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CALIFORNIA NURSING HOMES

Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations

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California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our findings on nursing home care in California. The federal government has a major stake in nursing home care, having paid the nation's roughly 17,000 homes $28 billion in 1997 through the Medicare and Medicaid programs. While the public relies on nursing homes to provide care to one of the most vulnerable segments of our population, allegations were raised to your Committee that some 3,000 residents died in more than 900 California nursing homes in 1993 as a result of malnutrition, dehydration, sepsis from improperly treated urinary tract infections, and other serious conditions for which they did not receive acceptable care.

The information I am presenting today is based on our recently issued report to your Committee.[1] Although I will begin with the care problems found through reviewing medical records for a sample of 62 residents who died in 1993, the majority of my comments will focus on our analysis of the current information on the quality of care in all California nursing homes. This analysis focused on care problems identified in recent state and federal quality reviews that California conducted in the last 2 or 3 years, obstacles to federal and state efforts to identify care problems, and implementation of federal enforcement policies to ensure that homes correct problems identified and then sustain compliance with federal requirements. The federal and state agencies with oversight responsibility for homes receiving funds from Medicare and Medicaid are the Health Care Financing Administration (HCFA) and the state of California's Department of Health Services (DHS). Together, they oversee care in the more than 1,400 California nursing homes, representing more than 141,000 resident beds. Medicare and Medicaid paid these homes approximately $2 billion in 1997 to care for nursing home residents.

In brief, we found that despite the presence of a considerable federal and state oversight infrastructure, a significant number of California nursing homes were not and currently are not sufficiently monitored to guarantee the safety and welfare of nursing home residents. We came to this conclusion, for the most part, by using information from California's DHS reviews of nursing home care covering 95 percent of the state's nursing homes and HCFA data on federal enforcement actions taken.

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

Looking back at medical record information from 1993, we found that, of 62 resident cases sampled,[2] residents in 34 cases received care that was unacceptable. However, in the absence of autopsy information that establishes the cause of death, we cannot be conclusive about whether this unacceptable care may have contributed directly to individual deaths.

As for the extent of care problems currently, between July 1995 and February 1998, California surveyors cited 407 homes—nearly a third of the 1,370 homes in our analysis—for care violations they classified as serious under federal or state deficiency categories. Moreover, we believe that the extent of current serious care problems portrayed in these federal and state data is likely to be understated. The predictable timing of on-site reviews, the questionable accuracy and completeness of medical records, and the limited number of residents whose care was reviewed by surveyors in each home have each likely shielded some problems from surveyor scrutiny.

Finally, even when the state identifies serious deficiencies, HCFA's enforcement policies have not been effective in ensuring that the deficiencies are corrected and remain corrected. For example, DHS surveyors cited about 1 in 11 California homes—accounting for over 17,000 resident beds—twice in consecutive annual reviews for violations involving harm to residents. (The national average was slightly worse—about one in nine homes were cited twice consecutively for violations of federal requirements involving harm to residents.) Nevertheless, HCFA generally took a lenient stance toward many of these homes. California's DHS, consistent with HCFA's guidance on imposing sanctions, grants 98 percent of noncompliant homes a 30- to 45-day grace period to correct deficiencies without penalty, regardless of their past performance. Only the few homes that qualify as posing the greatest danger are not provided such a grace period. In addition, only 16 of the roughly 1,400 California homes participating in Medicare and Medicaid have been terminated from participation, most of them have been reinstated quickly, and many have had subsequent compliance problems. Recognizing shortcomings in enforcement, California officials told us that they launched a pilot program this month intended to target for increased vigilance certain of the state's nursing homes with the worst compliance records.

