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RESIDENTS AT RISK? WEAKNESSES PERSIST IN NURSING HOME COMPLAINT INVESTIGATION AND ENFORCEMENT

HEARING

BEFORE THE

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UNITED STATES SENATE

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MONDAY, MARCH 22, 1999

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 1 p.m., in room SH–216, Hart Senate Office Building, Hon. Charles E. Grassley, (Chairman of the Committee), presiding.

Present: Senators Grassley, Hutchinson, Breaux, Reid, Wyden, and Bayh.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I am Senator Grassley and I welcome all my colleagues who are here. Members of the committee come and go because they have a lot of other obligations, and so I hope you understand that at any one time there may not be a full complement of the committee here. I also want to say good afternoon to all of you and welcome all of you, and before we go forward, I would like to thank our two witnesses who have traveled to be here with us today. They are going to share with us their personal and painful experiences with the complaint investigation and the enforcement processes.

I also want to thank our panel of nursing home experts, the Inspector General of the Department of Health and Human Services and the General Accounting Office. Their extensive work in this area deserves particular commendation. And of course I want to extend a special welcome to all of you who are members of our public, who have a right to be here, and who I also hope are here because you have an interest, and maybe even are advocating for nursing home residents.

Today's hearing is the second in a series to be held on the quality of care in nursing homes and the implementation of the Nursing Home Reform Act by the Health Care Financing Administration which I will refer to as HCFA. As most of you are aware, the committee held its first nursing home oversight hearing last July. This hearing was a 2-day oversight hearing on the quality of care provided in California nursing homes. At that hearing, the General Accounting Office released a graphic report exposing serious problems in California nursing homes.

The findings of the report were explosive and very disturbing. The report also included detailed common sense recommendations to improve the weaknesses disabling our regulatory system.

Days before the committee's hearing, the president announced a 22 point nursing home initiative and the release of a 900 page indictment of the status quo under HCFA's watch. I welcomed the president's announcement in July directing HCFA to work to improve the quality of life for nursing home residents.

Just last week, Nancy-Ann Min DeParle, the Administrator of HCFA, again announced several projects that had been identified in reports HCFA sends to me each month. And by the way, I want to thank HCFA because they have been very responsive to me and Senator Breaux along with the committee members regarding their monthly updates and giving us an opportunity to critique and to raise questions. So I want to thank them for that.

In addition, she sent a letter to the States with her announcement last week addressing several of the problems identified in the General Accounting Office report which will be released today. Again, I commend that positive action and I am glad today's hearing prompted such a quick response. I am almost of a feeling that I ought to have a hearing every month because we get very productive news conferences and examples of response from HCFA when we do that.

Since last July, I have been actively monitoring HCFA's implementation of those July recommendations. As I indicated to you in this notebook, I also requested two additional GAO studies to continue my oversight in this area. One of these reports analyzes enforcement, a process created in 1987 with the enactment of the Nursing Home Reform Act, and a second report examines state complaint investigative processes. The latter of these is the report that will officially be released today.

We are also fortunate to have the Inspector General's Office here today to release six reports. Testimony will focus on one of these reports, an overview report which analyzes trends within the long-term care setting and the capacity of current systems to protect nursing home residents. All of these reports provide further justification for the committee's ongoing nursing home oversight project.

Today, you will not hear from HCFA. HCFA is the Federal agency charged by law to protect nursing home residents. HCFA must ensure that the enforcement of Federal care requirements for nursing homes protect health, safety, welfare, and rights of nursing home residents. Yet HCFA today is a no-show. There is a very specific reason for today's hearing in this series of hearings. It is because the health, safety, welfare and rights of nursing home residents are at great risk. Yet, the agency responsible is not here.

The committee has invited two private citizens to testify. The value of their testimony, in the public interest, is that they lived and they suffered through the response process that HCFA oversees. It is a complaint process that is turned upside down. It is the testimony of citizen witnesses like these two that Congress, HCFA, and the public can learn from. That is how we can right the wrongs of a broken complaint system that puts nursing home residents at risk.

The reason HCFA is not here is puzzling, given the focus placed on listening to citizens' complaints. That is what this hearing is all about. HCFA is an agency within the Department of Health and Human Services, HHS. HHS has determined that HCFA cannot show up today because HHS witnesses do not testify after citizen witnesses. That is their so-called policy. In other words, HCFA, the organization that protects the health, safety, welfare and rights of nursing home residents, is not here because its protocol prevents them from testifying after a citizen witness.

Last Friday when discussing this matter with HHS officials, my staff was told the following, quote: "Our policy is that we testify before citizen witnesses."

Now, I have four comments on that point. First, how serious is the department about the problems we are uncovering in nursing homes when a protocol issue decides whether or not they testify?

Second, I have conducted hearings in which citizens go first since 1983. Other committees have done the same. I do not recall any department at any hearing I conducted since 1983 that failed to produce a witness even though their witness testified after a private citizen.

Third, the department may be trying to convince the public it cares, but this no-show does not help the cause. The public might confuse this with arrogance.

Finally, this situation today could not possibly have illustrated better the point that you are about to hear from our citizen witnesses. Namely, that their complaints fell on deaf ears. They have traveled many miles today hoping that government officials will hear their plea. Instead, what do they get? Nothing but a bureaucratic response. Their agency protectors are no-shows because of some rationale that they call protocol. But it could be because of arrogance.

So we will move forward with today's hearing learning how the nursing home complaint system is in shambles. And the agency responsible for fixing it is not here. Of course they can read about it once it is put in writing, a process that they seem to be very comfortable with.

Since I have been in Congress, I have never taken partisan shots at an administration. I believe only in accountability. My heaviest shots were against administrations of my own party. I think the record reflects that clearly. The easy thing to do would be to take partisan potshots over this. It is much harder to redouble our efforts in a bipartisan way on this committee until HHS and HCFA get the message.

When will HHS and HCFA hear what is going on out there in the nation's nursing homes? Perhaps when they learn to listen to citizens that we, all of us in government, serve. Until they get the message, these problems will get worse before they get better.

We also extended an invitation to nursing home industry representatives as well as States included in the General Accounting Office complaint report to submit written testimony addressing nursing home complaint investigation and enforcement processes. This testimony is available to the public and will be included in the official committee print.

In closing, there are a few things that I want to emphasize before I turn to Senator Breaux and my colleagues. First, we have a duty and a responsibility to know the truth regarding the quality of care being provided to nursing home residents and the systems designed to protect these residents. This hearing marks an additional step in this direction. Second, I am committed to this issue and will continue exploring the issue of quality of care in nursing homes as a general matter over the upcoming year. Elderly nursing home residents, those who do not have a voice, deserve no less.

And now I am happy to turn to my colleague, the ranking Democratic member who has always been so cooperative in the entire work of our committee over the last 3 years. Thank you, Senator Breaux.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good afternoon and welcome. Before we begin, I would like to thank our two witnesses who have traveled to be here today. They will share with us their personal and painful experiences with the complaint investigation and enforcement processes.

I also want to thank our panel of nursing home experts—the Inspector General of the Department of Health and Human Services and the General Accounting Office. Their extensive work in this area deserves particular commendation. And of course, I would like to extend a special welcome to members of the public.

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Since last July, I have been actively monitoring HCFA's implementation of the July recommendations and initiatives. I also requested two additional GAO studies to continue my oversight in this area. One of these reports analyzes the enforcement process created in 1987 with the enactment of the Nursing Home Reform Act. A second report examines state complaint investigation processes. This complaint report will be officially released by the GAO today.

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STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Well, thank you very much, Mr. Chairman, and to all of the witnesses who will be presenting testimony and testifying, let me thank them and for the interest in the audience that we have. It is an example of how important this issue is, that is the care of our nation's seniors and those who are disabled and find themselves in nursing homes in our respective States.

I am reminded of the statement that Senator Hubert Humphrey said many years ago about priorities as a nation and as a government, and I will paraphrase it because I do not remember it exactly, but in essence he said that the greatness of a nation is not judged by how many bombs, planes or missiles that we produce,

but rather a nation's greatness is judged by how we treat those who are in the dawn of their lives, the children, and how we treat those who are in the twilight of their lives, the nation's elderly.

And I think that is a very correct statement today as well as it was several decades ago because we truly, I think, are ultimately judged by how we treat and help and work with those who are helpless in many cases themselves and really that is what this hearing is about: to focus in on a large segment of a population which each day becomes even larger as the largest number of citizens that are increasing in population is our nation's seniors. And we are getting ready to see an additional 77 million soon become eligible for programs that are targeted for seniors, like Social Security and like Medicare.

So the real challenge for all of us on this side of the table as public policymakers is really to see how we can guarantee that an appropriate amount of revenues is available and set aside as a guarantee to address these very significant problems. And second, even more than the money, because the money is sort of a relatively easy thing to arrive at in the sense of how much do you need and then we find out how we find it, but the real test is how we use it. And all these programs, the best that can be written, will not work if they are not carried out appropriately and properly.

We can have all the rules on the books about safety and health and sanitary conditions and all of the things that make the lives of seniors, particularly in nursing homes and other type of facilities, as good as they should be, but if they are not enforced, they are not worth the paper that they are written on. And so today, we are going to look at how they are being enforced or how they are not being enforced. And I think that is a very important subject matter.

The final thing is your comment about the HHS and Health Care Financing Authority, the Medicare representatives of our government are not appearing. And I looked at the letter, Mr. Chairman, that the Department of Health and Human Services provided as to why they are not here, and I find it totally unacceptable. I find it totally unacceptable because they are, I think, basically saying they are not here because of protocol.

No. 1, they are off base on protocol. And No. 2, they should not be worried about protocol in the first place. I mean what difference does it really make whether people testify before government or government testifies before people in terms of protocol? That is not what we should be worried about. We should be worried about substance and how to make the program work. I know in the olden days when I was chairman of a committee when Democrats were in charge, years and years ago [Laughter.]

I mean I used to always want the Administration to testify second because they could hear the witnesses and then we could ask them questions about their testimony and get a dialog going. Are these people correct? If not, why not? If they are, what are we going to do to fix it? And it is difficult if the administration comes in—I am not saying they would do this, but I have seen it in any others—will come in and make their statement and then they leave. And then we have the witnesses come in who are citizens

who spell out the complaint and there is no one there to hear it from the administration who is in charge of fixing it.

So I mean I do not—I mean the fact that they say to honor the department's long-standing witness policy for HHS representatives testifying at congressional hearings, the policy predates the Clinton administration, which means that there are several administrations at fault, not just this one. And I do not buy it. I do not think it makes any sense. I think if that is their policy, the policy should be changed or maybe they will never get a chance to testify. Thank you.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Thank you, Mr. Chairman for holding this important hearing. I appreciate your demonstrated commitment to America's most vulnerable population, the frail elderly. Ensuring that this population receives quality care is undoubtedly the most important thing we do on this Committee. I also want to thank our witnesses, especially Ms. Gloria Cruz and Ms. Denise Bryant, for coming to share their stories.

Today we will hear that though some inroads have been made to improving the quality of care in nursing homes and the oversight these facilities receive, more work is needed. We must continue to ensure that our seniors receive only the best care. Moreover, when proper care is not given, Federal and state authorities must work with the industry to correct deficiencies once and for all, and investigate complaints in a timely manner.

In addition to enforcing current regulations, we must ensure that there are people to carry them out. As Mr. Grob of the OIG will testify, one of the underlying causes of quality of care problems is inadequate staffing of nursing homes. I noted at last July's hearing that in my own State of Louisiana, a dearth of qualified health care workers exists. It stands to reason that laws and regulations will never be effective without workers to carry them out. I will continue to work with the Health Care Financing Administration (HCFA) and the nursing home industry to find a solution to this problem.

Following July's hearing on the quality of care in nursing homes, HCFA embarked on implementing a very aggressive enforcement policy. Last week, HCFA announced plans to give greater guidance and oversight to the complaint investigation process. I believe that the complaint investigation process can be a very effective tool in monitoring the quality of care in nursing homes. I look forward to hearing these plans for improvement in more detail. Consumers have the right to know that when they file a complaint on behalf of a loved one, it is investigated swiftly and the appropriate enforcement action is taken.

Lastly, we need enforcement measures that deter deficiencies and maintain compliance with state and Federal regulations. We can no longer accept repeat offenders that yo-yo back and forth, in and out of compliance. The GAO report on enforcement reveals that 40 percent of homes with deficiencies are repeat offenders. This is not acceptable. We must also ensure that HCFA and the States have the needed resources to carry out enforcement measures. States cannot investigate complaints or conduct re-visits that determine compliance without the necessary resources and staff.

I look forward to continue working with HCFA and the nursing home industry to ensure that older Americans can trust the quality of life in nursing homes. The majority of nursing homes provide outstanding care, and we must work with them to make sure that bad apples are driven from the system. Congress, HCFA and the nursing home industry have all made strides toward improving the quality of care in nursing homes. However, we must not be afraid to take the further steps needed to eliminate all deficiencies and to provide only the best care for our seniors.

The CHAIRMAN. Thank you, Senator Breaux, and particularly for your last statement that again ratifies what has normally been done in this committee, a great bipartisan cooperation, and thank you very much. Senator Hutchinson and then Senator Wyden.

STATEMENT OF SENATOR TIM HUTCHINSON

Senator HUTCHINSON. Thank you, Mr. Chairman, and I appreciate what Senator Breaux said. I also appreciated his paraphrase of Senator Humphrey's comments because I agree any society's humaneness is best judged by how they treat their most vulnerable members and there are few who are more vulnerable than those who reside in our nation's nursing homes. So, Mr. Chairman, this is a critically important hearing. We have 1.6 million disabled and older Americans residing in America's nursing homes. This population is particularly vulnerable. We need to ensure that they receive high quality care.

Most nursing homes and nursing home operators do a good job. They do an outstanding job. However, the General Accounting Office report that will be released this afternoon points to a very disturbing trend of abuse and neglect in some of our nation's nursing homes. Although nursing homes must meet state licensure requirements, the vast majority of nursing homes participate in Medicare and Medicaid which require them to meet certain eligibility criteria. These standards simply do not appear to be being enforced.

Between July 1995 and October 1998, the GAO reports that 40 percent of nursing homes found to have serious deficiencies through an initial survey were found in a later survey to have deficiencies of equal or greater severity. In other words, the problems were not being corrected.

Mr. Chairman, let me also just say that I share your profound disappointment in HCFA's decision not to participate in the hearing today. I perused the letter that DHHS sent informing the committee of their decision not to participate and I think for whatever precedent they may have, whatever protocol they may be relying upon, it was a very profoundly disappointing decision and one that is counterproductive for the best interest of HCFA.

For some families, nursing homes are the only place equipped to care for their loved ones and the decision to place a relative in a nursing home is painful enough. Family members should have the assurance that they are placing their loved ones in a facility that is going to provide quality care, not substandard care, and where there will not be potential abuse or neglect.

A combined effort by the nursing home industry, state agencies, and the Federal Government is required to provide this assurance. HCFA's no-show today is a disappointing vote on their behalf not to be a part of that partnership. So I look forward to working with my colleagues, Mr. Chairman, particularly you, in identifying ways that we can address the concerns expressed in the GAO report today.

The CHAIRMAN. Thank you, Senator Hutchinson. Senator Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman, and I want to congratulate you and Senator Breaux for undertaking this effort in a bipartisan way. I have been reading these GAO reports about long-term care since my days when I was the director of the Gray Panthers at home in Oregon. I think this is a very important report, and I commend you, Mr. Chairman, and Senator Breaux for your efforts.

Mr. Chairman and colleagues, you cannot get the patient advocates and the nursing home industry to agree very often, but at this point both believe that Federal oversight of nursing homes is a mess. For example, though the two sides have a difference of opinion with respect to fining nursing homes for violations, both sides agree that the way the Health Care Financing Administration is setting in place the civil monetary penalties section of their program, both sides agree that that system is just riddled with holes.

And what is especially unfortunate about the situation that we are in today is that the Health Care Financing Administration is always playing catch-up ball with respect to the most serious problems. For example, at the bottom of page three of the GAO report, the auditors make it very clear that the best that you can say about the performance of the Health Care Financing Administration is they are getting around to tackling the problems found in the earlier studies done by the auditors. Suffice it to say we need to take some fresh new approaches. I hope the Health Care Financing Administration will be open to that.

My State is preparing a request for a demonstration project which would look at an innovative way to improve quality in nursing homes in our country. I hope the Health Care Financing Administration will look favorably on that request for a state demonstration project.

These issues are simply too important for the premier agency, the Health Care Financing Administration, to be sitting on the sidelines, and I think that is what we have today. They have for all practical purposes just dropped out of the process and I think that that is certainly not what the American people need and deserve. I look forward to working with you and your colleagues, Mr. Chairman, in a bipartisan way.

The CHAIRMAN. Thank you, Senator Wyden. Senator Reid and then Senator Bayh.

STATEMENT OF SENATOR HARRY REID

Senator REID. Mr. Chairman, I think that we should direct a letter to the Secretary Shalala to tell her that we do not appreciate what was done. I do not think the Secretary would do this. I mean she would be happy to wait around to see what the other witnesses said. I just think that we should, on behalf of the committee, write to her and say this is unacceptable.

The CHAIRMAN. I will follow your advice and I will ask as many of you who want to sign the letter to co-sign it with me.

Senator REID. Mr. Chairman, I have a statement that I would ask that you make part of the record as if given.

The CHAIRMAN. So be it.

Senator REID. I am anxious to hear the two witnesses before I leave. I just want to say, Mr. Chairman, in addition to my statement that I think, based on what I understand the two witnesses will testify in the first panel, one of the problems we have with long-term care in this country is that care goes where the money is rather than where the help is needed. As a result of that, we get a lot of very unfortunate things take place. We have to take a look at how we render long-term care in this country to put the money

where it is needed. If we did that, I think we would have far less abuse than what we do have because I repeat, the people who run these facilities, and I can certainly understand why they—I do not approve of it, but I can understand why—because they are trying to make money, they direct all their resources to where the money is. And we need to change the system so that they are rewarded for taking care of people who need help and I would hope that we would all keep this in mind.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

Good afternoon Mr. Chairman, members of the Committee, and distinguished panel of witnesses. I am pleased that the Committee is continuing to examine the quality of care provided to nursing home residents across the country. I commend the Chairman for convening this distinguished panel of witnesses.

During the 105th Congress, this Committee held a 2-day oversight hearing that addressed the quality of care in California nursing homes. It would be hard to forget the horrifying stories we heard from the families, nurses, doctors, and nursing home aides who witnessed nursing home abuse and neglect first-hand. While we cannot change what has already happened, we can take steps to prevent similar horrors from occurring again in the future. The witnesses at our last hearing all pointed to problems with the state complaint investigation process and the lack of proper enforcement of established regulations. I am pleased that we are taking a closer look at these issues today.

As the largest single payer of nursing home care, the Federal Government is charged with ensuring that our oldest, most vulnerable population receives quality care, and that our standards are strictly enforced. If we turn a blind to the serious lack of enforcement of nursing home standards in this country, we are no better than the facilities that condone negligent and abusive practices in their nursing homes.

We have worked hard to improve the enforcement of nursing home standards and to find ways to create greater protections for our seniors. Last Congress, Senator Kohl and I introduced legislation that would require criminal background checks of all prospective nursing home workers and establish a national registry of individuals convicted of nursing home abuse. By identifying those who have been abusive in the past, we can prevent similar crimes from reoccurring in nursing homes. I look forward to introducing similar legislation this session.

Although these efforts are a step in the right direction, it is still clear that a lot more must be done. And it must be done immediately. If we cannot provide protections for the 1.6 million seniors in nursing homes today, we certainly will not be equipped to accommodate the 4 million seniors expected to live in nursing homes by the year 2030.

Again, I thank the Chairman for convening these hearings. I understand that members of our first panel will be sharing their personal experiences with the Committee. I understand that reliving these memories can be painful, and I applaud your courage. Thank you.

The CHAIRMAN. Senator Bayh. Thank you, Senator Reid, for your suggestion.

STATEMENT OF SENATOR EVAN BAYH

Senator BAYH. Thank you, Mr. Chairman. I would like to echo the comments of my colleagues in expressing my gratitude to you and to Senator Breaux for your leadership in bringing us together here today on this important issue. I must say, Mr. Chairman, I am new to the U.S. Senate, but I find it to be amazing quite frankly the letter that we received from the department here that apparently in a fit of bureaucratic pique, HCFA has declined to be present today to discuss an issue of profound importance to the well-being of tens of thousands of our fellow citizens.

I am concerned that apparently some members of the Federal Government have it backwards. We work for the public, not the

other way around. And for them to refuse to appear here today I think sets a very, very sorry example. I would also like to say that I noticed in perusing their letter, it refers to the department's policy. Mr. Chairman, I would ask who takes precedence, the department's policy or this committee in Congress' policy, about trying to air the best interests of the American people?

So I am afraid that their failure to appear here today only exacerbates an unfortunate trend in the public at large to not have faith or confidence in our public institutions, and I regret their decision very much, and I will be more than happy to sign my name to the letter that Senator Reid suggested we put together and would hope that in the future they would not elevate form over substance but instead would focus on their job rather than who testifies in what particular order.

Just very briefly, I am going to take 1 minute here. This is an important issue for our State. We have more than 44,000 citizens in long-term care facilities in the State of Indiana with about 600 and some homes across the State. The families who place their loved ones in these institutions are counting on us to make sure that they provide the highest quality care that we can possibly provide, and although absent I would encourage the department if there are problems to come forward and freely admit them. Let us work on them together and see if we cannot make for a better environment for the people who have hired us to do this job.

Having said that, Mr. Chairman, I am looking forward to the testimony we are going to hear today and would thank the witnesses for coming.

[The prepared statement of Senator Evan Bayh follows along with prepared statement of Senator Larry Craig:]

PREPARED STATEMENT OF SENATOR EVAN BAYH

Good Afternoon, Thank you Mr. Chairman and Senator Breaux for holding a hearing on nursing homes and the complaint and enforcement process.

Seniors enter nursing homes because they are in need of around the clock medical attention, assistance with their day to day living needs, or due to illness or frailty can no longer live on their own without supervision. Those are the services nursing homes are intended to provide, to assist seniors with the basic necessities of life. They are expected to provide these services with a standard of care that does not lead to negligent behavior. It is unacceptable for seniors to have medical needs ignored. It is unacceptable for seniors to reach malnutrition because no one is watching if they are eating or what they are eating. And it is unacceptable for nursing homes to continue to use items that have already been deemed dangerous. If compassion isn't enough to motivate nursing homes, administrators and society, to provide this basic level of care, then we must use the strength of the law. We have a responsibility to take care of those who can't take care of themselves. We must protect our seniors when they are vulnerable.

There are over 44,000 residents located in one of the 614 nursing homes in Indiana. For the health of each resident, it is essential that the nursing homes be in compliance with the many state and Federal regulations.

