.



**Appendix II: Percentage of Nursing Homes  
Cited for Actual Harm or Immediate Jeopardy  
during Standard Surveys**

**Table 11: Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy, by State**

State	Number of homes surveyed, 7/03 - 1/05 <sup>a</sup>	Percentage of homes cited for actual harm or immediate jeopardy				Percentage point difference <sup>b</sup> 1/1/99 - 7/10/00 and 7/11/03 - 1/31/05
		1/1/99 - 7/10/00	7/11/00 - 1/31/02	2/1/02 - 7/10/03	7/11/03 - 1/31/05	
<b>Increase of 5 percentage points or greater</b>						
District of Columbia	21	10.0	33.3	38.1	33.3	23.3
Colorado	218	15.4	26.2	21.7	24.3	8.9
Connecticut	247	48.5	49.4	38.8	54.3	5.8
<b>Change of less than 5 percentage points</b>						
South Carolina	178	28.7	17.8	27.0	32.0	3.4
Oklahoma	376	16.7	20.6	22.6	18.6	2.0
Vermont	42	15.2	17.8	9.5	16.7	1.4
Maine	117	10.3	9.7	9.0	9.4	-0.9
West Virginia	137	15.6	14.0	14.1	13.1	-2.5
Rhode Island	86	12.1	10.1	2.4	9.3	-2.8
Wisconsin	413	14.0	7.1	9.1	10.2	-3.8
<b>Decrease of 5 percentage points or greater</b>						
Utah	94	15.8	15.8	22.6	10.6	-5.2
Iowa	492	19.3	9.9	7.7	14.0	-5.3
Georgia	365	22.6	20.5	20.1	16.4	-6.1
Kansas	380	37.1	29.0	24.9	30.5	-6.5
Tennessee	340	26.0	16.7	19.7	19.1	-6.9
New Mexico	81	31.7	17.1	16.2	24.7	-7.0
South Dakota	113	24.1	30.7	24.8	16.8	-7.3
Hawaii	45	25.5	15.2	12.8	17.8	-7.8
Maryland	239	25.6	20.2	14.6	17.6	-8.0
North Dakota	83	21.3	28.4	11.9	13.3	-8.1
Missouri	550	22.3	10.2	13.6	13.8	-8.4
Nebraska	238	26.0	18.9	19.6	16.4	-9.6
Louisiana	332	19.9	23.4	18.0	10.2	-9.7
Virginia	287	19.9	11.6	13.4	9.8	-10.1
Pennsylvania	729	32.2	11.6	14.4	20.6	-11.7
Nevada	43	32.7	9.8	6.7	20.9	-11.8
Illinois	833	29.3	15.4	15.3	16.2	-13.1
<b>Nation</b>	<b>16,463</b>	<b>29.3</b>	<b>20.5</b>	<b>17.1</b>	<b>15.5</b>	<b>-13.8</b>
Texas	1,185	26.9	25.5	18.5	12.7	-14.3