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

Background

The federal responsibility for overseeing nursing homes belongs to HCFA, an agency of the Department of Health and Human Services (HHS). Among other tasks, HCFA defines federal requirements for nursing home participation in Medicare and Medicaid and imposes sanctions against homes failing to meet these requirements. HCFA funds state survey agencies to do the on-site reviews of nursing homes' compliance with Medicare and Medicaid participation requirements. In California, DHS performs nursing home oversight, and its authority is specifically defined in state and federal law and regulations. As part of this role, DHS (1) licenses nursing homes to do business in California; (2) certifies to the federal government, by conducting reviews of nursing homes, that the homes are eligible for Medicare and Medicaid payment; and (3) investigates complaints about care provided in licensed homes. To assess nursing home compliance with federal and state laws and regulations, DHS relies on two types of reviews—the standard survey and the complaint investigation. The standard survey, which must be conducted no less than once every 15 months at each home, entails a team of state surveyors spending several days on site conducting a broad review of care and services with regard to meeting the assessed needs of the residents.[3] The complaint investigation involves conducting a targeted review with regard to a specific complaint filed against a home.

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

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

[3]The standard survey is used not only to meet HCFA's certification requirement but also to ensure that a home continues to meet its state licensing requirements.

Table 1: HCFA's Deficiency Classification System

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

HCFA guidance also classifies deficiencies by their scope, or prevalence, as follows: (1) isolated, defined as affecting a limited number of residents; (2) pattern, defined as affecting more than a limited number of residents; and (3) widespread, defined as affecting all or almost all residents.

Review of Records for 1993 Deaths Uncovered Serious Care Problems

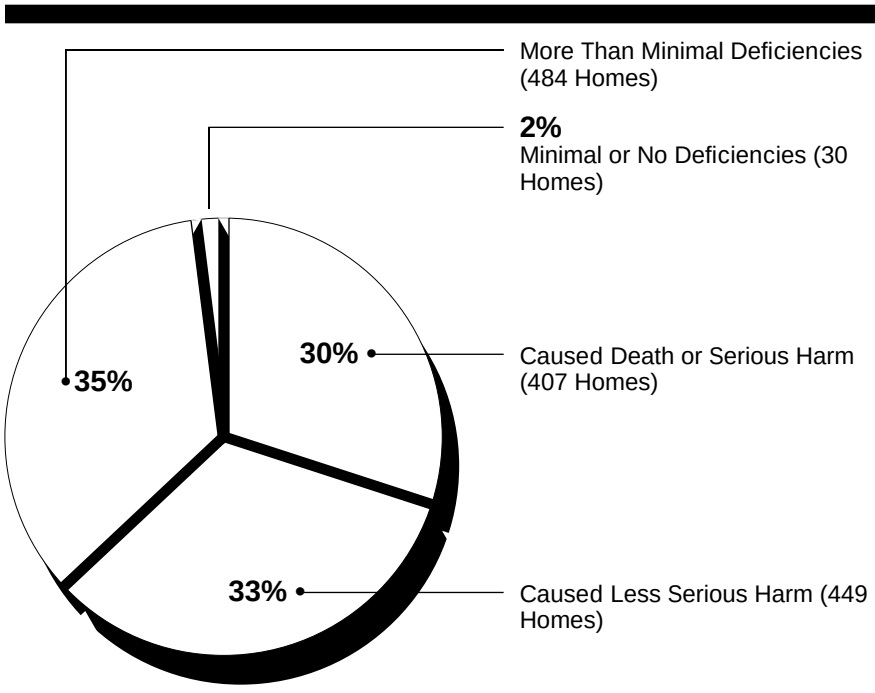
Our work indicates that 34 residents—more than half of our sample of 62 of California's nursing home residents who died in 1993—received unacceptable care. In certain of those cases, the unacceptable care endangered residents' health and safety; however, without an autopsy that establishes the cause of death, we cannot be conclusive about whether the unacceptable care directly led to any individual's death. Nevertheless, the care problems we identified were troubling, such as unplanned weight loss and failure to properly treat pressure sores. For example:

- A resident lost 59 pounds—about one-third of his weight—over a 7-week period. Only a small share of the weight loss was attributable to fluid loss. Until 2 days before the resident's death, the nursing home staff had not recorded his weight since the day he was admitted to the home or notified the physician of the resident's condition.
- A resident was admitted to a nursing home with five pressure sores, four of which exposed the bone. Although the physician ordered pain medication during treatments that removed the blackened dead tissue from her sores, the resident's medical record indicated that she received pain medication only three times during 5 weeks of daily treatments. The resident, who was not in a condition to verbalize her needs, was reported in the nursing notes to moan whenever this procedure was done without prescribed pain medication.