The reports released today from the General Accounting Office and the Office of the Inspector General detail the deficiencies in our current system of processing claims and enforcing the rules regarding nursing homes. It is important we do not try and place blame on any one group or implement more regulations without evaluating their true effectiveness. There must be changes that result in better care for our seniors. I look forward to hearing the testimony this afternoon, learning about not only the current problems, but the suggested solutions. Every system can continually be improved, I am interested in looking at ways to improve our current nursing home complaint and enforcement systems.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

I would like to thank the Chairman for holding this hearing today regarding the quality of care our elderly are receiving in nursing homes, and the enforcement needed to oversee this quality. I would also like to thank each of the witnesses for taking the time to appear before the committee to testify.

We have an opportunity to ensure that the vulnerable people who reside in nursing homes are protected. We need to better investigate future incidents and make sure we have a strong safety net for those living in the homes. Standards of quality, and the enforcement of those standards, whether they are established and enforced by the States or by the Federal Government, are an issue that will require the Congress continual oversight. Coming from a State with many rural areas, the commitment to high quality and accountability, requires a balance so that the regulations and bureaucracy do not become barriers of access to nursing home care. There are a lot of thoughts out there on this issue. My priority is to look at constructive ideas and build a strong, safe future for the many elderly who depend on nursing home facilities.

Again, I would like to thank the Chairman and our panel of witnesses here today. As dicsussion continues, it is crucial that we thoroughly discuss effective options for securing nursing homes. I look forward to the benefit of the insight of today's witnesses. Thank you.

The CHAIRMAN. Thank you very much. And I would now ask Ms. Bryant and Ms. Cruz to come together and take their respective places at the table and I will introduce you and then I ask you to speak. On this panel, the two individuals have experienced firsthand frustration experienced when complaints about nursing home neglect, and these were filed on behalf of loved ones, do not receive an adequate response.

Our first witness today is Ms. Gloria Cruz. She is here to tell us about her experience with the complaint investigation process. Ms. Cruz' grandmother entered a nursing home in December 1996. She was released from the nursing home in critical condition and died nearly a week later. She was suffering from an extremely low sodium level and pneumonia. Ms. Cruz filed a formal complaint on October 24, 1998 and now more than 20 weeks later has yet to receive a response.

Our second witness is Ms. Denise Bryant. Ms. Bryant is here to share with us her experience with both nursing home complaint investigation process and the Federal enforcement system. Ms. Bryant's aunt suffocated after becoming trapped between her nursing home bed and bed rail. Ms. Bryant filed a complaint. The State did an investigation but said nothing was wrong. Ms. Bryant persisted and another investigation was conducted. This time the home was cited. What followed was a yo-yo pattern of compliance.

I want to put you all at ease, first of all. Pull the microphone just a little bit close to you if you would to start with because these microphones do not work from such a distance. Second, I know it is a very traumatic experience that you have come here and your family to testify about, and obviously we only want to express our sympathy and condolences, more often our thanks for your coming to testify under troubled times for you. We would wish that we could do something about that. What we can do something about is to make you welcome. You have responded to our invitation. We thank you for that response. And to be comfortable in your presentation and also to be comfortable in the way that this committee is here because we know things are wrong and we want to find answers.

I would start with Ms. Cruz.

STATEMENT OF GLORIA CRUZ, A GRANDDAUGHTER WHO FILED A FORMAL COMPLAINT FOLLOWING THE DEATH OF HER GRANDMOTHER REGARDING THE CARE HER GRANDMOTHER RECEIVED IN A MARYLAND NURSING HOME

Ms CRUZ. Hi. I would like to thank you for the opportunity to express my concerns over the lack of response and care by the Licensing and Certification Administration. I am here today in hopes that something can be done to stop nursing homes from the abuse and neglect they inflict upon elderly and the physically handicapped. Unless and until we can get the Licensing and Certification Administration to take these complaints seriously and act upon them, the tragedies that befall these residents and ultimately their families will continue.

My complaint involves the gross negligence of the nursing home where my grandmother, was residing prior to her death. I would like to begin by offering you some history of the relationship I had with my grandmother. She was not only my maternal grandmother——

The CHAIRMAN. Just feel comfortable. Take your time.

Ms CRUZ. She was not only my maternal grandmother. She was my best friend, the kind of friend people can only dream about, but I was lucky enough to experience. Granny was there when I was born and I subsequently spent the next 40 years with her. She lived with my family so she was an important part of my childhood years. We were roommates for 10 years, we worked side by side as cashiers in a theater, she was my matron of honor when I married, and I remained at her side holding her hand from 8:30 in the morning on October 15, 1998 until 2 a.m., October 16, 1998, just 1 hour prior to her death. I was her power of attorney and her legal guardian. During her stay at the nursing home, I visited her three times a week and called her daily. I did her laundry, I took care of her finances and I took care of her general well-being, making sure she was treated properly while in the nursing home. And to this day, I carry her close to my heart in a locket.

Given this, I will briefly explain the events which necessitated my complaint to the Licensing and Certification Administration. My family and I moved to Millsboro, DE, on September 19, 1998, with the intention of having my grandmother transferred to a nursing home just a half a mile from my new home. The paperwork had already been implemented and we were awaiting approval for her transfer. On October 9, my parents drove up to Baltimore to transport my grandmother from Baltimore to Delaware. I would like to add that I had spoken with several staff members from the nursing home during the week of October 5, questioning her health and ability to be relocated to another facility.

A member of our family had been visiting her and was concerned about her health. She seemed to be quite ill. When I questioned the staff, including the administrator, I was informed that she was indeed well enough to be transferred and was excited about it as well. My grandmother was released just shortly after noon on October 9 with a critically low sodium level as well as a high white cell count. However, I was not informed of her critical health until after she had left the facility.

The nursing home received the lab report on the morning of October 8, yet chose to release her anyway on the following day. Please note that my parents questioned her health when they picked her up and were told she was just sleepy. In addition to not informing me of her critical situation, her physician was not notified either. A charge nurse called me after my parents had left with her to tell me she was quote "very, very sick" and they believed she had pneumonia. The physician was also called after her discharge and informed of her condition. My grandmother was immediately taken to a hospital upon her arrival at the Delaware nursing home as her sodium level had dropped from a critically low level of 114 to 93. One week later, on October 16, 1998, she passed away.

On the evening of October 19, 1998, I received a call from her physician. He spoke to me at length and indicated that had she been hospitalized immediately upon receipt of her lab findings, she would have lived. My grandmother's death was due to the negligence of the nursing home. After speaking with the physician and hearing his assessment, I decided to report this to the Licensing and Certification Administration.

On October 24, 1998, I sent a letter to the manager of Complaint Investigations of the Licensing and Certification Administration in Baltimore, MD. They never responded to my letter. So on December 15, 1998, I sent a letter to the Patient Abuse Coordinator at the Office of the Attorney General with a copy to the manager of Complaint Investigations of the Licensing and Certification Administration. I called the attorney general's office the following week to follow up. The gentleman informed me that he had just coincidentally discussed the matter with the manager and suggested I phone her. I immediately called. At first she acted as though she could not recall the case. When I reminded her that she had just hung up with the attorney general's office, she regained her memory.

She informed me that they were quite busy, as they receive about 80 complaints per month on nursing homes. She assured me that the case would be investigated and I would be notified of their findings. On February 25, 1999, I again spoke with the physician. I had previously been contacted by a reporter who was interested in the story. He asked me if the physician would agree to be interviewed for television. I told him I would contact the physician. The doctor reiterated his belief that my grandmother should not have been released with a critically low sodium level and that he was unaware of her lab report until after she had been discharged.

He further stated that the administrator and charge nurse at the nursing home were quote "blatantly lying" to me concerning the incident. Again, he stated that she could have lived had she been hospitalized immediately. He was, however, skeptical about being interviewed on the television. Nevertheless, he agreed to speak with a reporter. In addition, he suggested that I call the manager and inform her that the press was now involved.

On March 1, 1999, I phoned the manager. Once again, I had to initiate the call. I had still not received a response from the Licensing and Certification Administration. At this time, she repeated to me that they receive approximately 80 complaints per month. She

added that they deal with the live residents before they deal with the dead ones. I was appalled by this comment and I even stated to her that perhaps if they dealt with the complaints about those residents which had passed away due to neglect and/or abuse, the live ones may be saved. Once more, she assured me that the investigation was pending and I would be notified when it was completed.

I just received a letter from them on Saturday stating that—it says: Dear Ms. Cruz, this letter is confirmation that you have lodged a complaint against the above facility. An investigation will be conducted by the professional staff of this unit and you will be apprised of the results. If you have any questions or additional information, you may contact me and they have the phone number, and I just received that on March 20.

In closing, I would like to say that I am pursuing this because I don't want my grandmother's death to be in vain. I don't want another family to go through the pain and suffering we have endured because of the gross negligence of a nursing home and subsequently the lack of concern and care from the Licensing and Certification Administration. My parents are getting older. My dad is 70 years old and he suffers from emphysema and asbestosis. How can I conscientiously even consider placing him in a nursing home after what I have experienced?

I feel that by giving this testimony perhaps I can help save another family from the pain and suffering of losing a loved one. Thank you again for the opportunity to express my experience with both the nursing home and the Licensing and Certification Administration.

[The prepared statement and other related material follow:]

TESTIMONY OF GLORIA CRUZ

Senate Special Committee on Aging Hearing
"Residents At Risk? Weaknesses Persist in Nursing Home Complaint Investigation and Enforcement"
March 22, 1999

I would like to thank you for the opportunity to express my concerns over the lack of response and care by the Licensing & Certification Administration. I am here today in hopes that something can be done to stop nursing homes from the abuse and neglect they inflict upon the elderly and physically handicapped. Unless, and until, we can get the Licensing & Certification Administration to take these complaints seriously and act upon them, the tragedies that befall these residents, and ultimately, their families, will continue.

My complaint involves the gross negligence of the nursing home where my grandmother, the late Elsie Wagner, was residing prior to her death. I would like to begin by offering you some history of the relationship I had with Ms. Wagner. She was not only my maternal grandmother, she was my best friend. The kind of friend people can only dream about, but I was lucky enough to experience. "Granny" was there when I was born, and I subsequently spent the next 40 years with her. She lived with my family, so she was an important part of my childhood years. We were roommates for ten years, we worked side- by-side as cashiers at a theater, she was my matron of honor when I married; and I remained at her side, holding her hand, from 8:30 a.m. on October 15, 1998 until 2:00 a.m. October 16, 1998, just one hour prior to her death. I was her Power of Attorney and her legal guardian. During her stay at the nursing home, I visited her three times a week and called her daily. I did her laundry, I took care of her finances; and I took care of her general well-being, making sure she was treated properly while in the nursing home. And, to this day, I carry her close to my heart — in a locket.

Given this, I will briefly explain the events which necessitated my complaint to the Licensing & Certification Administration.

My family and I moved to Millsboro, Delaware on September 19, 1998 with the intention of having my grandmother transferred to a nursing home just 1/2 mile from my new home. The paperwork had already been implemented, and we were awaiting approval for her transfer. On October 9, my parents drove up to Baltimore to transport my grandmother from Baltimore to Delaware. I would like to add that I had spoken with several staff members from the nursing home during the week of October 5, questioning her health and ability to be relocated to another facility. A member of our family had been visiting her and was concerned about her health; she seemed to be quite ill. When I questioned the staff (including the administrator), I was informed that she was indeed well enough to be transferred and was excited about it as well. Ms. Wagner was released just shortly after Noon on October 9 with a critically low sodium level, as well as a high white cell count. However, I was not informed of her critical health until AFTER she had left the facility. The nursing home received the lab report on the morning of October 8 yet chose to release her anyway on the following day! Please note that my parents questioned her health when they picked her up and were

told she was just sleepy. In addition to not informing me of her critical situation, her physician was not notified either. A charge nurse called me after my parents had left with her to tell me she was "very, very sick" and they believed she had pneumonia. The physician was also called after her discharge and informed of her condition. My grandmother was immediately taken to a hospital upon her arrival at the Delaware nursing home as her sodium level had dropped from a critically low level of 114 to 93. One week later, on October 16, 1998, she passed away.

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On March 1, 1999, I phoned Ms. Balintfy. Once again, I had to initiate the call; I had still not received a response from the Administration. At this time, she repeated to me that they receive approximately 80 complaints per month. She added that they deal with the "live" residents before they deal with the "dead ones." I was appalled by this comment. I even stated to her that perhaps if they dealt with the complaints about those residents which had passed away due to neglect and/or abuse, the "live" ones may be saved. Once more, she assured me that the investigation was pending and I would be notified when it was completed. To date, I have not heard from them.

In closing, I would like to say that I am pursuing this because I don't want my grandmother's death to be in vain. I don't want another family to go through the pain and suffering we have endured because of the gross negligence of a nursing home and subsequently the lack of concern and care from the Licensing and Certification Administration. My parents are getting older; my Dad is 70

years old and suffers from emphysema and asbestosis. How can I conscientiously even consider placing him in a nursing home after what I've experienced?

I feel that by giving this testimony perhaps I can help save another family from the pain and suffering of losing a loved one. Thank you again for the opportunity to express my experience with both the nursing home and the Licensing and Certification Administration.

[redacted]
October 24, 1998

[redacted]
Manager, Complaint Investigations
Licensing & Certification Administration
4201 Patterson Avenue
Baltimore, MD 21215

Re: [redacted]

Dear [redacted]

I am writing to formally place a complaint against a nursing home in Baltimore, Maryland. The nursing home is [redacted] in [redacted]. The staff at [redacted] released my grandmother, [redacted], on Friday, October 9, 1998 in "critically ill" health. We are filing this complaint for the abuse and neglect that my grandmother has suffered in the hands of this nursing home. She passed away in a Delaware hospital the following Friday, October 16, 1998 due to the gross negligence of [redacted]

My family and I recently moved to Delaware and were in the process of moving my grandmother, [redacted], to a nursing home close to us in Millsboro, Delaware. I am extremely close to my grandmother and am her legal guardian. On or about Thursday, September 24, 1998, a staff member called me at approximately 10:45 p.m. to inform me that my grandmother had "fallen in the bathroom" at 9:30 p.m. and x-rays were being taken to see if she broke her arm. She was taken to the [redacted] Emergency Room early the next morning (approximately 5:30 a.m.). It was determined that she had broken her arm and a cast was placed just below her shoulder to slightly above her elbow (as reported to me by a [redacted] nurse). [It may be of interest to see if blood tests were taken on September 25 by [redacted] to see what her sodium level was at that time.]

On October 6, 1998, an approval (by Medicaid and the [redacted] came in that [redacted] could be admitted to the Delaware nursing home [redacted]. We scheduled to have her picked up on Friday, October 9, 1998. We were told by the staff at [redacted] that there was no medical reason for [redacted] to be transported by ambulance, so my parents (Paul and Barbara Harris) were driving up to Baltimore in their vehicle to pick up [redacted]. Please note that [redacted] was non-ambulatory and had a broken arm in addition to being wheelchair bound. [The ambulance crew in Delaware has told us that being non-ambulatory is medical reason enough to be transported by ambulance. However, as stated before, [redacted] (administrator) and [redacted] (social worker), both of [redacted] told us that Medicare would not pay for transportation because there was no medical reason to warrant this.]

However, in the meantime, a relative (Eva Tom) had been visiting my grandmother. My grandmother kept complaining of "being sick." Ms. Tom informed me that she felt a blood test should be done on [redacted] to find out why she was "feeling sick." [redacted] refused

to do the blood test, stating that [redacted] vital signs were normal; and there was no medical reason to perform a blood test. I called the staff at the nursing home, including my grandmother's nurses, the social worker [redacted] and the administrator [redacted] They kept telling me that my grandmother was well and did not need these tests. Ms. Tom persistently requested that these tests be done. After several phone calls, it was determined that I, as legal guardian, had to request these tests. I spoke to [redacted] on Wednesday, October 7 to request the blood tests, which I was told were to be taken at 6:00 a.m. on Thursday morning. Late Thursday, I was informed that her white blood cell count was very high. (Absolutely no mention of her "critically low sodium level" was made.) I questioned two nurses on that day as to the fact that high white blood cells meant leukemia, cancer or some type of infection. I was told that because my grandmother did not have a fever, there was nothing to worry about — "no fever, no infection." Because Ms. Tom kept questioning Ms. Wagner's health and ability to be transported, I asked Ms. [redacted] for an assessment of her health. Again, she reassured me that my grandmother was well and able to travel to Delaware. In addition, Mr. [redacted] informed me that my grandmother was "up and well," sitting in the hallway on Monday. He went on to say she had told him she was going to Delaware soon. He, too, said she was healthy enough to leave the nursing home. In addition, [redacted] (RN) stated she was well enough to leave. I informed Ms. [redacted] that my parents would be picking up [redacted] (since there "was no medical reason to be transported by ambulance") at approximately 11:00 a.m. on Friday, October 9. She said she would make sure Ms. Wagner was ready.

Upon arriving at the nursing home Friday at approximately 11:00, my grandmother was asleep. This is very unlike [redacted] because when she knew we were taking her out somewhere, she was ALWAYS dressed and waiting in her wheelchair. My mother, Ms. Harris, proceeded to go to the nurses' station to question whether [redacted] knew she was leaving and why wasn't she ready. They assured my mother that she was just sleeping and didn't want to get ready until my parents had actually arrived. My parents went down to her room where the nurses prepared her to leave. However, they did not even dress her; they left her in a lightweight duster which was placed on her backwards, with the back only partially buttoned (this wasn't discovered until she arrived in Delaware).

Approximately 30 minutes after my parents left [redacted] [redacted] had placed a call on my answering machine. (My parents had phoned me when they were placing my grandmother in the car. Ms. [redacted] call was recorded approximately 30 minutes later.) Her message said, "Gloria, you need to call me immediately. Your grandmother was very, very sick when she left here." Upon my return (I had gone to Rehoboth to purchase balloons and "Welcome" signs for my grandmother.), I phoned [redacted] immediately. She informed me of my grandmother's poor health. I asked her why she released her in such poor health, and she said "Your mother told us to." When my parents arrived in Delaware, I questioned them. They told me not only did they NOT insist on her leaving, but did not SIGN any release forms either. Again, they said [redacted] had stated that my grandmother was only sleepy. They felt she had been "doped up."

My grandmother was taken to [redacted] Medical Center immediately after the house doctor at [redacted] listened to her chest and lungs. The house doctor's name is Dr. [redacted] He called me out in the hall and said without even looking at chest x-rays, he was positive my grandmother had pneumonia. In addition, the nursing home staff noticed horrible, horrible bruises on my grandmother's arm, left side, left breast and right arm/hand. We do have pictures of these bruises which were taken upon her arrival at the hospital.

Blood tests were taken at [redacted] Medical Center on Friday, October 9 when she arrived. Her sodium level had dropped to somewhere in the 90's by that time. At this point in time, she had pneumonia and a condition called "adrenal crisis," a result of the critically low sodium level. I have been told by the medical personnel in Delaware, as well as Dr. [redacted] (her physician from [redacted]) that they have never had a patient with such low sodium levels. My grandmother fought for her life at [redacted] Medical Center for a week, with her systems slowly shutting down; a fete one doctor called a miracle. I can certainly go into details if you wish, including a temporary pacemaker, CT scans, etc.

I spoke to Dr. [redacted] of Baltimore on Monday, October 19, 1998 at approximately 8:00 p.m. He informed me that HE was not notified of the critically low sodium level until Ms. Wagner had been released from [redacted] Dr. [redacted] stated that Ms. [redacted] called him AFTER my parents had already left the nursing home. He went on to tell me that he and the medical director, Dr. [redacted], personally visited [redacted] the week of October 12 and found no mention of the call which allegedly had been made to him on October 8, 1998 informing him of the sodium level. In addition to arriving at [redacted] with pneumonia and adrenal crisis, [redacted] was dehydrated as well.

I visited [redacted] on Monday, October 19 in the morning to discuss several discrepancies I had found with Mr. [redacted] and Ms. [redacted] Again, they claimed that Ms. [redacted] was "waving to and kissing everyone goodbye" when she left on that Friday (October 9). In fact, I spoke to the nurse who took my grandmother down to my parents' car that afternoon; and she said that my grandmother was so "weak and out of it" that she had to turn the wheelchair around because my grandmother's feet were just dragging. She also stated that SHE had kissed my grandmother on the cheek, however, my grandmother DID NOT return the kiss nor did she kiss anyone else or wave goodbye to anyone else. (This was the same story my parents had given me which I relayed to Mr. [redacted] and Ms. [redacted] Their response was "your parents don't remember much of anything.") I questioned the dehydration; Mr. [redacted] said, "Well, she was in the car for five hours!" Fact: dehydration DOES NOT occur within a five hour period; particularly when my parents had stopped to get her a drink. In relation to the fact Mr. [redacted] and Ms. [redacted] stated that my grandmother was waving to and kissing everyone goodbye, Dr. [redacted] informed me that it would have been PHYSICALLY IMPOSSIBLE for her to even be alert with such a critically low sodium level (the lab report received by [redacted] on 10/8/98 at 5:02 a.m. stated the sodium level was at a critically low 114). In fact, he said that she could not have been "totally alert" all week — as is noted in the nurses' notes of that particular week. He told me those notes could not be correct as, again, it was physically impossible.

I also questioned whether Ms. [redacted] had checked my grandmother's arm (where it had been broken) before she left. She said yes. I asked her why she didn't notice that the bone was starting to protrude through the skin (which was noted by the orthopaedic surgeon at [redacted]

Medical Center who examined the injury and rebandaged it because of the poor bandaging which had been done in Baltimore). She stated it must have happened enroute to Delaware. So essentially what Mr. [redacted] and Ms. [redacted] are telling us is that within a five hour period (which technically was four and a half hours as she left at approximately 12:30 p.m. and arrived at the nursing home in Delaware at approximately 5:00 p.m.), my grandmother developed pneumonia, a critically low sodium level causing an adrenal crisis, dehydration and the bone protruding from her skin. In addition, a strap was placed around my grandmother's waist when they were transferring her to my parents' vehicle. The [redacted] personnel left this strap around her (unbeknownst to my parents) and by the time she arrived in Delaware, this strap was wrapped around her chest, causing more breathing problems. The ambulance crew in Delaware could not believe this had been done. When questioned about the strap, Ms. [redacted] and Mr. [redacted] told me they left it on so that the personnel at [redacted] would be able to transfer to a wheelchair. I asked them if they honestly felt that the nursing home in Millsboro would not have the proper equipment to transfer a patient from a vehicle to a wheelchair. Again, the ambulance crew questioned WHY she was not transported to Delaware by ambulance to begin with. Even Dr. [redacted] questioned why she wasn't transported by ambulance but was allowed to go in a vehicle.