**Appendix II: Percentage of Nursing Homes  
Cited for Actual Harm or Immediate Jeopardy  
during Standard Surveys**

State	Number of homes surveyed, 7/03 - 1/05 <sup>a</sup>	Percentage of homes cited for actual harm or immediate jeopardy				Percentage point difference <sup>b</sup> 1/1/99 - 7/10/00 and 7/11/03 - 1/31/05
		1/1/99 - 7/10/00	7/11/00 - 1/31/02	2/1/02 - 7/10/03	7/11/03 - 1/31/05	
New Jersey	363	24.5	22.4	12.7	9.6	-14.9
Mississippi	209	33.2	19.6	14.4	18.2	-15.0
Florida	694	20.8	20.1	9.8	5.5	-15.4
New Hampshire	83	37.3	21.5	21.7	21.7	-15.7
Massachusetts	468	33.0	22.9	22.5	16.9	-16.1
Arkansas	254	37.7	27.3	15.8	20.5	-17.3
Ohio	1,009	29.0	23.7	21.8	11.6	-17.4
Idaho	80	54.2	31.0	38.3	36.3	-18.0
Minnesota	414	31.7	18.8	17.1	12.3	-19.3
Kentucky	296	28.8	25.2	25.0	9.5	-19.4
Michigan	433	42.1	24.7	30.0	22.6	-19.5
Montana	101	37.5	25.2	16.0	17.8	-19.7
Alaska	14	20.0	33.3	0.0	0.0	-20.0
North Carolina	425	40.8	30.1	24.0	20.2	-20.6
California	1,325	29.1	9.3	3.4	6.3	-22.8
Alabama	229	42.2	18.4	12.6	19.2	-23.0
New York	666	32.2	32.3	20.0	9.2	-23.0
Indiana	523	45.3	26.2	17.4	21.4	-23.8
Arizona	134	33.8	8.8	3.6	8.2	-25.6
Washington	257	54.1	38.5	36.6	26.5	-27.7
Wyoming	39	43.9	22.5	26.3	12.8	-31.1
Oregon	141	47.5	33.6	14.4	14.2	-33.3
Delaware	42	52.4	14.3	4.8	16.7	-35.7

Source: GAO analysis of OSCAR data.

Note: The first two time periods reflect data in OSCAR as of June 24, 2002. The last two time periods reflect OSCAR data as of July 10, 2003, and April 13, 2005, respectively. The term states includes the 50 states and the District of Columbia.

<sup>a</sup>These data illustrate the significant variation in the number of nursing homes across states.

<sup>b</sup>Differences are based on numbers before rounding.

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# Appendix III: Percentage of Homes Surveyed Within 15 Days of the 1-Year Anniversary of Prior Survey

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In order to determine the predictability of nursing home surveys, we analyzed data from CMS's OSCAR database for a home's current survey as of April 9, 2002, and as of July 8, 2005 (see table 12). We considered surveys to be predictable if homes were surveyed within 15 days of the 1-year anniversary of their prior survey.

**Appendix III: Percentage of Homes Surveyed  
Within 15 Days of the 1-Year Anniversary of  
Prior Survey**

**Table 12: Percentage of Nursing Homes with Predictable Surveys, April 2002 and June 2005**

State	Number of homes <sup>a</sup>	Percentage of homes surveyed within 15 days of 1-year anniversary of prior survey		Percentage point difference, 4/9/02 and 7/8/05
		4/9/02	7/8/05	
<b>More than 50 percent</b>				
North Dakota	83	28.2	51.8	23.6
<b>More than 25 percent to 50 percent</b>				
District of Columbia	20	15.0	40.0	25.0
Iowa	439	31.1	35.8	4.7
Kansas	357	13.6	29.1	15.5
Oregon	138	14.1	28.3	14.2
California	1,287	9.5	27.8	18.3
Nebraska	221	3.1	27.6	24.5
Maryland	236	20.7	27.5	6.8
<b>10 percent to 25 percent</b>				
Virginia	270	30.5	20.4	-10.1
North Carolina	418	13.9	19.1	5.2
Wisconsin	396	19.6	18.7	-0.9
New Jersey	354	18.7	18.4	-0.3
Michigan	428	8.8	17.1	8.3
Alabama	227	5.8	16.7	10.9
Delaware	42	31.0	16.7	-14.3
Texas	1,111	15.7	16.7	1.0
Indiana	502	14.4	16.3	1.9
Massachusetts	461	17.3	16.3	-1.0
Wyoming	39	10.3	15.4	5.1
Colorado	213	9.0	15.0	6.0
Kentucky	294	10.6	15.0	4.4
<b>Nation</b>	<b>15,827</b>	<b>13.0</b>	<b>14.5</b>	<b>1.5</b>
Alaska	14	6.7	14.3	7.6
Rhode Island	92	12.5	13.0	0.5
Montana	100	8.7	13.0	4.3
New Mexico	78	13.8	12.8	-1.0
Pennsylvania	721	24.0	12.8	-11.2
Washington	246	22.4	12.6	-9.8
Vermont	41	11.6	12.2	0.6
Missouri	509	11.9	12.0	0.1