State's Recent Quality Reviews Reveal Significant Care Problems in Nearly One-Third of All Homes

DHS surveyors identified a substantial number of homes with serious care problems through their annual standard surveys of nursing homes and through ad hoc complaint investigations. Our analysis of these data shows that, between 1995 and 1998, surveyors cited 407 homes, or nearly a third of the 1,370 homes included in our review, for serious violations classified under the federal deficiency categories, the state's categories, or both. (See fig. 1, "Caused Death or Serious Harm.") These homes were cited for improper care leading to death (26 homes), posing life-threatening harm to residents (259 homes), other serious violations involving improper care (111 homes), or falsifying or omitting key information from medical records (11 homes).

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



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

Table 2: Categorization of Deficiencies by HCFA and by California DHS

Description of deficiency categories	HCFA deficiency category	State deficiency category
Caused death or serious harm	Immediate jeopardy Substandard care	Improper care leading to death, imminent danger or probability of death, intentional falsification of medical records, or material omission in medical records.
Caused less serious harm	Actual harm	Violations of federal or state requirements that have a direct or immediate relationship to the health, safety, or security of a resident.
More than minimal deficiencies	Potential for minimal harm	California has no state citation directly equivalent to the federal category.
Minimal or no deficiencies	Potential for minimal harm/no deficiencies	California has no state citation directly equivalent to the federal category.

Within the "caused death or serious harm" group are homes cited for several types of federal violations, including "improper care leading to death" and "life-threatening harm." Following is an example from the 26 homes California surveyors cited for improper care leading to death:[4]

- A resident who was admitted to a home for physical therapy rehabilitation following hip surgery died 5 days later from septic shock, caused by a urinary tract infection. The home's staff failed to monitor fluid intake and urine output while the resident was catheterized and afterwards. Nursing home staff failed to notify a physician as the resident's condition deteriorated. When his family visited and found him unresponsive, they informed the staff and his physician was contacted. His physician ordered intravenous antibiotics, but the staff were unable to get the intravenous line in place and continuously functioning until 8 hours had passed. The resident died 3 hours later.

The next example is from the 259 homes California surveyors cited for life-threatening harm:

- Because the home lacked sufficient licensed nursing staff on duty, residents did not receive treatments, medications, or food supplements as ordered. One resident's medical record indicated that, although a licensed nurse had noted the individual's deteriorating physical condition a half hour before she died, there was no evidence that the nurse continued to assess the resident's vital signs, administered oxygen as prescribed by a

[4]The subclassification "improper care leading to death" does not include all residents who died in homes cited for violations related to residents' care, because the category "life-threatening harm" can also include such violations and associated deaths.

physician's order, or notified the attending physician and family about the resident's deteriorating condition.

We also determined that cases of poor care were not limited to the 407 homes noted. State surveyors documented instances of serious quality problems that they categorized as federal deficiencies in the range of "actual harm" or "potential for more than minimal harm" or as lower-level state violations. Examples of these are included in our report.

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

The deficiencies that state surveyors identified and documented only partially capture the extent of care problems in California's homes, for several reasons. First, some homes can mask problems because they are able to predict the timing of annual reviews or because medical records sometimes misrepresent the care provided. In addition, state surveyors can miss identifying deficiencies because of limitations of the methods used in the annual review—methods established in HCFA guidance on conducting surveys—to identify potential areas of unacceptable care.

Predictability of On-Site Reviews

One problem masking the extent of poor care involves the scheduling of standard surveys. The law requires that a standard survey be unannounced and that it be conducted roughly every year.[5] Because many California homes were reviewed in the same month—sometimes almost the same week—year after year, homes could often predict the timing of their next survey and prepare to reduce the level of problems that may normally exist at other times.