I am enclosing a copy of the pertinent names and addresses of those people that came in contact with my grandmother. In addition to Dr. [redacted] she was seen by a cardiologist (Dr. [redacted] and an orthopaedic surgeon (I do not have his name at this time, but the [redacted] Medical Center could supply this information).

I would appreciate it if you could investigate this matter as soon as possible. I was Ms. Wagner's Power of Attorney and am the executor of her estate; therefore, if a signature is needed for records, etc., I would be more than happy to accommodate you.

Should you have any questions or wish to discuss this further via a phone call, I may be reached at (302) 933-0336. I look forward to hearing from you soon.

Sincerely yours,

Gloria Cruz

cc: [redacted] President,
[redacted]
Maryland State Department of Aging
JCAHO

[redacted]
[redacted]

December 15, 1998

[redacted]
[redacted]

Office of the Attorney General
200 Saint Paul Street
Baltimore, MD 21202

Dear [redacted]:

Per our conversation yesterday, I am writing this letter to explain in detail what we believe to be criminal neglect and abuse upon my grandmother, the late [redacted]. *It is our belief that she passed away due to the gross negligence of the nursing home where she was residing,* [redacted] *Maryland. I am enclosing several pieces of evidence, including photographs, nurses' notes, the physician's note, and most specifically, the lab report dated October 7, 1998.*

I would like to start off by offering you some history of the relationship I had with Ms. [redacted]. *She was not only my maternal grandmother, she was my best friend. The kind of friend people can only dream about, but I was lucky enough to experience. We were roommates for ten years, we worked side-by-side as cashiers at a theater, she was my matron of honor when I married; and I remained at her side, holding her hand, from 8:30 a.m. on October 15, 1998 until 2:00 a.m. on October 16, 1998, just one hour prior to her death. I was her Power of Attorney, her legal guardian. While she resided in the nursing home, I visited her three times a week and called her daily. I did her laundry, I took care of her finances; and I took care of her general well-being, making sure she was treated properly while in the nursing home. I did make a few calls to the Department of Aging during her stay at* [redacted] *complaining about the treatment of not only my grandmother, but the other residents as well. In addition, just prior to my moving out of state, I completed a survey which was mailed to me by an independent company seeking information on* [redacted] *treatment of residents. I was honest on this survey; I told them I did not feel the patients were being treated fairly. I even cited a few instances of "abuse," both verbal and physical.*

Our intent was to transfer Ms. [redacted] *to the* [redacted] *in Millsboro, Delaware prior to my moving so that she would be comfortably settled when I arrived. Our*

timeframe was to get her to the new nursing home just one week before we were to move. She has other family members living in Delaware, including her daughter, who would take care of her the week prior to my move. However, the paperwork was held up; and we were unable to transfer her as scheduled.

Given this background, I will explain in chronological order the events which occurred up to and including her funeral in Baltimore on Monday, October 19, 1998.

September 19, 1998: My family and I moved from Parkville, Maryland to Millsboro, Delaware. I visited my grandmother the day before (September 18) and she was feeling well. She was excited about us being together again soon in Delaware.

September 23, 1998: An x-ray was done on this date and 500 mg of augmentin was ordered for Ms. [redacted]. As her Power of Attorney and legal guardian, I was to be notified when her medication was changed and/or added to. I was never informed of this chest x-ray, nor was I informed of the medication she was given.

September 24, 1998: I received a call at approximately 10:45 p.m. from a nurse, [redacted] informing me that Ms. [redacted] had "fallen in the bathroom," and it was possible she broke her arm. It is interesting to note that they later said she did not "fall." They never exactly did explain what had happened; only that she was found slumped in her wheelchair in the bathroom at 9:30 p.m. He told me that they were sending her for x-rays. However, they did not take her to the [redacted] Emergency Room until 5:30 a.m. September 25. Please note that according to the Interim Order Form, telephone orders from Dr. [redacted] request, at 10:00 p.m. September 24, that x-rays of left shoulder and humerus be obtained. Then, orders of September 25 at 1:30 a.m. state "observe for tonight; send to [redacted] in morning for evaluation and treatment of left shoulder." Why such a change in orders within a three and a half hour period when someone was lying in pain? Later that morning (September 25), I spoke to a nurse who told me Ms. [redacted] did break her arm and that she had a "cast from just below her shoulder to just above her elbow." She never explained that it was a "light" cast (not a plaster cast) with an ace bandage wrapped around it, supported by a sling. I find it odd that they let her go back to bed with a possible broken arm -- not taking her to the hospital until eight hours after the "fall." It is notated throughout the Nurse's Notes of "discoloration and swelling" to the shoulder. I was never informed of this either. We were not aware of the discoloration and swelling until she arrived in Delaware; and you can imagine our shock, particularly given the fact that they were still black, blue and purple (not yellowish green like most three week old bruises would be). The ambulance crew, nurses and physicians were appalled at the bruises.

I would particularly like to note that the remarks made in the Nurse's Notes dated September 24, 1998 at 9:30 p.m. are very peculiar. The first sentence reads "Resident noted to

have swollen, tender upper arm by CNA while changing Resident." It goes on to say "Nurse called to room because of Resident yelling and c/o (complaining of) pain when left arm and shoulder was touched, swelling and pain noted." How long did she lay there if her arm was already swollen when they went in to check on her? She was "found in the bathroom turned completely on right side ..." Yet, her left side was all bruised; and her left arm broken? "Resident was still in w/c (wheelchair) at that time, and was assisted back to bed by both CNAs." Back to bed? Was she already in bed to begin with? If the CNA was changing her (as stated in first sentence), why didn't the CNA help her to the bathroom? X-ray results were noted at 1:30 a.m. of fractured humerus yet she was not transported to the hospital until 5:30 a.m. for treatment.

Furthermore, there is some controversy over the type of cast used when she broke her arm. My aunt (Jeannette Enos) visited my grandmother on September 25 and said she had a plaster cast on her arm. My parents went to see her on Saturday, September 26, less than two days after her "fall." My mother distinctly remembers my grandmother saying her arm was itching. She and my father both state that a plaster cast was on her arm at that time. Yet, Ms. [redacted] claims she never had a plaster cast.

Week of September 28, 1998: I called the nursing home several times, speaking to Ms. [redacted] (Social Worker) concerning my grandmother's transfer. At one time, I questioned the possibility of transporting her by ambulance. Ms. [redacted] told me that Medicaid would not cover the expense because there was no medical reason for her to be transported by ambulance. [However, when she was eventually picked up by ambulance in Delaware, the crew there notified me that the fact she was in a wheelchair was medical reason enough to be covered by Medicaid. In addition to being wheelchair bound, she NOW had a broken arm!] Ms. [redacted] stated that if she were transported by ambulance, the family would have to pay for it. So, given this, we set up for her to be picked up by my parents (Paul and Barbara Harris) as soon as she was approved for Medicaid in Delaware (to be transferred to the Delaware nursing home).

During this week and the one to follow, I tried several times to call my grandmother. However, when I did get through to her (when someone would pick up the phone for her as she could not reach it due to the broken arm), she sounded groggy, and we did not talk long. At one point, one of the nurses [redacted] told me that she wasn't even getting out of bed; that she wasn't feeling well enough.

October 5, 6 and 7, 1998: My cousin, Ms. Eva Tom, phoned me from my grandmother's room to voice her concerns over my grandmother's health. She said that Ms. [redacted] had been complaining of "not feeling well." She wasn't sure what was wrong, she just wasn't feeling well. My cousin suggested we have blood tests done. During the next two/three days, I spoke to Mr. [redacted] [redacted] (administrator), Ms. [redacted] Ms. [redacted] and Ms. [redacted] concerning my grandmother's health. Whereas my cousin kept saying my grandmother was "sick," the staff at [redacted] kept telling me she was fine. I questioned whether they felt she was well enough to even be

transferred to a new home. They adamantly stated that she was indeed well enough and she was excited about it as well. Mr. [redacted] even went as far as saying she was "down in the dining room eating ... I [redacted] passed her in the hallway and she told me she was excited about moving and would be leaving soon ... was just as well as she was when you [I] left ...." Inasmuch as I wasn't sure who was really assessing the situation correctly, I requested the blood tests be drawn. Ms. [redacted] had demanded the tests be taken; however, Mr. [redacted] informed her that her request was not acceptable. He stated that only Gloria (myself) could request these tests as she (me) was her legal guardian. I spoke to [redacted] and she informed me that the tests would be taken at 6:00 a.m. the following day. The tests were collected on October 7, 1998 at 10:13 a.m.

In the meantime, I had met with Ms. [redacted] of the Division of Social Services in Delaware on October 6. After going through the proper paperwork, Ms. [redacted] put in our application for approval. She informed me that it usually takes 90 days for an approval. However, she phoned me that evening to let me know Ms. [redacted] application was approved. She even stated that she had never received an approval so quickly but; she knew I was so excited and anxious to get my grandmother close to me once again that she requested a prompt reply for approval (and, surprisingly received it). I, in turn, called Ms. [redacted] to tell her my parents would pick up Ms. [redacted] on Friday, October 9, 1998 at 11:00 a.m. The arrangements were confirmed, and she said she'd make sure Ms. [redacted] was ready to go at that time.

October 8, 1998: Both my aunt (Ms. [redacted] daughter who resides in Baltimore) and I tried several times to get the blood test results from [redacted] to no avail. We were told the tests had not come in yet. [Please note that the results of these tests were faxed to [redacted] on October 8, 1998 at 5:02 a.m.] Finally, late that afternoon, I was informed that Ms. Wagner's white cell count was high. No mention of her <u>critically low sodium level</u> was ever made. In fact, we were not aware of her sodium level until the day of her funeral, October 19, 1998, when I visited [redacted] and requested her medical records. I questioned the possibility of infection, pneumonia or even leukemia because of the high white cell count. I was informed that Ms. [redacted] had no fever, therefore, there was no infection. Again, I was told she was definitely well enough to be transferred the following day. I was still apprehensive, so I called back that night (around 9:00 p.m.) and spoke to another nurse. She, too, informed me "no fever, no infection." Again, I was assured that Ms. [redacted] was fine and medically well enough to move to Delaware. I spoke with Mr. [redacted] Ms. [redacted] Ms. [redacted] and two nurses, all of whom confirmed that Ms. [redacted] was medically capable of moving and that no further tests need be done at that time. [Please note, however, that upon discharge (less than 24 hours later), they recommended chest x-rays when she arrived in Delaware. This was noted on her discharge papers, however, my parents <u>were not verbally informed of this</u>, as the nurse's notes state.]

October 9, 1998: My parents drove up to Baltimore to pick up my grandmother and arrived at 11:49 a.m. Upon their arrival, Ms. [redacted] was in bed asleep. This in and of itself is unusual as whenever we were taking Ms. [redacted] out (i.e. the mall, lunch, or even just for a

walk), she would be up, dressed and anxiously waiting for us. And, Mr. [redacted] had just told me the day before that she was excited to be leaving. My mother immediately went to the nurses' station and questioned the nurse [redacted] as to why Ms. [redacted] was not ready. She asked if there was some problem. [redacted] stated that Ms. [redacted] just wanted to stay in bed and wait for them to arrive before she got dressed. They returned to her room where the nurses got her out of bed and placed her in the wheelchair. However, they did not dress her; all she had on was a light duster which was placed on backwards. A sweater was placed over her shoulders. My parents questioned her health, stating she looked like she was "all doped up." The nurse answered that she was "just sleepy." Ms. [redacted] also stated that my grandmother was not taking any medication – only a Tylenol for the pain. However, when she arrived at the nursing home in Delaware, the physician there questioned me as to why she was on so much medication. He went on to say he would like to go over some of them (when she was feeling better) to try to eliminate some unnecessary medications. He asked for my approval to review them, and I agreed. (Of course, we never had that chance since she passed away one week later.) The nursing assistant [redacted] who took her down to the car had to turn the wheelchair backwards because my grandmother's feet were dragging. She felt they could get her down easier backwards. She, too, mentioned to my parents that Ms. [redacted] "did not look well at all." My mother called me at 12:20 to let me know they were leaving. The nurse handed my mother some paperwork to be given to the nursing home in Delaware but did not verbally give any instructions to my mother at all. In addition, my parents DID NOT sign any release forms or the discharge papers (as is required according to Instructions #3 and #4 of the Discharge Memo ("3) Fill out attached d/c instruction form, review it with resident and/or family, see that they sign it, receive a copy and place original in chart; and 4) Have resident or family sign valuables list and return it to chart.") Each and every time we took my grandmother out for the day (a shopping trip, party, etc.), we had to sign her out and then back in again. Isn't it odd that she wouldn't have to be signed out when discharged/transferred out of state?

When placing my grandmother in the car, a gait belt was secured around her waist. However, they did not take this belt off. Enroute to Delaware, apparently the gait belt slipped from her waist up to her chest, causing more constriction than what she was already experiencing. My parents were not aware that this belt was left on her. When I questioned Ms. [redacted] as to why this belt was left on (as the ambulance crew in Delaware had questioned me, which, of course, I could not answer, since I wasn't aware of its presence), she stated that they left it there so that the personnel at the Delaware nursing home could get her from the car to a wheelchair. I then questioned her as to whether she truly believed the nursing home staff would not have the sufficient equipment to transfer a patient on their own. She did not have an answer to this question.

It is interesting to note that on the Interim Order Form dated October 7, 1998 at 12:00 p.m., it states "repeat CXR next week" per Dr. [redacted] telephone orders. Yet, her discharge notes of October 9 stated that a chest x-ray be taken immediately upon her arrival in Delaware.

In addition, the Discharge Summary/Final Nurses Note says she was "alert and responsive" and "lungs clear." The entry at 12:15 p.m. on October 9 on the Nurse's Notes states "There is upper airway congestion ... recommended a chest x-ray once resident arrived at nursing home." So, one form says her lungs are clear yet an x-ray is suggested and another form (both dated October 9, 1998) says she has upper airway congestion and a chest x-ray is recommended. In addition, on the Nurse's Notes dated October 9 at 9:00 a.m., it is noted "cough and congestion." On October 9 at 5:00 a.m., "productive cough with small amount of white phlegm" is noted. When she arrived at the nursing home in Delaware on October 9 at 5:00 p.m. (just twelve hours later), her phlegm was a green color (noted personally by myself and the nurse). Again, at 12:00 p.m. on October 9, her lungs were clear; yet, just five hours later, she was heavily congested. It also states that her "color remains pale," however, no mention of pale coloring was made prior to this entry. Also noted on the Nurse's Notes of October 9 at 12:40 p.m., the chart was reviewed AFTER DISCHARGE. Why would a chart be reviewed after a resident was discharged? Ms. [redacted] goes on to say she "called Dr. [redacted] about CBC and SMA who stated he was aware of lab and also had the faxed copy." Then at 1:00 p.m., it says "Dr. [redacted] returned call and told us they were aware and to fax them the lab." Why would he "return" the call at 1:00 if he had just spoken to her at 12:40 p.m.; and if he had the faxed copy at 12:40 p.m., why did he request the copy at 1:00 p.m.? There are quite a few inconsistencies here.

A call was placed to me by [redacted] AFTER my parents had picked Ms. [redacted] up from [redacted] they were already enroute to Delaware. Ms. [redacted] left a message on my answering machine which said, "Gloria, you need to call me immediately. Your grandmother was very sick when she left here." As soon as I came home, I called Ms. [redacted] She told me that they thought perhaps my grandmother had pneumonia. Again, there was absolutely no mention of her critically low sodium level, just the fact that they felt she may have pneumonia. I asked her why they released her if she was so sick, and she responded that my mother had told them to. Upon their arrival in Delaware, I questioned my parents; and they stated they DID NOT insist that she leave. In fact, as I mentioned earlier, they questioned her health and were told she was just sleepy. Had they known she was so critically ill, they would have personally taken her to a Baltimore hospital for immediate treatment. Ms. [redacted] told me that chest x-rays should be taken as soon as she arrived in Delaware.

Enroute to Delaware, my parents' car broke down (in Bridgeville, DE). They called [redacted] who, in turn, called [redacted] Ambulance. The ambulance crew was shocked over several things: 1) the fact that she was not transported by ambulance to begin with; 2) the awful black, blue and purple bruises on her arm and sides; 3) the fact that she only had a light duster on; and 4) the gait belt which by then was wrapped around her chest. She finally arrived at the nursing home at approximately 5:00 p.m. At this time, a nurse immediately came in and listened to her lungs. Ms. [redacted] started coughing and I grabbed a tissue and told her to "spit it out." Her phlegm was green; the nurse and I looked at each other and said, "Infection!" The nurse immediately left to get the doctor. He listened to her lungs, ordered a

chest x-ray and called me into the hallway. He told me "without even taking a chest x-ray, I can tell you she has pneumonia. There's a lot of fluid on her lungs." However, they did take a chest x-ray right in her room. The next thing we knew, another ambulance crew was there, taking her to the hospital [redacted] in Lewes, Delaware). I don't think she was at the nursing home all of 45 minutes, if that long. By the time she reached the hospital, her sodium level had gone down to 93.

She passed away a week later, after fighting for her life. In addition to now having pneumonia and the adrenal crisis, an orthopaedic surgeon checked her arm as the "cast" had slipped down to beyond her elbow. The emergency room personnel was shocked at the poor job that was done in placing the cast on her. When the orthopaedic surgeon unbandaged the "cast," he found her bone protruding from her skin – just slightly, but enough to "tear" the skin. He rebandaged the arm with another type of orthopaedic cast.

Ms. [redacted] did not want to die; and the doctors believe that her desire to live kept her alive for that week. She asked us in the hospital to make her better, to get her out of the hospital. She told me she was not ready to die; that she had so much to live for – and she did. Every physician we have spoken to has told us that they have never, in all their years of practicing, heard of a patient's sodium level dropping to 93. The fact that she stayed alive for a week was just short of a miracle. She had pneumonia and what is called an "adrenal crisis," caused by the low sodium level. When one has pneumonia, the lungs are affected; so the heart has to take over, "over-time," so to speak. However, because of the adrenal crisis, her heart became weak and could not do its job either. Eventually, all her systems began shutting down.

October 16, 1998: 3:05 a.m., my best friend passed away.

October 19, 1998: Her funeral was scheduled for 12:00 p.m. in Baltimore. We had left to drive up to Baltimore on October 18 (the viewing was Sunday). On the morning of her funeral, October 19, I went to [redacted] to speak to [redacted] and [redacted] Upon my arrival, I requested her medical records. It was <u>then</u> that I discovered the lab report of October 7 which was faxed to the nursing home on October 8 at 5:02 a.m. I immediately questioned [redacted] as to why she was released with a "critically low sodium level." She stated they weren't aware of the level until after my grandmother was discharged. I said, "So, you're telling me no one knew she had a critically low sodium level until AFTER she was discharged?" She said, "Yes, that's right." (Note: my cousin, Marge Stanovich accompanied me on this visit to [redacted] and witnessed all these lies as well) I replied, "According to this lab report, it was faxed to you at 5:02 a.m. on October 8; yet you tell me no one knew?" No response was made by [redacted] just a shrug. I mentioned that my parents said my grandmother appeared to be doped up when she left. Both Mr. [redacted] and Ms. [redacted] stated that my grandmother was "very alert, waving and kissing everyone goodbye." I again replied that this is not what my parents saw. Mr. [redacted] said, "Your parents don't remember much of anything." I stated that when my

grandmother arrived at the nursing home, the staff there said she was dehydrated. Mr. [redacted] answered, "Well, I guess so. She was in the car for five hours!" I reminded him that one does not become dehydrated in just five hours (particularly given the fact that my parents bought her a large drink enroute). The gait belt was questioned, too. As mentioned before, Ms. [redacted] and Mr. [redacted] stated that it was left on so that the nursing home personnel in Delaware would be able to transport her from the car to a wheelchair. I told them I was sure the nursing home would have the proper equipment to do this on their own. They then said that they left it on in case my parents needed to transfer her for some reason. Why would my parents transfer her – she was wheelchair bound (they had no wheelchair) and had a broken arm? I also questioned the "cast" - I asked if her arm was checked before she left. Ms. [redacted] said that she had personally checked it. I asked why she had not seen the bone tearing the skin and why the cast was so low – past her elbow. She stated that the skin was not tearing when she looked at it and that the cast apparently slipped while enroute to Delaware. So, according to Mr. [redacted] and Ms. [redacted] within a five hour timeframe, my grandmother developed pneumonia, an adrenal crisis, dehydration, a tear in her skin from the bone protruding and her cast slipped down below her elbow.

When my cousin and I left, we happened to run into the nursing assistat [redacted] who wheeled her down to my parents' car that morning. I asked her how my grandmother appeared when she left – was she "waving and kissing everyone goodbye?" [redacted] stated that she was so weak, she had to turn her around in the wheelchair because her feet were dragging. She also said SHE had kissed my grandmother on the cheek but Ms. [redacted] did not respond. I told her that Mr. [redacted] and Ms. [redacted] had JUST told me that she was kissing everyone and waving to everyone and that she was very alert when she left. [redacted] told me they were lying; it wasn't true. At this point, Ms. [redacted] came out of the front office and saw me talking to [redacted] I then said to [redacted] "You better be careful. They may fire you for talking to me." (I hope this was not the case and that [redacted] is still employed. My grandmother thought the world of this nurse; she always treated my grandmother with the utmost respect and love. I even wrote a letter to [redacted] [redacted] sometime ago commending [redacted] on her unselfish, understanding mannerisms.)

October 19, 1998: At approximately 7:50 p.m., I received a call from Ms. [redacted] physician in Baltimore, Dr. [redacted] He informed me that Ms. [redacted] DID NOT inform him of the critically low sodium level until AFTER she had been discharged. As noted in the Nurse's Notes, Ms. [redacted] called Dr. [redacted] at 12:40 p.m. on October 9 – AFTER Ms. Wagner's discharge. Dr. [redacted] also told me that it was "PHYSICALLY IMPOSSIBLE" for my grandmother (or even a 16 year old with a sodium level that low) to be alert and responsive when she left; and it was most probably physically impossible for her to be alert and responsive the week prior to her leaving. What caused this low sodium level and why wasn't it treated immediately?

I told him that according to the lab report, he was notified by [redacted] LPN, on October 8 of the results of this test. In addition, there were "no new orders" given by him. He

stated that Ms. [redacted] did not notify him on October 8. In fact, he and the medical director (Dr. [redacted] visited [redacted] the week of October 12 (while my grandmother lay dying in a Delaware hospital) to question this alleged notification on October 8. Ms. [redacted] stated that she remembers calling Dr. [redacted] However, when Dr. [redacted] asked her what Dr. [redacted]'s actual verbal response to her notification was, she could not remember. Dr. [redacted] went on to question why it was NOT noted in the Nurse's Notes that a call was made to Dr. [redacted] and that he had requested "no new orders." In addition, Dr. [redacted] said to me, "Why would I give "no new orders" on October 8, and then, less than 24 hours later, give orders to get her to a hospital immediately for STAT electrolyte panels?" I also asked Dr. [redacted] if he indeed gave telephone orders on October 8 at 11:45 a.m. (which would have been AFTER the lab report was faxed to the nursing home) to transfer Ms. [redacted] to "Delaware nursing home (Millsboro) in A.M." He said he did not. I questioned him about dehydration as well. He claimed, too, that one does not become dehydrated in a five hour period of time.

