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NURSING HOMES

Complaint Investigation Processes Often Inadequate to Protect Residents

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

The 1.6 million elderly and disabled residents confined to nursing homes are a highly vulnerable population. They are frequently dependent on extensive assistance in basic activities of daily living like dressing, grooming, feeding, and using the bathroom, and many require skilled nursing or rehabilitative care. The vast majority of nursing homes participate in Medicare and Medicaid and are expected to receive nearly $39 billion in federal payments from these programs in 1999. For these nursing homes, providing adequate care is a federal mandate backed by about $210 million in federal funding going to state agencies that inspect and certify nursing homes' compliance with quality standards through annual surveys and complaint investigations. About $42 million of this goes to fund investigations of complaints that are lodged by various sources, including residents, their families, and nursing home employees, and incidents of potential abuse or neglect that nursing homes report to states.

In our July 1998 report to you, we found that unacceptable care was a problem in many California nursing homes, including one in three where state surveyors identified serious or potentially life-threatening care problems. We also reported that federal and state oversight is not sufficient to guarantee the safety and welfare of nursing home residents.[1] In a companion report issued last week, we further found that current federal enforcement efforts cannot ensure sustained compliance with federal standards for nursing home care.[2]

Concerned that annual surveys alone are inadequate to meet the federal goal of ensuring nursing home residents' health and safety, you asked us to examine how states implement the federal requirement that states

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

[2]Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

establish a process for nursing home complaint investigations. Complaint investigations offer a unique opportunity to identify and correct potential care problems because they can provide a more timely alert than annual inspections, and they target specific areas of potential problems identified by residents, their families, the concerned public, and even the facility itself. Specifically, this report assesses the effectiveness of (1) state complaint investigation practices as a component of the system to ensure sustained compliance with federal nursing home quality-of-care standards and (2) the Health Care Financing Administration's (HCFA) role in establishing standards and conducting oversight of states' complaint investigation practices and in using information about the results of complaint investigations to ensure compliance with nursing home standards. We assessed complaint investigation practices in Maryland, Michigan, and Washington State; reviewed state auditors' reports from 11 other states;[3] and examined HCFA's policies and procedures for overseeing state complaint investigation activities. Appendix I provides more details about our scope and methodology.

Results in Brief

Federal and states' practices for investigating complaints about care provided in nursing homes are often not as effective as they should be. Among many of the 14 states we examined, we found numerous problems, including

- procedures or practices that may limit the filing of complaints,
- understatement of the seriousness of complaints, and
- failure to investigate serious complaints promptly.

Serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months. Such delays can prolong situations in which residents may be subject to abuse, neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors.

Although federal funds finance over 70 percent of complaint investigations nationwide, HCFA plays a minimal role in providing states with direction

[3]The state reports examined Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin. These reports were produced by either the state auditor or similar organizations, such as the Office of Inspector General. In this report, we refer to these reports as state auditor reports.

and oversight regarding these investigations. HCFA has left it largely to the states to decide which complaints potentially place residents in immediate jeopardy and must be investigated within the federally mandated 2 workdays. If a serious complaint that could harm residents is not classified as potentially placing residents in immediate jeopardy, there is no formal requirement for prompt investigation. More generally, HCFA's oversight of state agencies that certify federally qualified nursing homes has not focused on complaint investigations. We found that

- a HCFA initiative to strengthen federal requirements for complaint investigations was discontinued in 1995, and resulting guidance developed for states' optional use has not been widely adopted;
- federal reviews of state nursing home inspections are primarily intended to focus on the annual surveys of nursing homes, and very few reviews are conducted of complaint investigations;
- since 1998, HCFA has required state agencies to develop their own performance measures and quality improvement plans for their complaint investigations, but for several of the 14 states we reviewed, such assessments addressed complaint processes superficially or not at all; and
- HCFA reporting systems for nursing homes' compliance history and complaint investigations do not collect timely, consistent, and complete information.

We are recommending stronger federal requirements for states to promptly investigate serious complaints alleging situations that may harm residents but are not classified as immediate jeopardy, increased federal monitoring of states' performance in responding to complaints, and improved tracking of the substantiated findings of complaint investigations. Such steps can strengthen the ability of federal and state regulators to use complaint investigations to protect and improve the care nursing home residents receive.

Background

Nearly all nursing homes accept residents with either Medicare or Medicaid and are projected to receive nearly $39 billion in federal payments from these programs in 1999. The federal government, through HCFA, has responsibility for establishing requirements that nursing homes must meet to participate in the Medicare and Medicaid programs and ensuring that these standards are met. HCFA carries out this responsibility by contracting with states to monitor nursing homes. As part of these

contracts, the states agree to comply with regulations and other general instructions that HCFA prescribes.

The Omnibus Budget Reconciliation Act of 1987 revised the standards for homes' participation in these federal programs and defined federal and state roles for ensuring that nursing homes meet these standards. In this regulatory framework, states (1) license nursing homes to do business in the state, (2) certify to the federal government, by conducting reviews of nursing homes, that homes are eligible for Medicare and Medicaid payment, and (3) investigate complaints about care provided in the homes. As part of their oversight, the states are required to conduct annual surveys of homes. While the annual surveys seek to provide a nationally uniform process to evaluate whether nursing homes meet a comprehensive range of federal standards, they are often predictable in their timing.[4] Complaint investigations can be less predictable than annual surveys and generally provide a unique opportunity for more frequent state inspections that assess conditions at the nursing home while focusing on specific concerns raised by residents, their families, or other observers. HCFA oversees states' performance by monitoring at least 5 percent of states' surveys and by requiring states to develop a quality improvement program that incorporates performance goals and measures in seven required core performance areas--including complaint investigations--and other optional state-identified areas.[5]

In addition to the requirement that states establish a complaint investigation process, HCFA requires that states investigate the most serious complaints that allege situations immediately jeopardizing the health or safety of residents within 2 workdays, but leaves the timing, scope, duration, and conduct of other complaint investigations to the discretion of the state survey agency. Thus, states establish their own priorities and time frames for investigating complaints that they determine do not represent immediate jeopardy to resident health and safety. In addition, states require nursing homes to report and investigate incidents such as injuries that might signal neglect or abuse. The state then determines whether it will further investigate the incident.

[4]HCFA has recently initiated efforts intended to reduce the predictability of the timing of annual surveys, such as doing some during evenings or weekends.

[5]A forthcoming GAO report will examine federal oversight of state agencies' nursing home certification activities, including the federal monitoring surveys and the State Agency Quality Improvement Program.

When states conduct a complaint investigation, they attempt to substantiate whether the allegations are valid. If a complaint is substantiated, the state may cite the nursing home for violating either federal or state standards. In such cases, the state agency will require the home to develop an approved plan of correction. The state may choose to take action under the state's licensing authority, using applicable state remedies and sanctions. If the deficiency relates to federal standards, information regarding the deficiency is also to be reported to HCFA. Serious deficiencies require that the home attain compliance within a set time frame or face enforcement sanctions, such as civil monetary penalties, by HCFA or the state.

Both federal and state funds finance the costs state agencies incur in inspecting nursing homes and investigating complaints. In 1998, the federal government paid states about $210 million for the nursing home survey and certification process, including about $42 million (20 percent) for investigating complaints. States contributed an additional $17 million for complaint investigations. On average, federal funds account for 71 percent of states' complaint investigation expenditures. Table 1 compares these expenditures for the states visited. Appendix II includes additional expenditure information for all states and further discusses the allocation of federal and state shares. Generally, the federal government finances states' complaint investigation costs for nursing homes in the same proportion that it finances annual and other surveys.

Table 1: Federal and State Expenditures for Complaint Investigations, 1998

	Total expenditures for complaint investigations	Percentage of total survey and certification expenditures	Percentage of total expenditures federally funded	Average expenditures per on-site investigation	Average expenditures per home
Maryland	$ 232,666	8	60	$1,199	$885
Michigan	1,204,179	16	71	1,361	2,694
Washington	2,156,161	30	59	664	7,592
U.S. total	$58,833,689	20	71	$1,430	$3,397

Some States' Complaint Practices Are Limited in Protecting Nursing Home Residents

Although investigations of complaints filed against nursing homes can provide a valuable opportunity for determining whether the health and safety of residents are threatened, complaint investigation practices do not consistently achieve this goal. Some states use procedures that may discourage the public from filing complaints. Furthermore, some states fail to recognize and promptly respond to complaints that may pose immediate jeopardy to a resident's health, safety, or life. Likewise, some states do not require that other serious complaints, including those that allege harm to residents, be investigated for months after the complaint's receipt. Additionally, many complaints are not investigated within states' required time frames for conducting an investigation. Consequently, we found several instances in which, after an extended delay, the complaint investigators substantiated that residents had been harmed and other cases in which the state was unable to determine whether the allegations were true partly because so much time had elapsed since the complaint was received.

Procedures and Practices May Limit the Public's Filing of Complaints

Because nursing home residents and the public need an effective and expedient means to seek correction of problems that they perceive endanger the health and safety of nursing home residents, the process of filing a complaint should not place an unnecessary burden on the complainant. Nevertheless, some states we reviewed have procedures or practices that may limit the number of complaints. For example, when a person calls with a complaint, Maryland and Michigan encourage him or her to submit the complaint in writing.

- Michigan requires that either complainants write a complaint or the state will provide assistance in writing the complaint. About 95 percent of publicly reported[6] complaints were submitted in writing between July 1997 and June 1998.
- Maryland's policy is to accept and act on a complaint by phone even though callers are encouraged to submit a written complaint. However, state officials provided us conflicting information as to whether calls would be consistently documented and investigated when callers agreed to submit a written complaint but did not do so. Over 70 percent of

[6]In this report, publicly reported complaints are those from residents, family, or friends.

Maryland's publicly reported complaints that the state investigated were identified as written complaints between July 1997 and June 1998.[7]

- In contrast, Washington readily accepts complaints by phone and nearly all complaints are received by phone. This contributes to Washington receiving a considerably higher number of complaints than Michigan or Maryland.

See table 2 for a comparison of the total number of nursing home complaints received in a year by these states.

Table 2: Complaints Received Between July 1, 1997, and June 30, 1998

	Number of complaints received	Number of complaints per 1,000 nursing home beds
Maryland	642	21
Michigan	2,243	45
Washington	8,748	336

States Establish Widely Varying Categories for Prioritizing Complaints

When a complaint is received, the state agency ascertains its potential seriousness. HCFA requires that complaints that may involve immediate jeopardy of a resident's health, safety, or life be investigated by states within 2 workdays of receipt.[8] For other complaints, states are permitted to establish their own categories and time frames for investigation. States have established varying time requirements for complaint responses and varying criteria for prioritizing these complaints, including criteria for complaints that may involve a significant risk of actual harm to nursing home residents. Some states permit relatively long periods of time to pass between the receipt of all such complaints and their investigation. For example, for complaints that may involve significant risk of actual harm to residents,

- Michigan's statute allows 30 days, but in 1998 Michigan's operating practice was to allow 45 days;

[7]The percentage is based on the total number of complaints that have information about whether the complaint was in writing or by telephone.

[8]Some states have a more stringent requirement than the federal requirement. For example, Michigan, Louisiana, and Kansas require immediate jeopardy complaints to be investigated within 24 hours.

- Tennessee allows 60 days; and,
- Kansas allows 180 days.

Some states have established other priority categories with similar time frame classifications, but their criteria for determining which complaints to include in these classifications differ substantially. Maryland and Washington both have classification schemes that include categories for complaints to be investigated within 2, 10, or 45 workdays or at the next on-site investigation.[9] Similarly, Pennsylvania classifies complaints to be investigated within 2, 5, 10, or 45 workdays or at the next on-site survey. Criteria for complaints to be included in the 10-day category for Washington and Pennsylvania are similar. Washington's 10-day category includes complaints alleging significant potential harm to a resident's physical and/or mental health or safety. Similarly, Pennsylvania characterizes 10-day complaints as those in which residents' needs, including medical, nursing, and dietary, are not being met. Maryland's 10-day time frame states that complaints in this category are those that appear to be especially significant, sensitive, or could attract broad public attention; those forwarded from a government or public official; and those where the provider has a history of poor performance relative to the allegations.

Complaints May Receive an Inappropriately Low Investigation Priority

States sometimes place complaints in an inappropriately low investigation category, thus postponing a prompt review. The infrequent use of high-priority levels in some states raises a question as to whether complaints are being appropriately categorized. Some states have explicit procedures or operating practices that result in the downgrading of a complaint's severity. We found several instances of complaints that, in our opinion, were inappropriately placed in a low-priority category.

As shown in table 3, two of the three states we visited seldom placed complaints in the immediate jeopardy category for the 1-year period we analyzed. Maryland did not identify a single complaint as potentially

[9]Washington specifies that the next on-site investigation is within 90 days, whereas Maryland does not have a maximum time frame for the next on-site investigation, other than the maximum 15-month time frame allowed for the annual survey. Washington also has four other categories that do not require an on-site investigation. Priority 5 includes cases where the nursing home has investigated an incident and found that no further action is required. In such cases, the home must retain records for possible future audit by the state agency. Priority 6 cases require no further action beyond recording the complaint, priority 7 cases are resident-to-resident noninjury incidents reported by the home, and priority 8 cases are those not requiring the state to record the complaint.

representing immediate jeopardy. Michigan did prioritize some complaints as immediate jeopardy, but they accounted for only 2 percent of total complaints received. The Pennsylvania state auditor also noted that the number of complaints considered immediate jeopardy in that state had dropped considerably during the first quarter of 1998 in comparison to earlier years, raising the auditor's skepticism and concern.

Table 3: State-Investigated Complaints That Were Considered Potential Immediate Jeopardy, July 1997 Through June 1998

State	Number of complaints classified as immediate jeopardy	Number of immediate jeopardy complaints per 1,000 beds	Immediate jeopardy complaints as a percentage of total complaints investigated
Maryland	0	0	0
Michigan	24	0.5	2
Washington	223	8.6	8

Some states also categorized relatively few complaints in other high-priority categories, such as those that should be investigated within 10 days. For example, Maryland placed most complaints in its lowest-priority category–to be investigated at the next on-site survey. This contrasts with Washington, which categorized nearly 90 percent of its complaints to be investigated within either 2 or 10 workdays. Table 4 compares the use of similar priority time frames among the states visited.

Table 4: Percentages of State-Investigated Complaints in Maryland, Michigan, and Washington, by Priority Category, July 1997 Through June 1998

Priority time frame[a]	Maryland	Michigan[b]	Washington
Within 2 days[c]	0	2	8
Within 10 days	22	N/A	81
Within 45 days	34	92	9
Next survey[d]	44	N/A	3

Note: Percentages may not add to 100 because of rounding.

[a]Maryland and Washington define their time frames as workdays, whereas Michigan defines its time frames as calendar days.

[b]About 5 percent of Michigan's complaints were placed in other miscellaneous categories or their priority was unknown.

[c]Michigan's highest priority category requires an investigation within 24 hours.

[d]Although Michigan's policy includes a priority level that permits complaints to be investigated at the next survey, none of the complaints we reviewed was categorized at this priority level. Maryland defines this category as "the next on-site survey," whereas Washington defines it as being within 90 days or at the next on-site survey, whichever is sooner.

Several states have explicit procedures or operating practices that place serious complaints in lower-priority categories. A Maryland official, for example, acknowledged reducing the priority of some complaints because the state recognized that it could not meet shorter time frames because of insufficient staff. Similarly, a Michigan official also told us that her office gives a complaint low priority if the resident is no longer at the nursing home when the complaint is received--even if the resident died or was transferred to a hospital or another nursing home.[10] The state may investigate these complaints during the home's next survey or not at all. Failure to investigate such a complaint in a timely manner may compromise the health and safety of other residents who may also be affected by problems cited in the complaint. We identified several cases in which a resident had died or been transferred from the nursing home that were assigned to Michigan's lower-priority (45-day) category, were uninvestigated for several months, or had not yet been investigated at the time of our visit. For example, a complaint in Michigan alleged in July 1998 that a resident died because the home did not properly manage his insulin injections or perform blood sugar tests. Because the resident died, the state had not investigated the complaint as of January 1999. We question why the state agency would not have concerns that this situation might affect other diabetic residents in the home.[11]

Michigan also delays investigating certain nonimmediate jeopardy complaints against nursing homes that are undergoing federal enforcement action. Officials told us that they adopted this practice to avoid potential confusion that may result from having two enforcement actions pending

[10]In reviewing our draft, Michigan stated that its policy is to investigate complaints whether or not a resident is still in the home.