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

The issue of the predictable timing of surveys is long-standing. More than a decade ago, the Institute of Medicine called for adjusting the timing of the

[5]Technically, the standard survey must begin no later than 15 months after the last day of the previous standard survey, and the statewide average interval between standard surveys must not exceed 12 months.

surveys to make them less predictable and maximize the element of surprise.[6] Subsequently, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) nursing home legislation and HCFA's implementing guidance attempted to address the predictability issue. However, a subsequent HCFA-conducted poll of nursing home resident advocates in most states and a 1998 nine-state study by the National State Auditors Association found that predictable timing of inspections continues to be a problem.

Questionable Records

Inaccurate or otherwise misleading entries in medical records can mask care problems or make it more difficult for surveyors to prove that care problems exist. We found such irregularities among the medical records we reviewed, a problem widely recognized in long-term-care research.[7] Discrepancies appeared in about 29 percent of the 1993 records we reviewed. The following two examples of such discrepancies were found in these records:

- During the hospital stay of a nursing home resident, doctors discovered that the resident was suffering from a fractured leg and that the fracture had occurred at least 3 weeks before the hospitalization. The nursing home's records were missing the clinical notes for the same 3-week period preceding the resident's hospital stay, thus omitting any indication that an injury had occurred, how it might have occurred, or how it might have been treated.
- Although a resident's medical record showed that each day she consumed 100 percent of three high-caloric meals and drank four high-protein supplements, the resident lost 7 pounds—10 percent of her total weight[8]—in less than a month. The implausibility of the resident's weight loss under these conditions raises major questions about the accuracy of the medical records regarding nutritional intake.

California state surveyors have also identified serious discrepancies in medical records. The following example is one of the cases they cited:

- A home's treatment records named a staff member as having provided two residents with range-of-motion exercises nine separate times. It was later

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

[7]Jeanie Kayser-Jones and others, "Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents," Nursing Home Medicine, Vol. 5, No. 3 (Mar. 1997), pp. 69-76, and John F. Schnelle, Joseph G. Ouslander, and Patrice A. Cruise, "Policy Without Technology: A Barrier to Improving Nursing Home Care," The Gerontologist, Vol. 37, No. 4 (1997), pp. 527-32.

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

determined that the staff member was not working at the home when the treatments were reportedly provided.

HCFA's Protocol for Identifying Potential Care Problems

A third monitoring weakness that can hinder surveyors' detection of care problems involves HCFA's guidance on selecting cases for review to help surveyors identify potential instances and prevalence of poor care. HCFA policy establishes the procedures, or protocol, that surveyors must follow in conducting a home's standard survey. However, HCFA's protocol—designed to increase the likelihood of detecting problems with care—does not call for randomly selecting a sufficient sample of residents. Instead, it relies primarily on the use of the individual surveyor's professional expertise and judgment to identify resident cases for further review.

In contrast, our expert nurses, in reviewing current medical records to identify areas with potential for poor care, took a stratified random sample—cases from different groups of the home's more fragile as well as average residents. Each sample was of sufficient size to estimate the prevalence of problems identified. In addition, the nurses used a standard protocol to collect and record quality-of-care information from chart reviews, staff interviews, and data analyses to ensure that the information was in a consistent format across the various individuals interviewed and documents reviewed.

For two homes receiving their annual surveys, we compared the findings of the DHS surveyors, who followed HCFA's survey protocol, with the findings of our expert nurse team, who accompanied the state surveyors and conducted concurrent surveys. The methodology our expert nurses used examined primarily quality-of-care outcomes and related issues, whereas state surveyors, following federal guidance, reviewed this and 14 additional areas, such as social services, resident assessment, and transfer and discharge activities. As a result, DHS surveyors sought and found deficiencies in some important areas that our expert nurses did not document. However, in the quality-of-care area, our nurses found serious care problems that DHS surveyors did not find, including unaddressed weight loss, improper pressure sore treatment, and ineffective continence management.