On October 14, 1998 on the Doctor's Progress Notes, Dr. [redacted] states "I was notified the <u>first time</u> of this abnormal lab data (Na 114 which is a panic value) on 10-9-98 at approx. 12 Noon. I was also made aware at that same time that the pt was in route to be transferred to another nursing facility out of state." "... I gave the nurse at that facility the information about the low Na and asked that when the pt arrives, a STAT electrolyte panel be done and her new physician be called immediately."

So, he, too, was not notified of her critically low sodium level until AFTER her discharge. In addition, he states that he was, on October 9, made aware that she was being transferred. Yet, according to the Interim Order Form dated October 8, he gave the orders for the transfer! More inconsistencies?

I asked him if my grandmother had been placed in a hospital (in Baltimore) immediately upon discovering her low sodium level, could she have lived. His reply was yes because it never would have dropped to an astounding 93 (he was one of the physicians who stated ,"in all his years of practice, he had never seen a patient with a sodium level in the 90's"). The pneumonia could have been taken care of immediately, as well as the sodium level, thus avoiding the adrenal crisis which developed due to the critically low (93) sodium level. There was no reason my grandmother had to die; [redacted]'s gross negligence killed her.

I will note that I asked Dr. [redacted] at that time if he would testify to this information, and he answered, "Yes, most definitely. She didn't have to die." I am sure that the physicians in Delaware would testify as well. I am enclosing a list, including addresses and phone numbers, of the nurses, doctors, etc. who came in contact with my grandmother. Perhaps they could assist in some way.

[redacted]
December 15, 1998
Page 10

In closing, I would like to say that I hope something can be done to stop nursing homes from the abuse and neglect they inflict upon the elderly and physically handicapped. I am doing this because I don't want my grandmother's death to be in vain – I don't want another family to go through the pain and suffering we have endured because of the gross negligence of one nursing home. My grandmother used to say, "You see what they do to me and I'm "sane." You should see how they treat these poor people that can't talk for themselves, that have no one to stand up for them. Those are the ones that need to be helped. Those are the ones I feel sorry for; it's pitiful." So often, she said these words to me. But she was afraid to report anyone for fear "they would get her." Yes, I did report this. I even spoke to one nurse at length regarding these concerns. Her name was [redacted] and she told me that no matter what they do to her, they should be reported. She, too, felt it had to be stopped. Please, please look into this matter. Don't let them "cover" this up, too. I am enclosing the photographs of the bruises. Why didn't they inform me, as her legal guardian, of the horrible discoloration? It may have been in the Nurse's Notes, but they never called me to tell me; and why wasn't something done about it earlier? Were these bruises a result of her so-called "fall" of September 24 or was someone "beating up on her?" My family and I constantly ask this question. And isn't it odd that everything started happening to her less than a week after I left – the one person who protected her always, who stood up for her rights, not only as a patient, but as a human? I called the State Department of Aging a few times to report "abuse" that I had witnessed. I complained several times (whether it was noted or not, I don't know) about her treatment.

I have also enclosed copies of her medical records in which I have highlighted pertinent information mentioned in this letter. And, most importantly, the lab report dated October 7 (received October 8) stating the critically low sodium level. Please note also that this test (sodium level) was "confirmed by repeat" – obviously the hospital questioned the low level if they felt it necessary to repeat the test. Additionally, Dr. [redacted] informed me, during his October 19 call, that even if he had ordered "no new orders" on October 8 (which he claims he did not), the nurse had the right and responsibility to override that decision considering the patient was at a critically low sodium level. He stated that if he had indeed told Ms. [redacted] "no new orders," she should have immediately contacted a RN to override his orders; or at best, informed someone (including the administrator) of this critical "panic value" situation. I don't understand why NO ONE at [redacted] acted upon the results of the lab report, knowing the significance of the facts stated within the report.

Should you need additional information, I may be reached at [redacted] I look forward to hearing from you soon. Thank you for your time and attention to this matter; it is greatly appreciated.

Sincerely,

Gloria Cruz

Gloria Cruz

Enclosures

GREATER BALTIMORE MEDICAL CENTER
DEPARTMENT OF PATHOLOGY
6701 NORTH CHARLES STREET
BALTIMORE, MARYLAND 21204

PATIENT: [redacted]
MRN: 01062583 000300540680
DOB: 12/20/1906 AGE: 91 SEX:
PHYSICIAN: [redacted]
LOCATION: CC-1 COMPLETE

TEST NAME		RESULTS	REFERENCE VALUES	UNITS
HEMATOLOGY				
AUTOMATED BLOOD COUNTS				
COLLECTED 10/07/98 10:13				
WHITE CELL COUNT	H	17.3	4.0-11.0	thou/cmm
RED CELL COUNT	L	3.10	4.20-5.90	mil/cumm
HEMOGLOBIN	L	10.4	12.0-16.0	gm/dL
HEMATOCRIT	L	30.0	36.0-47.0	%
MEAN CORP VOLUME		97	77-103	cu micrn
MEAN CORP HGB	H	33.5	27.0-32.0	picogram
MEAN CORP HGB CONC		34.6	32.0-35.0	%
RBC DIST WIDTH		13.1	11.5-14.5	
CHEMISTRY				
GENERAL CHEMISTRY				
COLLECTED 10/07/98 10:13				
SODIUM	CL	114	137-148	mEq/L
Confirmed by repeat				
POTASSIUM	H	5.5	3.7-4.9	mEq/L
CHLORIDE	L	77	98-111	mEq/L
CARBON DIOXIDE		23	22-30	mEq/L
ANION GAP		14	5-16	
UREA NITROGEN	H	39	6-23	mg/dL
CREATININE	H	1.4	0.7-1.2	mg/dL
BUN/CREAT RATIO	H	27.9	6.0-22.0	
GLUCOSE (FASTING)	L	62	67-133	mg/dL
OSMOLALITY, CALCULATED	L	245	281-310	

[redacted] Date 10/8/98
Remarks KNO SNO (circle)
Nurse Signature [redacted]

FAX FOR RESULTS [redacted]

DOCTOR'S PROGRESS NOTES

[illegible]		S 026
		O V.SS
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
10/14/98		I have reviewed the lab data dated 10-7-98. I was notified the first time of this abnormal lab data (Na 114 which is a panic value) on 10-9-98 at approx. 12 Noon. I was also made aware at that same time that the pt was ~~[illegible]~~ in route to be transferred to another Nursing Facility out of state. I immediately called that facility and was told the pt had not yet arrived. I gave the nurse at that facility the information about the low Na and asked that when the pt arrives a STAT electrolyte panel be done & her new physician be called immediately. I had no further contact with the new facility after that time.
		M [illegible]

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The CHAIRMAN. Thank you very much. Obviously your example is very important basis for what the General Accounting Office has done on a nationwide basis by looking into this survey that they have conducted. Thank you, Ms. Cruz. Ms. Bryant.

STATEMENT OF DENISE BRYANT, A NIECE WHO FILED A FORMAL COMPLAINT FOLLOWING THE DEATH OF HER AUNT REGARDING THE CARE HER AUNT RECEIVED IN A MICHIGAN NURSING HOME

Ms BRYANT. Good afternoon. Thank you, Senator Grassley and other members of the committee for allowing me to speak today. I will be discussing the shameful response of the State of Michigan to my complaint about my aunt's death in a Detroit nursing home.

My mother died when I was 3 years old. Afterwards, my Aunt Catherine provided care and she was like a mother to me. When I was 7 years old, I moved to Detroit to live with her. I have very strong and fond memories of my childhood days with her. She taught me so many important things. We sang, we laughed and we talked often. As I grew older, I babysat and cared for her children and she for mine. I loved my aunt very dearly.

When she became ill, I resigned from a well-paying job to care for my Aunt Catherine at home. Eventually, due to her overwhelming care needs and as a last resort, she moved into a local Medicare/Medicaid certified nursing home. The care at the home was very poor. Aunt Catherine had many unexplained injuries, was left wet and soiled on many occasions, and suffered many other indignities. I often complained about the neglectful conditions, but it did little good. I tried to compensate by helping with some of her care needs myself.

On March 2, 1997, tragedy struck. The local hospital notified me that my aunt had just arrived from the nursing home in critical condition. Nobody at the hospital or the nursing home seemed to know what happened. I later learned that a nursing home aide discovered her non-responsive, hanging from the side of her bed with her head and neck caught between the bed side rails and the mattress. The cause of death was asphyxia.

Shortly after my aunt was found hanging off the side of her bed, the homicide section of the Detroit police department was called in. A young aide at this facility told the investigator that my aunt had been found in this type of position before that day. My aunt was very petite and the beds at this facility are very old.

Shocked by this news, I went looking for answers. Not knowing whom to contact, I contacted the local advocacy group who referred me to Michigan Public Health officials. After speaking with the licensing officer, I was instructed to call their complaint hotline. After contacting the complaint hotline, I was asked to reduce my complaint to writing and to make it immediately. I asked them to conduct an immediate investigation. The investigation's results were almost as shocking as my aunt's death.

The investigator told me she found nothing wrong with my aunt's death and rejected my many other written concerns about neglect, claiming that my concerns were not recorded in the nursing home records nor the state records. Case closed. The disgraceful one-page report documents that the investigator did not interview any of the

staff or residents of the home. It does not even mention my detailed complaints of neglect. I call it a "drive-by" investigation.

I spoke with the manager of Complaint Investigations for the State of Michigan and expressed my concerns. He said his office was short staffed and that investigators had very little time to conduct investigations. He also told me that his office could not investigate many complaints and had to rely on nursing home records for its reviews. The reliance on nursing home records led me to develop a special complaint form that consumers could use to document problems and notify nursing home and public officials of their concerns beyond the walls of the nursing home.

The manager could not have cared less about my aunt's gruesome death. I did not give up. Working with my State representative and a local advocacy group, I pressed for a reinvestigation. Finally, 5 months later, on August 5, 1997, the Health Care Financing Administration, HCFA, and the State conducted another investigation. This investigation confirmed that the nursing home had not taken appropriate precautionary measures, that a large gap between the bed and side rails contributed to my aunt's death, and that other current residents were at current risk due to the same problem.

At first, I felt assured that appropriate actions would be taken. Imagine my surprise when the nursing home was given a grace period to correct the problem. Then after the nursing home failed to file a timely plan of correction, the State recommended that a threatened Federal fine be dropped. No Federal enforcement action was ever taken. The State ordered the nursing home to pay a fine of $100 to my aunt. I continue to be outraged by this lenient treatment. This lax treatment makes the state and Federal Government complicit in my aunt's death.

My aunt's death and the hapless investigation and enforcement are not the end of this story. I was saddened to learn that this same nursing home is still neglecting residents and that this neglect has contributed to the deaths of other residents. On January 29, 1999, Michigan public health officials investigated numerous complaints about the home, some of them made several months before they were investigated.

One of the complaints made 5 months before it was investigated reported that residents were still at risk due to large gaps between the mattresses and the bed side rails. The State took no immediate action, instead threatening to take action if the home did not fix the problems within about 7 weeks. By a coincidence, tomorrow, March 23, 1999, is the correction date.

It is too late to do anything for my aunt. It is not too late for others. As Senator Breaux stated, the late Senator Hubert Humphrey said that the moral test of government is how government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadow of life, the sick, the needy and the handicapped.

We need to stop "drive-by" investigations. Complaints must be acted upon immediately and not months later. Serious violations must be addressed with serious enforcement and meaningful fines. It is time to stop giving a blank check to the nursing home industry. I urge and pray that this most powerful body strengthen and

enforce the law protecting nursing home residents and hold skilled care facilities responsible and accountable for providing appropriate and safe care to individuals such as my aunt. Thank you.

[The prepared statement of Ms. Bryant follows:]

TESTIMONY OF DENISE BRYANT

Senate Special Committee on Aging Hearing
"Residents At Risk? Weaknesses Persist in Nursing Home
Complaint Investigation and Enforcement"
March 22, 1999

Thank you Senator Grassley and the other members of the committee for allowing me to speak today. I will be discussing the shameful response of the state of Michigan to my complaint about the tragic death of my aunt at a Detroit nursing home.

My mother died when I was three years old. Afterwards my Aunt Catherine helped provide care and was like a mother to me. Later, when I was seven, I moved to Detroit to live with her. I have very strong and fond memories of my childhood days with her. She taught me so many important things. We sang, laughed and talked often. As I grew older, I babysat and helped take care of her children and she for mine. I loved her dearly.

When she became ill, I resigned from a well paying job to care for Aunt Catherine at my home. Eventually, due to her overwhelming care needs, and as a last resort she moved into a local Medicare and Medicaid certified nursing home.

The care at the home was poor. Aunt Catherine had several unexplained injuries, was left wet and soiled on many occasions, and suffered many other indignities. I often complained about the neglectful conditions, but it did little good. I tried to compensate by helping with some of her care needs myself.

On March 2, 1997, tragedy struck. The local hospital notified me that my aunt had just arrived from the nursing home in critical condition. Nobody at the hospital or nursing home seemed to know what happened. I later learned that a nursing home aide discovered her non-responsive hanging with her head and neck caught between the bed side rails and the mattress. The cause of death was asphyxia.

Shortly after my aunt was found hanging off the end of her bed, the Homicide Section of the Detroit Police Department was called in. A young aide at this facility told the homicide investigator that my aunt had been found in this type of position before that day. My aunt was very petite. The beds at this facility are very old.

Shocked by this news, I went looking for answers. Not knowing whom to contact, I contacted the local advocacy group who referred me to Michigan public health officials. After speaking with the licensing officer, I was instructed to call their complaint hot line. After calling the complaint hot line I was asked to reduce my complaint to writing and mail it immediately. I asked them to conduct an immediate investigation. The investigation results were almost as shocking as my aunt's death. The investigator told me she found nothing wrong with my aunt's death and rejected my many other written concerns about neglect, claiming that my concerns were not recorded in the nursing home's records nor the state's records. Case Closed. The disgraceful one page report documents that the investigator did not even interview any of the staff or residents of the home. It does not even mention my detailed complaints of neglect. I call it a "drive-by" investigation.

I contacted the manager of complaint investigations for the State of Michigan and expressed my concerns. He said his office was short-staffed and that investigators had very little time to conduct investigations. He also told me that his office couldn't investigate many complaints and had to rely on nursing home records for its reviews. The reliance on nursing home records led me to develop a special complaint form that consumers can use to document problems and notify nursing home and public officials of their concerns beyond the walls of the nursing home. The manager couldn't have cared less about my aunt's gruesome death.

I didn't give up. Working with my state representative and a local advocacy group, I pressed for a reinvestigation. Finally, five months later, on August 5, 1997, the Health Care Financing Administration (HCFA) and the state conducted another investigation. This investigation confirmed that the nursing home had not taken appropriate precautionary measures, that a large gap between the bed and side rails contributed to my aunt's death and that other current residents were at current risk due to the same problem.

At first I felt assured that appropriate actions would be taken. Imagine my surprise when the nursing home was given a grace period to correct the problem. Then, after the nursing home failed to file a timely plan of correction, the state recommended that a threatened federal fine be dropped. No federal enforcement action was ever taken. The state ordered the nursing home to pay a fine of $100 to my aunt. I continue to be outraged by this lenient treatment. This lax treatment makes the state and federal government complicit in my aunt's death.

My aunt's death and the hapless investigations and enforcement are not the end of this story. I was saddened to learn that the same nursing home is still neglecting residents and that this neglect has contributed to the deaths of other residents. On January 29, 1999, Michigan public health officials investigated numerous complaints about the home, some of them made several months before they were investigated. One of the complaints made five months before it was investigated reported that residents were still at risk due to large gaps between the mattresses and bed side rails. The state confirmed numerous instances of neglect. But just like in my case, the state took no immediate action, instead threatening to take action if the home did not fix the problems within about seven weeks. By coincidence, tomorrow, March 23, 1999 is the correction date.

It is too late to do anything for Catherine Hunt. It is not too late for others. The late Senator Hubert Humphrey said that the moral test of government is how government treats those who are the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped. We need to stop drive by investigations. Complaints must be acted upon immediately and not months later. Serious violations must be addressed with serious enforcement and meaningful fines. It is time to stop giving a blank check to the nursing home industry.

I urge and pray that this most powerful body strengthen and enforce the laws protecting nursing home residents and hold skilled care facilities responsible and accountable for providing appropriate and safe care to individuals such as my Aunt Catherine Hunt.

Thank you.

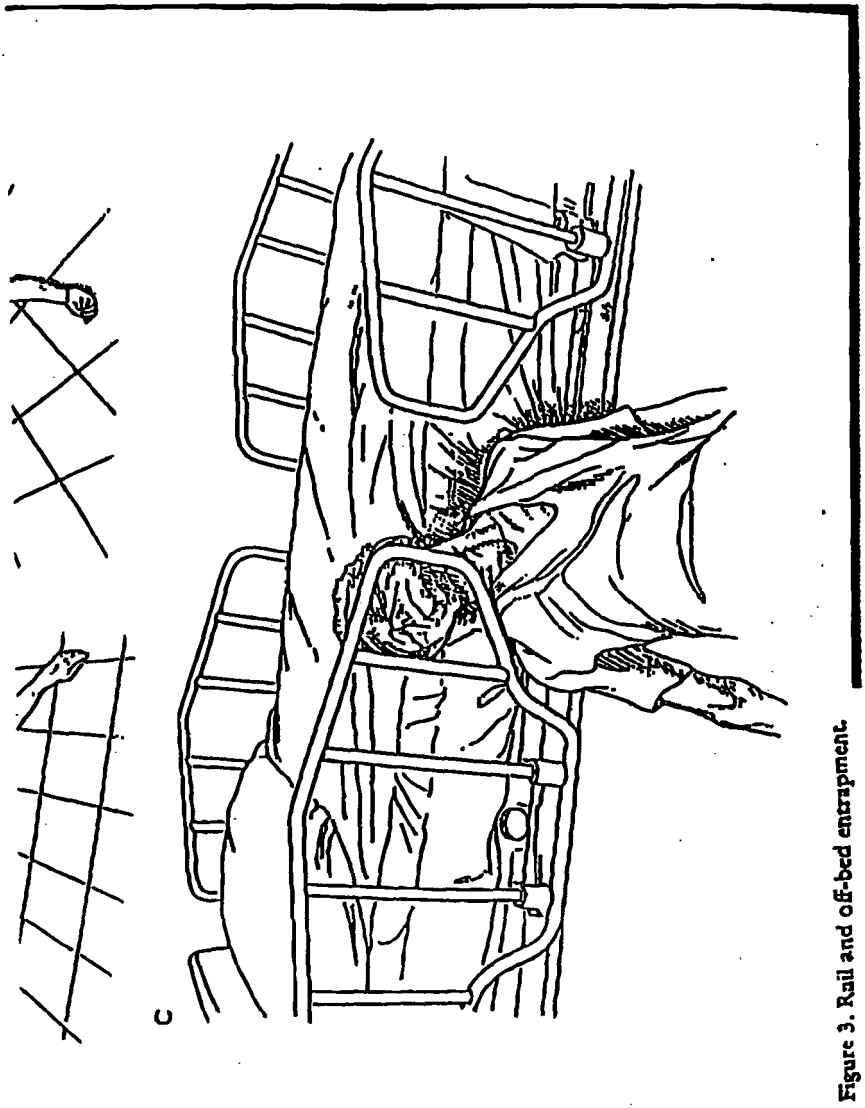


Figure 3. Rail and off-bed entrapment.

LC-150a

MICHIGAN DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEALTH SYSTEMS

SUBJECT: FACILITY REPORTE

Intake #: [redacted]
Investig #: [redacted]

Facility No.: [redacted]
Facility Name: [redacted]
Address: [redacted]
City: [redacted]
Zip: [redacted]
Date: 03/13/97

Investigated by:
[redacted] Registered Nurse

Announced ___ Unannounced XXX

PARTICIPANTS:
[redacted] Administrator
[redacted]: Director Of Nursing

REPORT

Pursuant to Act 368, Public Acts of 1978, as amended, an unannounced visit was made to [redacted] to investigate this complaint.

INVESTIGATION

Licensing Officer was contacted on / /
Facility was toured: YES
Interviews: # RESIDENT 0
STAFF 0
ALLEGED PERPETRATOR 0
OTHER 1

Medical Record(s) reviewed: YES
Other pertinent documentation reviewed: YES
Exit conference: YES

FACILITY-REPORTED ITEM #1:

IT WAS REPORTED THAT A RESIDENT WAS FOUND ON THE FLOOR, UNRESPONSIVE, WEDGED BETWEEN THE SIDERAIL AND MATTRESS. RESIDENT WAS TRANSPORTED TO THE HOSPITAL. POSSIBLE NEGLECT.

FINDINGS #1: NO BASIS

BASED ON RECORD REVIEW AND INTERVIEW WITH FACILITY STAFF AND THE MEDICAL EXAMINER'S OFFICE THIS ALLEGATION COULD NOT BE SUBSTANTIATED DURING THE SURVEY ON 3/11/97.

REVIEW OF THE RESIDENT'S RECORD REVEALED THAT THE RESIDENT WAS BEING MONITORED ON A REGULAR BASIS. STAFF INTERVIEW REPORTED THAT THE RESIDENT HAD BEEN OBSERVED, POSITIONED IN BED, AND HAD BEEN ATTENDED BY THE NURSING STAFF SHORTLY BEFORE BEING FOUND WEDGED BETWEEN THE BED'S SIDERAIL AND MATTRESS.