**Appendix III: Percentage of Homes Surveyed  
Within 15 Days of the 1-Year Anniversary of  
Prior Survey**

State	Number of homes <sup>a</sup>	Percentage of homes surveyed within 15 days of 1-year anniversary of prior survey		Percentage point difference, 4/9/02 and 7/8/05
		4/9/02	7/8/05	
New Hampshire	81	12.0	11.1	-0.9
New York	659	14.8	11.1	-3.7
South Dakota	109	18.9	11.0	-7.9
Florida	685	9.3	10.4	1.1
Illinois	792	9.7	10.4	0.7
Maine	116	8.3	10.3	2.0
<b>Less than 10 percent</b>				
Georgia	359	0.6	7.2	6.6
Nevada	43	24.4	7.0	-17.4
Hawaii	45	13.6	6.7	-6.9
Idaho	80	4.8	6.3	1.5
South Carolina	176	6.9	6.3	-0.6
Arizona	133	21.0	6.0	-15.0
Louisiana	288	19.0	5.9	-13.1
Tennessee	326	6.2	5.2	-1.0
Minnesota	408	4.4	4.7	0.3
West Virginia	129	8.7	3.9	-4.8
Arkansas	235	27.6	3.8	-23.8
Utah	87	1.1	3.4	2.3
Connecticut	245	15.8	2.9	-12.9
Ohio	960	3.0	2.2	-0.8
Mississippi	201	2.1	2.0	-0.1
Oklahoma	333	0.6	1.8	1.2

Source: GAO analysis of OSCAR data.

Note: The term states includes the 50 states and the District of Columbia.

<sup>a</sup>Represents the number of nursing homes with a prior and a current survey as of July 8, 2005.

# Appendix IV: Percentage of State Nursing Home Surveyors with 2-Years' Experience or Less, 2002 and 2005

State	2002	2005	Percentage point change
<b>Increase</b>			
Arizona	20	53	33
Colorado	24	53	29
Alaska	29	57	28
Illinois	5	25	20
Rhode Island	9	23	14
North Carolina	33	44	11
Ohio	17	21	4
Virginia	21	25	4
Florida	55	57	2
Arkansas	33	33	0
<b>Decrease</b>			
Indiana	20	18	-2
New Jersey	30	26	-4
Oregon	34	29	-5
Texas	32	26	-6
Wisconsin	25	19	-6
Nebraska	29	20	-9
Alabama	48	38	-10
Georgia	51	35	-16
Tennessee	45	28	-17
New York	40	18	-22
Washington	54	26	-28
Louisiana	48	19	-29
Maryland	70	14	-56
South Carolina	<sup>a</sup>	52	N/A
Vermont	<sup>a</sup>	38	N/A

Source: State survey agency responses to July 2002 GAO questions, and updates obtained from AHFSA in July 2005.

Note: The term states includes the 50 states and the District of Columbia.

<sup>a</sup>This state did not respond to our 2002 questions about surveyor experience.

# Appendix V: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

NOV 25 2005

Administrator  
Washington, DC 20201

**TO:** Kathryn G. Allen  
Director, Health Care

**FROM:** Mark B. McClellan, M.D., Ph.D.  
Administrator

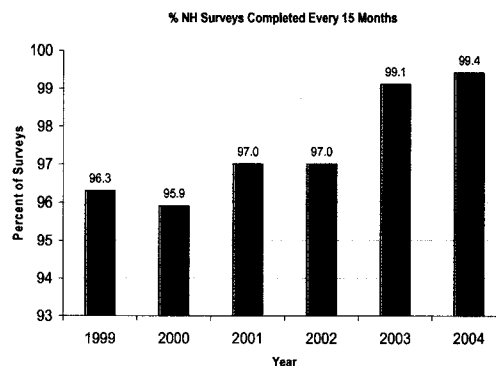
**SUBJECT:** GAO Draft Report: "Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety," GAO-06-117

The title to this GAO report succinctly expresses a dual message with which we fully concur: there has been significant improvement in federal oversight of nursing homes, while important challenges remain. We appreciate the considerable time and expertise the GAO has invested in identifying key oversight challenges and in contributing, from 1998 through 2005, ideas that helped strengthen the federal and state quality assurance systems for the nation's nursing homes.