HCFA's Enforcement Policies Ineffective in Bringing Homes With Serious, Repeated Violations Into Sustained Compliance

We also examined the efforts of the state and HCFA to ensure that the homes cited for serious deficiencies were correcting their problems and sustaining compliance with federal requirements over time. Encouraging sustained compliance and appropriately sanctioning deficient providers are among HCFA's stated enforcement goals. However, we found that, under HCFA's policies, enforcement results often fall far short of those goals.

Between July 1995 and March 1998, DHS surveyors cited 1 in 11 homes, or 122 homes, in both of their last two surveys for conditions causing actual harm, putting residents in immediate jeopardy, or causing death.[9] These homes represent over 17,000 resident beds. The national compliance rate for about the same period and for the same repeated, serious harm deficiencies was slightly worse: about 1 in 9 homes, representing more than 232,000 beds, were cited.

However, HCFA enforcement policies have led to relatively few federal disciplinary actions taken against these homes in California. Before OBRA 87, the only sanction available to HCFA and the states to impose against such noncompliant homes, short of termination, was to deny federal program payments for new admissions. OBRA 87 provided for additional sanctions, such as denial of payment for all admissions, civil monetary penalties, and on-site oversight by the state ("state monitoring").[10] Nevertheless, these sanctions were seldom applied, even to the 122 homes in our analysis cited twice consecutively for serious harm deficiencies. Specifically, only a fourth—33 homes—had any federal sanctions that actually took effect.

HCFA Policies Lead to Lenient Enforcement Stance

HCFA's forgiving stance toward homes with a "ping-pong" history of compliance helps explain how these homes could repeatedly harm residents without facing sanctions. Generally speaking, HCFA sanctioning policy divides homes into two groups: those that the state agency is instructed to refer to HCFA immediately to initiate sanctioning and those

[9]The data on deficiencies cited in standard surveys are contained in the OSCAR (On-Line Survey, Certification, and Reporting) System, a federal database maintained by HCFA.

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

for which the state agency is permitted to grant a grace period first to correct deficiencies without the imposition of federal sanctions.[11]

To qualify for immediate referral under HCFA policy, homes must have been cited for deficiencies in the immediate jeopardy category or rated as a "poor performer." The criteria for meeting HCFA's poor performer definition include an intricate combination of immediate jeopardy and substandard quality-of-care deficiencies.[12] Since July 1995, when the federal enforcement scheme established in OBRA 87 took effect, 59 California nursing homes have been cited for immediate jeopardy deficiencies and about 25 have been designated poor performers. HCFA guidance permits the state to broaden the definition of poor performer, but California has chosen not to do so.[13]

Noncompliant homes that are not classified in the immediate jeopardy or poor performer categories do not meet HCFA's criteria for immediate referral for sanctioning, even though some may have seriously harmed residents. HCFA policy permits granting a grace period to this group of noncompliant homes, regardless of their past performance. Between July 1995 and May 1998, California's DHS gave about 98 percent of noncompliant homes a grace period to correct deficiencies. For nearly the same period (July 1995 through April 1998), the rate nationwide of noncompliant homes receiving a grace period was higher—99 percent—indicating that the practice of granting a grace period to virtually all noncompliant homes is common across all states.

Following HCFA policy, DHS is not required to and does not appear to take into account a home's compliance history for the bulk of noncompliant homes receiving a grace period. Our report describes a home that, despite

[11]Homes in the immediate referral group do not necessarily receive sanctions. If homes come into substantial compliance before sanctioning is scheduled to take effect, HCFA rescinds the sanction.

[12]Under HCFA's definition of poor performer, a home must have been cited on its current standard survey for substandard quality of care and have been cited in one of its two previous standard surveys for substandard quality-of-care or immediate jeopardy violations. HCFA also has a special definition for "substandard quality of care," as follows: the deficiencies must constitute immediate jeopardy to resident health and safety in one of three categories of deficiencies, or belong to the same three categories and include the following combination of severity and scope levels: pattern of or widespread actual harm that is not immediate jeopardy, or widespread potential for more than minimal harm.