THE BED AND MATTRESS WERE EXAMINED AND FOUND TO BE A MATCH OF STANDARD SIZE, HOWEVER, THE SMALL SPACE BETWEEN THE SIDERAIL AND THE BED/MATTRESS WAS ENOUGH FOR A PERSON OF SMALL STATURE TO WEDGE INTO. INTERVIEW WITH THE MEDICAL EXAMINER'S OFFICE REPORTED THAT THE RESIDENT'S CAUSE OF DEATH WAS A RESULT OF POSITIONAL ASPHYXIA ACCELERATED BY CEREBRAL HYPERTROPHY, FURTHER, THAT THE RESIDENT WAS THIN BUT WELL NOURISHED AND APPEARED WELL CARED FOR. (10389)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVE
2567-L

STMENT OF DEFICIENCIES ...D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: [redacted]	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED 08/05/97

NAME OF PROVIDER OR SUPPLIER [redacted]	STREET ADDRESS, CITY, STATE, ZIP CODE [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
F 323 SS=G	483.25(h)(1) REQUIREMENT: QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: BASED ON OBSERVATION, RECORD REVIEW, AND STAFF INTERVIEW, THE FACILITY FAILED TO ENSURE THAT THE RESIDENT ENVIRONMENT REMAINED AS FREE OF ACCIDENT HAZARDS AS POSSIBLE RESULTING IN HARM TO ONE RESIDENT (#1) AND POTENTIAL HARM TO AT LEAST 3 OTHER RESIDENTS (#'S 2, 5, AND 6.) FINDINGS INCLUDE: RESIDENT #1 WAS A 66 YEAR-OLD RESIDENT WITH A DIAGNOSIS OF SENILE DEMENTIA. RECORD REVIEW AND STAFF INTERVIEW REVEALED THAT ON 3/2/97 AT 8:10 A.M. A NURSE AIDE FOUND THIS RESIDENT WITH HER FEET AND LEGS ON THE FLOOR AND HER HEAD AND NECK UNDER THE BED SIDE RAIL WITH HER NECK WEDGED BETWEEN THE SIDE RAIL AND THE MATTRESS. THE NURSE WAS CALLED AND STAFF EXTRICATED THE RESIDENT FROM THE SIDE RAIL. THE RESIDENT WAS TRANSFERRED TO THE HOSPITAL WHERE SHE EXPIRED ON 3/4/97 OF POSITIONAL ASPHYXIA, ACCORDING TO THE COUNTY MEDICAL EXAMINER'S REPORT. SIDE RAIL ON 8/5/97 REVEALED THAT THE MATTRESS DID NOT FIT SNUGGLEY AGAINST THE SIDE RAIL, LEAVING A GAP THAT THIS THIN, COGNITIVELY IMPAIRED RESIDENT WAS ABLE TO SLIP THROUGH.	F 323

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
	ADDITIONAL OBSERVATIONS OF SIMILAR BEDS IN THE FACILITY REVEALED RESIDENTS BE AND 6 HAD GAPS BETWEEN THE MATTRESS AND THE BOTTOM OF THE SIDE RAIL. WHEN ASKED, ONE NURSE AIDE SAID THAT WHEN THE RAILS WERE NOT TIGHT THAT SHE PUSHED THEM BACK TO TIGHTEN THEM. ON EXAMINATION, THE CROSSBARS ATTACHING THE RAILS TO THE BED SPRINGS WAS ADJUSTABLE AND COULD BE MOVED IN AND OUT ON SOME OF THE BEDS. ONE RESIDENT (#2) WAS OBSERVED IN HIS BED WITH THE HEAD OF THE BED ELEVATED ABOUT 75 DEGREES. THIS HAD CAUSED THE SIDE RAIL TO RAISE UP, LEAVING A LARGE, TRIANGULAR SHAPED, SPACE BETWEEN THE SIDE RAIL AND THE BED WHICH ANY AVERAGE SIZE ADULT COULD SLIP THROUGH. THE MAINTENANCE SUPERVISOR DEMONSTRATED THAT THIS SPACE COULD BE REDUCED IN SIZE BY LOWERING THE SIDE RAIL ONE OR TWO NOTCHES. HOWEVER, NURSING STAFF SEEMED UNAWARE THAT THIS ADJUSTMENT COULD BE MADE IN ORDER TO BRING THE MATTRESS AND THE SIDE RAIL CLOSER TOGETHER. ALTHOUGH THE FACILITY WAS USING SIDE RAIL PADS ON SOME RESIDENTS' BEDS, THE PAD DID NOT ALWAYS REDUCE THE SIZE OF THE SPACE AND DID NOT CORRECT THE PROBLEM WHEN THE HEAD OF THE BED WAS ELEVATED. THE DESIGN OF THE BED SIDE RAIL AND THE FAILURE OF THE FACILITY TO ENSURE THAT IT WAS ADJUSTED SNUGGLY TO THE MATTRESS AND ADJUSTED PROPERLY WHEN HEADS OF BEDS WERE ELEVATED WAS A HAZARD TO THE SAFETY OF THE RESIDENTS IN THOSE BEDS. (08888)	

October 9, 1997

[redacted] Director
Department of Consumer & Industry Services
Law Building - 4th Floor
P.O. Box 30004
Lansing, MI 48909

Dear [redacted]:

On September 2, 1997 I spoke with [redacted] to ascertain the deadline date [redacted] was given to submit 'plans of correction' in response to the reinvestigation into complaint [redacted] informed me that the deadline date was August 31, 1997 and the 'plans of correction' had not been received. She also indicated that it may have been delayed due to the holiday and would give them until the end of the week. At that time, I requested a copy of the 'plans of correction' and was promised it would be mailed to me. On October 1, 1997 a message was left on [redacted] voice mail regarding the matter; no return call was received. I telephoned again on October 2, 1997 and left another message; no return call was received. To date, I have not received a copy of the 'plans of correction' nor is it known to me, whether or not it was received by the Department.

At this point, not only am I requesting a copy of the 'plans of correction' and the date received, I am requesting a copy of the correspondence mailed to [redacted] requesting the 'plans of correction', the Department's response to the 'plans of correction', citations issued, if any, as well as a copy of all data collected during the investigation that is available for review.

[redacted] I have been very patient waiting to receive a copy of the 'plans of correction'. My experience with the Department of Industry and Consumer Services has not been a pleasant one. Certainly, I would not want to contact my State Representative or Governor [redacted] again in order to get a response to my inquiry.

Thank you in advance for your assistance in this matter.

Sincerely,

Denise F. Bryant

Denise F. Bryant
for Catherine Hunt

c: Citizens for Better Care
-Chief of Detroit Field Services/Special Services
Licensing Officer
- Ombudsman
- Surveyor

The CHAIRMAN. Thank you, Ms. Bryant. I think some of the points that you made at the end of your remarks, you will find if you can stay around to listen to the General Accounting Office and the Inspector General's report, are recommendations that they are making and it is going to be our job on this committee to see that HCFA does carry out those recommendations because I think the points you make are very legitimate or there would not be any point of having HCFA be an enforcement agency. Thank you.

We will each have questions. I would ask staff to have 5 minute questions for each one of us. And I will take people in the order in which they gave their opening statement. I will start with questions. By the way, that is a drawing of how you found your aunt; right?

Ms BRYANT. That is my aunt. That is not—oh, the drawing, yes. That is the position she was found in similar to that.

The CHAIRMAN. Yes. And you found her in that position or that was what you were reported?

Ms BRYANT. That is what was reported to me. She was discovered by an aide at the facility in that position.

The CHAIRMAN. OK. So I will start with Ms. Cruz. In your testimony, you state——

Senator REID. Mr. Chairman.

The CHAIRMAN. Yes.

Senator REID. Could I ask permission to submit my questions in writing instead of in person?

The CHAIRMAN. I would be willing to let you ask your questions.

Senator REID. Oh, no. No, no. No, that is fine. No, I would not do that.

The CHAIRMAN. No, I think you should because I think it might be easier for these two people.

Senator REID. I will wait my turn then.

The CHAIRMAN. Well, I am willing. OK. In fact, it is a policy in this committee to give attention to people who do have conflicts.

Senator REID. Go ahead.

The CHAIRMAN. OK. In your testimony, Ms. Cruz, you state that you sent a letter on October 24, 1998 to the manager of the Complaint Investigations Office in Baltimore. How did you know where or to whom you sent this complaint and would the office have accepted a complaint over the phone?

Ms CRUZ. I had gotten in contact with them prior to that over various abuses and neglects I had witnessed at the nursing home. So I had called them before. So I knew to get in touch with them and, no, they do not take complaints over the phone. Well, they will take the complaint over the phone, but then they do want it followed up in writing.

The CHAIRMAN. Now, I understand that you attached a letter. You gave us a copy of the letter that is attached to your testimony. What did you say in that letter? What was your complaint?

Ms CRUZ. To the licensing investigation?

The CHAIRMAN. Yes.

Ms CRUZ. That my complaint was for the abuse and neglect that my grandmother had suffered due to a nursing home and felt that they needed to investigate it.

The CHAIRMAN. Yes. And you laid out in very explicit terms what you found to be totally wrong and, of course, you make a very, what sounds like a very serious complaint to me. I would like to make sure that I understand it right. So 7 weeks passed and you still had not heard from the Complaint Investigative Office?

Ms CRUZ. That is correct.

The CHAIRMAN. Then you sent another letter on December 15, 1998 to the Patient Abuse Coordinator in the Maryland Attorney General's Office with a copy to the Complaint Investigations Office; is that correct?

Ms CRUZ. Yes.

The CHAIRMAN. After another week had passed, you followed up with a call to the Attorney General's office. You were told that they had just discussed the matter of your complaint with the manager of the Complaint Investigation Office and they suggested that you phone her. Did you inform the Attorney General office that 8 weeks had passed since you first raised your complaint?

Ms CRUZ. Yes, I did.

The CHAIRMAN. And did they say anything other than suggest you call the Complaint Investigation Office?

Ms CRUZ. No, they said that there was nothing they could do about it, that I would have to call the Licensing and Certification and speak with them.

The CHAIRMAN. I understand that the letter you sent to the Attorney General's office is also attached to your testimony. Someone filing a complaint should not have to send another letter or make a follow-up phone call to get a response from the State, but you did follow up on the attorney general's suggestion to call the Complaint Investigations Office. What happened when you called?

Ms CRUZ. She told me that they get approximately 80 complaints per month and that they only had two investigators to do the investigations.

The CHAIRMAN. Were you given an estimate as to when you would hear something from them?

Ms CRUZ. No, not at all.

The CHAIRMAN. On March 1, 1999, 18 weeks since you first wrote a letter to the State filing your complaint, you phoned the Complaint Investigation Office again. You still had not received a response from your complaint letter; is that right?

Ms CRUZ. Yes, that is right.

The CHAIRMAN. What were you told when you called?

Ms CRUZ. Again, she reiterated that they get 80 complaints per month regarding nursing home.

The CHAIRMAN. Did they say anything to you like we want to investigate live ones before we——

Ms CRUZ. Yes, she did.

The CHAIRMAN [continuing]. Investigate dead ones?

Ms CRUZ. She went on, she further stated, after she had told me they get 80 complaints per month, she said, well, to be honest with you, we investigate the live ones before we investigate the dead ones.

The CHAIRMAN. How did you respond to that disturbing statement?

Ms CRUZ. I was appalled and I said to her that perhaps if they investigated the abuse of the ones who have passed away that perhaps they could save the ones that were alive and being neglected and abused.

The CHAIRMAN. OK. I will turn to Senator Breaux and then I will ask Ms. Bryant some questions on my second round.

Senator BREAUX. Well, Ms. Cruz and Ms. Bryant, thank you very, very much. Your grandmother and Aunt Catherine, I would dare say, would be very proud of both of you being here in this rather awkward position of telling the whole country what happened to them, but you can take great comfort, I think, in knowing that what you are doing today will help many others who hopefully will never find themselves in the same situation that you found your family members involved in.

Let me just ask, Ms. Cruz, how long was your grandmother in that nursing home before she was transferred to the second one?

Ms CRUZ. OK. In that particular nursing home, she went in in December 1995 so about 2½ years before she was being transferred.

The CHAIRMAN. So up until the time she was transferred, 2½ years or so, how was her treatment during that period of time?

Ms CRUZ. I never had any major complaints, but I did have several minor complaints, as I said, that I did speak to Licensing and Certification such as leaving her in the bed until 11 o'clock wet and soiled. They would leave her—at this point, she was wheelchair bound and they would leave her in the restroom for, you know, quite a long time. I would come to visit her and she would be in the restroom just calling for help. The nurse's light was on, but she would be calling for help.

Senator BREAUX. Did you all consider or were not able to transfer her or it was not something that was possible to do or you just did not think it was necessary or what?

Ms CRUZ. At that point, it really was not possible. I had checked into other nursing homes, but because she had Medicare and Medicaid, they had restrictions as to the different types of bed, you know. If this one needs more care than the other, then they have a bed opening. If this one does not need that much care, they do not have a bed opening. They had very stringent rules and some of the other nursing homes would not accept her for different reasons.

Senator BREAUX. I take it that procedures did not require that a doctor sign her out when she was being transferred? I mean the nursing home just did that on their own accord at the request of your family? I mean they did not have to have the doctor sign out that it was sufficient and OK to transfer her in her condition?

Ms CRUZ. Well, apparently they were supposed to get his approval for discharge, but there is some discrepancy as far as that goes as to whether he actually was notified or not.

Senator BREAUX. Ms. Bryant, how long was Aunt Catherine at the nursing home before this tragic event happened?

Ms BRYANT. Less than a year approximately. She went in in I believe the beginning of April 1996 and she expired——

Senator BREAUX. And up to the date of the accident there——

Ms BRYANT. March 2.

Senator BREAUX. Excuse me. Up to the date of this tragic accident, how was her treatment up to that time?

Ms BRYANT. There were problems that I complained about. She had received several injuries. She was hospitalized once for pneumonia. Her bed was next to a window and I would often go into the nursing home on the off hours just to see what type of care she was receiving and went in one morning and they had the window open and she was laying in the bed freezing, and it was shortly after that that she was hospitalized with pneumonia. She received injuries to her shin which was unexplained. I went in one time. Her hand was swollen twice its normal size. There was still also no explanation as to why.

Senator BREAUX. As disturbing—my final question is as disturbing as all of this information is, what disturbs me as well of great proportions is the fact that the State in investigating this event has really only three paragraphs about what happened and no recommendations on how to prevent it from happening again. I mean, was this the sum and substance of the investigation——

Ms BRYANT. Are you talking about the first report?

Senator BREAUX [continuing]. from the State, just one page and three paragraphs?

Ms BRYANT. Yes, that was the initial report.

Senator BREAUX. I mean when a person dies in your own facility, I mean it just seems that there should be a more extensive investigation and some recommendations to prevent that from happening again. That is really what we are talking about, Mr. Chairman, or about the adequacy. I mean the laws are there. I mean do not treat people like this. The problem is making sure that they are enforced properly and it would seem in this case it certainly was not. Thank you, both, very much.

The CHAIRMAN. Senator Hutchinson.

Senator HUTCHINSON. Mr. Chairman, I want to thank our witnesses for their very compelling testimony and for their courage in coming forward. I think you have laid out for us in very simple and very heartfelt terms the tragic circumstances of your experiences. What you have told us today lays the foundation and puts a human face and human feelings on the findings in the GAO report that we will be discussing.

I really do not have any questions for you. My questions are for HHS and for HCFA, but I do want to thank you and extend to you my heartfelt sympathy.

The CHAIRMAN. Senator Reid.

Senator REID. Mr. Chairman, these two women represent what is going on in this country today, people who do everything they can to keep their loved ones out of an extended care facility, but there comes a time when you cannot do it on your own. And these two—one of these women resigned a well paying job to take care of her loved one. The other visited three times a week, called her daily, did her laundry. This is an example of why we need to have a tax credit for people who do this. They should be rewarded in some way and I hope we can get this specialized tax credit that is being talked about this year so that the people like Ms. Cruz and Ms. Bryant are compensated in some fashion.

Also, under the Older Americans Act, we have provided a state ombudsman, which provides help for people like you, and the ombudsman is supposed to work in looking into abuses that take place in rest homes like this. In a lot of instances, they do work. Here obviously it did not.

I would also say, Mr. Chairman, one of the problems we have in Nevada, and I am sure around the country, is what if there are numerous examples of abuse, not meeting the standards that are necessary, what do you do with a rest home that has a couple hundred people in it? Do you close it and where do these people go? That is a problem we have all over America. And I would suggest, Mr. Chairman, that this committee should look into establishing a receiver, for lack of a better word.

In the State of Nevada when we have large resorts that need to be closed because people are cheating, we have established in the State of Nevada a group of people we can call on so that we do not have to close the hotel, the hundreds and sometimes thousands of people who are working there could continue to work even though the present management is, in effect, told to step out. And I think we need to do that with rest homes, have a reserve of people we can call on to continue running the operation when the present management simply is incapable of doing so.

And we do not have that so a lot of rest homes in the United States are kept open even though they should not be because there is nothing to do with the hundreds of people who are in those rest homes. I am not going to name names, but there are places in Nevada that should have been closed, but we were not able to close them because there was nothing to do with those patients.

I also—this is an example of why it is sad to say, but a lot of these complaints that people like Cruz and Bryant have here, Ms. Cruz and Ms. Bryant, are settled in the courts. People file lawsuits. They should not have to file lawsuits and have their cases remedied in the court system, but that is what is happening all over America today because the process for having your grievances heard, they have no alternative. People, in effect, are ignored and I think that is too bad. Mr. Chairman, as I said, I have some other questions I would like to submit.

The CHAIRMAN. Yes.

Senator REID. And we could do that. And you do not have to be in a rush to answer them, but if you could get back to us at the earliest possible date, that would be appreciated. Thank you a lot, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Reid.

Senator Bayh.

Senator BAYH. Thank you, again, Mr. Chairman. Ladies, I would like to compliment you for being here today and, Ms. Bryant, it may have been you who said that by being here today you felt that your loved one had not died in vain, and I think that is absolutely right. And I hope both of you, Ms. Cruz, you as well, can take some small comfort in the fact that perhaps your ordeal will help to prevent this sort of tragedy from happening to others. So I want to thank you for your courage in stepping forward. As Senator Breaux mentioned, it is not easy to talk about intimate personal matters, particularly tragedies in front of a whole lot of folks you do not

know, but you are helping a lot of other people hopefully not be in a similar situation. So I would like to thank you both for that.

I would also like to echo something that Senator Reid said about passing Federal legislation to help provide a tax benefit for those of you who are caring for an elderly parent. I think it is a family friendly. It would help recognize the real sacrifices that you make to care for a loved one, and it is in the finest traditions of our basic values as a society, encouraging families to stick together to care for one another, to provide compassionate treatment, and so I want to go on record of supporting that as well.

Just very quickly, I would like to ask you both a question. We have to strike the right balance here between Federal oversight and state oversight, and you have obviously both had a very tragic experience with Maryland and Michigan in this regard. From my own experience, I would say that Federal bureaucracy and oversight is not always more compassionate than state bureaucracy or oversight.

I think the Federal agency's failure to attend here today may be further evidence of that. And I would like to ask each of you if you have any thoughts about the appropriate balance there. I mean in some ways we need to have the Federal Government here to make sure that States are active dealing with these problems, making sure that they do not occur. At the same time, if the person you have got to call is out here in Washington some place as opposed to being a little closer to home, it might be more difficult for you. Do you have any thoughts about the appropriate balance between Federal and state oversight in this area to try and make sure these things do not happen?

Ms BRYANT. Well, I think primarily the State, I believe, is regulated by the Federal requirements and I feel if the Federal agency oversees the State more closely than what it is currently doing and making sure that the States abide by the Federal regulations would create a better balance and actually enforce those regulations.

Senator BAYH. So the State would be your first area of recourse, but the Federal Government would be here to keep an eye on the States to make sure that using statistics and otherwise they were getting their job done rather than the Federal Government substituting itself for the State at the beginning?

Ms BRYANT. Yes, I think the first response should be to the States since they are the closest.

Senator BAYH. Ms. Cruz, do you agree with that?

Ms CRUZ. Yes, I agree with that because the State that you are dealing with is going to be more familiar possibly with the facility that you are dealing with and therefore they would be more informative of what was going on, and then if that did not work, then go higher above to the Federal agency. But I agree with Ms. Bryant that the Federal agencies need to put more effort into it and control it better.

Senator BAYH. If I could ask each just one more question. One of my colleagues alluded to the role of an ombudsman in trying to provide more information to consumers before you would select a care facility for your loved one. Were either of you, did you feel, did you have access to information about the history of violations or

care of the facilities that you chose, and if you did not, would it have made an important difference to you knowing what you know now in terms of choosing where to put your loved one?

Ms BRYANT. I did look at the ombudsman report in regard to the annual survey of the nursing home prior to my aunt moving into the certified nursing facility, but the report is pretty much representative of the first investigation that was conducted in regard to my aunt's death. So it was deceiving that this home did not have major problems.

Senator BAYH. Because it had not been updated to reflect violations from the time subsequent to the first evaluation?

Ms BRYANT. Correct.

Senator BAYH. Ms. Cruz?

Ms CRUZ. And yes, I checked into it as well, and I would say there were quite a few omissions from what I saw.

Senator BAYH. What you subsequently learned?

Ms CRUZ. Yes. There were a lot of things in there that I would have to say were covered up. They were not in there. There were a lot of omissions.

Senator BAYH. So you tried to be informed consumers, but there was something about the process that did not allow you to get the information that now you feel you needed to make an informed decision?

Ms CRUZ. Yes, and I think we need to get it out in the public what is going on. I mean there were a lot of things that were omitted and had I known them, I think I would have been more reluctant to put her in there, but they just tend to cover up things. And we as the family, we go by what we see and if in writing it says it is OK, then we assume it is.

Senator BAYH. Thank you both.

Ms CRUZ. Thank you.

The CHAIRMAN. Thank you, Senator Bayh. Ms. Bryant, I would like to ask you a few questions, similar along the lines that I did, Ms. Cruz. I would like to have you tell us more about what happened when you called the complaint hotline at the Michigan Department of Consumer and Industry Services. This hotline, it is my understanding, is set up to receive and evaluate reports of substandard care in nursing homes. How did you know about this hotline, No. 1? No. 2, what response did you receive? And No. 3, were they helpful and cooperative?

Ms BRYANT. I learned about the hotline after I contacted the local advocacy group who referred me to the licensing officer for the Consumer and Industry Services in Detroit, MI, and after I contacted her and complained, filed my complaint orally, that is when I was informed to contact their complaint hotline and to give my complaint.

The response I received from the complaint hotline was to reduce my complaint to writing and to Federal Express it overnight since they were already going out to the home to conduct an investigation. I would say that they were not cooperative in regards to responding to my immediate complaint. Rather this is what you must do in order for us to act upon it; your verbal complaint is not enough.

The CHAIRMAN. So then you had to write a complaint. They would not take it over the phone. Did they give you a reason why they would not take it over the phone?

Ms BRYANT. No, they did not. They just said put it in writing, and this occurred just days after, the day after the death of my aunt.

The CHAIRMAN. Did they imply that they receive too many complaints or you cannot investigate every one or anything like that?

Ms BRYANT. I did get that response later when I spoke with the manager of the Complaint Investigation.

The CHAIRMAN. You complied with the requirement to put it in writing and wrote up your complaint. It is my understanding you did that in great detail. At least that is the way it looks to me. You then sent it to the State March 6, 1997. Approximately 2 weeks later, on March 21, you received a response. What did that letter say?

Ms BRYANT. That the State investigators were unable to substantiate my complaint and no violations were found.

The CHAIRMAN. After you received this letter, you wrote letters to your Governor and to your State legislators. This was to put pressure on the State to look again at your complaint. What happened as a result of all those letters that you wrote?