[11]In its comments on a draft of this report, Michigan provided additional information about this complaint. It stated that the state did not investigate this complaint because state investigators had investigated the home shortly before the complaint was received and found that previous problems related to treatment of diabetic residents had been resolved. About 8 months after the complaint was received (Mar. 12, 1999), state investigators conducted the most recent annual survey of the home and found no problems relating to the monitoring of diabetic residents. However, we still question why the state did not more immediately investigate the complaint given that (1) the resident died, (2) the state had identified previous problems with this home's treatment of diabetic residents, and (3) the attorney general's office had been notified. This appears to violate Michigan's policy that complaints should be investigated within 24 hours if the incident involves "injury or . . . death or potential criminal activity under investigation by a state or local law enforcement agency."

simultaneously. We believe this practice could unreasonably delay the investigation of serious complaints at nursing homes already identified as violating federal standards.

In reviewing complaints from the states visited, we identified several complaints in two states that raise questions about why they were not considered as potentially immediate jeopardy. Examples of these allegations include the following:

- The complaint alleged that a resident was found dead with her head trapped between the mattress and the side rail of the bed, with her body lying on the floor. The state categorized this complaint as one needing to be investigated within 45 days. The state investigated this complaint within 13 days and determined that 11 of 24 sampled beds had similar side rail violations. Our concern about whether this complaint was appropriately classified is supported by another HCFA region's interpretation of HCFA's guidance to states. The Denver region would have considered this situation to be an immediate jeopardy complaint to be investigated within 2 workdays, noting that "an unexplained resident death related to a medical device, side rails, or other restraints exemplifies a possible immediate jeopardy situation requiring an on-site investigation within two workdays."
- Another complaint alleged that an alert resident who was placed in a nursing home for a 20-day rehabilitation stay to recover from hip surgery was transferred in less than 3 weeks to a hospital because of what the complainant termed an "unprecedented rapid decline [in the resident's condition]." One of the members of the ambulance crew transporting the resident to the hospital filed a written report stating that the resident "had dried . . . blood in his fingernails and on his hands . . . sores all over his body . . . smelled like feces and [was] unable to walk or take care of himself. Patient is in very poor condition as far as his hygiene. I personally feel he was not being properly cared for." The state categorized this complaint as needing an investigation at the next on-site inspection, took more than 4 months to begin its investigation, and determined that the nursing home had harmed the resident.
- Another complaint alleged that the home's staff would not send a resident with maggots in the sores on his feet to the hospital because the home's director of nursing did not want the state agency to be notified by the hospital and investigate the home. The state categorized this complaint, received 105 days before our visit, as needing to be investigated within 45 days, but it had not yet been investigated.

- In another instance, the police reported suspected abuse and neglect to the state survey agency after a resident was brought twice to the hospital emergency room because of falls. The resident's first hospitalization identified a broken elbow, and the second found a contusion on the resident's cheek. The police did not believe the nursing home staff's account of how the resident had sustained these injuries. This complaint, filed 13 workdays before our visit, was being held by the state until the next on-site investigation.

State auditors' reports identified additional complaints that the auditors found should have been placed in a higher category. Examples follow:

- Kansas' auditors said that about 10 percent of 213 complaints reviewed were classified too low, given their potential seriousness. Among the complaints categorized as not requiring an investigation until the earlier of the home's next annual survey or within 6 months of receipt was one alleging that a resident had skin tears, purple lesions, feces and food on his clothing, broken eyeglasses, and was not being fed regularly. Another complaint charged that a nurse's aide abused several residents.
- Pennsylvania's auditors identified several complaints as categorized too low, including one filed by a licensed practical nurse recently employed by the home. The nurse alleged that there had been at least 12 deaths at the home over a 2-week period, including a resident who choked to death because she had mistakenly been given solid food; a resident who was sent to the emergency room because her feeding tube had become dislodged and was entirely within her stomach; and a resident who had received 10 times the prescribed dosage of a medication. This nurse's complaint was placed in the lowest category, delaying its investigation until the home's next annual survey.

States Frequently Do Not Investigate Complaints Within Required Time Frames

States often do not conduct investigations of complaints within the time frames they assign, even though some states frequently place complaints in lower investigation categories to increase the time available to investigate them. Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation. These delays may contribute to investigators being unable to determine whether the allegations are true because, by the time the investigation starts, evidence needed to establish validity may no longer be available.

To determine whether states investigate complaints within state-required time frames, we reviewed state data covering 1 year from July 1997 through June 1998. Table 5 shows the percentage of complaints that met the assigned time frame for investigation.

Table 5: Percentage of State-Investigated Complaints Meeting Time Frame for Investigation, July 1997 to June 1998

Time frame	Number of complaints	Percentage investigated within time frame
Maryland		
2 workdays	0	N/A
10 workdays	47	21[a]
45 workdays	72	69[a]
Michigan		
24 hours	24	21[b]
45 days[c]	1,273	26
Washington		
2 workdays	223	78
10 workdays	2,331	47
45 workdays	252	89
90 workdays	78	100

Note: N/A = not applicable.

[a]Maryland's data provide information on the last date of the investigation, but not when the investigation was initiated. Based on our review of complaints received in early 1998, only 1 of 18 complaints was initiated within the assigned time frame of 10 workdays, and only 4 of 11 complaints were initiated within the assigned time frame of 45 workdays.

[b]When using the federal requirement of 2 workdays to investigate immediate jeopardy complaints, Michigan investigated 42 percent of these complaints on time.

[c]About 5 percent of Michigan's complaints were identified as those to be investigated within miscellaneous time frames. Although state law requires serious complaints other than immediate jeopardy to be investigated within 30 days, Michigan's Department of Consumer and Industry Services changed the 30-day requirement to a 45-day requirement in 1998. As shown, Michigan did not meet even the 45-day time frame in most cases.

We asked each state visited to provide copies of all complaints in the Baltimore, Detroit, and Seattle areas that had not yet been investigated and that exceeded the assigned time frame. Baltimore and Detroit each had

over 100 such complaints, while Seattle had 40.[12] From the complaints provided, we identified those for homes having at least three outstanding complaints not investigated within the states' prioritized time frames, and we summarized the allegations of each complaint. Many of these complaints alleged potential resident abuse by staff; resident neglect, including malnutrition and dehydration; preventable accidents; medication errors; and understaffing. See appendix III for this summary.

Delayed Investigations of Complaints Prolong Harm to Residents

Failure by states to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions. Furthermore, delayed investigations can prolong, for extended periods, situations in which residents are harmed. Table 6 identifies complaints received in early 1998 in which the state's complaint investigation concluded that the resident had been harmed. In Maryland and Michigan, a large percentage of such cases was not investigated for extended periods.

Table 6: Complaints in Which Investigation Substantiated Federal Deficiency and Resulted in Home Being Cited for Actual Harm to One or More Residents

Description of allegations	Days until investigation started	Scope of harm found[a]
Maryland		
Nurse charted that resident's intravenous fluid was flowing well; however, fluid was going under the resident's skin and not into a vein. Resident had to be hospitalized.	139	Isolated
Resident had caked feces all over his body, dried blood under his fingernails and on his hand, and pressure sores all over his body. A member of the ambulance team that transported the resident to the hospital questioned whether the home properly cared for the resident.	130	Isolated
Inadequate supervision led to falls. One resident suffered a dislocated jaw and could not chew. A feeding tube was inserted into the resident. The resident later developed pneumonia, was hospitalized, and was put on life support.	54	Isolated
Three residents were hospitalized with several pressure sores. One resident had a sore that was exposed to the bone. Another resident had four sores; a third resident had three sores. The state noted that the home did not ensure proper nutrition for one of these residents to prevent the development of the sores.	39	Isolated

(continued)

[12]As discussed in app. I, this includes only the unassigned complaints in Baltimore. Other assigned complaints were also uninvestigated.

Description of allegations	Days until investigation started	Scope of harm found[a]
Michigan		
Resident had multiple pressure sores and multiple fractures caused by falls, resulting in hospitalization.	228	Pattern
Resident had swelling and bruising on chest, shoulder, and forearm. The emergency room diagnosed fractured ribs.	216	Isolated
Resident was verbally abused by an aide, who told resident to go to the bathroom in her diaper after resident asked for a bedpan. The home failed to draw a conclusion about the incident, but suspended the aide. The state noted the home had a history of not being able to draw conclusions about abuse incidents.	152	Isolated
Aide was rough in transferring resident from wheelchair, resulting in laceration needing 25 stitches.	146	Isolated
Resident with history of 13 altercations with other residents hit a resident who suffered a laceration. The home had not implemented safeguards to prevent such occurrences.	112	Isolated
Resident's weight and fluids were not monitored. Also, resident's foot was swollen, possibly requiring amputation. Resident also found sitting in urine, not clean, and missing personal property. Resident rushed to emergency room.	99	Pattern
Male aide slapped a female resident and squeezed her hand causing a bruise. Another resident struck a home employee, who slapped the resident's face in response.	88	Isolated
Resident sustained a fractured nose and laceration of her forehead as a result of improper positioning in her wheelchair. Resident sent to hospital for stitches.	45	Isolated
Resident, who had blood drawn, was noted to have a badly bruised hand and elbow. Complainant alleged that a laboratory representative stated that sometimes they "have to get rough" in order to draw blood from residents.	37	Isolated
Home failed to monitor resident's condition; resident became unresponsive and was hospitalized for dehydration and a urinary tract infection. Home failed to use bed side rails for seven residents, resulting in lacerations/injuries to four residents who fell out of bed.	33	Pattern
A resident's leg was fractured three different times, possibly due to rough handling of resident during transfer by aide. Allegation also stated that aides are not properly trained to transfer residents who have fragile bones.	33	Pattern
Resident hit another resident.	17	Isolated
Resident found dead with head between mattress and bed side rail, with body lying on the floor.	13	Isolated
Washington		
Resident had repeatedly developed pressure sores while in the nursing home.	27	Isolated
Resident fell while being transferred from wheelchair to toilet, and as a result, re-broke hip.	9	Isolated
Quadriplegic left the home in an electric wheelchair and died of hypothermia after the battery ran out.	3	Isolated
Inadequate staffing resulting in deteriorated care of many residents. Medications were late, and a diabetic's blood was not tested for sugar level.	1	Widespread
Resident suffered a hairline fracture of the foot while being transferred from wheelchair to bed.	0	Isolated

Note: Data include a complete chronological sample of complaints received in early 1998 that were investigated and resulted in a violation indicating that actual harm had occurred. In Maryland, we reviewed 102 complaints received between January 1 and February 28, 1998; in Michigan, we

reviewed 59 complaints received between January 1 and January 15, 1998; and in Washington, we reviewed 132 complaints received between January 1 and January 7, 1998.

[a]Isolated, pattern, and widespread are terms that state investigators must use to classify the scope of a violation. In general, isolated violations affect one or a limited number of residents and/or occur only occasionally; pattern violations affect more than a limited number of residents and/or have occurred repeatedly; widespread violations are pervasive, affecting a large number of residents and occurring frequently.

HCFA's Complaint Investigation Standards Are Minimal, and Its Oversight of States' Complaint Practices Is Weak

Although HCFA funds, on average, 71 percent of state agencies' complaint investigation costs, HCFA has established minimal standards for investigating complaints and has conducted little monitoring of states' complaint practices. HCFA provides limited guidance to states on complaints beyond the 2-workday requirement for allegations classified as posing immediate jeopardy to resident health and safety.[13] HCFA established a taskforce in 1993 to develop more stringent federal policies for complaint investigations, but it was disbanded in 1995, and formal policies were not revised. Finally, HCFA's ability to oversee states' performance in handling complaints is limited because major monitoring efforts are focused instead on annual surveys; it primarily relies on states to develop performance measures for complaint investigations; and it has inadequate reporting systems for capturing the results of complaint investigations.

Previous HCFA Efforts to Strengthen Federal Standards for Nursing Home Complaint Investigations Were Abandoned

Between 1993 and 1995, a HCFA task force worked to develop formal complaint guidance for states and a complaint investigation manual to help state investigators. The task force activities included consideration of additional minimum federal priority and time frame classifications, including requirements that time frames be set for complaints alleging serious care issues but at levels less than immediate jeopardy. However, the formal guidance and the manual were never finalized or released. HCFA attributes the decision to discontinue this initiative to a shift in HCFA's focus toward revising enforcement regulations and its concern that some states that exceeded the proposed federal standards might weaken their standards.

Instead of formal guidance, HCFA sent a portion of the task force's work to its 10 regional offices as a set of optional protocols. These were released as

[13]HCFA's request for state budget proposals for fiscal year 1999 noted that "in some cases, it may be appropriate for the complaint to be investigated during the next scheduled visit to the facility."

"tools, not rules" for specific situations an investigator may encounter while conducting an on-site complaint investigation. These protocols did not address the prioritization and timeliness aspects of complaint investigations. This optional guidance has not been widely used. Officials at several HCFA regional offices did not recall receiving these on-site investigative protocols. Another HCFA regional office reported that it did not release the document to states in its area because the document appeared to be in draft form. HCFA does not provide additional guidance to states on ways to manage complaint workloads efficiently, how to categorize complaints, or when to expand a review beyond the residents involved with the original complaint.

In contrast, the HCFA regional office in Boston established its own task force to enhance the protocols. The region adopted its own guidance for how state agencies should classify complaints. This guidance suggests that "at a minimum, your [state] agency should have at least three action levels based on the degree of safety or health hazard alleged: high-level action, mid-level action, and low-level action."

Although HCFA had not established a priority and timeliness scheme for complaints other than those alleging immediate jeopardy to residents, the form it uses for states to report the results of investigations includes four priority and timeliness categories. The form asks states to specify whether an investigation was conducted within 2, 10, or 45 workdays or at an annual survey. It is intended for reporting state agencies' investigation results for all types of health care facilities--including home health agencies and clinical laboratories–as well as nursing homes. Thus, the form does not formally establish additional time frames for nursing home investigations. However, some states have interpreted the categories included on the HCFA form as suggested priority and timeliness categories and have modeled their standards after them. For example, officials in Maryland and Washington indicated that they adopted their priority categories in part to conform with the categories on the HCFA form. Other states, however, maintain complaint priority levels and time frames that are distinct, and often less stringent, than those identified on the HCFA form.

Federal Monitoring of States' Complaint Practices Is Limited

HCFA's major efforts to monitor states' performance in surveying and certifying nursing homes are largely focused on annual surveys–not on complaint investigations. HCFA requires its regional investigators to replicate or observe a 5-percent sample of state investigators' nursing home inspections and requires states to develop performance measures and

quality improvement programs. However, nearly all of the state nursing home inspections that HCFA monitors are annual surveys rather than complaint investigations. Even though HCFA has begun requiring states to include complaint investigations as part of their performance measurement and improvement programs, some states have not yet begun to do so. For states that have developed quality improvement programs, some programs have not identified or focused on concerns that state auditors and we have found.

Few Federal Monitoring Surveys Are Performed for Complaint Investigations

HCFA's principal method for monitoring state agencies' performance in certifying nursing homes is through the statutory requirement that HCFA staff conduct monitoring surveys of at least 5 percent of the states' nursing home investigations. This process allows HCFA either to repeat a state's survey of a nursing home and compare findings or to observe state investigators while they perform a nursing home survey. However, these federal monitoring surveys are largely intended to focus on annual surveys rather than on complaint investigations, and few federal monitoring surveys are conducted of complaint investigations.

In 1998, of the 824 federal monitoring surveys that HCFA conducted nationwide, only 39 were of complaint investigations. Furthermore, 25 of the 39 were conducted by HCFA's Chicago regional office, which oversees 6 states, and 10 were conducted in Illinois. Therefore, in the remaining 44 states and the District of Columbia, only 14 federal monitoring surveys focused on complaint investigations. Thus, federal monitoring surveys provide HCFA with little insight into state agencies' performance in conducting nursing home complaint investigations.

As of October 1, 1998, HCFA had revised its requirements for federal monitoring surveys, allowing its regions to include only a small number of complaint investigations in each state to meet the requirement that 5 percent of surveys be monitored. Under this revision, HCFA may assess only one complaint investigation as part of its quota for most states, while even in the largest states, HCFA may include no more than four complaint investigations as part of the 5-percent requirement. As a result, it is clear that HCFA intends that federal monitoring surveys principally should be a method to oversee state agencies' performance in conducting annual surveys, resulting in minimal oversight of states' complaint investigations.

Initial State Quality Improvement Reports Identify Few Problems With Complaint Practices

HCFA requires each state to evaluate its performance in complaint investigations beginning in 1998 as part of the State Agency Quality Improvement Program. However, our review of the 1998 reports submitted to HCFA by states that either we visited or had a recent state auditor's report[14] indicated that several states had not yet developed performance measures or improvement plans related to nursing home complaints, and that the states that had evaluated complaint processes ignored concerns that we and the state auditors raised. Furthermore, under the new Quality Improvement Program, HCFA regional offices appeared to be less directly involved in evaluating state agencies' performance in complaint handling than with previous oversight approaches.