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

being cited by DHS for the same violations—the unacceptable treatment of pressure sores—4 years consecutively, has continued to receive a grace period to correct its deficiencies following each annual review. We question the wisdom of granting such homes a grace period with no further federal disciplinary action.

For the few California homes that have had federal sanctions imposed, HCFA has been less than vigilant. In principle, sanctions imposed against a home remain in effect until the home corrects the deficiencies cited and until state surveyors find, after an on-site review (called a "revisit") that the home has resumed substantial compliance status. However, if some of the home's deficiencies persist but are no more serious than those in the "potential for harm" range, HCFA policy is to forgo a revisit and accept the home's own report of resumed compliance status. HCFA officials told us this policy was put into place because of resource constraints. In California, however, this policy has been applied even to some of the immediate referral homes that, on a prior revisit, had been found out of substantial compliance.

Our report describes the case of an immediate referral home for which HCFA twice accepted the home's self-reported statement of compliance without having DHS independently verify that the home had fully corrected its deficiencies:

- In an October 1996 survey, DHS cited the home for immediate jeopardy and actual harm violations, including improper pressure sore treatment, medication errors, insufficient nursing staff, and an inadequate infection control program. By early November 1996, however, surveyors had found in an on-site review that the problems had abated, although they had not fully ceased. A week later, the home reported itself to HCFA as having resumed substantial compliance.[14] HCFA accepted this report without further on-site review. About 6 months later (May 1997), in the home's next standard survey, DHS found violations that warranted designating the home as a poor performer. On a revisit to check compliance in July 1997, surveyors found new, but less serious, deficiencies. In August 1997, however, when the home reported itself in compliance, HCFA accepted the report without further verification. Between October 1996 and August

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

1997, HCFA imposed several sanctions but rescinded them each time it accepted the home's unverified report of resumed compliance status.[15]

Similarly, HCFA's level of vigilance appears to be inadequate for homes that have been terminated and later reinstated. HCFA has the authority to terminate a home from participation in Medicare and Medicaid if the home fails to resume compliance. However, termination rarely occurs and is not as final as the term implies. In the recent past, California's terminated homes have rarely closed for good. Of the 16 homes terminated in the 1995 through 1998 time period, 14 have been reinstated. Eleven have been reinstated under the same ownership they had before termination. Of the 14 reinstated homes, at least 6 have been cited with new deficiencies that harmed residents since their reinstatement, such as failure to prevent avoidable accidents, failure to prevent avoidable weight loss, and improper treatment of pressure sores.

A home that applies for reinstatement is required to have two consecutive on-site reviews—called reasonable assurance surveys—within 6 months to determine whether the home is in substantial compliance with federal regulations before its eligibility to bill federal programs can be reinstated. HCFA officials told us that HCFA cannot prevent a home from being reinstated if it is in substantial compliance during these reviews. However, HCFA has not always ensured that homes are in substantial compliance before reinstating them. Consider the following example:

- A home terminated on April 15, 1997, had two reasonable assurance surveys on April 25 and May 28, 1997. Although the nursing home was not in substantial compliance at the time of the second survey, HCFA considered the deficiencies minor enough to reinstate the home on June 5, 1997. The consequence of termination—stopping reimbursement for the home's Medicare and Medicaid beneficiaries—was in effect for no longer than 3 weeks.[16] About 3 months after reinstatement, however, the home was cited for harming residents. DHS surveyors investigating a complaint found immediate jeopardy violations resulting from a dangerously low number of staff. In addition, surveyors cited the home for providing substandard care. Dependent residents, some with pressure sores, were

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

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

left sitting in urine and feces for long periods of time; some residents were not getting proper care for urinary tract infections; and surveyors cited the home's infection control program as inadequate.

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

California DHS officials recognized that the state—in combination with HCFA's regional office—has not dealt effectively with persistently and seriously noncompliant nursing homes. Therefore, beginning in July 1998 and with HCFA's approval, DHS began a "focused enforcement" process that combines state and federal authority and action, targeting providers with the worst compliance records for special attention.