Ms BRYANT. The State representatives, accompanied by HCFA, went out and conducted a reinvestigation and performed the annual survey on August 5, 1997. This was over 20 weeks later.

The CHAIRMAN. OK. And what did they find after that survey and when did you get word of the findings of the second survey?

Ms BRYANT. They found the home to be in non-compliance on three Federal requirements and I received the survey results September 16, 1997.

The CHAIRMAN. And what did you have to do to obtain information about the results of this survey?

Ms BRYANT. Well, initially I requested the results on several occasions and was not able to get them and eventually I wrote a letter dated October 9, 1997, demanding the results and threatening to contact my Governor's office again, and I received the results on October 16, 1997.

The CHAIRMAN. And this report contradicted the earlier complaint investigation about your aunt's death and we have shown here on two posters, which I think they have already been up there, that they showed findings of these complaint investigations. Was there any explanation on the part of the State about the different findings?

Ms BRYANT. None at all. They just said here are the results.

The CHAIRMAN. OK. What happened to the facility as a result of the August survey and the deficiencies that were identified and cited?

Ms BRYANT. The home was ordered to pay my aunt $100.

The CHAIRMAN. You mentioned that after the August 1997 survey, the nursing home received a grace period to correct the quality of care problems that were identified before any enforcement action would be taken. The home came back into substantial compliance during the grace period so nothing happened. No enforcement action was taken against the home and just recently on February 12,

1999, this same nursing home received the results of the annual survey. Has this home improved?

Ms BRYANT. I doubt it, but we will know March 23, 1999, which is the date for the reinvestigation.

The CHAIRMAN. OK. I want to ask your opinion about a proposal by the ombudsman's office in my State which I just learned about recently. The proposal would call for the creation of an appeals board made up mostly of consumers like yourself but also with some State officials. This board would provide a further review of unsubstantiated complaints to determine whether any further action should be taken. So in your case, you could have an opportunity to have your case heard before this appeals board. Would something like this have been helpful in your case; do you feel?

Ms BRYANT. I do not know. I have not seen the results of that proposal. Without knowing the specifics, I do not know, but it may have been helpful or it may be helpful in situations that do not involve death to where she was injured, I could have sat before a board and made a complaint. But I am not certain in situations resulting from death. I feel that I may have had to go through the same process.

The CHAIRMAN. OK. My last question would be to both of you and it is a very general question because maybe in summation or may be something that you want to say that you have not said yet. What advice would you have for other family members shopping for a nursing home?

Ms CRUZ. I would suggest that they talk to family members that have loved ones in a nursing home. I actually did that. When I was having my grandmother transferred to Delaware, I stopped several people that were coming out of the nursing home where I was having her transferred and asked them how they felt about the care in that particular nursing home, whether they were happy with it, whether they had any instances of abuse, neglect or anything.

So I would say that if they find someone who has a loved one in the nursing home get it directly from them, do not get it from a piece of paper because it will not tell you anything.

The CHAIRMAN. And Ms. Bryant?

Ms BRYANT. And I agree with Ms. Cruz. Individuals should actually conduct a site visit of the home, perhaps during visiting hours, and speak with other family members that have loved ones in the home to get a detailed report of their experiences within a nursing home because my experience in regards to getting information on paper is deceiving.

The CHAIRMAN. OK. Senator Breaux and then Senator Bayh for a second round.

Senator BREAUX. No. Thank you very much.

The CHAIRMAN. OK. Well, then for the entire committee—oh, wait, before you go. For this panel as well as for other panels, for members who cannot be here, even those of us who are here, you might get questions for answer in writing. And if you do, we would like to have responses to them in a couple weeks. And for you two folks, if that is a problem for you, my staff would be glad to help accommodate you in responses to the questions. We could help you do that, if you would, please.

So I thank you not only for this committee and for the Congress and its oversight responsibilities to make sure that laws are faithfully carried out, but for all people in nursing homes today. For the advice you just gave, for those that are prospectively going to be in nursing homes, I just thank you tremendously for coming here to tell your story to alert others to these problems. We can collectively through your examples and through the hard work of the General Accounting Office, the Inspector General for today's hearing, and eventually to have HCFA respond and do its job better so that we do not have repeats of these things in the future. Thank you very much.

Ms CRUZ. You are welcome. Thank you.

Ms BRYANT. Thank you.

The CHAIRMAN. And you are also welcome to stay, but I know that you have got your own schedules, but understand you are welcome to stay if you want to.

Ms CRUZ. Thank you.

The CHAIRMAN. Our second panel is comprised of representatives from the Department of Health and Human Services, Inspector General's Office, and the General Accounting Office. Mr. George Grob is here today to present the findings of six reports which will be released today at this hearing. These reports provide staggering statistics on our nation's nursing homes. And then we have Dr. Scanlon, currently Director of the Health Financing and Systems at the General Accounting Office. He is here to present the findings of two recently completely General Accounting Office reports which detail the weaknesses disabling the nursing home complaint investigation and enforcement process. I will start with Mr. Grob, you may begin.

And we thank you, gentlemen, for not only coming here to testify but obviously for the work that you have done over a long, long period of time, getting to the point where you are issuing these reports, and Dr. Scanlon, I would applaud you because you responded to the needs of this committee way back in early or late 1997 in looking into the nursing home situation in California. And so I know you have had a team of people working long and hard on this, and we appreciate your attention to this very important problem. Mr. Grob, you may begin.

STATEMENT OF GEORGE GROB, DEPUTY INSPECTOR GENERAL, OFFICE OF EVALUATION AND INSPECTIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. GROB. Good afternoon, Mr. Chairman. There are serious problems in our nation's nursing homes, at least in pockets and possibly more broadly. The systems designed to protect nursing home residents have serious defects which leave them vulnerable to harm. I base this conclusion on six reports which our office is releasing today. These are the first reports in what will be a continuing series on the quality of care in nursing homes.

Our findings are consistent with those of the General Accounting Office, the Health Care Financing Administration, and this committee. A concerted effort over several years and involving numerous parties will be needed to bring the quality of life and care in nursing homes consistently up to the level envisioned in Federal statutes.

Last summer this committee focused on conditions in nursing homes in the State of California. Our studies broadened this look to the ten largest States. We found that survey deficiencies overall have been decreasing in recent years. However, 13 of 25 quality of care deficiencies have increased. These include serious problems such as those related to accident hazards, pressure sores, and incontinence care. These and other such deficiencies are highlighted on the chart before you. That would be the first chart right there.

As you can see, between 10 and 16 percent of nursing homes in our sample received citations for these problems. Furthermore, complaints to state ombudsmen have been steadily increasing since 1989. Complaints about residents' rights, nutrition and food, and resident care increased faster than others. From 1996 to 1997, some of the top increases in complaints included symptoms unattended to or no notice to others in change of condition. They went up 26 percent. Fluid availability and hydration went up 26 percent. And weight loss due to inadequate nutrition went up 24 percent. These and other serious complaints are on the second chart, "Ombudsmen Complaints.

Some nursing homes are repeatedly deficient. Nine hundred nursing homes or 13 percent of our sample, have been cited with the same deficiencies over the past four surveys, six percent for the same substandard quality of care deficiencies.

Many of the problems I have been talking about suggest that inadequate levels of nursing home staff contribute to this poor quality of care. In all ten sample States, survey and certification staff, state and local ombudsmen and state agency unit directors agreed that inadequate staffing levels are one of the major problems in nursing homes. Most believe that these staffing shortages lead to chronic quality of care problems such as failure to adequately treat and prevent pressure sores.

Our studies found shortcomings in the survey and certification system similar to those previously discussed by this committee. Today I would like to highlight our finding on the inadequacy of the complaint resolution process. When complaints come into the Survey and Certification Agency, a survey or is required to go to the nursing home and substantiate the complaint. We found that

about one-third of complaints are substantiated. Of these, 47 percent receive no action. This is highlighted in our third chart.

The Omnibus Budget Reconciliation Act of 1987 established a visionary but practical framework for protecting nursing home residents and elevating their quality of life. As you can see, our findings indicate that the vision of OBRA 1987 is not yet fulfilled and its requirements not entirely met. An effective strategy to achieve these goals should include actions to correct shortcomings in the survey and certification process, strengthen the ombudsman program, improve nursing home staffing levels, improve coordination between survey and certification agencies and ombudsmen, and systematically evaluate the nursing home reform provisions of OBRA 1997.

We also believe that a periodic report card on conditions in nursing homes should be established in order to measure progress made in raising the standard of nursing care. This report could be based on deficiency trends, ombudsmen complaints, insiders' perspectives, and resident and family satisfaction.

The Health Care Financing Administration is taking action to address many of the problems discussed in our reports with strong oversight from this committee. We wish to commend all involved for the progress that is being made. The Office of Inspector General is committed at all levels to improving care in nursing homes through our evaluations and audits and through our investigatory and legal authorities. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Grob and related material follow:]

Nursing Homes: Quality of Care

Testimony of
George F. Grob
Deputy Inspector General
for Evaluation and Inspections

Hearing Before:
Senate Special Committee on Aging

March 22, 1999

Office of Inspector General
Department of Health and Human Services
June Gibbs Brown, Inspector General

INTRODUCTION

Good morning, Mr. Chairman. I am George Grob, Deputy Inspector General for Evaluation and Inspections within the Department of Health and Human Services. The Office of Inspector General shares your keen interest in the quality of the care received by some of our Nation's most vulnerable citizens. I am here today to describe some serious problems and the steps that need to be taken to improve them. Some substantial initiatives are already underway by the Department of Health and Human Services, and based on our work, we believe that a concerted effort over several years and involving numerous parties will be needed to bring the quality of life and care in nursing homes consistently up to the level envisioned in Federal statutes. So, I will lay out an agenda of such actions for the consideration of Federal and State governments and the nursing home industry.

Recent reports by the Health Care Financing Administration, our office, and the General Accounting Office have raised serious concerns about patient care and well-being. Your Committee held hearings on this in Summer 1998, and I know you are following the results carefully. We had also undertaken a series of studies aimed at assessing the quality of care in nursing homes. Your Committee focused on the State of California in your earlier hearing, and our studies broaden the look at conditions in nursing homes to the 10 largest States, representing 56 percent of all skilled nursing facility beds and 56 percent of all expenditures by Medicaid for institutional long-term care. Today, we are releasing six reports describing the findings of our initial inquiry. We are grateful for the opportunity to present our results to you, hoping they can be folded into the overall partnership emerging between the Congress and the Department on this subject.

For our series of reports, we tried to step back to look at the "big picture" in nursing homes. First, we looked at conditions in nursing homes, using currently available program data that could serve as an indicator of conditions in nursing homes. Next, we examined the capacity of the systems that are currently in place to protect nursing home residents. These systems primarily included the State survey and certification system and the Long Term Care Ombudsman Program. We also looked at State resident abuse safeguards, law enforcement, family involvement, and the legislative reforms established by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

CONDITIONS IN NURSING HOMES

Deficiency and complaint trends. State surveys determine a nursing home's compliance with Federal standards. When a facility fails to meet a specific standard, a deficiency is given to the facility. According to data from these surveys in our 10 sample States, deficiencies overall have been decreasing in recent years. However, 13 of 25 *quality of care* deficiencies have increased in recent years. These deficiencies include such serious problems as a lack of supervision to prevent accidents, improper care for pressure sores, and lack of necessary care for the highest practicable well being.

Some of these serious deficiencies were given to a number of facilities in our 10 State sample on the latest survey. For example, 16 percent of sample State facilities received a deficiency for improper treatment to prevent or treat pressure sores. Sixteen percent received a deficiency for failing to promote care that maintains or enhances dignity. Fourteen percent failed to provide necessary care for the highest practicable well-being. Thirteen percent had deficiencies for the right to be free from physical restraints. Ten percent were cited for failure to provide appropriate treatment for incontinence. Table 1 highlights quality of care deficiencies for which 10 percent or more nursing homes in our 10 State review received citations on the latest survey.

Table 1
The Top 10 Substandard Quality of Care Deficiencies Include Some Serious Problems

Deficiency	# of Sample State Deficiencies	% of Sample State Facilities
Proper treatment to prevent or treat pressure sores	1186	16%
Facility free of accident hazards	1164	16%
Facility promotes care that maintains/enhances dignity	1115	16%
Housekeeping and maintenance	1023	14%
Provides necessary care for highest practicable well-being	972	14%
Right to be free from physical restraints	958	13%
Should have policies that accommodate needs	787	11%
Drug regimen free from unnecessary drugs	768	11%
Appropriate treatment for incontinence	750	10%
"Activities of daily living" care provided for dependent residents	699	10%

At the same time, complaints made to the Ombudsman program in the 10 State sample have been steadily increasing since 1989. Complaints about residents' rights, nutrition and food, and resident care increased at a rate higher than the overall complaint rate during this time period. From 1996 to 1997, some of the top increases in complaints included symptoms unattended or no notice to others in change of condition (+ 26 percent); fluid availability/hydration (+ 26 percent); and weight loss due to inadequate nutrition (+ 24 percent). These and other serious complaints are evident in Table II.

Table II

Top Increases in Ombudsman Complaints Also Include Serious Problems

Complaint Type	Number, 1996	Number, 1997	% Increase, 1996 - 1997
Information on advance directive*	178	458	157%
Denial of eligibility	188	292	55%
Staff turn-over, overuse of nursing pools	107	159	49%
Psychoactive drugs-assessment, use, evaluation	122	176	44%
Other: activities & social services**	194	262	35%
Vision and hearing	174	226	30%
Administrator(s) unresponsive, unavailable	242	308	27%
Symptoms unattended, no notice to others of change in condition	1,193	1,507	26%
Staff training, lack of screening	374	471	26%
Fluid availability /hydration	459	576	26%
Furnishing/storage	338	421	25%
Weight loss due to inadequate nutrition	216	267	24%

* Failure to notify resident in advance of changes in nursing home policy or procedure.

Miscellaneous complaints about resident activities and social services. **Source: NORS data

Experienced officials with inside information based on onsite visits to nursing homes -- including State survey directors, surveyors, ombudsmen, and State Aging Unit Directors -- express some reservations about relying exclusively on program data to gauge conditions in nursing homes. Nevertheless, they confirm that problems persist in nursing homes, such as malnutrition, abuse, pressure sores, and over-medication. The problems they identify are similar to the problems highlighted in their program reporting systems.

In addition to trends in survey and certification deficiencies and ombudsman complaints, there are further indications that problems continue to exist in nursing homes. For example, the Office of Inspector General is responsible for excluding from participation in the Medicare and Medicaid programs nursing home workers who are convicted of patient abuse or neglect. Since 1995, we excluded 668 nursing home workers for this reason nationwide.

Repeat offenders. Some nursing homes appear to be repeatedly deficient. Data from our 10 sample States show that 900 nursing homes (or 13 percent of all nursing homes) have been cited with the same deficiencies over the past four surveys. Six of the 13 percent (or 463 nursing homes) have been cited with the same *substandard quality of care* deficiency over the past four surveys.

Nursing home staffing levels. Many of the problems I have been talking about suggest that inadequate levels of nursing home staff contribute to this poor quality of care. In all 10 sample States, survey and certification staff, State and local ombudsmen, and State Aging Unit Directors agree that inadequate staffing levels is one of the major problems in nursing homes. Most believe these staffing shortages lead to chronic quality of care problems, such as failure to adequately treat and prevent pressure sores.

In addition, the type and extent of survey deficiencies and ombudsman complaints suggest that nursing home staffing levels may be inadequate. Common personal care problems such as lack of nutrition and poor care for incontinence suggest that staffing is inadequate to provide the level of care needed to avoid these problems. Furthermore, specific complaints about nursing home staff are some of the most common types of ombudsman complaints in 1997.

PROTECTION SYSTEMS

In addition to looking at the conditions in nursing homes, we also made a general assessment of the capacity of the systems already in place to monitor and improve this care.

Survey and certification process. When we looked at State survey and certification agencies, we found that they are following required standard protocols with timely and standard surveys, complaint procedures, and other State procedures. However, we also found that this system has several weaknesses. First, it is limited by the predictability of its surveys. Although all States use unannounced surveys, State survey and certification directors and surveyors believe that nursing homes can anticipate their survey date and modify their procedures to avoid being cited for deficiencies.

The system is also limited by weak enforcement. Inadequate survey staff may be one of the causes of that weakness. While there may be enough survey staff to conduct timely standard surveys, there may be inadequate staff to conduct follow-up surveys that are required for nursing homes with deficiencies and for nursing homes with complaints. This lack of staff may contribute to the lack of action on complaints. When complaints come in to the survey and certification agency (from residents, families, employees, etc.) outside of the regular survey process, a surveyor is required to go to the nursing home and substantiate the complaint. We found about one-third of complaints are substantiated. Of those substantiated complaints, 28 percent have a plan of correction, but 47 percent receive no action. Finally, State survey and certification directors and surveyors say that the current process allows deficient facilities too many opportunities to avoid enforcement action.

Ombudsman Program. Our general assessment of the Ombudsman program found that it is well-designed but limited by inadequate resources. This program has several functions to promote and monitor quality of care in nursing homes, including identifying and resolving complaints, making regular visits to nursing homes, and engaging in a variety of different advocacy activities. Ombudsmen act as independent advocates and work solely on behalf of residents to ensure they have a voice in their own care, but they do not have enforcement or regulatory oversight. However, the Ombudsman program is limited by inadequate resources, including inadequate staffing. Staffing levels varied greatly across our sample, from 5,000 beds per paid ombudsman in one State to 1,100 beds in another. Only 1 of 10 States in our sample had a paid ombudsman to bed ratio higher than the standard suggested by the Institute of Medicine of 2,000 beds. This lack of adequate staffing is particularly evident in the limited extent to which ombudsmen make regular nursing homes visits. Some nursing homes may only be visited once or twice a year for a couple of hours. The program is further constrained by the lack of a common standard for complaint response and resolution and limited collaboration with surveyors.

Resident abuse systems. We also found that State systems to safeguard nursing home residents from abuse by nursing home employees are inconsistent and unreliable. Our recent audit report, "Safeguarding Long Term Care Residents," revealed great diversity in the way States systematically identify, report, and investigate suspected abuse, and it found that there was no assurance that individuals who posed a risk of abusing residents were systematically identified and barred from nursing home employment. Additionally, a more in-depth audit of Maryland examined eight nursing homes in the State and found that five percent of employees in those homes had criminal records.

Families. Another important resource to monitor the quality of care in nursing homes is a resident's family. We looked at whether residents' families knew about the availability of nursing home survey results. We found that two-thirds of 155 families interviewed in eight sample cities did not know that the results of Federal and State nursing home surveys are available on request. Additionally, half were unaware such inspections are required, and only 15 had ever requested a copy of survey results. Of the 11 who obtained a copy, 6 said the results were not based on the most recent survey. Furthermore, when we visited 32 sampled nursing homes, most did not fully meet the requirements for making survey results readily available. On

a positive note, HCFA has recently taken a major step to improve access to survey results by establishing an Internet site entitled *Nursing Home Compare.* This website presents the survey results in a user friendly, summary form. It appears to be very promising way to make survey result more accessible to people with access to the Internet.

Law enforcement. Additionally, new initiatives based on law enforcement approaches are being considered to make better use of law enforcement as a way to handle the most egregious cases of poor quality of care in nursing homes. The Department of Justice, the Office of Inspector General, and HCFA, are now examining the full range of enforcement issues and developing corresponding action plans for each. By targeting key strategic areas and coordinating among the various agencies responsible for nursing home enforcement, these initiatives appear promising. However, it is too soon to determine their full impact.

Omnibus Budget Reconciliation Act of 1987. The Omnibus Reconciliation Act (OBRA) of 1987 mandated that nursing home residents be given certain rights and services and also added several administrative standards that nursing homes are required to meet. It further changed enforcement and survey procedures. While it has now been more than a decade since this legislation was passed, there has been no systematic assessment of its extensive agenda and no methodical evaluation of whether the reforms it intended are actually working. While some studies have attributed positive changes to OBRA 87, the lack of a systematic review makes it difficult to determine if this major legislation has been successful in improving nursing home care.

AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

Recently, considerable attention has been paid to addressing persisting concerns about the survey and certification process. In particular, we wish to commend this Committee for its attention to nursing homes and the Health Care Financing Administration for its extensive nursing home initiative since it addresses many of these persisting problems. This initiative includes many individual action items which should result in positive changes. Additionally, the Administration on Aging (AoA) has been taking steps to enhance the Ombudsman program, including improving the program reporting system and conducting annual training of ombudsman staff.

The problems I have described today will require continuing attention, possibly for several years. The broad outline of an effective strategy would include actions to:

- further enhance the survey and certification process;
- strengthen the Ombudsman program with increased resources;
- improve nursing home staffing levels;
- improve coordination between State survey agencies and Ombudsmen; and
- systematically evaluate the nursing home reform provisions of OBRA 1987.

I have attached to my statement our full agenda for continuing improvement in nursing home care. In it, we lay out steps for immediate action, acknowledging many of the efforts currently underway by HCFA and AoA. We also lay out an agenda for future research and evaluation of

the nursing home reform provisions of OBRA 1987. The Office of Inspector General plans to conduct a number of evaluations of the implementation of OBRA 1987 over the next few years, and we invite others to join us in this evaluation.

Report card. Finally, we believe that a periodic "report card" on conditions in nursing homes should be established in order to measure progress made in raising the standard of nursing home care. This report card could be based on deficiency trends, ombudsman complaints, insiders' perspectives, and resident and family satisfaction.

CONCLUSION

Mr. Chairman, I hope my comments this morning have been useful for you and the committee as you consider your own agenda for improving conditions in nursing homes. The Office of Inspector General is committed at all levels to improving care in nursing homes through our evaluations and audits and through our investigatory and legal authorities. I would be happy to answer any questions you or the committee may have.

AN AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

I. Immediate Action

We believe immediate action should be taken to strengthen the capacity of systems designed to oversee nursing home care. We also believe improvements should be made in nursing home staffing levels, since this directly impacts on the care residents receive.