Among the states visited,

- Maryland had not developed a Quality Improvement Program or baseline performance measures for nursing home complaints.[15]
- Michigan's final 1998 quality improvement report noted that staff turnover had delayed its ability to begin evaluating whether all complaints were investigated and processed within the time frames but stressed that the state agency "feels confident that this [performance standard] will be (and currently is) met." This statement conflicts with our findings that most investigations in Michigan were conducted later than the 45-day time frame adopted by the state agency.
- Although Washington's quality improvement program includes performance measures related to training staff in conducting complaint investigations and properly documenting the results, it did not evaluate the timeliness of complaint investigations. As noted above, we found that Washington categorizes its complaints at a higher priority level than do Maryland and Michigan and is more timely in investigating them. Nevertheless, Washington met its time frames in only about 55 percent of the complaints investigated.

For the states reviewed by state auditors, our review of the quality improvement reports submitted to HCFA showed that several states had

[14]We reviewed the reports submitted by the 11 states reviewed by state auditors and the 3 states we visited.

[15]While not reflected as a part of HCFA's quality improvement program, Maryland's director of the survey and certification unit indicated that the unit has implemented some improvements and is planning others. For example, the unit has hired three additional staff persons and is planning to merge the complaint and survey units.

not yet initiated quality improvement programs while few others identified concerns regarding complaints. Examples follow:

- New York had not yet established performance standards for nursing home complaints.
- Tennessee reported that it planned to begin implementing new complaint performance standards in October 1998.
- Wisconsin cited the implementation of a new data system as the cause of its delay in tracking complaints as part of quality improvement efforts but stressed that "our belief is that we are fine, but we have no data to support or refute this belief."

North Carolina's 1998 quality improvement report acknowledged that the state agency "has fallen behind significantly on investigating complaints within 60 days for nursing homes due to [a] shortage in nursing staff and the large number of complaints." As remedial actions, North Carolina reported that it intended to reevaluate its hiring practices, increase salaries to attract and retain qualified staff, improve training, and request that the state legislature either provide additional funds or repeal the 60-day statutory requirement.

The relatively new process relies largely on self-measurement of performance, resulting in less direct involvement by the HCFA regional offices than previous approaches to evaluating state agencies' performance. For example, HCFA regional offices are no longer required to review state procedures for complaint investigations and other types of nursing home oversight. Based on our interviews, some HCFA regional offices have had very little involvement in developing or monitoring states' quality improvement plans, even though this involvement is a HCFA requirement.

Inadequate Reporting Systems Hamper Effective Federal and State Management of Complaint Investigations

An effective complaint reporting system is important to support both federal and state efforts to maintain an accurate and complete record of a nursing home's federal compliance history as well as to track the state agencies' performance in complaint investigations. Tracking of complaints is integral to identifying the status of complaint investigations and to managing complaint workloads to appropriately protect residents' health. In particular, a full compliance history is key to several parts of the survey and certification process, such as HCFA's enforcement and oversight of standards, states' prioritization of complaints, and HCFA's ability to provide

full information to consumers via its Internet page and other sources.[16] We found that inadequacies in HCFA's data system and the linkage between state and federal systems hinder HCFA's and states' ability to adequately track the status of complaint investigations and for HCFA to maintain a full nursing home compliance history. In short, one HCFA official stated that the complaint system is "not used as a management tool."[17]

HCFA requires states to develop tracking systems and to submit summary information about all complaint investigations. For monitoring purposes, HCFA maintains a database of nursing home complaint investigation information. Although HCFA standards require states to report this information, the process for collecting it results in inaccurate and incomplete information. For example, HCFA collects summary information for on-site complaint investigations with a form that was created for recording information about a single complaint. Some states, including Maryland and Michigan, use the form for multiple complaints. Therefore, timeliness, prioritization, and other important tracking information that relates to multiple complaints is reported as though it applies to one complaint. In this situation, states typically record the highest priority level assigned to any of the individual complaints and are limited to choosing timeliness dates reflective of only one of the complaints. As a result, HCFA is unable to effectively monitor states' performance on prioritization and timeliness.[18]

In our report on California nursing homes, we determined that the results of complaint inspections are often cited as state, not federal, deficiencies.[19] Thus, the results of complaint investigations may not appear in federal databases. Furthermore, state officials reported that complaints might appear to be unsubstantiated in federal databases when the state has actually substantiated the complaint. In contrast, Washington and Michigan report that they record most violations they identify in both

[16]HCFA recently has begun posting results of nursing homes' most recent annual survey on the Internet, available at http://www.medicare.gov/nursing/home.asp. Results of complaint investigations are not publicly available from the Internet.

[17]For an assessment of the weaknesses of HCFA's management information systems and the impact those weaknesses have on HCFA's enforcement activities, see GAO/HEHS-99-46, Mar. 18, 1999.

[18]HCFA regional offices are also required to maintain a complaint log with the information reported by states. We spoke with all HCFA regions, and none indicated that it had any additional tracking system for complaints other than the central HCFA tracking system.

[19]GAO/HEHS-98-202, July 27, 1998.

federal and state information systems. For example, Washington has developed a crosswalk between its state licensing and federal regulations to assist providing full information in both federal and state information systems.

Overall, there is also a time lag on states reporting data to HCFA. Washington, for example, estimated that its input into the federal data system was 3 months behind. HCFA estimated that some states might lag by as much as 6 months in entering complaint investigation information into federal management systems.

Conclusions

Our work in selected states reveals that serious complaints alleging harm to residents often remain uninvestigated for extended periods. Such delays do not provide this vulnerable population the protections intended by the federally mandated complaint investigation process. Some practices, such as Washington's ready acceptance of phone complaints and its relatively prompt investigation, as well as the HCFA Boston office's guidance to states recommending improved prioritization of complaints, merit replication. Despite these positive efforts, we identified frequent systemic weaknesses in HCFA's and many states' practices that can leave nursing home residents in poor care and unsafe conditions for extended periods. The combination of inadequate state practices and limited HCFA guidance and oversight have too often resulted in extensive delays in investigating serious complaints alleging harmful situations, a lack of careful review of states' policies and practices, and incomplete reporting on nursing homes' compliance history and states' complaint investigation performance.

Recommendations

To make complaint investigations a more effective tool for protecting nursing home residents' health and safety, we recommend that the HCFA Administrator revise federal guidance and ensure state agency compliance through the following actions:

- 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.

- 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.
- Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.

Agency, State, and Industry Comments and Our Response

We obtained comments on our draft report from HCFA and the three states we visited. (See apps. IV through VII for their written comments.) In general, HCFA and the states concurred with our recommendations and highlighted efforts being taken to improve complaint investigations. They also suggested clarification on certain findings and technical changes, which we included in the report where appropriate.

HCFA, in concurring with our recommendations, also immediately announced several initiatives to address issues we raise. These include

- a new interim requirement that states should investigate complaints alleging actual harm to residents within 10 workdays, and a complaint improvement project with the intention of developing additional minimum standards for complaint investigations;
- increased federal oversight of complaints, including allowing HCFA regional offices to conduct additional monitoring surveys based upon complaints and new state agency performance measures relating to complaints; and
- improved reporting on complaint information, including a review of the form states use to report complaint information to HCFA, further direction to states requiring that complaint findings be included in the federal as well as state database in a timely manner, and a review of potential long-term improvements in the federal data system.

Maryland, Michigan, and Washington each highlighted resource limitations as contributing to the problems we identify. Specifically, Maryland noted that in recognition of many of the problems we identify, the state has recently hired additional staff and plans additional improvements, including merging its complaint and annual survey investigative staff and improving the tracking of complaints. Maryland also commented that the scope of our work was narrowly focused on complaint investigations and, as only one component of its broader nursing home oversight efforts, should not be used to evaluate the state's entire regulatory process. While we concentrated this aspect of our work on complaints, we continue to

believe that, in coordination with annual surveys, complaint investigations are an essential component of state efforts to protect residents and ensure that nursing homes provide adequate care. They afford a unique opportunity to increase state inspectors' unexpected presence in homes and to target specific areas of potential problems identified by residents and other concerned individuals.

Michigan's comments noted that prior to the period we examined the state had experienced a loss of staff and that it has been hiring and training additional investigators. Michigan also reiterated its criteria for including complaints in its highest priority level. However, we found several cases that appear to meet these criteria but were not classified as requiring a 24-hour visit. Michigan also noted that several state practices we highlight were developed with guidance from the HCFA regional office, including investigating complaints concurrently with annual surveys and delaying the investigation of certain complaints regarding nursing homes nearing the deadline for enforcement actions. Michigan disputes that its policy or practice places egregious complaints in a lower priority level. However, we remain concerned that state investigators we interviewed reported that some complaints where residents died or left the nursing home would not be investigated until the next on-site inspection. Furthermore, several cases we reviewed where a resident had died or had been transferred from the home were assigned to Michigan's lower (45-day) category, were uninvestigated for several months, or had not yet been investigated at the time of our visit. Michigan indicated that it plans a more thorough review of its handling of complaints and intends to make recommendations to address any concerns it identifies by April 1999.

Washington concurred with the importance of an effective complaint system and stressed attributes of its system, including prioritizing most complaints at a high level and a highly trained professional staff. Washington acknowledged that, because of the large volume of complaints categorized as requiring an investigation within 10 days and the need for increased resources, the timeliness of complaints within this category depends on investigators' determinations of which complaints are the most serious.

We also provided a copy of the report for review by the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA). AHCA officials expressed agreement with the report's recommendations. Both AHCA and AAHSA officials noted that the report summarizes some uninvestigated complaints and that the

allegations had not yet been substantiated or unsubstantiated. We acknowledge that many of the complaints summarized reflect allegations rather than substantiated problems and believe that the report adequately reflects that many had not yet been investigated at the time of our visit to determine their validity. We included these allegations to reflect the information that a state agency would have as it determines the priority level to assign complaints and how promptly to investigate them.

We are making copies of this report available to the honorable Nancy-Ann Min DeParle, the HCFA Administrator; appropriate congressional committees; and interested parties upon request.

Please contact me or Kathryn G. Allen, Associate Director, at (202) 512-7114 if you or your staffs have any further questions. This report was prepared by Jack Brennan, Mary Ann Curran, C. Robert DeRoy, Gloria Eldridge, and Chick Walter under the direction of John Dicken.

William J. Scanlon
Director, Health Financing
and Public Health Issues

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Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
HCFA	Health Care Financing Administration

Scope and Methodology

To develop this report, we examined state nursing home complaint investigation practices in Maryland, Michigan, and Washington. We selected these three states as case studies because they are geographically diverse and have different approaches to investigating complaints. For each state, we reviewed laws, regulations, and policies and interviewed leading state agency officials and complaint investigators.

In each of the three states visited, we

- interviewed state officials and complaint investigators and obtained documentation of each state's complaint investigation procedures and practices,
- analyzed computerized data on all complaints the states had received from July 1997 through June 1998,
- obtained and reviewed the files of complaints that each state received and investigated in early 1998, and
- obtained and reviewed the files of complaints that the states had not yet investigated at the time of our visits in late 1998 and early 1999.

For each of the 14 states included in our work, we reviewed the state agency quality improvement program report that was submitted to HCFA at the end of 1998. In addition, we interviewed HCFA officials, including representatives of each of HCFA's 10 regions, regarding federal guidance to and oversight of state agencies. We also obtained from HCFA data on federal and state expenditures on nursing home complaint investigations for all states.

State Auditors' Reports

We also reviewed reports from 11 states whose state auditor (or similar organization such as the Office of Inspector General) had performed reviews of the state's long-term-care activities and whose investigation reports were issued between December 1995 and April 1998. Each of these reports addressed some aspect of the state's nursing home complaint process. The 11 states were Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin.

Data Analysis

Each of the three states we visited provided us with electronic databases on complaints received in 1997 and 1998. These data include information such as the number of complaints received and investigated, the priority category assigned, and when the complaint was received and investigated.

Recognizing that there may be a lag in recording information regarding complaints, we excluded data on complaints received after June 30, 1998, and report data for the 1-year period from July 1, 1997, to June 30, 1998. We also only included complaints related to federally certified nursing homes. For data on timeliness, we report data only for state-investigated complaints, excluding any complaints that were either not investigated at all or were investigated only by another entity, such as the ombudsman, local law enforcement agencies, or the nursing home itself. We excluded any complaint that either did not have all dates in the database or would have resulted in a negative number of days between receipt and investigation of the complaint.

Complaints Received in Early 1998

We asked each state to give us access to its file of complaints received in early 1998.

- In Maryland, we reviewed 102 complaints that the state received between January 1, 1998, and February 27, 1998.
- In Michigan, we reviewed the 59 complaints the state received between January 1, 1998, and January 15, 1998.
- In Washington, we reviewed the 133 complaints received between January 1, 1998 and January 7, 1998.

We reviewed the nature of complaints received, the priority levels assigned, whether the complaint resulted in an investigation and the timeliness of the investigation, and whether an investigation substantiated the allegations and resulted in any federal or state deficiencies. Table 6 summarizes all complaints received in the three states during these periods in early 1998 that resulted in the state identifying a violation of federal standards and that were of a severity level that actual harm to residents was found.

Uninvestigated Complaints in Baltimore, Detroit, and Seattle

Each of the three states visited had a backlog of uninvestigated complaints and we asked each state to give us the files for these complaints. For the Baltimore, Detroit, and Seattle metropolitan areas, the tables in appendix III summarize the uninvestigated complaints that (1) had already exceeded the state's assigned time frame at the time of our visit and (2) were lodged

against nursing homes with at least three such pending complaints.[1] In Baltimore, these include only complaints that had not yet been assigned to an investigator; they do not include additional uninvestigated complaints assigned to an investigator. For Detroit and Seattle, appendix III includes any uninvestigated complaint (whether unassigned or uninvestigated) meeting these criteria.

HCFA Oversight Efforts

We contacted each of HCFA's 10 regional offices and requested

- the number of federal monitoring surveys the region conducted during 1996, 1997, and 1998, and how many of these represented reviews of complaint investigations;
- State Agency Quality Improvement Program reports for the 14 states we or state auditors had reviewed and that the states had submitted to HCFA at the end of 1998; and
- any additional guidance or oversight methods for complaint investigations that the regional office had developed.

Complaint Investigation Expenditure Data

To estimate 1998 expenditures by state for nursing home complaints, we collaborated with HCFA to develop a method to distinguish expenditures associated with (1) nursing homes for the elderly and physically disabled from other types of facilities, including those serving individuals with mental health disabilities, and (2) complaint investigations from annual surveys and other state certification and licensing activities. These estimates are based in large part on survey hours for complaint investigations compared with all survey hours as reported to HCFA by the states. Expenditure data are from 1998, except in some states where the information was not yet available for the fourth quarter of the federal fiscal year.[2] In addition, 1997 survey hours were used because 1998 data were not complete at the time of the analysis. In addition to Medicare and Medicaid expenditures, the expenditures include state licensing activities of federally certified nursing homes in all states where federal certification and state licensing activities are conducted as part of the same process.

[1]In Baltimore, complaints that were assigned a priority classification of next on-site investigation were included if they were not investigated within 45 working days.

[2]For these states, expenditure data from the fourth quarter of 1997 and the first three quarters of 1998 were used.

Appendix II further discusses, by state, how these costs are allocated between federal and state governments and reports expenditures for all types of surveys; complaint investigations; federal and state shares; complaint expenditures per visit, nursing home, and bed; and the number of complaint visits per home and per thousand beds.

We conducted our work between October 1998 and March 1999 in accordance with generally accepted government auditing standards.

Nursing Home Complaint Investigation Expenditures

In fiscal year 1998, about $300 million was spent by the federal and state governments to certify and perform state licensing functions of federally certified nursing homes, with the federal government contributing about 70 percent ($210 million) of these costs. The federal government pays the states for costs associated with certifying that nursing homes meet Medicare's standards and pays for 75 percent of the costs associated with certifying that they meet Medicaid's standards. States contribute the remaining share of the costs associated with Medicaid standards, and they also pay additional costs related to ensuring that nursing homes meet state-established licensing standards. States generally conduct these licensing reviews concurrently with their federal certification activities. HCFA and each of the states agree on the share of total costs that corresponds to the effort spent for state licensure during federal certification. Most nursing homes (77 percent) are dually certified for both the Medicare and Medicaid programs. The expenditures for these homes are split evenly between the Medicare and Medicaid programs after deducting the portion to be paid by the state for its licensing activities.