As a start, DHS has identified about 34 homes with the worst compliance histories—approximately 2 in each of its districts. Officials intend to conduct standard surveys of these homes about every 6 months, rather than the normal 9-to-15-month frequency. In addition, DHS expects to conduct more complete on-site reviews of homes for all complaints received about these homes. DHS officials also told us that the agency is developing procedures—consistent with HCFA regulations implementing OBRA 87 reforms—to ensure that, where appropriate, civil monetary penalties and other sanctions stronger than a corrective action plan will be used to bring such homes into compliance and keep them compliant. In addition, DHS has begun to screen the compliance history of homes by owner—both in California and nationally—before granting new licenses to operate nursing homes in the state. State officials told us that they will require all homes with the same owner to be in substantial compliance before any new licenses are granted.

Conclusions and Recommendations

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

As serious as the identified care problems are, many care problems may escape the scrutiny of surveyors. Homes can prepare for surveyors' annual visits because of their predictable timing. Homes can also adjust resident records to improve the overall impression of the home's care. In addition,

DHS surveyors can overlook significant findings because the federal survey protocol they follow does not rely on an adequate sample for detecting potential problems and their prevalence. Together, these factors can mask significant care problems from the view of federal and state regulators.

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

Under current policies and practices, noncompliant homes that DHS identifies as having harmed or put residents in immediate danger have little incentive to sustain compliance, once achieved, because they may face no consequences for their next episode of noncompliance. Our findings regarding homes that repeatedly harmed residents or were reinstated after termination suggest that the goal of sustained compliance often eludes HCFA and DHS. Failure to bring such homes into compliance limits the ability of federal and state regulators to protect the welfare and safety of residents.

Our report makes recommendations to the HCFA Administrator to address these issues. Although our report focuses on selected nursing homes in California, the problems we identified are indicative of systemic survey and enforcement weaknesses. Our recommendations therefore target federal guidance in general so that improvements are available to any state experiencing problems with seriously noncompliant homes. Thus, through HCFA's leadership, federal and state oversight of nursing homes can be strengthened nationally and residents nationwide can enjoy increased protection. In summary, we are recommending that HCFA revise its guidance to states in order to reduce the predictability of on-site reviews, possibly by staggering the schedule or segmenting the survey into two or more reviews; revise methods for sampling resident cases to better identify the potential for and prevalence of care problems; and, for those homes with a history of serious and repeated deficiencies, eliminate the offer of a grace period for resuming compliance and substantiate all of the home's reports of resumed compliance with an on-site review.

HCFA, DHS, and nursing home industry representatives have reviewed our report. Acknowledging that the findings were troubling, HCFA officials informed us that they are planning to make several modifications in their survey and enforcement process. DHS also suggested a number of changes—in addition to its new, focused enforcement program—intended to improve the federal survey and enforcement process. Last week, the administration announced a series of actions related to federal oversight of nursing homes, including night and weekend survey visits and increased inspection of homes with a record of noncompliance. HCFA, DHS, and industry representatives generally concurred with our recommendations, although both HCFA and DHS expressed some reservations about segmenting the standard survey. They contend that dividing the survey into two or more reviews would make it less effective and more expensive. However, we believe that this option—which could largely eliminate the predictability issue and increase the frequency of surveyors' presence at problem homes—warrants consideration of the benefits to be derived relative to the disadvantages that were raised.

Finally, despite the survey and enforcement modifications promised by HCFA and DHS, we remain concerned about the gap between stated goals and results. In 1995, HCFA enunciated its emphasis on encouraging sustained compliance and appropriately sanctioning deficient providers. Its practices since that time, however, argue for swift and significant changes, as illustrated in California by the persistence of problem homes with little federal sanctioning. We support the administration's recent initiative to strengthen the survey and enforcement process. However, we also believe that continued vigilance by the Congress is needed to ensure that the promised changes in federal and state oversight of nursing home care are implemented.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or the Committee Members may have.

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