We also appreciate the opportunity to comment on a few important indicators of progress, such as improved frequency of nursing home surveys (99.4% surveyed within the previous 15 months), a 45% increase in complaints investigated, more fire-safety protections and oversight, fewer serious deficiencies in nursing homes overall, and at least a 17% decline in serious deficiencies missed by state survey agencies (from 1999-2004). We conclude with observations about future challenges.

## Improvements in Oversight

Improvement in nursing home oversight is illustrated by the progress toward 100% completion of full nursing home surveys at least once every 15 months (from 96.3% in 1999 to 99.4% in 2004). This

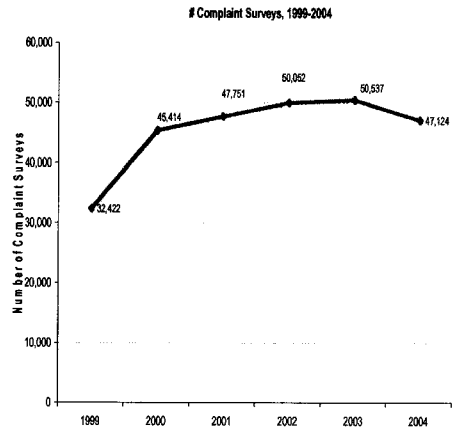


graph portrays the consistent march toward 100% fulfillment of our commitment to ensure that all nursing homes have an objective, on-site review every 15 months.

Prompt and effective investigation of resident complaints has been another key focus of our improvement effort in recent years.

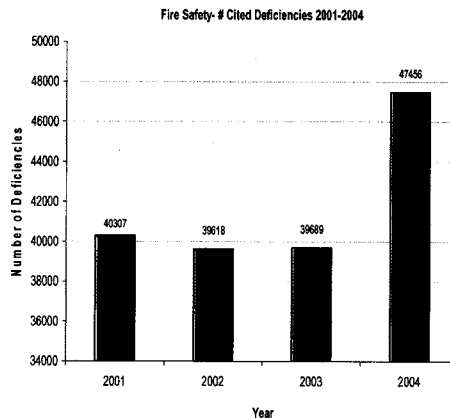
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From 1999 to 2004 the number of completed complaint investigations increased from 32,422 to 47,124. This 45% increase in completed complaint investigations is shown in the following graph. The graph illustrates both stronger performance and added commitment to be as responsive as possible to nursing home residents and their families.



Fire-safety assumed a higher priority after the nursing home fires in Tennessee and Connecticut in 2003. Those fires indicated that the downward trend toward fewer fires might not continue without added impetus. Through greater oversight, in 2004 we identified about 7,800 more fire-safety deficiencies compared with 2003 (a 20% increase).

Most recently, in 2005 we promulgated a new rule that required all nursing homes to have smoke detectors in un-sprinklered areas, including hallways and residents' rooms. We also increased by 17-fold (from 41 to 732) the number of CMS validation surveys ("comparative life-safety code surveys") in which we check on the adequacy of each state's fire-safety inspections.



A new "State Performance Standards System (SPSS)" has been expanded and strengthened each year since it was initially piloted in 2000. We initiated a "Special Focus Facility (SFF)" regimen in which surveyors visit more frequently those nursing homes that are judged to be most at risk of quality breakdowns. When SFF nursing homes improve, those homes are removed from the list. SFF nursing homes that do not show improvement have a higher chance of being terminated from the Medicare and Medicaid program under the new protocols. In 2005 we expanded

the number of such nursing homes by 30% and strengthened the enforcement consequences for nursing homes that fail to improve significantly.