Survey and Certification	
Survey enforcement efforts. Strengthen survey enforcement efforts by: making surveys more timely, effective, and unpredictable; increasing the number of night and weekend surveys and surveys at chronically substandard homes; focusing on specific problems, such as pressure sores; eliminating grace periods for homes with repeat serious violations; proposing new civil monetary penalties; and placing survey results on the internet.	Addressed in HCFA initiative
Enhanced monitoring. Enhance monitoring of special focus facilities.	Addressed in HCFA initiative.
Surveyor training. Provide additional training and assistance to State surveyors.	Partially addressed in HCFA initiative
Surveyor staffing. Evaluate State surveyor staffing to assure adequate staffing is available.	Action under consideration by HCFA
Surveyor coordination. Provide a forum for surveyors to meet and discuss common issues.	Action under consideration by HCFA
Abuse. Add survey task to look at provider's abuse intervention system, develop national abuse intervention campaign, and promote prosecution of egregious violators.	Addressed in HCFA initiative
Ombudsman Program	
Visibility. Develop guidelines for minimum levels of Ombudsman program visibility, including criteria for frequency and length of regular visits and staffing ratios.	Partially addressed through annual training

Volunteers. Formulate strategies for recruiting, training, and supervising more Ombudsman volunteers.	Partially addressed through annual training and Ombudsman Resource Center
Complaint response and resolution. Develop guidelines for Ombudsman complaint response and resolution times.	Not currently addressed
Reporting system. Continue to refine and improve the Ombudsman program's data reporting system.	Continuing attention by AoA
Coordination with Survey and Certification. Establish ways to enhance coordination between survey and certification and Ombudsman programs.	Continuously addressed
Resident Abuse Safeguards	
Employment safeguards. Improve the safety of residents and strengthen safeguards against employment of abusive workers.	Addressed in HCFA initiative
Nursing Home Staffing	
Staffing standards. Develop staffing standards for registered nurses and certified nurse assistants in nursing homes to assure sufficient staff on all shifts to enable residents to have proper care.	Currently being studied by HCFA
Care Guidelines	
Malnutrition and dehydration. Develop best practice guidelines for malnutrition and dehydration care and national campaign to increase awareness of these problems.	Addressed in HCFA initiative
Drug usage. Develop guidelines and protocols for using effective drugs.	Addressed in HCFA initiative
Family Involvement	
Family awareness and access. Promote and facilitate greater awareness and access to survey results by strengthening existing avenues for receiving information and identifying new avenues.	Action under consideration by HCFA

II. Research and Evaluation

We also propose the development of a research and evaluation program to assess the quality of care in nursing homes, including a systematic look at each of the legislative reforms established with OBRA 1987 and other quality of care issues. In the following table, we indicate where the OIG is conducting or planning work. As the Office of

Inspector General, we have a particular interest in assuring that the standards mandated by OBRA 1987 are being met. Since we do not expect to address all of the nursing home requirements and issues we have identified, we invite others to join us in this evaluation.

OBRA 1987	
Prescription drugs. Assess the extent and appropriateness of prescription drug use by nursing home residents and describe consultant pharmacists' concerns about drug use.	OIG report issued
Resident assessment. Determine the systems used by nursing homes to conduct periodic resident assessments and plans of care and evaluate how this impacts reimbursement.	OIG study underway
Nurse aide training. Evaluate nurse aide training	In OIG workplan
Abuse reporting. Examine the extent to which States have implemented abuse reporting requirements.	In OIG workplan
Medical director. Examine the role medical directors play in assuring quality of care.	In OIG workplan
Resident rights. Assess the extent to which nursing homes are assuring resident rights.	
Admission rights. Assess the extent to which nursing homes are assuring admission, transfer, and discharge rights.	
Restraints and abuse. Assess whether rights to be free from restraints and abuse are being met.	
Quality of life. Assess whether or not nursing homes are providing care which promotes each resident's quality of life.	
Resident well-being. Determine if nursing homes are providing care and services to maintain the highest levels of residents' physical, mental, and psychosocial well-being.	
Nursing home services. Determine if nursing home staffing levels are adequate to provide required nursing, dietary, physician, rehabilitative, dental, and pharmacy services.	
Physical environment. Determine if nursing homes are maintaining a healthy and safe physical environment.	
Other Quality of Care	
Resident satisfaction. Determine the level of resident satisfaction with nursing home care.	OIG study underway
Immunizations. Examine the obstacles to immunizing 80% of nursing home residents against pneumoccocal disease and influenza.	OIG study underway

III. Progress Measurement

Finally, an independent, continuous assessment is needed to measure the progress made in raising the standard of nursing home care.

Periodic Assessments	
Periodic report card. Conduct periodic evaluations describing conditions in nursing homes based on deficiency trends, Ombudsman complaints, and insiders' perspectives.	Under consideration by OIG

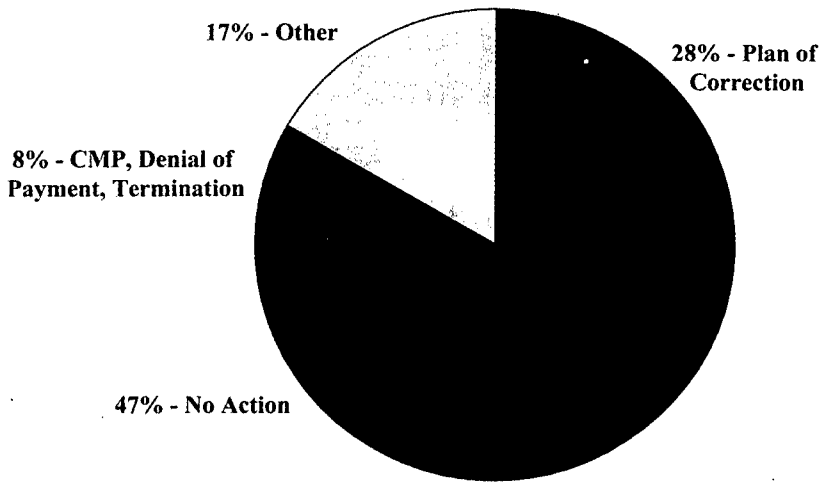
Percent of Sample Homes with Serious Deficiencies

■ Pressure sores	16%
■ Accident hazards	16%
■ Dignity	16%
■ Physical restraints	13%
■ Unnecessary drugs	11%
■ Incontinence	10%

Ombudsman Complaints
1996-1997

- Staff turnover +49%
- Symptoms unattended +26%
- Fluid availability/hydration +26%
- Staff training, screening +26%
- Weight loss due to inadequate nutrition +24%

Actions on Substantiated Complaints



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Quality of Care in Nursing Homes: An Overview, OEI-02-99-00060

Nursing Home Survey and Certification: Deficiency Trends, OEI-02-98-00331

Nursing Home Survey and Certification: Overall Capacity, OEI 02-98-00330

Long Term Care Ombudsman Program: Complaints Trends, OEI-02-98-00350

Long Term Care Ombudsman Program: Overall Capacity, OEI-02-98-00351

Public Access to Nursing Home Survey and Certification Results, OEI-06-98-00280

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Quality of Care in Nursing Homes: An Overview

JUNE GIBBS BROWN
Inspector General

MARCH 1999
OEI-02-99-00060

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's New York regional office prepared this report under the direction of John I. Molnar, Regional Inspector General and Renee C. Dunn, Deputy Regional Inspector General. Principal OEI staff included:

REGION	HEADQUARTERS
Demetra Arapakos	Susan Burbach

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Quality of Care in Nursing Homes: An Overview

JUNE GIBBS BROWN
Inspector General

MARCH 1999
OEI-02-99-00060

EXECUTIVE SUMMARY

PURPOSE

To describe general conditions in nursing homes and assess the overall capacity of systems designed to monitor and improve quality of care.

This report is based primarily on recent studies conducted by the Office of Inspector General (OIG) on quality of care in nursing homes. It draws additionally upon work completed by the General Accounting Office (GAO), the Health Care Financing Administration (HCFA), and others. The report summarizes steps taken recently and now underway to address weaknesses in the system. It also provides a long term program of action and research needed to assure nursing home care meets government standards for quality of care.

BACKGROUND

While some studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home patients, recent reports by HCFA and GAO have raised serious concerns about patient care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these reports. At the same time, the OIG undertook a series of studies aimed at assessing the quality of care in nursing homes.

Various systems are in place to monitor and promote quality of care in nursing homes. These include the State survey and certification system, the State Long Term Care Ombudsman Program, State resident abuse safeguards, law enforcement, and legislative reforms established by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

We used multiple methods for this report. They consist of an analysis of national nursing home program data, a review of written program procedures, structured telephone interviews, an examination of nursing home survey results availability, a literature review, and an analysis of nursing home legislation.

FINDINGS

Serious Quality of Care Problems Persist in Nursing Homes

An analysis of currently available program data reveals that problems with quality of care continue to exist in nursing homes. First, according to survey and certification data, 13 of

25 "quality of care" deficiencies have increased in recent years. They include a lack of supervision to prevent accidents, improper care for pressure sores, and lack of proper care for activities of daily living. At the same time, ombudsman complaints have been steadily increasing since 1989 and complaints about resident care, such as pressure sores and hygiene, have been particularly prevalent. Since 1995, the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid programs as a result of a conviction related to patient abuse or neglect. On a related note, approximately one percent or more of nursing home residents have had an experience serious enough to register an abuse complaint. Lastly, survey and certification data, as well as discussions with survey and certification staff and ombudsmen, reveal that some nursing homes are chronically substandard.

Experienced officials with inside information based on onsite visits to nursing homes, including State survey directors, surveyors, ombudsmen, and State Aging Unit Directors, express some reservations about relying exclusively on program data to gauge conditions in nursing homes. Nevertheless, they confirm that problems persist in nursing homes, such as malnutrition, abuse, pressure sores, and over-medication. The problems they identify are similar to the problems highlighted in their program reporting systems.

Evidence Suggests Inadequate Levels of Nursing Home Staff Contribute to Quality of Care Problems

In all 10 sample States, survey and certification staff, State and local ombudsmen, as well as State Aging Unit Directors identify inadequate staffing levels as one of the major problems in nursing homes. Most believe these staffing shortages lead to chronic quality of care problems, such as failure to adequately treat and prevent pressure sores.

The type and extent of survey deficiencies and Ombudsman program complaints also suggest that nursing home staffing levels are inadequate. Common personal care problems such as lack of nutrition and poor care for incontinence suggest that staffing is inadequate to provide the level of care needed to avoid these problems. Furthermore, specific complaints about nursing home staff are some of the most common types of Ombudsman program complaints in 1997.

Survey and Certification Agencies are Following Required Standard Protocols but Weaknesses in the Survey System Itself Limit Their Effectiveness

State survey and certification agencies monitor nursing home care with timely and standard surveys, complaint procedures, and other State procedures. However, the survey and certification system has several weaknesses, such as the predictability of surveys. Although all States use unannounced surveys, State directors and surveyors believe that nursing homes can anticipate their survey date and modify their procedures to avoid being

cited for deficiencies. The system is also limited by weak enforcement, including inadequate follow-up and common inaction on abuse complaints. State directors and surveyors believe that the current process allows deficient facilities too many opportunities to avoid enforcement action. Lastly, survey and certification agencies have some staffing constraints and do not always effectively coordinate with ombudsmen.

While the Ombudsman Program is Well Designed, Inadequate Resources Limit Its Capacity

The Ombudsman program has several functions to promote and monitor quality of care in nursing homes, including identifying and resolving complaints, making regular visits to nursing homes, and engaging in a variety of different advocacy activities. While lacking enforcement and regulatory oversight, ombudsmen act as independent advocates and work solely on behalf of residents to ensure they have a voice in their own care. However, the Ombudsman program is limited by inadequate resources, including inadequate staffing. Only 1 of 10 States in our sample had a paid ombudsman to bed ratio higher than the standard suggested by the Institute of Medicine. This lack of adequate staffing is particularly evident in the limited extent to which ombudsmen make regular nursing homes visits. The program is further constrained by the lack of a common standard for complaint response and resolution, inconsistent advocacy efforts, a lack of support, and limited collaboration with surveyors.

State Systems to Safeguard Nursing Home Residents from Abuse are Inconsistent and Unreliable

Based on findings from a recent OIG audit, "Safeguarding Long Term Care Residents," A-12-97-0003, it appears that some weaknesses exist in State efforts to safeguard nursing home residents from abuse. This audit revealed great diversity in the way States systematically identify, report, and investigate suspected abuse, and it found that there was no assurance that individuals who posed a risk of abuse were systematically identified and barred from nursing home employment. Additionally, a more in-depth audit of Maryland examined eight nursing homes in the State and found that five percent of employees in those homes had criminal records.

Public Awareness and Access to Nursing Home Survey Results is Limited

Public awareness of nursing home survey results is limited and these results are not always readily available. Two-thirds of 155 families interviewed in eight sample cities did not know that the results of Federal and State nursing home inspections are available on request. Additionally, half were unaware such inspections are required, and only 15 had ever requested a copy of survey results. Of the 11 who obtained a copy, 6 said the results were not based on the most recent survey. Furthermore, when staff from the OIG visited

the 32 sampled nursing homes, most did not fully meet the requirements for making survey results available. The HCFA has established a more easily accessible version of nursing home survey results with an internet site entitled *Nursing Home Compare* which appears promising.

New Initiatives Based on Law Enforcement Approaches are Being Considered

Initiatives that use the False Claims Act and other law enforcement approaches as a way to strengthen nursing homes are relatively new. National task forces comprised of representatives from the Department of Justice, HCFA, OIG, and others are being formed at the local, State, and national levels. These groups will examine the full range of enforcement issues and develop corresponding action plans for each. By targeting key strategic areas and coordinating among the various agencies responsible for nursing home enforcement, these initiatives appear promising. However, it is too soon to determine their full impact.

Nursing Home Reforms Established by OBRA 1987 Have Not Been Systematically Assessed

The nursing home reforms created by OBRA 1987 impacted both nursing home systems and nursing home care. The OBRA 1987 mandated that residents be given certain rights and services and also added several administrative standards that nursing homes are required to meet. It further changed enforcement and survey procedures. While it has now been more than a decade later since this legislation was passed, there has been no systematic assessment of its extensive agenda and no methodical evaluation of whether the reforms it intended are actually working. While some studies have attributed positive changes to OBRA 1987, the lack of a systematic review makes it difficult to determine if this major legislation has been successful in improving nursing home care.

AN AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

Since OBRA 1987 was first passed, real improvements have been made in nursing home care. More recently, considerable attention has been paid to addressing persisting concerns about nursing home conditions and systems. In particular, we commend the Health Care Financing Administration (HCFA) for its extensive nursing home initiative since it addresses many of these persisting problems. This initiative includes many individual action items which should result in positive changes. Additionally, the Administration on Aging (AoA) has been taking steps to enhance the Ombudsman program, including improving the program reporting system and conducting annual training of ombudsman staff.

The problems we describe in this report will require continuing attention, possibly for several years. The broad outline of an effective strategy would include actions to:

- enhance the survey and certification process;
- strengthen the Ombudsman program with increased resources;
- improve nursing home staffing levels; and,
- improve coordination between State survey agencies and ombudsmen.

We also believe that further evaluation and progress measurement would make an important contribution to efforts to advance nursing home care. We specifically suggest:

- a systematic assessment of OBRA 1987 and
- the creation of a periodic report card on conditions in nursing homes.

We have incorporated action items from HCFA's nursing home initiative, AoA's ombudsman activities, recommendations for additional steps to be taken, current OIG work, and areas requiring further evaluation into one comprehensive, long term agenda to continue improvements in nursing home care. This agenda consists of a three stage approach of immediate action, research and evaluation, and continued progress measurement. The full agenda can be found on page 28.

AGENCY COMMENTS

This report is based primarily on a series of recent studies conducted by the Office of Inspector General on nursing home care. They are:

Nursing Home Survey and Certification: Deficiency Trends, OEI-02-98-00331;
Nursing Home Survey and Certification: Overall Capacity, OEI 02-98-00330;
Long Term Care Ombudsman Program: Complaints Trends, OEI-02-98-00350;
Long Term Care Ombudsman Program: Overall Capacity, OEI-02-98-00351;
Public Access to Nursing Home Survey and Certification Results, OEI-06-98-00280; and
Safeguarding Long Term Care Residents, A-12-97-0003.

We received detailed comments from HCFA, AoA, and the Assistant Secretary for Planning and Evaluation on the above reports. We made modifications in each report to respond to the comments received and to reflect the actions already being taken to improve nursing home conditions. This overview report also incorporates many of these modifications. We encourage everyone to read the individual reports and the comments we received on them. The comments are included in each report.

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INTRODUCTION

PURPOSE

To describe general conditions in nursing homes and assess the overall capacity of systems designed to monitor and improve quality of care.

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BACKGROUND

While some studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home residents, recent reports by HCFA and GAO have raised serious concerns about residents' care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these results. The OIG subsequently undertook a series of studies aimed at assessing the quality of care in nursing homes. This report looks at both the general state of nursing home care as well as the systems designed to oversee that care.

Generally, a nursing home is a residential facility offering daily living assistance to individuals who are physically or mentally unable to live independently. Residents are provided rooms, meals, assistance with daily living, and in most cases, some medical treatment. In 1989 Medicare paid $2.8 billion to nursing homes, an amount totaling 4.7 percent of the Medicare budget. In 1996 this amount had increased to $10.6 billion, totaling 9 percent of the Medicare budget. Medicaid expenditures for nursing homes in 1996 totaled $24.3 billion.

In 1986, the Institute of Medicine conducted a study on nursing home regulations and reported prevalent problems regarding the quality of care for nursing home residents, as well as the need for stronger Federal regulations. Just one year later, GAO reported that over one third of nursing homes were operating below Federal minimum standards. These reports, along with widespread concern regarding nursing home conditions, persuaded

Congress to pass the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). As a part of OBRA 1987, Congress passed the comprehensive Nursing Home Reform Act (PL 100-203). These actions expanded requirements that nursing facilities had to comply with in order to obtain Medicare certification. The Nursing Home Reform Act also strengthened the rights to nursing home residents, such as the right to be free of physical or mental abuse, and the right to be free from chemical and physical restraints. It additionally altered the enforcement of Federal standards for nursing home care.

Medicare Nursing Home Requirements

The Health Care Financing Administration (HCFA) has the responsibility to act as a "prudent purchaser" by ensuring that nursing homes participating in Medicare and/or Medicaid meet certain requirements for quality environment and services. These requirements are found at 42 Code of Federal Regulations (CFR) Part 483, Subpart B. The Nursing Home Reform Act added to these requirements by introducing an increased focus on the quality of life and care, the importance of the individual resident, the need to help residents reach the "highest practicable level" of functioning, and the requirement that residents be interviewed and assessed.

Nursing homes must "conduct standardized, reproducible assessments of each resident's functional capacity..." within 14 days of admission. Additionally, periodic assessments must occur throughout the duration of a patient's stay in order to continually address their fluctuating needs. With the Nursing Home Reform Act, HCFA developed the Minimum Data Set (MDS) which is comprised of core elements and common definitions used in conducting resident assessments. The Minimum Data Set collects data through resident assessment measures, with subsequent progress or decline documented in electronic format.

The Nursing Home Reform Act additionally established new enforcement provisions, which were enacted when the State Operations Manual (SOM) became effective on July 1, 1995. The HCFA had several process goals during the implementation of these new provisions: promoting consistency through extensive training; linking appropriate remedies to deficiencies; and avoiding unnecessary procedures. Congress recognized that one enforcement response would not be appropriate for all deficiencies. It therefore established enforcement policies that gave HCFA the license to impose a variety of corrective measures for noncompliant facilities. These include: temporary management; denial of payment for new admissions; civil money penalties; termination of the facility; and State monitoring of the facility. States are responsible for establishing their own remedy guidelines.

Following the implementation of the State Operations Manual, HCFA also imposed a number of administrative changes on enforcement procedures . In June 1995, HCFA

enacted a temporary moratorium on the collection of certain lower-level money penalties (CMPs). This moratorium preceded HCFA's decision to alter the State Operations Manual in December of 1996. "Civil monetary penalties are now limited to situations of immediate jeopardy or to nursing facilities that are poor performers or have serious deficiencies that are not corrected at the time of a revisit." Additional changes by HCFA redefined the scope of deficiencies, permitted States to avoid revisits in facilities that have lower level deficiencies, and established new terms to define facilities that are not in substantial compliance.

Nursing Home Systems

Survey and Certification. All nursing homes participating in Medicare and/or Medicaid must be certified in meeting certain Federal requirements. The Nursing Home Reform Act defines the State survey and certification process for determining nursing home compliance with these Federal standards. The HCFA is responsible for certifying Medicare and dually-eligible facilities, while States are responsible for Medicaid only facilities. Nursing home certification is achieved through routine surveys, and HCFA contracts with States to perform such surveys for Medicare and dually-eligible nursing homes, in addition to those they perform for Medicaid nursing homes.

State surveys determine the compliance or noncompliance of nursing homes. When a nursing home fails to meet a specific requirement, surveyors give it a deficiency or citation. Generally, there are 20 principles that are considered in the citation of deficiencies on the HCFA-2567. Surveyors also provide the reasons justifying any resulting enforcement action and the record on which to defend that action in the appeals process. State survey teams generally consist of multi-disciplinary professionals and must include a registered professional nurse. Other professionals who may be on the survey team include social workers, therapists, dieticians, pharmacists, administrators, and physicians.

Each State is also required to maintain written procedures and adequate staff to investigate complaints of violations at nursing homes. States must review all allegations of resident neglect and abuse, and misappropriation of resident property. All allegations, regardless of source, must be reviewed in a timely manner. If an allegation is found to have occurred, the State must notify, in writing, the individuals implicated and the administrator of the nursing home where the incident transpired.

A new survey and certification process was implemented in 1995. All nursing facilities are now subject to an unannounced standard survey "no later than 15 months after the date of the previous standard survey." Since the Statewide average interval between standard surveys "must be 12 months or less," this creates a Federal standard survey window between 9 and 15 months. Each standard survey includes a stratified case mix of nursing home residents, and measures their medical, nursing and rehabilitative care, dietary and

nutrition services, activities, social participation, sanitation, infection control, and physical environment. Written plans of care are reviewed to determine their adequacy and an audit of residents' assessments are conducted to determine the accuracy of such assessments. There is also a review of facility compliance with residents' rights.

In addition to regular surveys, States also conduct "special" and "extended" surveys. Special surveys may be conducted within two months of any change in ownership, administration, management, or director of nursing to determine if the change is having an effect on the quality of care in the nursing home. Extended surveys are performed immediately or within two weeks after the standard survey completion, on those nursing homes found to have provided substandard quality of care. The survey team reviews the policies and procedures that produced the substandard care, expands the size of the sample of resident's assessments, reviews staffing, in-service training, and if necessary, contracts with consultants.

Within two months of the State survey, HCFA conducts validation surveys on a representative sample of nursing homes in each State utilizing the same survey procedure as the State agency. Recently, some HCFA regional offices have chosen to conduct these validation surveys simultaneously with the State. The HCFA must survey at least five percent of the number of facilities surveyed by the State each year, and this number must never be less than five surveys a year.

In order to improve the survey process, the State Agency Quality Improvement Program (SAQIP) was developed to establish a process for State agencies and HCFA regional offices to work together to develop the State's individual quality improvement plans (IQIPs). The regional office will assist the State by providing training, technical assistance, and support as necessary and appropriate. These individual plans are tailored to the specific needs and circumstances of each State, and are revised and improved based on changing needs. The SAQIP is designed to promote quality and ongoing improvement in survey and certification activities, and applies to all aspects of the survey and certification process.