Nearly $60 million, about 20 percent of total nursing home certification and licensing expenditures, was spent on complaint investigations. The federal government contributed about $42 million, or 71 percent, of the costs associated with investigating complaints. The proportion of federal and state expenditures for annual surveys is similar to that for complaints. Table II.1 shows the total expenditures by state for the federal certification and state licensing activities for federally certified nursing homes, the percentage dedicated to complaint investigations, and federal and state shares of complaint investigations.[1]

[1]The information presented in tables II.1 and II.2 was developed by HCFA in collaboration with GAO. It is based on Medicare and Medicaid certification expenditure data, workload data and state licensure percentages reported by states to HCFA. When states investigate a complaint as part of annual inspections, HCFA requires states to separate work hours between complaint and annual surveys, but some states may neglect to distinguish complaint hours. Therefore, complaint expenditures may be understated in some states. The estimates are based on certification expenditures only, so that if a state places any portion of its certification responsibilities within other noncertification-related Medicaid-administered expenditures, this portion will not be reflected in the expenditure amounts. Also, the state licensing percentages were reported by the HCFA regional offices after verification by the states. While 77 percent of federally certified nursing homes participate in both the Medicare and Medicaid programs, there are some homes that participate solely in one or the other. The state licensing percentage is affected slightly by this mix of facilities' certification in each state. Some, but not all, of the state licensing percentages reflect a mix of facilities. This may slightly vary the federal and state shares in those states where mix of facilities was not reflected in the state licensing percentage. Data on U.S. territories are reflected in the national numbers.

The total expenditures include those for Medicare, Medicaid, and state licensing activities related to federally certified nursing homes.[2]

The amount spent on complaint investigations was estimated by HCFA and GAO on the basis of the staff time dedicated to complaints. The distribution of federal and state shares varied depending on

- the share of costs that are attributed to state licensing activities and not shared by the federal government and
- the proportion of nursing homes that are Medicare certified, Medicaid certified, and dually certified for Medicare and Medicaid.

Table II.2 presents complaint investigation expenditures, by state, per on-site investigation, nursing home, and federally certified bed, as well as the number of complaint investigations per home and per 1,000 beds.

(continued)

[2]The total expenditures also include activities for federal life-safety certification, which are separate reviews generally performed by local fire departments that ensure safety of nursing homes.

Table II.1: Estimated Expenditures for Nursing Home Complaint Investigations, by State, Fiscal Year 1998

			Federal complaint expenditures		State complaint expenditures	
State	Nursing home federal certification and state licensing expenditures	Nursing home complaint expenditures as a percentage of total expenditures	Dollars	Percentage	Dollars	Percentage
National	**$300,923,161**	**19.6**	**$41,851,120**	**71.1**	**$16,982,569**	**28.9**
Alabama	4,513,957	25.8	915,584	78.7	247,381	21.3
Alaska	718,294	10.6	44,929	59.1	31,132	40.9
Arizona	2,974,070	16.4	326,283	67.0	161,001	33.0
Arkansas	4,572,890	23.5	864,920	80.5	209,945	19.5
California	32,295,110	22.3	5,371,302	74.5	1,834,312	25.5
Colorado	4,411,078	16.4	604,763	83.7	117,878	16.3
Connecticut	6,513,868	13.1	501,715	58.8	351,886	41.2
Delaware	1,571,149	14.0	123,536	56.3	96,028	43.7
District of Columbia	884,804	10.0	54,461	61.3	34,340	38.7
Florida	10,074,324	11.4	886,421	77.1	263,636	22.9
Georgia	5,129,227	20.2	698,176	67.3	339,661	32.7
Hawaii	904,436	11.4	72,672	70.2	30,814	29.8
Idaho	1,717,627	11.9	128,585	62.7	76,334	37.3
Illinois	20,141,264	20.3	2,361,634	57.6	1,735,050	42.4
Indiana	7,221,142	24.6	1,252,656	70.6	522,195	29.4
Iowa	3,680,882	20.9	483,649	62.9	284,659	37.1
Kansas	5,795,741	19.5	760,129	67.1	371,992	32.9
Kentucky	2,990,823	27.9	615,417	73.8	218,894	26.2
Louisiana	2,620,308	6.3	137,827	83.6	27,128	16.4
Maine	1,786,290	24.9	335,846	75.6	108,512	24.4
Maryland	**2,980,394**	**7.8**	**140,614**	**60.4**	**92,053**	**39.6**
Massachusetts	8,009,692	11.6	723,255	77.9	205,546	22.1
Michigan	**7,627,160**	**15.8**	**858,315**	**71.3**	**345,864**	**28.7**
Minnesota	7,011,762	10.7	538,930	71.6	213,828	28.4
Mississippi	2,396,923	17.5	298,351	71.2	120,824	28.8
Missouri	9,585,434	30.2	2,112,904	73.1	778,952	26.9
Montana	2,615,725	15.6	328,038	80.5	79,519	19.5
Nebraska	2,783,633	18.6	342,063	66.0	176,260	34.0
Nevada	1,628,137	15.7	143,965	56.2	112,089	43.8

(continued)

State	Nursing home federal certification and state licensing expenditures	Nursing home complaint expenditures as a percentage of total expenditures	Federal complaint expenditures		State complaint expenditures	
			Dollars	Percentage	Dollars	Percentage
New Hampshire	891,682	4.7	32,665	78.1	9,134	21.9
New Jersey	8,701,678	11.5	569,847	57.1	428,978	42.9
New Mexico	1,315,590	15.9	177,305	85.0	31,284	15.0
New York	17,089,866	17.1	1,613,194	55.3	1,303,696	44.7
North Carolina	5,751,723	24.4	1,029,176	73.3	374,173	26.7
North Dakota	1,393,939	7.2	73,931	73.4	26,745	26.6
Ohio	15,592,087	17.7	2,129,053	77.1	632,731	22.9
Oklahoma	2,809,476	12.1	262,191	77.4	76,718	22.6
Oregon	3,467,206	2.9	76,050	76.9	22,874	23.1
Pennsylvania	15,295,820	13.8	1,097,780	52.2	1,005,789	47.8
Rhode Island	2,113,621	12.4	195,587	74.4	67,243	25.6
South Carolina	1,548,950	24.1	328,645	87.9	45,184	12.1
South Dakota	1,260,880	7.2	73,517	80.9	17,347	19.1
Tennessee	3,863,975	14.0	363,191	67.1	178,414	32.9
Texas	29,270,138	35.5	8,638,940	83.1	1,761,302	16.9
Utah	1,551,866	17.3	236,563	88.2	31,702	11.8
Vermont	603,018	5.5	26,204	78.8	7,068	21.2
Virginia	3,454,394	15.5	299,591	56.0	235,466	44.0
Washington	**7,245,469**	**29.8**	**1,278,506**	**59.3**	**877,655**	**40.7**
West Virginia	1,762,342	16.3	163,071	56.8	123,803	43.2
Wisconsin	9,895,572	15.7	1,048,376	67.4	507,816	32.6
Wyoming	879,581	16.0	110,802	78.8	29,732	21.2

(continued)

Table II.2: Expenditure Rates by Home, Visit, and Bed, by State, Fiscal Year 1998

State	Nursing home complaint expenditures	Complaint expenditures per home	Number of complaint visits per home	Complaint expenditures per visit	Number of complaint visits per 1,000 beds	Complaint expenditures per bed
National	**$58,833,689**	**$3,397**	**2.4**	**$1,430**	**23.7**	**$34**
Alabama	1,162,965	5,215	1.4	3,716	12.7	47
Alaska	76,061	5,071	0.8	6,338	16.7	106
Arizona	487,284	2,901	2.0	1,463	19.4	28
Arkansas	1,074,865	3,894	2.1	1,844	22.2	41
California	7,205,614	5,074	3.7	1,353	41.7	56
Colorado	722,641	3,156	1.9	1,684	22.3	38
Connecticut	853,601	3,296	0.9	3,632	7.4	27
Delaware	219,564	4,990	0.9	5,778	8.4	48
District of Columbia	88,801	4,036	1.5	2,691	10.6	28
Florida	1,150,057	1,542	1.2	1,333	11.1	15
Georgia	1,037,837	2,859	2.7	1,061	25.0	27
Hawaii	103,486	2,407	0.8	2,957	9.4	28
Idaho	204,919	2,440	1.2	2,029	17.8	36
Illinois	4,096,684	4,655	3.7	1,256	32.4	41
Indiana	1,774,851	3,097	2.6	1,203	27.0	32
Iowa	768,308	1,645	1.8	936	23.7	22
Kansas	1,132,120	2,795	3.8	739	57.8	43
Kentucky	834,312	2,649	2.5	1,057	32.5	34
Louisiana	164,955	501	0.6	805	5.7	5
Maine	444,357	3,392	2.5	1,351	36.2	49
Maryland	**232,666**	**885**	**0.7**	**1,199**	**6.5**	**8**
Massachusetts	928,801	1,647	1.1	1,553	10.5	16
Michigan	**1,204,179**	**2,694**	**2.0**	**1,361**	**17.8**	**24**
Minnesota	752,759	1,680	0.8	2,057	8.2	17
Mississippi	419,175	2,065	1.8	1,145	21.7	25
Missouri	2,891,856	5,100	4.4	1,159	49.3	57
Montana	407,557	3,881	0.8	4,739	11.4	54
Nebraska	518,323	2,160	2.3	953	31.2	30
Nevada	256,054	5,226	2.1	2,510	23.4	59
New Hampshire	41,799	504	1.1	475	11.5	5
New Jersey	998,825	2,782	2.7	1,032	19.4	20

(continued)

State	Nursing home complaint expenditures	Complaint expenditures per home	Number of complaint visits per home	Complaint expenditures per visit	Number of complaint visits per 1,000 beds	Complaint expenditures per bed
New Mexico	208,589	2,513	2.5	993	29.4	29
New York	2,916,890	4,406	2.2	1,978	12.5	25
North Carolina	1,403,349	3,482	1.7	2,013	17.7	36
North Dakota	100,677	1,144	0.4	3,248	4.4	14
Ohio	2,761,784	2,732	1.5	1,802	16.2	29
Oklahoma	338,909	823	1.1	762	13.2	10
Oregon	98,924	607	0.2	3,805	1.9	7
Pennsylvania	2,103,569	2,626	0.9	2,827	7.8	22
Rhode Island	262,830	2,602	2.3	1,143	22.5	26
South Carolina	373,829	2,124	1.8	1,194	18.9	23
South Dakota	90,864	797	0.4	1,893	6.0	11
Tennessee	541,605	1,517	1.5	1,028	13.5	14
Texas	10,400,242	8,006	4.5	1,772	50.7	90
Utah	268,265	2,885	1.8	1,597	22.7	36
Vermont	33,272	739	0.5	1,512	5.9	9
Virginia	535,057	1,891	0.7	2,585	6.8	18
Washington	**2,156,161**	**7,592**	**11.4**	**664**	**124.6**	**83**
West Virginia	286,874	1,938	0.4	4,347	5.4	24
Wisconsin	1,556,191	3,662	2.0	1,839	17.8	33
Wyoming	140,534	3,513	1.3	2,703	16.5	45

Summary of Unassigned or Uninvestigated Complaints for the Baltimore, Detroit, and Seattle Metropolitan Areas

Baltimore

As of December 14, 1998, there were 101 complaints, received between January and November 1998, filed against 56 nursing homes in the Baltimore metropolitan area that had not yet been assigned to an investigator and that also exceeded Maryland's investigation timeframes.[1] The following table summarizes the complaints filed against 12 of these homes that received three or more such complaints.

Table III.1: Unassigned Complaints for Nursing Homes in Baltimore With Three or More Such Complaints

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Maryland Home 1		
Next on-site	189 days (130 workdays)	A nurse allowed a respite resident with Alzheimer's disease to leave the nursing home; family disputes nurse's belief that resident was aware of where she was going. Family requested that a physician examine resident; however, a nurse examined her instead. Family was also unaware that home ordered a psychiatric consultation resulting in medication being ordered, and disputes home's claim that family was notified. Family alleges that the resident's medical records were falsified.
Next on-site	152 days (104 workdays)	Blind resident does not get needed assistance—such as identifying food provided her, or help leaving room.
Next on-site	123 days (83 workdays)	Understaffing, with 64 residents and only 3 to 4 aides.
Next on-site	120 days (81 workdays)	Understaffing, with 64 residents and only 3 to 4 aides.
Maryland Home 2		
10 workdays	249 days (171 workdays)	Nurse aide struck resident in the chest.
Next on-site	230 days (158 workdays)	Nursing home and complainant agreed on a time to discharge a 91-year-old resident with dementia. Home discharged the resident earlier, and the new nursing home was unprepared for resident's arrival. The family was not notified that resident was transferred early and arrived to help the resident move to find that resident had already been transferred.
10 workdays	229 days (157 workdays)	Visitor overheard a nurse aide verbally abusing a resident.
10 workdays	125 days (85 workdays)	Resident alleged that a nurse aide verbally abused her. Aide was suspended pending investigation.

(continued)

[1]For complaints designated to be investigated during a home's next on-site survey, we included only those received 45 or more workdays before December 14.

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Next on-site	96 days (65 workdays)	No hot water for several weeks or months at a time, so resident was not bathed or cleaned properly. Inadequate supply of diapers, towels, washcloths, resulting in resident sitting in urine for extended periods of time. Lack of staff, resulting in resident not being adequately hydrated, fed, turned, or kept clean. Unskilled nursing assistants attended resident. Charting of intake and bowel movements was false. It was charted that resident had a bowel movement, but resident was severely impacted and needed immediate medical intervention. Scales and thermometers did not always function properly. Fluids were not routinely offered and time was not taken to make sure that the resident drank enough. If feeding took too long, the staff would not wait to ensure that the resident ate enough. Resident was admitted to the hospital 4 times in 10 years with dehydration and a urinary tract infection.
Maryland Home 3		
Next on-site	147 days (101 workdays)	Complainant visited resident on a Saturday and Sunday and found resident dirty with dried feces and no sheet on the bed. On Sunday, resident was wet. When complainant asked aide for a towel, wash cloth, and soap, she was given paper towels and told the home did not have any soap. The complainant asked the home's staff for a water pitcher and was told that the home does not use water pitchers, only cups in the utility closet. Complainant could not find a cup in the closet and the aide told her that none was available. Call lights unanswered on both days.
Next on-site	137 days (93 workdays)	Staff does not stay to ensure that resident takes medications. Resident in same clothes for 3 days. Resident received no medications for 10 days; family not notified.
45 workdays	70 days (47 workdays)	Resident sent to emergency room with diagnosis of possible infection. Hospital staff found resident's intravenous line dirty and clogged because nursing home staff did not flush the line.
Maryland Home 4		
Next on-site	236 days (162 workdays)	Physical, verbal, and emotional abuse of a resident by nursing home staff and resident's physician who is part of the home's staff.
10 workdays	223 days (153 workdays)	Resident feeds self with a special spoon but is dependent in all other activities of daily living. On two shifts, aides refused to help the resident out of bed. Resident's supper tray was delivered but the resident was not provided any assistance to eat. Aide grabbed the resident's shoulder after the resident told the aide that her shoulder hurt. Pressure sores have worsened since admission to the home.
45 workdays	116 days (78 workdays)	Resident developed contractures because the home did not provide range-of-motion exercises as ordered.
Next on-site	101 days (67 workdays)	Management's treatment of employees is affecting care. Promised pay raise never came.
Next on-site	97 days (66 workdays)	Nursing home staff did not answer call lights. A resident with infection was not given an antibiotic as ordered.
10 workdays	67 days (44 workdays)	Nursing home offered no explanation to family for resident's leg fracture, so the family moved resident to another home. Home told state survey agency that it would investigate; however, no indication as of December 1998 that agency had received the home's report.
Maryland Home 5		
Next on-site	115 days (77 workdays)	Understaffing: unit has 1 nurse and 7 aides for 52 residents, including 2 with stage III and IV pressure sores, 13 with stomach feeding tubes, and 13 requiring injections. The nurse is unable to complete what she needs to do.