Critical improvements in the information and tracking system used by surveyors will increase the effectiveness of surveys and remedial action. The "Aspen Complaint Tracking System (ACTS)"



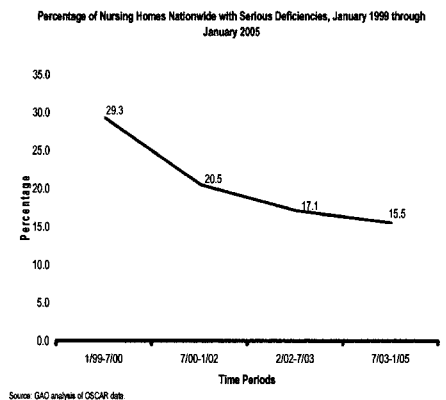
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was implemented in FY 2004. It provides an automated medium in which to record and track the progress of every federally-required complaint investigation. The “Aspen Enforcement Manager (AEM),” was implemented in FY 2005. The system will improve the application and management of enforcement actions (e.g., denial of payment, state monitoring, directed plans of correction, civil money penalties, temporary management, termination).

The CMS Web site (“Nursing Home Compare”) provides consumers, families, and others with key information about every nursing home. It includes quality measure data, as well as deficiencies identified through the survey process. The “Nursing Home Compare” website remains one of the most frequently-used CMS Web sites, with over 1.6 million page-views by the public each year. We continue to take steps to make publicly reported data as reliable and accurate as possible under current authority. For example, this year CMS instituted back-end edits of staffing data to help identify suspect data. We return such suspect data to the state survey agencies for confirmation or correction. We are further improving consumer information on the CMS website by posting information about past non-compliance. A finding of past non-compliance occurs when a nursing home was out of compliance with federal requirements but corrected the problem prior to the most recent survey or complaint investigation. The new information will identify the specific deficiencies that gave rise to the past non-compliance.

Through the Quality Improvement Organizations (QIOs) we have made a strong investment in providing technical assistance to help nursing homes improve their care. Beginning August 2005 all QIOs are charged with working with nursing homes to achieve progress in four areas: pressure sores, physical restraints, pain management, and depression. We also inaugurated a “Collaborative Focus Facility CFF” initiative in which state survey agencies refer (for QIO assistance) certain nursing homes judged to have significant and persistent quality challenges. Results from the first (pilot) year of the CFF are quite promising: the 42 nursing homes agreeing to work with their QIO (in 18 states) successfully reduced their prevalence of pressure ulcers in high risk residents by almost 20%, reduced the use of daily restraints by 27%, and reduced the incidence of “serious survey deficiencies” (see paragraph below) by 24%. Building on the success of the pilot program, the CFF will be expanded with the new QIO 8<sup>th</sup> scope of work contract that began in August 2005.

Oversight and regulatory improvements documented in the GAO report have contributed to an improved quality picture for the nation’s nursing homes. For example, Figure 1 in the GAO report shows a consistent decline in the percentage of nursing homes nationwide with serious deficiencies.<sup>1</sup>



<sup>1</sup> “Serious deficiencies” in this context means deficiencies in which there is actual harm to one or more residents. The decrease occurred despite an increase in monitoring for fire-safety code violations.

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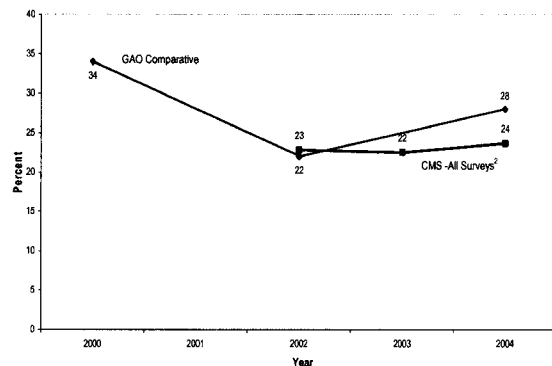
While noting the overall decrease in nursing home deficiencies nationwide, GAO expressed concern that state survey agencies sometimes understate the seriousness of deficiencies, or fail to cite them at all. We also remain concerned about possible understatement or omission of serious deficiencies by state survey agencies. But we do not believe that the trend of fewer deficiencies in nursing homes is due to this problem. That is, we do not believe that the understatement is worsening.

