Highlights of GAO-05-78, a report to congressional requesters

November 2004

NURSING HOME DEATHS

Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care

Why GAO Did This Study

GAO was asked to assess the effectiveness of nursing home oversight by considering the effect of a unique Arkansas law that requires county coroners to investigate all nursing home deaths. Coroners refer cases of suspected neglect to the state survey agency and law enforcement entities such as the state Medicaid Fraud Control Unit (MFCU). The Centers for Medicare & Medicaid Services (CMS) contracts with survey agencies in every state to periodically inspect nursing homes and investigate allegations of poor care or neglect. MFCUs are charged with investigating and prosecuting resident neglect. GAO examined (1) the results of Arkansas coroner investigations, (2) the state survey agency's experience in investigating coroner referrals, and (3) whether weaknesses in state and federal nursing home oversight identified in prior GAO reports were evident in the survey agency's investigation of coroner referrals.

What GAO Recommends

GAO recommends that the CMS Administrator revise CMS's policy on citing deficiencies to better ensure that nursing homes are held accountable for care problems identified after a resident's death. CMS concurred with GAO's recommendations and listed numerous initiatives it plans in response to the report's findings.

www.gao.gov/cgi-bin/getrpt?GAO-05-78.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

According to the Pulaski County coroner, he referred 86 cases of suspected resident neglect to the state survey agency for the period July 1999, when the Arkansas law took effect, through December 2003. Agency officials said that other state coroners referred four cases during this time period. Importantly, these 86 referrals constituted just 2.2 percent of all nursing home deaths the coroner investigated. However, the referrals included disturbing photos and descriptions of the decedents, suggesting serious, avoidable care problems; more than two-thirds of the 86 referrals listed pressure sores as the primary indicator of neglect. Some photos of decedents' pressure sores depicted skin conditions so deteriorated that bone or ligament was visible, as were signs of infection and dead tissue. The referrals involved 27 homes, over half of which had at least 3 referrals.

Arkansas state survey agency officials told GAO that they received 36 (fewer than half) of the Pulaski County coroner's referrals. The 50 referrals not received described decedents' conditions similar to those the survey agency did receive. Of the 36 referrals for alleged neglect that it received, the survey agency complaint investigations substantiated 22 and eventually it closed the home with the largest number of referrals. However, the agency's investigations often understated serious care problems—both when neglect was substantiated and when it was not. For 11 of the 22 substantiated referrals, the state survey agency either cited no deficiency for the decedent or cited a deficiency at a level lower than actual harm for the predominant care problem identified by the coroner. In contrast, MFCU investigations of many of the 11 referrals found the homes negligent in caring for decedents, and the MFCU reached settlements with the owners of several homes. In half of the 14 referrals not substantiated, the MFCU or an independent expert in long-term care either found neglect or questioned the "not substantiated" finding. Moreover, they found gaps and contradictions in the medical records for some decedents, raising a question about the survey agency's conclusions that the same records indicated appropriate care had been provided.

GAO's prior work on nursing home quality of care found that weaknesses in federal and state oversight nationwide contributed to serious, undetected care problems indicative of resident neglect. GAO's review of the Arkansas survey agency's investigations of coroner referrals confirmed that serious, systemic weaknesses remain. Oversight weaknesses GAO previously identified nationwide and those it found in Arkansas included (1) complaint investigations that understated the seriousness of allegations and were not timely; (2) predictable timing of annual state surveys that could enable nursing homes so inclined to cover up deficiencies; (3) survey methodology weaknesses, coupled with surveyor reliance on misleading medical records, that resulted in missed care problems; and (4) a policy that did not always hold homes accountable for neglect associated with a resident's death.