(continued)

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Next on-site	113 days (76 workdays)	Understaffing: only 1 nurse on the 7 a.m. to 3 p.m. shift with 8 aides for 52 residents, including 2 residents requiring treatment, others requiring injections, and 13 stomach tube feedings.
10 workdays	47 days (31 workdays)	Resident alleged caregiver at the home bruised her right forearm and later threw the resident onto the bed. The hospital emergency room report indicated that the arm had soft tissue injury. Pictures of the resident show a "badly bruised arm."
10 workdays	35 days (23 workdays)	Complainant not satisfied with the home's investigation of an incident report that a resident had fallen about 13 times in 4 months. The last fall resulted in laceration of the resident's forehead.
Maryland Home 6		
Next on-site	245 days (169 workdays)	Understaffing—call lights not answered in a timely manner; residents not bathed as scheduled; and residents not turned and changed as needed. One aide for 15 residents requiring total care on 7 a.m. to 3 p.m., and 3 p.m. to 11 p.m. shift.
Next on-site	179 days (122 workdays)	Discharge planning at home is not done appropriately, for example, a hospital-style bed was not ordered until resident's Friday discharge, so was not delivered until Monday. Residents not given choices of home health agencies or equipment companies. Residents' medical records do not indicate discharge planning. Discharge planning form usually is not completed and given to families to inform them of arrangements.
Next on-site	167 days (114 workdays)	Family requested restraints for resident because of falls, but home refused.
Next on-site	145 days (99 workdays)	Understaffing. Resident lost 22 lbs. in 5 months. Resident's feet have sores and are bandaged, but not always changed as ordered. Sores are beginning to smell. Complainant found resident's face swollen, but staff was unable to explain what happened.
Maryland Home 7		
Next on-site	287 days (199 workdays)	Resident told therapist that an aide verbally abused her. Home was to investigate and report to the state survey agency. However, as of December 1998, the state did not have the home's investigative report.
10 workdays	270 days (186 workdays)	Aide smokes in the home and around residents. Same aide mishandled residents—threw them into bed and used nasty language. Home was to investigate and report to the state; however, as of December 1998, there was no indication home had done an investigation.
10 workdays	88 days (59 workdays)	After contacting home about its investigation of physical abuse of a resident, ombudsman was uncomfortable with the home's inconsistent responses.
Maryland Home 8		
10 workdays	182 days (125 workdays)	Resident had discoloration of chest that family believed was bruise caused by physical abuse. Home to investigate and report to the state; but, as of December 1998, there was no indication home had investigated.
45 workdays	103 days (69 workdays)	Understaffing, resulting in the dining room being closed for 2 days. During this time, there were only 3 aides for 70 to 80 residents.
10 workdays	69 days (46 workdays)	Complainant saw a nursing home employee shaking resident. Employee terminated by home.
Maryland Home 9		
10 workdays	160 days (110 workdays)	Hygiene inadequate--resident was not bathed, teeth not cleaned, and hair not combed. Weight loss from April to June, was 134 lbs. to 120 lbs. Home said resident spit food out and that home had recommended a stomach tube.

(continued)

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Next on-site	157 days (107 workdays)	Resident was not provided food from Monday night until Wednesday at 3:00 p.m. Resident was sent to hospital after complainant insisted. At hospital, the resident was found to have infected sacral decubitus ulcer, was dehydrated, and had urinary tract infection. Nursing home staff said they had not sent resident to the hospital because resident was dying.
45 workdays	147 days (101 workdays)	New aide tried to transfer resident without another aide to assist, although the care plan called for two people for transfers. Aide said she could not get timely help, so attempted to do it by herself. Five days later, resident was found to have two fractured legs. Home wrote incident report, but did not interview new aide as required until ombudsman opened a case as a result of family's concern about home misrepresenting circumstances of resident's fall. Family called doctor, who ordered X-rays. It is unclear whether home also called doctor simultaneously, or earlier—as home reported.
Maryland Home 10		
45 workdays	181 days (124 workdays)	Resident was blind, intelligent, and sociable. Complainant has found resident alone, begging for help, screaming " . . .help, where am I?", or "please, someone get me a drink of water," or "please take me to the bathroom." No one responded or reassured resident that she was not alone. On one occasion, resident was found still in bed at 3:00 p.m.—urine-soaked, hungry, and thirsty. She had no breakfast or lunch. Nurse said home was short of staff that day.
10 workdays	145 days (99 workdays)	Aide spoke to resident in a very poor manner--told resident to "shut up" and if she kept ringing her call bell, she would be the last one to be answered. Administrator spoke with other staff who noted that the aide's attitude was poor toward residents and some staff had seen him in altercations with residents. They indicated that the aide appeared to be "fired/wired up."
10 workdays	119 days (81 workdays)	Aide was verbally abusive to resident in presence of the family.
45 workdays	68 days (45 workdays)	When admitted to home from hospital in July, resident could bathe, walk, and feed self. After 1 month in home, these activities stopped. Family met with home's staff about three times on quality-of-care issues, but problems persisted. Resident readmitted to hospital three times in her 2-month stay--a result of poor care at the home. Resident had series of falls. Home said no injuries resulted, but the resident suffers pain to the touch of bruised areas. As organ transplant recipient, needs sufficient fluids, but had not been getting, as evidenced by hospital diagnosis of dehydration. Hospital staff questioned whether resident had been receiving medications as prescribed. Staffing ratio at home was sometimes 1 aide to 20 residents on evening shift, so family had to bathe resident and put to bed. Resident placed on a toileting program by the home, but family has found her with a saturated diaper on, indicating resident was not being toileted on a regular basis.
Maryland Home 11		
10 workdays	243 days (167 workdays)	Caregiver handled resident roughly causing her to "suffer all night." The resident was in a rehabilitation unit receiving treatment for a fractured hip. Resident's roommate witnessed the incident.
10 workdays	243 days (167 workdays)	Aide was verbally abusive: called resident a "witch" and threatened to throw water on the floor and make her walk in it, hoping she would slip; said he would put her out of the unit because he was the boss on the floor; put a pillowcase over his head to try to disguise himself as resident's doctor; threatened to unplug another resident's call bell. Police were notified.
Next on-site	231 days (159 workdays)	Resident had two bruises on her arms. Ombudsman found no documentation of the bruises in records.

(continued)

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Maryland Home 12		
10 workdays	112 days (76 workdays)	A resident diagnosed with schizophrenia alleged someone in the home was sexually abusing her. Complaint investigated by nursing home, but no formal report generated.
10 workdays	81 days (54 workdays)	Resident alleged an aide placed a pillow over the resident's face; resident removed pillow, and aide did it again.
10 workdays	81 days (54 workdays)	Resident said a nurse aide yanked the bed covers off and grabbed resident's hand real hard. Ombudsman noted resident's hand had a discolored area.

[a]This column represents the number of days from the date the complaint was received to the day GAO visited the state agency.

Detroit

As of January 11, 1999, there were 129 complaints, received between February and November 1998, filed against 62 nursing homes in the Detroit metropolitan area that had not been investigated and that exceeded the state's 45-day investigation time frame. The following table summarizes the complaints filed against 17 of these homes that received three or more such complaints.

Table III.2: Uninvestigated Complaints for Nursing Homes in Detroit With Three or More Such Complaints

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
Michigan Home 1		
45 days	262 days	The nursing home changed its billing formula resulting in a large increase in fees.
45 days	160 days	The air conditioning does not work properly in one of the wings of the home.
45 days	144 days	Questionable infection control practices. Two roommates died within days of each other of complications of infections. One roommate was admitted to the home with gangrene between two toes and an ulcer on her foot, but with no oozing or infection. Despite being diabetic, which required close monitoring of her feet, the home did not change the dressings as her physician ordered. The resident's foot began to ooze and became swollen. A culture was taken and the resident was moved to another room without explanation. Twenty-five days after being admitted to the nursing home, she was returned to the hospital where she died 6 days later. The resident's roommate, who entered the home 11 days after the resident, was a diabetic with open wounds on her feet and legs when she was admitted. Twelve days after being admitted, the roommate had an elevated temperature. Despite her family's request to have her hospitalized, her doctor prescribed liquid Tylenol. That same day, she experienced breathing problems, was given antibiotics for an infection, and died.
Michigan Home 2		
45 days	122 days	Resident was not repositioned timely, developed pressure sores, and was neglected, resulting in dehydration requiring hospitalization.
45 days	111 days	Resident's condition declined visibly in a short period of time resulting in her becoming lethargic, weak, and listless. The complainant suspected dehydration even though she was taken to the hospital and not treated for dehydration. Later that week, the home advised the complainant that the resident had "perked up" and that she would have dressings applied to her feet because of skin breakdowns. During a 4-hour visit 2 days later, the complainant contends that staff did not reposition the resident during this 4-hour period and that the dressings promised earlier had not been applied.

(continued)

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
45 days	73 days	Complaint discussed treatment of several different residents over the past several years. One resident was dropped on the floor during the middle of the night, suffered knee damage, and was placed back in bed. She moaned with severe pain until the day shift nurse found her at 7:00 a.m. She was sent to the hospital where her knee, although severely damaged, could only be bandaged. She died days later. A second resident received the wrong medication that burned her mouth, throat, and lower regions causing discomfort for many weeks. She was later dropped while being weighed. A third resident entered the home with no visible skin problems but developed bedsores that led to the amputation of a limb.
45 days	54 days	Resident's feeding tube was running and vomit was evident in her mouth and on her hands and face. She was found lying in a urine-soaked sheet, and a pressure sore was also urine soaked. She also had skin tears, but no wound care was performed. On the day she was admitted, she received no insulin as scheduled. The staff reportedly said that there was no insulin in the nursing home at that time.
Michigan Home 3		
45 days	139 days	The home failed to assess a resident's injury in a timely manner. The resident fell at 12:30 p.m. suffering a broken left hip, but was not transferred to the hospital until the next day.
45 days	67 days	A resident sustained a fracture of unknown origin to the right hip. Neglect is alleged.
45 days	63 days	A resident sustained a fracture of her wrist while taking a shower without supervision.
Michigan Home 4		
45 days	195 days	Family member found a portable X-ray company taking X-rays of resident without an explanation. The floor nurse said the resident's knee was swelling. X-rays revealed a fracture in the knee. Family questions if resident was properly restrained. The hospital physician felt the resident was either dropped or fell down. The home staff stated they thought the resident might have bumped the side rail. The family also felt the resident was not receiving required assistance with eating.
45 days	119 days	During lunchtime an employee of the nursing home slapped a resident who needs assistance with eating.
45 days	96 days	A resident was not adequately groomed (soiled clothing), did not receive services ordered by a physician, was harmfully neglected, and suffered a preventable injury.
Michigan Home 5		
45 days	293 days	Resident fell sometime during the evening or the early morning of the next day. The facility put her back in bed without ordering X-rays, even though she complained of pain in her leg. X-rays were not taken for 3 days and then were taken only upon the family's insistence. The resident was transferred to the hospital where it was determined that she had a shattered hip.
45 days	255 days	A resident fell from her bed and suffered injuries including a skin tear on her hand and an abrasion on her left temple. X-rays also revealed a fracture to her left hip.
45 days	140 days	Complainant alleged a series of problems with the care provided to her father: he had no access to water despite being diabetic and was often very thirsty; he frequently slipped down in his cardiac chair but was not offered a wheelchair because the home did not have one that would fit him; the home failed to provide an assessment of the resident's breast for breast cancer; his oxygen machine was broken but complainant suspects that the home nevertheless bills Medicare for oxygen; resident was advised that his family should come and help to feed him; the resident's belongings were missing and he was wearing the clothes of other residents; complainant was told by staff that the laundry in the home is done infrequently.

(continued)

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
45 days	111 days	During a 16-month period, the resident–who is unable to turn in bed, speak, or move her right side–suffered pneumonia, numerous bruises, cracked ribs, a broken hip, a broken shoulder, and a broken leg.
Michigan Home 6		
45 days	252 days	A resident was brought into the hospital and was not breathing, was severely dehydrated, and had acute rib fractures and pneumonia.
45 days	251 days	A resident signed himself out of the home and did not return.
45 days	241 days	The resident had an untreated pressure sore. The complainant indicated that the staff intentionally hid the resident's condition from her for possibly up to one year.
Michigan Home 7		
45 days	292 days	Resident ran a temperature of 100+ degrees for three days without the home contacting the family. The resident died from bronchial pneumonia and a closed-head injury.
45 days	115 days	Nursing staff failed to provide the resident with a breakfast tray. When the resident asked the nursing assistant for the tray, the nursing assistant responded "because of your attitude, no one wants to give it to you. Do it yourself."
45 days	105 days	The home schedules only one aide per floor on the midnight shift. The home reuses the feeding tube bags between the residents. One resident was found to have maggots in the sores on his feet, but the home would not send him to the hospital because it was afraid the hospital would call the state. The Director of Nursing specifically told the staff that the resident was not to go anywhere "because the state would be called in to investigate and we do not need that right now."
Michigan Home 8		
45 days	116 days	Resident sustained an injury (fracture of the femur) of unknown origin.
45 days	116 days	Resident sustained an injury (femoral neck fracture) of unknown origin.
45 days	116 days	Resident had a hematoma over her left eye, with bruising, as well as a black left eye. The cause of the injuries is unknown.
45 days	103 days	Resident sustained a fracture (left ankle and lower leg) of unknown origin.
Michigan Home 9		
45 days	181 days	Home was understaffed; a resident was found sitting in the dining room with wet pants; resident found in a gown with no underwear; resident's clothing missing; resident not helped to bathroom in a timely manner; no therapeutic activities for residents; meals are inadequate; a dog is allowed to roam through the nursing home; offensive odors in the home; resident has been injured as a result of falls.
45 days	165 days	The resident was not allowed to take a leave of absence from the home; her privacy was not protected; she had a difficult time getting her personal expense money from the administration.
45 days	95 days	The resident fell out of a chair and was sent to the hospital where she received six stitches in the back of her head. This was the fourth time she had fallen. One of the falls resulted in permanent loss of vision in her right eye. The family also alleges that they have been denied access to her clinical records.

(continued)

Priority	Calendar days (workdays) since complaint was received[a]	Summary of allegation(s)
Michigan Home 10		
45 days	320 days	When resident returned to the home following amputation of part of his leg, the home did not take necessary precautions to ensure that the leg did not become infected. It became infected and more of the leg had to be subsequently amputated. He was also handled roughly, over-medicated, and his feeding tube was not kept clean.
45 days	320 days	Although the resident could not get out of bed without assistance, the home informed the family that he had to be taken to the hospital emergency room because he had gotten out of bed and fallen. When the family saw him, his arm was completely black and blue. He was also constantly overmedicated.
45 days	292 days	The resident was in the home for three months recovering from a stroke. Complainant alleges that the resident was left in soiled clothing for hours and was prescribed a mixture of medication that caused internal bleeding that led to a blood transfusion. The nursing home advised the resident on numerous occasions that insurance would cover all her costs and convinced her to remain in the home for the entire period of Medicare coverage. After leaving the home, she received a bill for $7,000, which a credit agency is attempting to collect from her son.
45 days	292 days	The resident was not properly groomed; food was observed in the heaters; staff did not answer call bells; staff harassed the resident and his family if they complained about care.
45 days	292 days	Resident developed pressure sores on both feet and had to have part of one leg amputated due to improper care of the sores.
45 days	291 days	The home was short of staff and was falsifying the books.
45 days	273 days	Staff would not respond to the resident's buzzer; resident was often found sitting in urine and feces; a week before he died, he complained of an upset stomach and was vomiting, but staff told the family there was a virus going around and there was nothing to worry about; family was not informed of a change in his condition.
45 days	273 days	Resident was not washed or shaved; his teeth were not brushed and his fingernails were dirty; call lights went unanswered.
45 days	189 days	The certified nursing assistants were not qualified to care for residents; staff failed to follow the care plan that requires two people to move this resident; the resident was left alone in the bathroom, fell down, struck her head, and suffered cracked ribs and various cuts and bruises.
45 days	180 days	Several residents fell out of bed one evening because the side rails were not put up; food was served cold and there was no staff person to help residents eat; the home was very short staffed and on several nights the complainant was the only nonresident adult in the wing; the resident's roommate was choking but no one responded when the complainant pulled the call light; during a shift change, all the nursing staff was gathered around the nursing station calling in lotto tickets.

(continued)

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
45 days	178 days	A resident made the following allegations: her telephone was taken away; she did not receive adequate whirlpool baths ordered by her doctor; she did not receive two baths weekly; her food was cold and unpalatable; she was not allowed to attend the church of her choice; her discharge planning was inadequate.
45 days	174 days	The resident had injuries (bruises and swelling) of unknown origin. The home provided conflicting reports as to what may have happened.
45 days	172 days	The food was not palatable; the home was short staffed; physical therapy provided was very limited; money was stolen from the night stand; beds did not raise up and down and the mattresses were very thin.
45 days	168 days	The resident had bed sores on his heels; he was refused readmission to the home following a hospital stay; he was not properly groomed (bathed and shaved); dirty bed linens were not changed; he was not turned; physicians did not visit residents but instead took the word of the nurses concerning residents' condition; resident was not timely transferred to the hospital for treatment, resulting in his death.
45 days	129 days	A nurse verbally abused the resident.
45 days	76 days	Staff failed to assess and monitor a resident who was later sent to the hospital for treatment of a seizure; they did not take proper precautions for pressure sores; they did not treat the resident with dignity and respect because they forced him to wear diapers.
Michigan Home 11		
45 days	178 days	The home did not check the blood sugar level of a diabetic resident for three days following his admission. On the third day he received two units of insulin when he should have received 100 units. When brought to the attention of the nurse, she said they were not supposed to check his blood sugar. The resident's wife insisted that the doctor be called, and it was determined that the resident's blood sugar was more than six times the normal amount. On the physician's order, the home gave him potassium pills to normalize his sugar level, but his heart rate went so high that he was taken to the hospital, where he died.
45 days	96 days	Nursing home staff would not permit the resident to leave the home to visit with his family.
45 days	55 days	Resident fell out of bed and suffered a cut on her head. Staff bandaged the cut but because she had no other marks on her body and could move her arms and legs, X-rays were not taken. Three days later she was taken to the emergency room with elevated heart rate, blood pressure, and sugar level. The doctor in the emergency room ordered an X-ray after noticing that she cried and reached for her hip when he tried to turn her. The X-ray confirmed a hip fracture, necessitating hip surgery. The complaint also alleges that the resident previously had experienced dehydration and a urinary tract infection, had two hearing aids and her dentures lost in the home, and was discovered wearing another resident's dentures, which resulted in a sore mouth and an inability to eat.
Michigan Home 12		
45 days	245 days	A resident walked out of the home and was found a block away by a passerby. He had fallen and suffered a swollen eye, a bruised hand, and a knee abrasion.
45 days	217 days	An employee was verbally abusive to a resident.
45 days	137 days	A resident developed a cut on his foot that became infected. It was left unchecked and spread into the bone. The heel had to be amputated.