In its report, the GAO seeks to address the question of whether state survey agencies are getting better or worse in identifying deficiencies. It does so by comparing CMS findings with state agency findings. CMS conducts two types of “validation surveys” to check on the accuracy of state surveys. The first, a “comparative” validation survey, involves a CMS survey team conducting a full survey within 60 days after the state survey. The second type of validation survey is “observational.” In an observational validation one or more federal surveyors accompany the state team. The federal surveyors observe both (a) conditions in the nursing home and (b) the state team’s survey process. The two types of validation surveys offer different advantages, so CMS uses both.

In the GAO analysis, the data are restricted to the “comparative validation” surveys. The comparatives represent 15-20% of the validation checks that CMS conducts to assess the adequacy of the state surveys. The remaining 80-85% are “observational validation surveys.”

The graph on the right first shows the GAO data line (taken from Figure 2 in the GAO report). It shows the percentage of deficiencies missed by state surveyors but identified by federal surveyors. The data line runs from 34% in 1999 and declines to 28% in 2004. While GAO acknowledges that there is a trend showing fewer deficiencies missed by state surveyors, GAO calls our attention to the increase between 2002 and 2004. We believe the increase between 2002 and 2004 is an artifact of the limited data used.

Comparison of GAO and CMS Percentages of Federal Surveys with Serious Deficiencies<sup>1</sup> Not Identified in State Surveys



Source: CMS Regional Office Comparative Survey Database  
<sup>1</sup> Serious Deficiencies<sup>1</sup> is defined by a scope and severity rating of G and above.  
<sup>2</sup> Defined as the overall disparity of both the FOSS and Comparative surveys.

To investigate the trend when all the data are used, CMS added (to the GAO graph above) a second line showing the trend from 2002-2004 when both “comparative” and “observational” validation surveys are used. The second line shows that the percentage of serious deficiencies missed by state surveys (when we use all the data) is remaining relatively constant (moving from 23% to 24% from 2002-2004), rather than worsening.

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Some states are improving in their ability to identify deficiencies, while some other states are failing to improve. We are increasingly focused on those states whose performance is not up to par. In fact, for one of the five states selected by GAO as indicative of the problem, we withheld \$1.6 million from the state's 2005 Medicare survey budget until an appropriate corrective action plan was developed. Future CMS actions will promote further resolution in those states that appear to be missing a significant number of deficiencies identified by federal surveyors.

Consistency in how States conduct surveys is also being addressed through improved training for surveyors and the development of an improved survey process. The new "Quality Improvement Survey (QIS)" is being pilot-tested and evaluated in 2006. The system uses quality data to highlight, in advance, the areas in which there are more likely to be quality problems in a particular nursing home. The survey process is loaded onto a tablet personal computer to improve productivity and to augment the amount of information readily available to the surveyor on-site. The QIS offers a standardized approach designed to increase surveyor consistency and effectiveness.

#### **Adopting a Comprehensive Approach**

A new, internal Long Term Care (LTC) Task Force was initiated in December 2004 to coordinate nursing home improvement efforts throughout CMS. It functions as a subcommittee to the Administrator's Quality Council. The LTC Task Force published a *2005 Nursing Home Action Plan* in December 2004. The *Nursing Home Action Plan* summarizes our comprehensive strategy and consists of 32 separate initiatives in four inter-related and coordinated approaches. It describes in detail CMS commitments to improving quality in nursing homes. A copy of the *Nursing Home Action Plan* can be found at <http://www.cms.hhs.gov/quality/nhqi/NHActionPlan.pdf>. The *Action Plan* organized CMS actions into four "pillars of progress:"

**Consumer Awareness and Action:** Providing consumers and families with more information to enable them to use both the federal survey system and the power of the marketplace more effectively. Enhanced assurance that complaints will be investigated by federal or state surveyors, more information on the CMS website (NH Compare), development of enhanced public reporting on pressure ulcers, and the early stages of developing a staffing measure are examples.

**Standards, Survey and Certification:** Additional quality standards (e.g., for fire safety), increased monitoring and follow-through by surveyors are examples.

**Technical Assistance:** The new QIO contract, for example, augments the technical assistance being provided to nursing homes.

**Partnering:** Quality is best assured when all parts and all actors in the health care system collaborate to fulfill the common goal. In particular, we greatly strengthened the coordination between state survey agencies and the QIOs. For example, when CMS strengthened the survey agencies' "Special Focus Facility (SFF)" effort, we inaugurated a companion "Collaborative Focus Facility (CFF)" initiative with the QIOs. In the "CFF"

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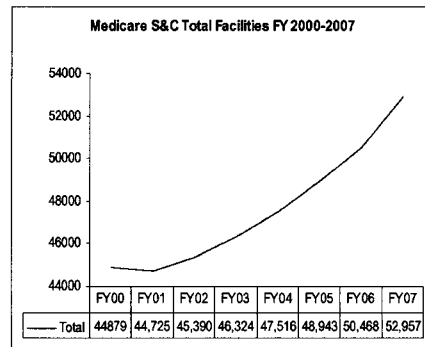
initiative, state survey agencies refer for QIO assistance certain nursing homes judged to have significant quality challenges. The success of this pilot has led to a national rollout in the latest contract with the QIOs. Each QIO will be required to work with a subset of these poor performing nursing homes as part of their contract.

In 2006 we expect to pilot test, via a demonstration, an additional area of endeavor: making the payment system more sensitive to variations in quality. Known by various phrases (e.g., “value-based purchasing” or “pay for performance”), the theory is that we ought to use and coordinate all available means to carry forward the quality mandate. The payment system is an important leverage point by which quality may be promoted. The *2006 Nursing Home Action Plan* is under development now. It will include a plan for value-based purchasing demonstration, making a total of five (5) “pillars of progress” in the *Action Plan*.

While the progress from 1998-2005 documented by the GAO is comprised predominantly of improvements in the survey and certification process, we believe that future progress will require even more alignment of all parts of the health care system, and improvements in every aspect.

**Challenges**

As the GAO noted, the total number of providers that participate in Medicare and/or Medicaid is increasing. This trend enlarges the overall survey and certification workload for both state and CMS regional offices. Providers subject to survey & certification include not only nursing homes, but hospitals, home health agencies, dialysis facilities, hospices, intermediate care facilities for the mentally retarded (ICFs-MR), ambulatory surgical centers, and others. This graph illustrates the total cumulative effect of increased numbers of all types of regulated providers.



The combination of (a) more providers and (b) fewer resources poses a significant challenge that will exceed many of the issues upon which the GAO has focused in the past.

We expect resources to be significantly constrained for some time. In 2005, for example, Medicare funding appropriated by Congress for survey and certification was \$11.7 million below the President’s budget request. State budgets (for Medicaid surveys) remain very limited. And as the GAO well observed, state survey agencies continue to struggle from the effects of state hiring freezes and the difficulties in recruiting and retaining professional staff.