(continued)

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
45 days	82 days	The resident had a condition that, if vomiting takes place, dictates that the resident should be taken immediately to the emergency room. Although the resident was suffering spells of vomiting, the nursing home failed to send her to the hospital until she was found unconscious. Following surgery, she improved, but died about a month later. Although peritonitis was listed as the cause of death, a doctor at the hospital told family members that "if she hadn't been so dehydrated and malnourished, she would have been better able to fight off the infection."
Michigan Home 13		
45 days	102 days	An employee slapped a resident.
45 days	81 days	The resident had bruises on her chin, her stomach, and her arms and legs; the home did not notify family when resident was hurt or sick; she suffered a head injury of unknown origin; the family had to request that she be hospitalized after she was ill for several weeks; she was so over-medicated that the doctor was unable to perform needed gall bladder surgery; she suffered a stroke but was not sent to the hospital until the family observed the problem and insisted on hospitalization.
45 days	55 days	The home failed to provide proper dental care. The dental progress notes were inconsistent and of dubious accuracy. Despite the home's assurance to the complainant that its dentist was capable of providing care, the resident had to visit an oral surgeon to resolve the problem that had lasted for 15 months.
Michigan Home 14		
45 days	145 days	The resident was found on the floor bleeding from an injury to her head that required 17 stitches. In addition to the head injury, the resident had bruises on her face by her mouth and under her ear and her eyes were black and blue. The complainant feels she did not get a satisfactory answer from the home about the reason for the injury.
45 days	115 days	This complaint included 28 separate allegations about the care provided to 17 residents. The allegations include: the administrator would not order needed equipment (such as recliners and geri-chairs) which forced the residents to stay in their beds; 90 percent of the home's beds are old and faulty (big gaps in the side rails); a resident got her head caught in the side rails, was sent to the hospital, and later died; side rail pads are not put on the beds; the nurses are not passing the medications; the administrator told staff to call EMS (the community emergency medical service) instead of 911 when a resident was nonresponsive, possibly to save money; one resident was gritting her teeth in the dining room and the director of nurses shoved her and her chair out of the dining room because she couldn't stand the sound; a resident was sent to the hospital due to malnutrition and dehydration and died two weeks later; a resident who entered the home with both legs is now a bilateral amputee because he developed pressure sores when staff failed to turn and reposition him or provide heel protection or foot elevation; a resident frequently complained of leg pains but his complaints were not addressed. It was later determined that he had deep vein thrombosis; a resident was frequently sleeping but no assessment or lab tests were performed to determine the problem; residents are restrained for convenience; as a result of understaffing, residents are not cleaned, changed, or provided oral care; a resident was admitted with no pressure sores, but developed sores on her heels and legs, became septic, and died; a resident with very bad teeth and gums has received no dental care; residents complain that their food trays are removed before they are finished eating.

(continued)

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
45 days	73 days	The complainant alleges that this home does not care for its residents. His father, a cancer patient, has a radiation machine in his room. Although this machine generates a great deal of heat, the thermostat in his father's room has not been adjusted accordingly and the room is very hot. The complainant also indicated that the home cannot accommodate its residents and make them comfortable as it would have people believe. The home is not clean and no one seems to care. Complaints are made to the home's staff, but nothing improves.
Michigan Home 15		
45 days	136 days	Staff told complainant that her husband had fallen and that the fall was likely due to his medication. When complainant went to the resident's room, she found that he was shaking, hot, gasping for air, that his respirations were only 30-38, and that his hands were blue. Complainant indicates that the physician assistant had been in her husband's room only two minutes earlier and had only ordered a chest X-ray. The resident was taken to the emergency room where it was determined that he had a temperature of 103 degrees and was placed on life support. The emergency room doctor determined the resident had pneumonia.
45 days	109 days	The resident receives cold showers and once went for two weeks without a shower; she lays in urine and feces; staff lost her address book and she cannot contact any of her friends; she has been denied seeing a doctor to explain her pain; no one helps her with her meals; the facility is short staffed.
Not shown	48 days	A nurse aide, thought to be but later determined not to be certified as a nurse aide, was verbally and physically abusive to a resident.
Michigan Home 16		
45 days	196 days	Nurse aide was seen striking a resident with a towel.
45 days	152 days	A resident's personal belongings (clothes and shoes) were missing and the resident had to wear another resident's shoes to a doctor's appointment; when she returned from the late-afternoon appointment, she was given cold leftovers as her evening meal; she suffered facial cuts of unknown origin; she was constantly falling but the home failed to notify the legal guardian; the home failed to coordinate transportation for a medical appointment; during visiting hours, residents were being changed in their rooms with the doors left wide open.
45 days	48 days	An employee slapped a resident across the face.
Michigan Home 17		
45 days	152 days	The resident was hospitalized for a blood infection and pressure sore; she experienced a significant weight loss; another resident was observed eating the resident's food and using her comforter; her personal property was missing.
45 days	136 days	A former employee said the home fired her after 3 weeks of employment because she refused to falsify documents; the home is understaffed; wound care is put off for two to three days; falls and aspirations (introducing food or liquids into the lungs) are common but are often not documented or reported; supplies are low; the home learned that state officials were coming for an inspection and directed the employee to falsify residents' charts.
45 days	94 days	The home failed to change the resident's incontinence products, resulting in a rash and blisters; he was hospitalized for fluid in the lungs because the home failed to provide adequate care; he lost at least 40 pounds because his dentures were lost and the home failed to provide the necessary dental care to ensure that his new dentures fit properly.

(continued)

Priority	Calendar days since complaint was received[a]	Summary of allegation(s)
45 days	63 days	At 10:00 a.m., family members arrived at the home to take the resident to a medical appointment and found her lying in bed, totally soaked in urine, including her hair and pillow. She was lying on top of the made bed, dressed in a hospital gown with her bare feet and legs totally exposed. Complainant believes she was left this way all night because no other beds on the ward were made. A week later, another family member found the resident in a similar condition. This time, she was wearing a sweatshirt, but no underwear or diaper. There were no clothes in her closet for her to be changed into. A week later, the resident was rushed to the hospital with an extremely low sugar level. She has never had diabetes and never had a problem with her blood sugar. Complainant believes it is possible that the resident was accidentally or intentionally injected with insulin (possibly that of her roommate, who is a diabetic).

[a]This column represents the number of days from the date the complaint was received to the day GAO visited the agency. Because Michigan measures its time frame in calender days, not in workdays, as do Maryland and Washington, we show only calendar days for Michigan.

Seattle

As of January 6, 1999, there were 40 complaints, received between September 1998 and December 1998, filed against 11 nursing homes in the Seattle metropolitan area that had not been investigated and that exceeded the state's investigation time frame. The following table summarizes the complaints filed against nine of these homes that received three or more such complaints.

Table III.3: Uninvestigated Complaints for Nursing Homes in Seattle With Three or More Such Complaints

Priority in workdays	Calendar days since complaint was received[a]	Summary of allegation(s)
Washington Home 1		
45 workdays	69 days (45 workdays)	Floor of resident's room was dirty; urine on floor at noon was still there at 4:30 p.m. Staff never asked preference on meals. Staff told resident he could not have bed rails because it was against the law.
10 workdays	68 days (44 workdays)	Resident fell from wheelchair and was cut above eye. Complainant asked staff to call medical aid, but staff said not needed because laceration was not deep. Complainant insisted, and resident was taken to hospital where he received 6 sutures and was observed for pain in right arm. Complainant was removing the resident from this home, but was concerned about the residents who remain.
10 workdays	68 days (44 workdays)	(Same resident and incident as previous complaint; new allegations.) Fell from wheelchair, apparently because staff did not strap in properly. Staff of new nursing home visited home where incident occurred and was allowed to read resident's chart without a release from the resident. Complainant concerned about confidentiality.
Washington Home 2		
10 workdays	89 days (58 workdays)	Staff did not feed resident and told the complainant to feed resident. Staff ignored resident after they learned family complained to state. Did not maintain cleanliness of urinary catheter. Resident now hospitalized, and home will not take resident back.
10 workdays	77 days (51 workdays)	Insufficient staffing resulted in inadequate hygiene, resident falls. Resident was charged for wheelchair management training, but home never provided training.
10 workdays	76 days (50 workdays)	Resident (same as in above complaint) billed for wheelchair management training, but never received training.
Washington Home 3		
10 workdays	71 days (47 workdays)	Resident sustained two fractures of her leg, which home believed occurred while moving resident. Sent resident to hospital for X-ray, and suspended person who made the transfer.
10 workdays	54 days (35 workdays)	Nurse allowed relative and others to give resident his medication. Nurse did not always administer recommended dosage of morphine, but gave more. Room and facility not always clean and staff did not bathe resident until complaint was made. Nurses changed diet from regular to liquid to keep him from throwing up, and would not restore regular diet because didn't want to clean up the mess if he threw up again. Doctor never came to see resident.
10 workdays	48 days (31 workdays)	Resident did not receive pain medications ordered by the doctor. Resident's family was not given proper admission paperwork to sign.

Priority in workdays	Calendar days since complaint was received[a]	Summary of allegation(s)
10 workdays	44 days (29 workdays)	Resident who was generally confined to bed got up, walked down hall, fell, and fractured hip. Was in hospital for surgery.
10 workdays	30 days (20 workdays)	Stolen items. Facility reeks of urine. A resident lies on floor in front of elevator and attacks visitors.
10 workdays	27 days (17 workdays)	Resident was found urine-soaked every visit. Left in nightclothes. Not wearing eyeglasses or hearing aid.
Washington Home 4		
10 workdays	96 days (63 workdays)	Resident fell out of bed in spite of side rails, and suffered head laceration requiring stitches.
10 workdays	71 days (47 workdays)	Staff member slapped resident on leg, which already had nerve damage.
10 workdays	68 days (44 workdays)	Verbal abuse and public humiliation of talkative resident by therapist.
10 workdays	37 days (25 workdays)	Fracture of leg below kneecap of unknown origin. Patient has osteoporosis.
10 workdays	54 days (35 workdays)	Home is billing 12 percent interest on outstanding charges. Home cannot locate lift chair that was owned by deceased resident.
10 workdays	26 days (16 workdays)	Verbal abuse by nursing assistants, including a threat to take away call light because of the resident's frequent use of it.
10 workdays	24 days (15 workdays)	Alleged neglect--untreated leg wound was bed sore; leg may have to be amputated. Patient showing mental decline, without satisfactory diagnosis.
Washington Home 5		
10 workdays	90 days (59 workdays)	Home trying to force a resident out, into adult home not suitable to needs of wheelchair-bound resident.
10 workdays	54 days (35 workdays)	Resident with history of hitting staff and other residents apparently hit fellow resident on head, causing bruise and abrasion with slight bleeding.
10 workdays	28 days (18 workdays)	Resident with history of aggression hit another resident in jaw.
10 workdays	21 days (13 workdays)	Poor care and service; quality of care in home has declined. Catheter leaked and soaked resident, but aide left resident wet; so resident called 911--taken to hospital.
10 workdays	19 days (11 workdays)	Resident wanted to leave nursing home, as could function on own. Overmedicated to point that could not think and speak clearly. Nothing to do in nursing home. Disagreements among family, resident, and nursing home staff impeded eventual transfer to independent living. Nursing home social worker and state case manager tried to prevent independent living by labeling suicidal. A near-failure of system of rights and protections, requiring ombudsman's repeated intervention.
10 workdays	16 days (10 workdays)	Resident has had numerous falls--12 within a few weeks--in spite of mats around bed, special alarm, lap tray on wheel chair. Latest fall required emergency room visit and stitches, as did another fall.
Washington Home 6		
10 workdays	93 days (62 workdays)	Resident found covered in blood, feeding tube pulled out, yet resident unable to have pulled out on own due to physical limitations. Hospitalized.

(continued)

Priority in workdays	Calendar days since complaint was received[a]	Summary of allegation(s)
10 workdays	43 days (28 workdays)	Resident had burn on leg, which was brought to complainant's attention by home's staff.
10 workdays	36 days (24 workdays)	Resident was served cup of coffee so hot that it caused her to drop it and burn her right leg.
10 workdays	22 days (14 workdays)	Resident, who is being treated for mental and other difficulties, receives visits from son who verbally abuses resident. Resident gets upset and stops eating. Complainant fears son contributing to recurrence of mental difficulties.
Washington Home 7		
10 workdays	108 days (72 workdays)	Ongoing problem with theft of resident's personal items. Difficult to contact nursing home staff by phone to resolve issue. Facility has not resolved issue.
10 workdays	71 days (47 workdays)	Neglect, inadequate staffing, untrained staff: Resident looked like swallowed watermelon due to impacted bowel—a recurrent problem. No bowel movement charted in 10 days. Medications not given, but appears records falsified to show given. Home discontinued ordered medication.
10 workdays	64 days (42 workdays)	Home unresponsive in addressing care problems brought to its attention. Due to reduced staff, administration of medications is erratic. Call lights not answered for 2 hours, so not getting to bathroom timely—now have rash from being urine-soaked. Missed 3 weekly baths. Turnover of temporary staff creates communication problems.
Washington Home 8		
10 workdays	33 days (21 workdays)	Concern over care needs not being met.
10 workdays	44 days (29 workdays)	Staff shortages leading toward burnout.
10 workdays	37 days (25 workdays)	Resident says young man fractured his hand. Staff treated resident roughly and tried to force him to eat. Doctor unable to answer questions about medications or other care questions.
Washington Home 9		
10 workdays	58 days (38 workdays)	Staffing inadequate to meet needs of residents. Call lights not answered, or answered late. Reportable incidents not reported and recorded properly.
10 workdays	27 days (17 workdays)	Medication error—order was changed but missed by staff, so that resident received higher dosage than ordered for a month.
10 workdays	18 days (10 workdays)	Medication error—mix-up of residents, so that resident received own medications and another resident's on same morning. Doctor and nurses intervened, and close monitoring of vital signs followed.

[a]This column represents the number of days from the date the complaint was received to the day GAO visited the state agency.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FROM: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration (HCFA)

SUBJECT: General Accounting Office (GAO) Draft Report, "Nursing Homes: Complaint Investigation Processes Inadequate to Protect Residents"

TO: William J. Scanlon, Director
General Accounting Office (GAO)

We appreciate the opportunity to review your draft report regarding state complaint investigation processes. This report underscores the need for the states and for HCFA to develop and maintain an effective complaint monitoring program for all nursing homes, and for nursing homes to do a better job caring for residents.

We generally agree with, and will address, the recommendations set forth by the GAO in this report. Our specific comments are attached. We look forward to working with the GAO and the Congress as we further our commitment to protecting the health and safety of beneficiaries residing in nursing homes.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

COMMENTS OF THE HEALTH CARE FINANCING ADMINISTRATION ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "NURSING HOMES: COMPLAINT INVESTIGATION PROCESSES INADEQUATE TO PROTECT RESIDENTS"

In 1995, the Clinton Administration implemented the toughest-ever enforcement regulations, which resulted in measurable improvement in quality of care in nursing homes. Building on that foundation, the President announced an aggressive initiative in July 1998 to further strengthen enforcement and to ensure that all nursing home residents receive the quality care that they deserve and their families expect.

We have already implemented many aspects of the initiative. We have issued new guidance to States to strengthen their nursing home inspection systems and to crack down on nursing homes that repeatedly violate safety rules. We have also taken other steps to reduce the incidence of bed sores, dehydration and malnutrition, and to give consumers ready access to comparative information about nursing home quality. The President's Fiscal Year 2000 budget request includes additional resources to fully implement all aspects of the initiative.

We very much appreciate the opportunity to review the GAO report entitled "Nursing Homes: Complaint Investigation Processes Inadequate To Protect Residents." This report underscores the need for the states and for HCFA to develop and maintain an effective complaint monitoring program for all nursing homes, and for nursing homes to do a better job caring for their residents.