These trends could likely cause some erosion of the gains already made, particularly the gains from increased survey frequency and the 45% increase in complaints investigated (2004 compared with 1999). As the GAO noted, we also recently increased CMS oversight of states through more comparative health surveys (which the GAO has recommended). The improvement was accomplished partly through a national contractor. As a result of the 2005 budget limitations,

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however, the contract that helped increase the number of nursing home comparative health surveys will no longer be supported. More states have resorted to bundling complaint investigations together so as to investigate multiple complaints in one visit. Such bundling will affect the timeliness of the complaint investigations, as well as the total number conducted. Implementation of the new "Quality Improvement Survey (QIS)" will be much slower than we desired due to the cost implications of new computers needed in most states, as well as the training challenge. Survey predictability will possibly increase since it is so directly connected with funding. The adequacy of surveyor training will be severely challenged. As we seek to preserve nursing home oversight within resource constraints, there will be some trade-offs to make with surveys for other types of regulated providers, such as hospitals, hospices, ambulatory surgical centers, dialysis facilities, and home health agencies. The frequency of surveys and complaint investigations for such non-long term care providers will likely decrease.

To counteract some of these forces we are redoubling efforts to increase productivity. We will reexamine CMS policies with a determine the value added compared with the cost. We will enlarge the scope of the state performance standards and seek to focus as much as possible on substantive issues. We will continue to prioritize survey activities and coordinate with other actors in the health care system to promote the best possible outcomes. Fuel efficiency improvement must be another focal point. Survey agencies represent one of the larger transportation-dependent agencies in state and federal governments. The recent 20-60% increase in the cost of fuel creates a diversion of resources away from other important functions. Increases in fuel economy, improved on-site transportation planning, and strategic investments will be vital.

The future will require that we respond to new challenges as well as those previously identified. Enhanced emergency preparedness is one such imperative. Recent experiences from Hurricanes Katrina and Rita point to the need for more robust preparedness planning. Such planning must more effectively take into account the type of community-wide health care crisis that occurs when all major types of interdependent health care providers (e.g. hospitals, nursing homes, home health agencies) are all simultaneously and severely affected by a common cascade of adverse events.

We greatly appreciate the comprehensive approach represented in this GAO report. Greater challenges ahead require a keen sense of priorities among the competing activities and enhancements that are theoretically possible while working within the available programmatic resources. Together with our own *Nursing Home Action Plan* posted on our website, the GAO report offers an excellent overview of many of the initiatives underway.

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# Appendix VI: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathryn G. Allen, (202) 512-7118 or [allenk@gao.gov](mailto:allenk@gao.gov)

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## Acknowledgments

In addition to the contact named above, Walter Ochinko, Assistant Director; Jack Brennan; Joanne Jee; Elizabeth T. Morrison; and Christal Stone made key contributions to this report.

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# Related GAO Products

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*Nursing Home Deaths: Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care.* [GAO-05-78](#). Washington, D.C.: November 12, 2004.

*Nursing Home Fire Safety: Recent Fires Highlight Weaknesses in Federal Standards and Oversight.* [GAO-04-660](#). Washington D.C.: July 16, 2004.

*Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight.* [GAO-03-561](#). Washington, D.C.: July 15, 2003.

*Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature.* [GAO-03-187](#). Washington, D.C.: October 31, 2002.

*Nursing Homes: Quality of Care More Related to Staffing than Spending.* [GAO-02-431R](#). Washington, D.C.: June 13, 2002.

*Nursing Homes: More Can Be Done to Protect Residents from Abuse.* [GAO-02-312](#). Washington, D.C.: March 1, 2002.

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*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives.* [GAO/HEHS-00-197](#). Washington, D.C.: September 28, 2000.

*Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality.* [GAO/HEHS-00-6](#). Washington, D.C.: November 4, 1999.

*Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable.* [GAO/HEHS-99-154R](#). Washington, D.C.: August 13, 1999.

*Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit.* [GAO/HEHS-99-157](#). Washington, D.C.: June 30, 1999.

*Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents.* [GAO/HEHS-99-80](#). Washington, D.C.: March 22, 1999.

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**Related GAO Products**

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*Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards.* [GAO/HEHS-99-46](#). Washington, D.C.: March 18, 1999.

*California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.* [GAO/HEHS-98-202](#). Washington, D.C.: July 27, 1998.



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