We strongly believe that the President's nursing home initiative has done much to strengthen enforcement and to enhance the quality of care for all nursing home residents. Nevertheless, we are troubled by what the GAO has found in its most recent draft report on complaints, and agree that further refinements to our complaint processes are needed. We remain committed to taking appropriate steps to ensure that residents are safe and receive quality care, and we will continue to work with the States, Congress, residents and their families, advocacy groups, and nursing home providers to advance this essential mission. We generally agree with, and will address, the recommendations set forth by the GAO in this report.

Complaint Investigation Process

We have long viewed complaints as a valuable source of information about the health and safety of nursing home residents. In response to these problems, we created an internal workgroup in 1995 to develop formal complaint guidelines for the states. Unfortunately, survey and certification budgets, a large increase in providers, and the difficulty associated with devising national standards and maintaining state flexibility proved to be a formidable challenge. Instead, we developed a set of complaint investigation protocols that were sent to the regional offices for distribution to the states as "tools, not rules." Clearly these protocols for the states must be strengthened.

Therefore, in order to address our own concern that the complaint process is not responsive to beneficiaries and their families, and the GAO recommendations, we have taken two major steps. First, we have sent a letter to all state survey agencies notifying them that any complaint that alleges actual harm to an individual in a certified facility must be investigated within 10 working days of its receipt. We have also reminded the states to enter complaint information into the OSCAR system in a timely manner.

Second, as we focus our resources on improving the survey and certification system, we have also begun an examination of states' responses to nursing home complaints from residents, their families, nursing home staff, and other sources. To this end, we have initiated a Complaint Improvement Project (CIP). This project will assist us in developing cost-effective standards for prioritizing and determining the appropriate time frames for complaint investigations. As we proceed, the concerns of beneficiaries, their families, consumer representatives, and representatives from AoA's Ombudsman program will be solicited and incorporated into the design and final work products.

GAO Recommendations

The following more specifically outlines our responses to the findings and recommendations in this report:

Recommendation #1

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 timeframes for investigating serious complaints and for complaints that are deferred until the next survey schedule.

HCFA Comment

We concur. Effective immediately, any complaint that alleges actual harm to an

individual in a certified facility must be investigated by the state within 10 working days of its receipt. We have sent a letter to all state survey agencies notifying them of this new interim requirement, and reminding them that all complaint data must be entered in a timely fashion into the On-line Survey, Certification and Reporting system (OSCAR). The states have also been reminded of current policy -- any allegation involving immediate jeopardy must be investigated within two working days.

Furthermore, as we begin to conduct an analysis of complaint investigation processes, we anticipate developing more standards and long-term improvements (for example, in the OSCAR system). These standards may have resource implications and we look forward to working with the Congress to address critical resource issues.

The Complaint Improvement Project (CIP) will help HCFA strengthen the key elements of the complaint investigation and resolution process. These elements include: (1) how consumers are informed of their right to make complaints and how to do so; (2) the complaint intake process, including how complaints are received, classified and scheduled for investigation; (3) the investigation process, including the training, knowledge, attitudes, and case load of investigators; (4) the resolution process, by which the determination is made about whether a complaint is substantiated; (5) the administrative hearing process, including back-log of cases; (6) the compliance or response process for addressing substantiated complaints, including the range and actual use of remedies and back-log of actions; and (7) interaction of the complaint investigation process with the licensure and certification systems, the legal system, and facility-level grievance or continuous quality improvement processes.

HCFA will use this information to set minimum standards for complaint investigations. HCFA will then produce a manual for the states that describe each element of a model complaint investigation process, how states have implemented these processes, and staffing levels, training, and other needs. In addition, HCFA will specify measures to strengthen federal monitoring/audits of state performance, including the elements that should be included in a federal complaint investigation reporting system and database. And HCFA will explore other changes needed to strengthen oversight of the states in order to enhance the responsiveness of the complaint investigation process and to better protect beneficiaries.

Recommendation #2

Strengthen federal oversight of state complaint investigations, including monitoring state practices regarding priority-setting, on-site investigation, and timely reporting of serious health and safety complaints.

HCFA Comment

We concur. We have taken steps to address this problem and other steps will be initiated:

- We will allow the HCFA Regional Offices to perform "look-back," (or verification) surveys based upon complaints from nursing home residents. This means, in effect, that a complaint from a resident can trigger a standard survey for a nursing home.

- Consistent with the nursing home initiative, we are working on improving federal oversight of state performance. Currently, we are in the process of outlining a number of actions that HCFA can take when there is evidence that states are not fulfilling their survey responsibilities. In order to evaluate and improve state accountability specifically for complaints, we will include state responsiveness to complaints as a performance measure. Since we are also concerned about the backlog of complaints for several states that are not entered into our OSCAR database, we will also include this as a performance measure. In addition, as part of the Complaint Improvement Project (CIP), we plan to review federal monitoring processes to identify those practices which are most effective in monitoring State processing of complaints.

- HCFA regional offices are required to maintain a log of complaint information reported by the states. If we confirm that these logs are not being maintained, as reported by the GAO, we will take immediate steps to reemphasize the requirement and correct this omission.

Recommendation #3

Require that the substantiated results of complaint investigations be included in federal data systems or be accessible by federal officials.

HCFA Comment

We concur. States are currently required to report this information. If the current complaint form is not adequate, as suggested by the GAO report, interim improvements will be made and states will be monitored more closely. To this end, HCFA has:

- directed the states to immediately enter all complaints into HCFA's OSCAR system even if the complaint has been or is going to be entered into a State licensure system. States will be closely monitored to ensure that the information currently required is actually entered into HCFA's database. The reporting of complaints will be a new performance evaluation element for the states.

- directed staff to revise the current complaint form so that HCFA can effectively monitor states' performance and prioritization and timeliness.

Nursing Home Initiative Accomplishments

We very much appreciate the opportunity to review this report and to receive critical information and recommendations from the General Accounting Office. While this report demonstrates the need for additional steps we are taking on state complaint investigations, I would like to share with the GAO the accomplishments that have been made within the past eight months as a result of the President's nursing home initiative:

Faster Remedies
HCFA has expanded its definition of the type of facility for which HCFA would take an immediate enforcement action without a grace period (i.e., an opportunity for the facility to correct before sanctions are imposed). We previously labeled these facilities as "poor performing facilities (PPFs)". However, we are now revising our guidance to remove this label, and provide, in its place, direction about when facilities will be given an opportunity to correct. The guidance will make the assumption that unless a facility has no actual harm on the current survey it would not automatically be given an opportunity to correct before sanctions are imposed. Because facilities have no right to a period of correction prior to the imposition of sanctions, there could be other instances where facilities would not be given such an opportunity; for example, where a facility's pre-termination history indicated no commitment to achieve and maintain compliance with participation requirements, we believe it would be appropriate to impose sanctions immediately.

Enhanced Enforcement Training
HCFA has been vigorous in encouraging States to apply appropriate sanctions for the noncompliance identified in the President's initiative. We will be providing training and guidance to States beginning this Spring on the nursing home initiatives including enforcement, use of quality indicators in the survey process, survey tasks in the areas of medication review, pressures sores, dehydration, weight loss, and abuse prevention.

Enhanced Oversight of Selected Facilities
As part of our July 1998 initiative, HCFA has identified facilities in each State for more frequent inspection and intense monitoring. In selecting these special focus facilities (SFFs), HCFA scored each nursing home based on the results of its most recent annual inspection and any substantiated complaints during the past 2 years. HCFA presented each State survey agency with the names of those homes that generated the highest scores. States selected two facilities and have begun to monitor them more frequently.

Baseline data has been collected on each facility and monthly status reports are required. The monthly status report includes any survey outcomes, complaint investigations, enforcement actions, or press attention for each facility. The purpose of more intense monitoring of these facilities is to determine whether or not closer scrutiny and imposition of immediate remedies will have a lasting effect on these homes, i.e., whether the "yo yo" compliance history is affected. HCFA will conduct systematic analysis to determine if more intense monitoring is effective and if there are innovations with monitoring these facilities which can be used in the overall program.

Stronger Federal Oversight
HCFA has also initiated a national program for improving the accuracy and consistency of State survey results. In October 1998, a standardized system for evaluating State survey performance was implemented. The Federal Oversight and Support Survey (FOSS) is a structured protocol for HCFA staff to use onsite in assessing the State survey teams' adherence to Federally mandated procedures and policies. Where training needs or corrective actions are identified, HCFA staff works with the State to assure that the necessary changes are implemented. We expect that this more standardized and aggressive approach to oversight will improve national consistency in the performance of nursing home surveys.

Quality of Care Enhancements
HCFA is in the process of implementing a wide range of initiatives to improve its ability to detect and prevent bed sores, dehydration, and malnutrition in nursing homes. In conjunction with national experts in nursing home care and quality indicator development, HCFA is developing a systematic data driven process for assessing quality problems in nursing homes. This data driven surveillance system will use indicators of potential care problems for facility residents to identify a sample for more in-depth on-site assessment including a larger sample to review for weight loss and pressure sores. National roll outs of this systematic approach are expected to be completed by the end of 2000 with an interim enhancement to the survey process implemented in 1999. In addition, HCFA staff are working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for residents at risk for weight loss, dehydration, and pressure sore development. This includes better guidance and training for surveyors on standards of care practices. A national campaign to educate residents, families, other consumers, and nursing home staff about the risks of malnutrition and dehydration as well as nursing home residents' rights to quality care in nursing homes will begin this year.

Abuse Prevention Campaign
HCFA has concentrated efforts on the reduction of abuse and neglect in facilities. A national abuse and neglect forum consisting of representatives from groups concerned with the frail elderly and disabled has been formed. A survey protocol developed through

the forum workgroup for evaluating nursing homes' abuse and neglect prevention processes will be implemented nationally by July 1999. A national consumer education campaign on prevention and detection will also be inaugurated this Spring.

Management Information System
HCFA is in the process of a major redesign and enhancement of its information system for nursing home quality. The goal is to implement in stages a system that is both user friendly for HCFA, State survey agencies, providers and consumers, and includes information necessary for nursing home quality of care evaluation and improvement. In June 1998 the first segment of this information system began with the development of State and national repositories with resident-specific data on declines and improvement (Minimum Data Set (MDS) longitudinal data). In July 1999, HCFA will start using quality indicators developed by national experts to analyze MDS data and identify domains of potential care problems. These quality indicator reports will be available to HCFA and State survey agencies for enhancing the survey system as well as to providers for internal quality improvement activities.

In addition, in July 1999, an improved system for information collection, consolidation, and integration will be available to State survey agencies. State staff and managers will be able to generate, for individual facilities, tables that include relevant survey results as well as quality indicator information. This improved information system will enhance States' ability to assess the overall performance of an individual nursing home and to better manage survey resources. Future stages of the improved information system on facility quality will include: enhancement to the State systems on enforcement actions; major revisions to the current On-line Survey, Certification and Reporting (OSCAR) system to provide better and more integrated national information in a more user friendly environment; consumer information on quality indicators; updated quality indicators; and better national enforcement data. HCFA will proceed as quickly as possible with development of its improved information system for nursing home quality although there will be some delays attributable to Y2K priorities.

Consumer Information
HCFA is working to make survey results more accessible to the public. HCFA's new Internet site -- Nursing Home Compare -- now gives families and consumers direct Internet access to comparative information about nursing homes as well as provides incentives for nursing homes to improve the quality of care. Since the site was established last September, approximately 826,000 pages have been viewed and we are working with consumers, industry and others to make it more useful to consumers and their families. These and other such projects reflect HCFA's commitment to improving care in nursing homes through better information, education and enforcement.

Budget

In support of the nursing home initiatives, Congress appropriated an additional $4 million to the $167 million in total survey and certification funds requested and approved for fiscal year (FY) 1999. The additional $4 million earmarked by Congress will be used primarily to fund four key components of the nursing home initiative announced last July.

The Administration has proposed to expand its total survey, certification and enforcement related funding in the FY2000 budget request to $204.3 million, an increase of $33.3 million over the FY 1999 funding. This increase includes another $18.1 million for survey and certification activities associated with the nursing home initiative. In addition, HCFA requests another $32.5 million in FY 2000 for the nursing home initiative, including: $15.6 million in mandatory Medicaid funds to supplement State inspection and enforcement activities in dually-certified and Medicaid-only nursing homes, and $16.9 million in other discretionary funds to improve Federal oversight of State surveyor efforts and establish a national patient abuse registry.

With the approval of this funding, HCFA envisions making significant gains in improving the care of beneficiaries and in providing the oversight necessary to assure that all are working toward this common goal.

Comments From Maryland's Department of Health and Mental Hygiene

State of Maryland
Department of Health and Mental Hygiene
Parris N. Glendening, Governor - Martin P. Wasserman, M.D., J.D., Secretary

March 15, 1999

Kathryn G. Allen
Associate Director, Health Financing and Public Health Issues
General Accounting Office
HEHS/HFPH - 5th Floor
441 "G" Street, NW
Washington D.C. 20548

Dear Ms. Allen,

Thank you for the opportunity to review the draft report concerning nursing home complaint investigation processes. Even in draft form it is a valuable planning and management tool for us. When released, it will undoubtedly be cited in numerous public policy discussions. This places upon all of us the responsibility to ensure that the document is as accurate as possible. After a careful examination of the draft report, we offer the following comments in response:

In late 1997, because of a growing backlog of unresolved complaints, we conducted an internal review of our complaint process. We identified several operational issues in the Complaint Unit and began corrective action on several fronts. In early 1998, we assigned an additional investigator and manager to the Complaint Unit staff. In mid-1998, we added an attorney to work specifically on abuse allegations. We have also worked to improve our complaint procedures. These initiatives have included revisions to our intake process and tracking mechanisms, and the merger of the survey and complaint units under a single administrative head. These actions have brought increased efficiency to the process, resulting in a shorter response time and a reduction in the complaint backlog. This is especially significant in light of our projections that complaint volume will increase by 25 per cent in 1999.

Recent evidence suggests that our initiative is succeeding. In the last few months, we have prosecuted several allegations of abuse against geriatric nursing assistants and have threatened nursing homes with termination and or fines for quality of care complaints. All the investigations were conducted timely and efficiently. The new management structure which merges the Survey and Complaints Units has eliminated internal communications bottlenecks and will continue to improve our ability to respond efficiently and consistently. The internal review process that brought about these changes is also in the process of being formalized and institutionalized, with the goal of establishing a permanent internal quality assurance program within the Maryland State Agency.

201 West Preston Street - Baltimore, Maryland 21201
TDD for Disabled - Maryland Relay Service (800) 735-2258

Healthy People in Healthy Communities

Finally, we think it is important to draw attention to the relatively narrow focus of the GAO survey. Complaint investigation consumes only a small portion (8 per cent according to both the GAO and HCFA) of the resources allocated for nursing home regulation; the results of a survey which targets only the complaint process should not be used to evaluate the entire regulatory process, nor should it be used to justify the shifting of resources into complaint investigation at the expense of the rest of the regulatory process. There exists at present a critical need for additional Federal resources in all facets of the regulatory process; it is our sincere hope that this GAO survey report can be used to help us obtain those resources.

Sincerely yours,

Carol Benner

Carol Benner
Director, Licensing and
Certification Administration

Comments From Michigan's Department of Consumer and Industry Services

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

P.O. Box 30004
Law Building
Lansing, MI 48909-7504
517-373-1820

March 16, 1999

William Scanlon, Ph.D., Director
Health Financing Public Health
HEHS/HFPH
U.S. General Accounting Office
441 G Street NW
Washington, D.C. 20548

Re: Nursing Homes: Complaint Investigation Processes Inadequate to Protect Residents
GAO/HEHS-99-80)

Dear Doctor Scanlon:

Attached are comments from the Michigan Department of Consumer and Industry Services, Bureau of Health Systems, regarding the above referenced report.

Thank you for granting an extension for the submission of our comments. If you have questions, please contact Walter Wheeler, Director, Bureau of Health Systems, at 517/241-2632.

Sincerely,

Kathleen M. Wilbur
Director

Attachment

Michigan Relay Center (Voice and TDD) 1-800-649-3777

MICHIGAN COMMENTS ON GAO REPORT ENTITLED "NURSING HOMES: COMPLAINT INVESTIGATION PROCESS INADEQUATE TO PROTECT RESIDENTS (GAO/HEHS 99-80)

PROCEDURES OFTEN DISCOURAGE PUBLIC FROM FILING COMPLAINTS

Page 10 **"For instance, Maryland and Michigan strongly urge the public to file complaints in writing rather than accepting complaints by phone."**

The Michigan program is governed by a State law (MCL 333.21799a) which requires that all complaints either be in writing or reduced to writing within seven (7) business days. This accounts for the high percentage of Michigan complaints which are written.

Oral complaints are accepted and the process for making an oral complaint is set forth in the **Citizen's Guide for Filing a Complaint Against a Health Facility**, a pamphlet published by the Department and widely distributed. Assisting complainants to reduce their concerns to writing ensures that their matters of concern are correctly identified so that they can be addressed during the complaint investigation.

Page 10 **"In Michigan, only about 4 percent of publicly reported complaints were submitted by phone."**

Michigan has a well-publicized 1-800 number for the purpose of receiving oral complaints. This number is published in the citizen's guide which was distributed to all nursing homes in 1998 and which must be available in facilities' lobbies.

Virtually all of our citizen complaints are initially submitted by phone. However, our records are changed to show a complaint was written once it is reduced to writing as required by law. The most egregious complaints, Priority 1, are always accepted verbally and acted upon.

A 24-hour emergency hotline was established in 1998 for receipt of facility reported incidents that occur after-hours which endanger residents. This emergency number is for facility reporting only and is rotated among managers for a two-week period. This emergency line does not replace the Complaint Hotline for individuals to register complaints. In Michigan, there are two 1-800 numbers - one for facility reported after-hours events which endanger residents and the second for individual complainants to call. Facilities use both the complaint and 24-hour emergency hotlines to report incidents.

STATES ESTABLISH WIDELY-VARYING CATEGORIES FOR PRIORITIZING COMPLAINTS

Page 11 **Table 2: Complaints Received Between July 1, 1997 and June 30, 1998**

In Michigan, each complaint may have more than one allegation and each allegation must be investigated separately. Our data system indicates that the total number of complaints and facility-reported incidents in this period were 2,507 with a total of 5,678 allegations.

Page 11 **(Footnote) "Michigan statute requires an investigation within 30 days, but in 1998 the state agency operated under a 45 day timeframe."**

Page 19 **(Footnote) "Although state law requires non-immediate jeopardy Priority 2 complaints to be investigated within 30 days of receipt, Michigan's Department and Industry Services changed the 30-day requirement to a 45-day requirement. As shown in the table, Michigan was unable to meet even the 45-day time frame in most cases."**

The GAO report focuses on files and complaints investigated beginning in July 1997. Immediately before the study period, Michigan experienced a massive statewide early retirement program for state employees (April to June 1997). The licensing and certification program lost 20 positions of which 9 were directly related to long term care surveys and complaint investigations. Although we were authorized to replace these survey positions, hiring and training of replacement staff took almost a year. There were additional regular retirements following the early retirement program which left more long term care surveyor vacancies.

Because of the resulting delays in complaint surveys, for a period of six months from May 1998 to November 1998, Michigan used 45 days as the time frame to conduct complaint investigations because we were not meeting the more stringent 30-day requirement. During this period, the shortage of staff was reviewed by the Governor and Michigan Legislature in the annual budget process.

Effective October 1, 1998, the Governor and State Legislature approved eight additional surveyor positions for complaint investigations. All positions are now filled except one. The new surveyors are undergoing orientation and training. There is a lag period of nine months before a surveyor is fully trained, proficient in conducting surveys and complaint investigations independently, and tested by the federal government.

The Department of Consumer and Industry Services is committed to improving its performance in conducting complaint investigations in a timely manner. The new surveyor staff will improve this performance. However, an evaluation of the timeliness of conducting the standard surveys, issuance of survey reports and performance of complaint investigations are under review. This evaluation was started January 1, 1999, when the Department began to initiate off-hour surveys and complaint investigations and monitoring of special focus facilities. In addition to this review, the Department is conducting an in-depth study of the complaint handling process and

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expects recommendations by the middle of April 1999.

COMPLAINTS MAY RECEIVE AN INAPPROPRIATELY LOW INVESTIGATION PRIORITY

Page 14 **"The infrequent use of high-priority levels in some states raises a question as to whether complaints are being appropriately categorized..... Michigan did prioritize some complaints as immediate jeopardy, but they accounted for a small percentage of total complaints received."**

We do not artificially classify complaints at lower levels. In Michigan, Priority I criteria for categorizing complaints are stringent identifying concrete examples of types of complaints that are in this category (see criteria listed below). If the criteria for categorizing complaints for this priority level are too stringent and should be broader, additional guidance is needed as to what other examples should be included.

Complaints or facility-reported incidents that are categorized in Priority I (24 hour response) are: 1) Injury or incident involving death or potential criminal activity under investigation by a state or local law enforcement agency; 2) Abuse with injury; 3) Elopement of a resident/patient missing for more than eight (8) hours; 4) Serious injury which is life-threatening to the resident/patient; 5) Sexual assault; and 6) An allegation of failure to readmit a Medicaid resident/patient (report to be written and processed immediately for enforcement). Additional complaints may be moved to this priority level if the situation or concerns are progressively worsening, the complaints involve an increasing number of individuals involved or at risk, or there is an administrative need to expedite the investigation, such as the recurrence of a known problem in the facility.

Page 14 **(Footnote) "Although Michigan's policy includes a priority level that permits complaints to be visited at the next annual survey, none of the complaints we reviewed were categorized at the priority level...."**

Prior to OBRA enforcement, the Complaint Unit conducted complaint investigations as stand-alone abbreviated surveys. In 1996, it was jointly determined by Michigan and HCFA Regional Office that sanctions resulting from standard surveys and complaint investigations had to be coordinated so that the facility was under one enforcement cycle rather than having two cycles running separately and not covering the same time period. Specifically, the RO strongly urged that complaint investigations be conducted concurrently with standard surveys wherever possible. In response partly to this issue, in May 1996 Michigan abolished the Complaint Unit and combined its complaint and survey functions.

Michigan's complaint database was not originally designed to accommodate the combining of a

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standard survey or revisit with a complaint investigation. In August 1997, a modification of the database system was made to calculate the number of complaints and incidents that are combined with the standard survey. For the period of July 1, 1997 through June 30, 1998, sixty-nine (69) complaints were combined with the annual survey. Additionally, 269 facility reported incidents were combined with annual surveys. This represents 13% of the 2507 complaint and facility reported incidents for the same period.

Page 14-15 **"Michigan also adopted procedures that result in lower priorities assigned to serious complaints. Specifically, Michigan gives a complaint low priority if the resident is no longer at the nursing home when the complaint is received – even if the resident dies or was transferred to a hospital or another nursing home due to care problems. The state may investigate these complaints during the home's next survey or not at all.... For example, in one such complaint, in Michigan, it was alleged in July 1998 that a resident died because the home did not properly manage the patient's insulin injections and blood sugar tests. Because the resident died, the state had not investigated the complaint as of January 1999. We question why the state agency would not have concerns that this situation was affecting other diabetic residents in there home."**

This is not an acceptable description of Michigan policy or procedure. Michigan does not place egregious complaints in a lower priority level. The Michigan Complaint Manual requires that we investigate complaints whether or not a resident is in the facility to ensure that the remaining residents in the home are not at risk for abuse and inadequate care--whether or not the resident has died or transferred to another facility. If the resident is alive, the investigator is required to visit and interview the resident in his or her new home as well as visit the resident's former home to interview staff and review the closed record in order to reach a conclusion regarding the allegations.

The case cited in the report regarding management of a diabetic resident requires further explanation. The complaint regarding monitoring of a diabetic resident was received July 17, 1998, and was transmitted to the manager on July 28, 1998. The survey team had just completed a second revisit on July 7, 1998, to the standard survey of April 10, 1998. One of the issues followed-up on during the survey was the monitoring and treatment of diabetic residents. The facility was in compliance and following its plan of correction. The next standard survey was conducted March 12, 1999. The findings at this survey were four Level II citations and no problems were identified in relation to monitoring diabetic residents.

Page 15 **"Michigan also delays investigating non-immediate jeopardy complaints against nursing homes undergoing federal enforcement action. Officials told us that they adopted this practice to avoid the potential confusion that may**

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result from having two enforcement actions pending simultaneously. We believe this practice could unreasonably delay the investigation of serious complaints at nursing homes already identified as violating federal standards.

All complaints are evaluated as to priority level and if the complaint is egregious, it must be investigated at once no matter where it falls in an open enforcement cycle.

In other instances, however, the current OBRA enforcement procedures will effectively terminate a provider even for minor deficiencies, if the complaint is substantiated late in the 180 day OBRA enforcement cycle because there will be no time to verify corrections if they are made. We do not believe this was intended by OBRA and guidance from HCFA on the handling of such cases would be appreciated because we think that this problem is not unique to Michigan.

STATES FREQUENTLY DO NOT INVESTIGATE COMPLAINTS WITHIN REQUIRED TIME FRAMES

Page 18 **"States often do not conduct investigations of complaints within the time frames they assign them, even though they frequently place these complaints in lower investigation categories to increase the time available to investigate them. Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation."**

Michigan's delays in complaint investigations have been due to staff deficiencies which are in the process of correction. The Governor and State Legislature approved eight new surveyor positions of which all have been filled except one. While this will assist in improving the performance of complaint investigations, the Department is currently evaluating and exploring other ways to correct the timely performance of complaint investigations including standard surveys, such as the off-hour survey and surveys of facilities identified for increased monitoring.

DELAYED INVESTIGATIONS OF COMPLAINTS PROLONG HARM TO RESIDENTS

Pages 20 - 22 **"Table 6: Complaints Where Investigation Resulted in Substantiated Federal Deficiency and Home Cited for Causing Actual Harm to One or More Residents"**

Complaints must be done timely. However in Michigan, cases cited on page 21 and 22 do indicate that complaints with extended delays were substantiated.

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Page 24 **"However, some states have considered the categories included on the HCFA form as suggested priority and timeliness categories and modeled their standards after them. For example, officials in the three states visited (Maryland, Michigan and Washington) each indicted that their priority categories were adopted in part to be in conformance with the categories on the HCFA form."**

Michigan received the complaint investigation guidance from HCFA and has taken this information into consideration relative to updating the Complaint Investigation Manual. The Priority 1 criteria are defined with concrete examples as to what complaints and facility-reported incidents are to be classified at this level. Michigan procedure manual which is under revision includes HCFA's guidance.

INADEQUATE REPORTING SYSTEMS HAMPER EFFECTIVE AND STATE MANAGEMENT OF COMPLAINT INVESTIGATIONS

Page 30 **"In particular, a full compliance history is key to several parts of the survey and certification process such as HCFA's enforcement and oversight of standards, states' prioritization of complaints, and HCFA's ability to provide full information to consumers via its internet page and other sources."**

The Michigan state agency uses the complaint investigation findings in monitoring facilities. Through the Resident Protection Initiative, facilities' compliance history is reviewed and includes complaint findings to determine if a facility requires early review. In January 1998, Michigan initiated a computer-based formula to identify facilities for early enforcement. The system analyzes a facility's past and current standard survey compliance and complaint history and compares it to all other facilities to identify problems. Facilities identified with a poor performance as analyzed by the system receive early oversight and enforcement action. This is an additional action to that required under the federal definition of poor performers.

Page 31 **"For example, HCFA collects summary information for on-site complaint investigations from a form that was created for a single complaint. Some states, including Maryland and Michigan that we visited, use the form for multiple complaints. Therefore, timeliness, prioritization, and other tracking information that relates to multiple complaints is reported as though it applies to one complaint...."**

When multiple complaints are investigated during the same onsite survey, the OSCAR/ODIE Data System will not permit the state agency to enter the individual findings for each complaint. On the Medicare/Medicaid/CLIA Complaint Form, the control number for the complaint is entered. In addition to placing the control number, the state agency records the complaint

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numbers that were investigated. While the state agency can go back and track the individual complaint investigations through its computer system, there is no mechanism for multiple complaints to be entered into the OSCAR System when investigated together. Priority I complaints are investigated as a stand alone investigation.

Page 31-32 "Furthermore, state officials reported that complaints may appear to have been unsubstantiated in federal databases whereas the state had actually substantiated the complaint. In contrast, Washington records most violations it identifies in both federal and state information systems."

Michigan records complaint citations in both the federal and state data systems. Our records reflect this.

APPENDIX III

The facilities have been identified and comments are to be sent by staff.

The Department is reviewing the complaint listed in Appendix III to determine the delays in the investigations.

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Comments From Washington State's Department of Social and Health Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND ADULT SERVICES ADMINISTRATION
PO Box 45600 • Olympia WA 98504-5600

March 16, 1999

William J. Scanlon, Director
Health Financing & Public Health Issues
General Accounting Office
441 "G" Street NW
Washington D.C. 20548

Dear Mr. Scanlon;

Washington supports the GAO report recognition of the importance of a resident focused complaint system that includes appropriate prioritization, reliable methods for seeking and receiving complaints, and federal direction. However, it has been the experience of this state that the success of a complaint system is based in the state's ability to employ highly trained and qualified professionals who can prioritize appropriately, and complaint investigators who have reasonable caseloads that provide the opportunity to execute quick and thorough investigations. Without resources adequate to effectively investigate each complaint in a timely fashion, the most perfectly designed and monitored intake and prioritization system will fail in it's ultimate ability to ensure quality of life and care for the residents.

Timeliness of Complaint Investigations:

Washington law requires facilities to self-report abuse, neglect, or exploitation. Washington also encourages the public to utilize a toll-free complaint number to notify the state regarding abuse, neglect, exploitation, and care concerns. Washington's Complaint Resolution Unit utilizes aggressive prioritization criteria that results in ninety per cent (90%) of the complaints prioritized for investigation to be "Priority 1's" (investigate within 2 working days) or "Priority 2's" (investigate within 10 working days). It is important to note that seventy-one per cent (71%) of the complaints during the time frame of January 1st through March 31st, 1998, were called in by facilities.

There may be a significant difference in the risk to the resident based upon the skill and knowledge base of the reporting complainant, which is the reason for Washington procedures that may require initiation prior to the federally mandated on-site visit. The state procedure requires that all complaints are initiated in a timely manner, but the act of initiation may vary depending upon complainant source. The information entered into the state database utilizes the federal definitions for "dates of investigation". This definition captures on-site time. Due to the design, procedures, and inherent limitations of the Health Care Financing

Administration (HCFA) federal data system, the state was unable to provide data to the GAO that captured initiation date.

Due to the large volume of "Priority 2" complaints and a need for increased resources, the complaint investigators must prioritize which of the "Priority 2" complaints have on-site visits first, based on contact with the complainant. The timeliness of the "Priority 2" on-site visit is focused on the seriousness of issues in all "Priority 2" complaints, around the greatest protection of the residents, and not driven by date alone.

Quality Improvement Program:

The GAO's sample of complaints covered two different review periods under Washington's quality improvement program.

> Washington's quality improvement report for the quarter July 1997 through September 30, 1997 addressed performance in monitoring the complaint investigation system. Quality Improvement Standard 4 stated: "The state agency effectively investigates and processes complaints." Washington reported that it met the two objectives under review at 100%. Neither objective dealt with time frames for completion of the complaint investigation. Therefore, the quality improvement report was an accurate reflection of Washington's performance of the two stated goals. The stated goals were to assure all complaints were logged into the complaint system, and that priorities and investigators were assigned to the complaint.
>
> Effective October 1, 1997 through July 1, 1998, Washington redirected it quality improvement efforts toward identifying ways to improve heath care for Medicare beneficiaries. Rather than expend additional quality improvement efforts monitoring a complaint system that appeared to be effective, Washington developed quality improvement projects using MDS data to monitor health care through Quality Indicator Protocols, to reduce avoidable pressure sores, to reduce restraint use and to identify fraud in long term care facilities.

In conclusion, we would like to emphasize several points about Washington's program. The mission of Washington's Nursing Home Quality Assurance program is to serve the public, as an external quality assurance and regulatory agency, in assuring that a foundation level of resident health and safety, quality of care and quality of life is achieved by long term care providers.

- On a fundamental level, the complaint system in Washington is extremely responsive.
- We believe, and act upon the premise, that the complaint system is our most direct link to the public and consumers that we are charged with protecting.

William J. Scanlon, Director
March 16, 1999
Page 3

- Washington conducts more on-site complaint investigations per 1000 beds than any other state.
- The staff that do complaint investigations in Washington are skilled professionals with a high level of professional and regulatory expertise.
- Due to Federal data systems used to capture complaint-tracking information, Washington's timeliness in initiation of complaint investigations is not accurately captured.
- State laws require facility self-reporting for any issue or allegation related to abuse and neglect of vulnerable nursing home residents.
- We have extensively published the complaint intake number, and maintain an on-going positive partnership with stakeholders and advocates.
- Washington believes that with adequate Federal investment of resources, the complaint system would perform at an even greater level of effectiveness.

Thank you for the opportunity to comment.

Sincerely,

Patricia Lashway

Patricia K. Lashway, Director
Residential Care Services

cc: Joyce Pashley Stockwell, Administrator
Washington State Nursing Home Quality Assurance
Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues

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