The HCFA's Online Survey Certification and Reporting System (OSCAR) came online in October 1991. The HCFA uses OSCAR in its survey of Medicare and Medicaid providers to monitor State agency and provider performance. The OSCAR contains data for the current and 3 previous surveys. Some of the data is overwritten as new information is entered (e.g. number of beds, address, and employment information), but deficiency data remains and is tracked historically. The HCFA recently began tracking the scope and severity of deficiencies historically as well. Part of the OSCAR data is self-reported information by the nursing homes about the facility and its' patients. The remaining data is information generated by the surveyors and is based on deficiencies. The Federal regulations detailing survey requirements are classified into 17 major categories. The

specific survey requirements within these categories were consolidated from 325 individual items to 185 items on July 1, 1995.

Ombudsman Program. In response to growing concerns about poor quality care in nursing homes and to protect the interests of residents, the State Long Term Care Ombudsman program was established in 1978 in the Older Americans Act. The ombudsmen advocate on behalf of residents of all long term care facilities, including nursing homes, to ensure residents have a strong voice in their own treatment and care.

The Ombudsman Program operates in all fifty States, the District of Columbia, and Puerto Rico, and in hundreds of local communities, and uses both paid and volunteer staff. The program receives funding from Federal, State and local levels, and is overseen by the Administration on Aging (AoA). Most State ombudsmen operate within the State Unit on Aging, some of which are independent while others are part of a larger State umbrella agency. The remaining State Ombudsman programs are contracted out and administered by an entity separate from the State Unit on Aging. These programs are operated by non-profit organizations, legal services agencies, or by freestanding Ombudsman program agencies.

State Ombudsman programs have multiple functions that are mandated by law, many of which are closely tied to ensuring quality care for long term care residents. They include:

- identifying, investigating, and resolving complaints;
- protecting the legal rights of patients;
- advocating for systemic change;
- providing information and consultation to residents and their families; and
- publicizing issues of importance to residents

States have recently started to collect and report data under a new system. In FY 1995, States began to systematically collect and report data under the National Ombudsman Reporting System (NORS). Prior to NORS, States reported data to AoA, which was of limited use due to the lack of common definitions for key data elements. The NORS was created in response to earlier recommendations made by the General Accounting Office and the Office of Inspector General, and was developed by the ombudsmen themselves. It includes more specific data elements than were reported before NORS. For example, it separates complaints by type, distinguishes between complaints and complainants, counts unresolved complaints, and reports program funding streams. Twenty-nine States reported under NORS in 1995 and all States did so annually beginning in 1996.

Resident abuse safeguards. Federal regulations require States to establish a registry of nurse aides that includes information on any aide found guilty of abuse or neglect. Regulations also mandate that nursing homes not employ individuals who have been found

guilty of abusing or neglecting nursing home residents. States are additionally required to provide criminal information to the OIG national database, which is then used to publish a monthly exclusion list. However, there is no Federal requirement to conduct criminal background checks of all current or prospective employees of Medicare and/or Medicaid participating nursing homes.

Other procedures have also been established to coordinate the reporting of resident abuse allegations. Each State is required to designate a coordinator with central State authority to receive complaints of mistreatment or neglect of nursing home residents. While this individual or entity may be located in any number of State agencies or within a designated complaint unit, the responsibility is often assigned to an employee of the State survey and certification agency.

Families. Families are in the best position to help choose a nursing home and to monitor the care provided in that home. To do this, they need accurate and timely information about the quality of care in the nursing home they choose. A nursing home's most recent annual survey results are, theoretically, ideally suited for this purpose. Various laws and regulations are intended to make these results available to the public, including the requirement that nursing homes post a notice giving the location and availability of its most recent survey results.

Law enforcement. Several different agencies have responsibility for nursing home law enforcement, including the Department of Justice, the OIG, and State agencies such as the State Attorney General. The local police force also plays an enforcement role. A nursing home facility, owner, or other employee (such as a nurse aide or administrator) may be excluded from participation in Medicare and Medicaid after appropriate enforcement action is taken.

Recently, poor quality of care has been the basis of a prosecution under the False Claims Act. When providers submit claims for reimbursement, they certify either explicitly or implicitly that the services provided meet professional standards; if they "knowingly" present a claim for substandard services, they could be liable under the False Claims Act. Thus, under appropriate circumstances, the Government can use the False Claims Act to prosecute a provider who knowingly presents false or fraudulent claims to the government for substandard care in nursing homes. The two major cases where the False Claims Act has been used involve grossly deficient diabetes monitoring, pressure sore care, and other nursing care. In both the landmark 1996 case against Geriatric & Medical Cos., Inc. and its Tucker House facility and the 1998 case against the Chester Care chain of four nursing homes, the OIG obtained civil settlements for $500,000 each. As part of the settlement agreements, the companies were required to develop comprehensive compliance programs. In addition, in the Chester Care case, the company was required to pay for a temporary manager and monitor to oversee provision of care.

Legislative reforms (OBRA 1987). As previously noted, the OBRA 1987 legislation and ensuing regulations established a framework for nursing home reform. It specifically provided an agenda for nursing home care by mandating that residents be given certain rights and services, and adding several administrative standards that nursing homes were required to meet. It also established new survey and enforcement requirements, including making surveys more resident focused and augmenting existing enforcement options.

Prior Studies and Recent Initiatives

Several studies have been completed which have examined the survey and certification process. One recent study entitled "The Regulation and Enforcement of Federal Nursing Home Standards," written by Charlene Harrington and published in March of 1998, details problems with nursing home certification. She challenges the declining State deficiency averages by raising the notion that the enforcement process may be weakening rather than nursing facilities improving quality of care.

Furthermore, "The National State Auditors Association Joint Performance Audit on Long-Term Care," completed in May of 1998 by the Louisiana Office of the Legislative Auditor, compiled information from ten States regarding survey and certification concerns. Issues discussed include licensing, inspection, sanctions, complaints, and reimbursement. The audit findings conclude that States should vary the timing of inspections, evaluate how aggressively they are imposing State sanctions on facilities with deficiencies, and avoid delaying the investigation of complaints.

Many studies have also reported on the progress and impact of the Ombudsman Program. One of the most recent, "Real People, Real Problems," published in 1995 by the National Academy of Sciences' Institute of Medicine, looked at the Ombudsman program overall. This study reported on State compliance, conflicts of interest, effectiveness, resources, and the need for future expansion of the program. It found that, overall, the Ombudsman program is effective. It also reported lack of access to ombudsman services by residents and their families, disparities in ombudsman visitation patterns and service provision, and uneven legal services available to ombudsmen.

Additionally, the Inspector General issued several reports on the Program in 1991 and 1992. First, "Successful Ombudsman Programs," (OEI-02-90-02120), the main report in a series of reports on the Ombudsman program, found that successful programs are highly visible and obtain adequate funding and support. Furthermore, "State Implementation of the Ombudsman Requirements of the Older Americans Act," (OEI-02-91-01516), found, among other things, that State program staffing and long term care facility visitation varies significantly. It also found that ombudsmen use many methods to increase their visibility.

In July, 1998, the President announced a new nursing home care initiative to provide enhanced protections and to target needed improvement in nursing home care. Proposed actions include checking criminal backgrounds of nursing home workers, establishing a national registry of employees convicted of abusing patients, targeting nursing home chains with poor records, cutting off inspection funds to States with poor records of citing substandard quality of care, publishing annual nursing home surveys on the Internet, increasing Federal oversight of State inspections, providing additional training to State officials, changing the survey schedule to make them more unpredictable, and increasing the number of night and weekend surveys.

In conjunction with the President's nursing home initiative, the Secretary released a report to Congress in July of 1998, a "Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System," indicating that significant improvements in the quality of care had been made since 1995. These improvements included more appropriate use of physical restraints, anti-psychotic drugs, anti-depressants, urinary catheters, and hearing aids. However, the report did find a need for further improvements by States, nursing homes, and others. Additional steps will be taken to address the problems identified in the report and include tougher enforcement of Medicare and/or Medicaid rules. Efforts will be aimed at preventing instances of pressure sores, dehydration, and nutrition problems. The following are new approaches aimed at improving quality of care: facilities that have repeat offenses will face sanctions without a grace period; inspections will be conducted more frequently for repeat offenders without decreasing inspections at other facilities; inspections will be staggered; a set amount of inspections will be conducted on weekends; and efforts will be focused on facilities within chains that have a record of non-compliance.

One week after the President's initiative, the General Accounting Office (GAO) published a report examining the quality of care in 1,370 California nursing homes that were inspected from 1995 to 1998. They found 30 percent of the homes had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying medical records. As a result of this report, the US Senate Special Committee on Aging held hearings in July 1998 to discuss the findings on the quality of care in nursing homes.

METHODOLOGY

Multiple methods were used for this report. They include an analysis of national nursing home program data, a review of written program procedures, structured telephone interviews, a literature review, and an analysis of nursing home legislation.

Description of nursing home conditions

Data Analysis

Survey and certification data. We used a purposive sample of 10 States which represent 55.8 percent of total skilled nursing beds nationally. These States are New York, California, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, Florida, New Jersey, and Tennessee. The OSCAR contains data for the current and 3 previous surveys and categorizes deficiencies into 17 major categories. Using the most recently available OSCAR data (from August 4, 1998), 3 of the 17 categories which could determine poor quality of care were analyzed. These are: 1) resident behavior and facility practices, including the areas of restraints, abuse and staff treatment of residents; 2) quality of life, including the resident's ability to make decisions about his or her daily activities and the nursing home's accommodation of his or her needs; and 3) quality of care, including the technical ability of the nursing home to prevent and treat the medical conditions of its residents. Substandard quality of care deficiencies repeated over the last four surveys and abuse complaint data were also examined.

Ombudsman data. Using the same purposive sample of 10 States, we analyzed 2 sets of Ombudsman program data. For 1996 and 1997, data from the National Ombudsman Reporting System (NORS) was examined; from 1989 to 1994, data from the pre-NORS reporting system was used. Data from 1995 is not analyzed due to a lack of comparable data elements for that year. For both pre-NORS and NORS data, figures for both total complaints and broad complaint categories are presented; for NORS data, 125 specific complaint types were also looked at. Finally, data on Ombudsman program staffing, visitation rates, advocacy activities, and coordination with survey and certification agencies was also examined.

Abuse complaints. Using a fax survey, we obtained data from all 10 States on the numbers and types of nursing home resident abuse complaints. We specifically analyzed data on four types of complaints selected as key indicators of recent abuse trends: physical abuse, inappropriate use of restraints, physical neglect, and medical neglect.

OIG convictions. We reviewed data from the Office of Inspector General on nursing home convictions relating to resident abuse or neglect, from 1995 to 1998.

Literature review

We examined findings on nursing home conditions from several studies, particularly the recent GAO report entitled "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight."

Assessment of nursing home systems

Procedures review

Survey and certification procedures. For the eight States that have their own survey guidelines which they use in addition to HCFA guidelines, we obtained and reviewed their written program procedures and other related documents. The remaining two States had no survey requirements of their own.

Ombudsman procedures. Written procedures for all 10 sample State Ombudsman programs were obtained and reviewed. Using a structured review guide, these procedures were reviewed to determine the different processes used by ombudsmen to monitor and promote quality of care in nursing homes. Standards mandated for these processes, such as complaint response times, were also looked at.

Interviews

Survey and certification telephone interviews. A total of thirty structured telephone interviews were conducted. In each of the 10 sample States, one interview was conducted with the State survey and certification director (or designee) and two State surveyors. The two State surveyors were selected randomly from a list of at least 10 surveyors submitted by the State director. During these interviews, information was obtained about the State survey and certification program structure, the processes utilized to monitor quality of care, how deficiencies are addressed, and the satisfaction of State survey and certification directors and surveyors with the process. Information provided by the directors was compared to that provided by surveyors, and special attention was given to consensus within and among the groups.

Ombudsman telephone interviews. A total of 30 structured telephone interviews were conducted. In each of the 10 sample States, one interview was conducted with the State ombudsman, one local program ombudsman, and the State Aging Unit Director or designee. In selecting ombudsmen from local programs to interview, individuals from a variety of local program structures were chosen. These three groups of respondents were selected to obtain their different perspectives of the program and consensus among the groups was particularly noted while analyzing the interviews.

Examination of nursing home survey results availability

To examine the availability of survey results, we used a different sample and methodology. We selected a purposive sample of eight cities, each one having a regional Office of Evaluations and Inspections (San Francisco, Atlanta, Chicago, Boston, Kansas City, New York, Philadelphia, and Boston). We then combined five methods to assess the availability of survey results: telephone interviews with 155 family members; a simulation by OIG staff of families' access to nursing home results; telephone requests to HCFA and State

officials for survey results; a review of HCFA's new internet site for survey results; and a review of Federal rules and procedures regarding access to survey results.

Literature review

We also conducted a literature review of recent nursing home studies which assessed nursing home systems. We particularly used an OIG report entitled "Safeguarding Long Term Care Residents."

Legislation review

Finally, we reviewed nursing home legislation, particularly OBRA 1987. We identified each of the individual reforms outlined in OBRA 87 and determined which ones had been assessed for impact and outcome. Lastly, we reviewed the mission statement and agenda for recent nursing home law enforcement initiatives.

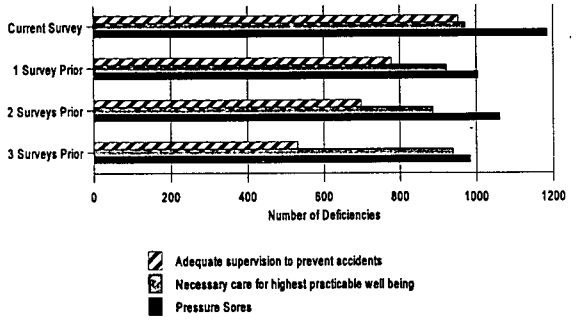
This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Serious quality of care problems persist in nursing homes

Survey and certification deficiencies. An analysis of survey and certification deficiencies indicates that problems with quality of care continue to exist in nursing homes. Deficiencies are grouped into one of three main categories, and while two of these categories have been decreasing, many deficiencies in the "quality of care" category have actually been increasing. More specifically, 13 of the 25 deficiencies that make up this category are higher now than they were on the last 3 surveys. These 13 deficiencies were cited 6,413 times on the current survey, compared to 5,246 times three surveys prior, an increase of almost 25 percent. They include a lack of adequate supervision to prevent accidents, a lack of appropriate care for activities of daily living, and improper care for pressure sores. Graph A below shows how some of these serious deficiencies have grown over the prior 3 surveys.

Graph A
Some Serious Quality of Care Deficiencies Have Been Increasing



Deficiencies often lead to further medical problems or indicate other issues. For example, pressure sores could be an indication that residents also have other problems, such as urinary incontinence, malnutrition, or dehydration. Table 1 below shows the nature and extent of the top 10 substandard quality of care deficiencies from the latest standard survey in the 10 sample States.

Table 1
The Top 10 Substandard Quality of Care Deficiencies Include Some Serious Problems

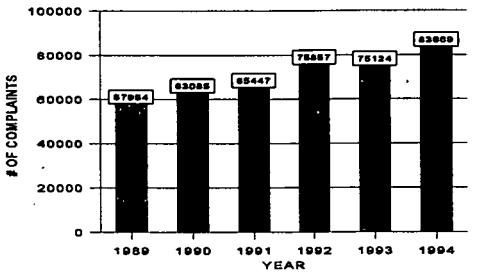
Deficiency	# of Sample State Deficiencies	% of Sample State Facilities
Proper treatment to prevent or treat pressure sores	1186	16%
Facility free of accident hazards	1164	16%
Facility promotes care that maintains/enhances dignity	1115	16%
Housekeeping and maintenance	1023	14%
Provides necessary care for highest practicable well-being	972	14%
Right to be free from physical restraints	958	13%
Should have policies that accommodate needs	787	11%
Drug regimen free from unnecessary drugs	768	11%
Appropriate treatment for incontinence	750	10%
"Activities of daily living" care provided for dependent residents	699	10%

In its recent report entitled "California Nursing Homes: Care Problems Persist Despite Federal and State Oversight" the GAO examined the quality of care in 1,370 nursing homes in California. It found that 30 percent had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying records. Among the problems it reports are poor nutrition, dehydration, and improper care of incontinent and immobile residents which leads to pressure sores.

Ombudsman complaints. Ombudsman nursing home complaints have also been steadily

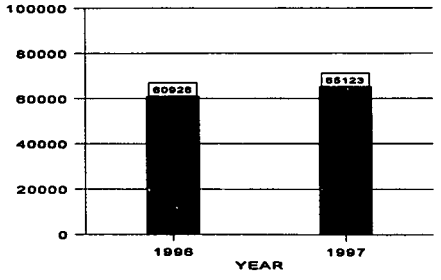
increasing, as illustrated in graph B below. Based on data from 1989 to 1994, total complaints in the 10 sample States grew from 57,954 to 83,669, an increase of 44 percent. (Due to the transition to a new data system in 1995, we do not have comparable complaint rates for that year).

Graph B
At the Same Time, Ombudsman Program Complaints Increased from 1989 to 1994



Beginning in 1996, a new Ombudsman program reporting system was used that counted complaints differently from the prior system. Data from 1996 and 1997 also show that complaints increased seven percent between these two years, from 60,926 to 65,123, as illustrated in Graph C below.

Graph C
Ombudsman Program Complaints Also Increased from 1996 to 1997



Ombudsman complaints about resident care have been particulary prevalent. Of the five main Ombudsman program complaint categories, the resident care category increased the most from 1996 to 1997, growing by 13 percent. This category includes specific complaints about personal care (such as pressure sores and hygiene), lack of rehabilitation, and the inappropriate use of restraints. On a more specific level, 12 complaints had increases of 24 percent or more from 1996 to 1997. Two of these -- staff turnover and lack of staff training -- may indicate other problems with resident care.

In 1997, the majority of all Ombudsman program complaints (63 percent) fell into 2 of 5 categories -- resident care (32 percent) and residents' rights (31 percent). The top 10 complaints for that year include 3 related to inadequate nursing home staffing, as well as specific complaints about poor quality of care, such as poor hygiene, physical abuse, and improper handling and accidents.

Resident abuse complaints. Data obtained from nursing home abuse complaint coordinators in the 10 sample States lack common definitions and are therefore inconsistent. Furthermore, these complaints are not always substantiated. Among the 10 States, there are no obvious trends in reported complaints; some States have upward trends and others downward trends. Nevertheless, approximately one percent or more of nursing home residents in the 10 States have had an experience serious enough to register an abuse complaint.

Additionally, since 1995 the OIG has excluded 668 nursing home workers from participation in the Medicare or Medicaid programs as a result of a conviction related to patient abuse or neglect. The excluded workers were primarily nurses and nurse aides.

Chronically substandard homes. Some nursing homes appear to be chronically substandard. Data from OSCAR show that some are repeatedly deficient; 463 nursing homes have been cited with the same deficiencies over their last past four surveys, representing 6 percent of all homes in the 10 sample States. State directors and surveyors also report that between 1 to 20 percent of nursing homes in their State have chronic quality of care problems. Finally, three-fourths of ombudsmen say there are some homes (10 percent or fewer) that routinely treat residents poorly.

Insiders' perspectives. Survey and certification staff and ombudsmen express some reservations about relying exclusively on program data to identify nursing home problems. While generally satisfied with OSCAR data, more than half of State directors and surveyors believe it is not a true indicator of nursing home quality of care since it only portrays the situation of the nursing home at the time surveyors are physically conducting the survey. Ombudsmen also say that higher complaint rates do not always indicate more problems, pointing out that higher complaint rates could be due to a greater presence of Ombudsman staff in nursing homes.

Nevertheless, in all 10 sample States, State surveyors and survey directors, State and local ombudsmen, and State Aging Unit Directors confirm that problems with care persist in nursing homes. These are many of the same problems reported in program data. State surveyors and survey directors say the biggest problems they see are resident abuse, failure to treat incontinent patients, and improper medication distribution. Ombudsmen and State Aging Unit Directors identify malnutrition and other dietary concerns, bed sores, dehydration, poor hygiene, over-medication, toileting, and physical abuse as problems nursing home residents face.

Evidence suggests inadequate levels of nursing home staff contribute to quality of care problems

In all 10 sample States, survey and certification staff, State and local ombudsmen, and State Aging Unit Directors identify inadequate staffing levels as one of the major problems with nursing homes in their States. Most believe that these staffing shortages leads to chronic quality of care problems, such as failure to adequately treat and prevent pressure sores. They cite further concerns about the proficiency and training of nursing home staff.

The type and extent of survey deficiencies and Ombudsman program complaints also suggest that nursing home staffing levels are inadequate. Common personal care problems such as lack of nutrition and poor care for incontinence suggest that staffing is inadequate to provide the level of care needed to avoid these problems. Furthermore, specific complaints about nursing home staff are some of the most common types of Ombudsman program complaints. The top complaint in 1997 was unanswered call lights and requests for assistance, while staff attitudes and lack of respect was third and shortage of staff was ninth.

Survey and certification agencies are following required standard protocols but weaknesses in the survey system itself limit their effectiveness

State survey and certification agencies monitor nursing home care with timely and standard surveys, complaint procedures, and additional State processes. Based on OSCAR data over the last 4 standard surveys, all sample States completed 97 percent of their standard surveys in the mandated time frame of 9 to 15 months. Furthermore, all State survey directors and surveyors report following HCFA guidelines for their surveys, including starting with an entrance conference, touring the facility, interviewing residents and family members, reviewing medical records, and concluding with an exit conference. They also report having a complaint process to address complaints about nursing home practices.

Seven States have their own survey guidelines which they use in addition to HCFA guidelines, and some have additional databases and information sources.

Despite following standard procedures, however, the survey and certification system has several weaknesses, including the predictability of surveys. Although all States use unannounced nursing home surveys, almost all directors and surveyors believe that facilities can anticipate the survey start date. They say that facilities often modify their normal daily procedures to reduce potential deficiencies, such as increasing staff on certain shifts. In most States, surveyors also do not begin or continue standard surveys on the weekend or in evening hours. State directors and surveyors therefore voice concerns about whether standard surveys represent an accurate reflection of quality of care in nursing homes.

The survey and certification process is also limited by weak enforcement, including inaction on abuse complaints. From January 1997 to July 1998, OSCAR data reports 4,707 abuse complaints (involving almost one third of all nursing homes) in the 10 sample States. Two-thirds of these were unsubstantiated and the remaining third were substantiated. Over 90 percent of both substantiated and unsubstantiated complaints concluded with no action, plans of correction, or other remedy. Furthermore, half of the State directors and three-fourths of surveyors indicate that current enforcement measures are questionable. They express concern that civil monetary penalties do not compel nursing homes to observe Federal regulations, are insufficient to influence nursing home chains, and are not imposed immediately, allowing facilities to remain non-compliant for longer periods of time. Others believe that current enforcement process allows deficient facilities far too many opportunities to avoid enforcement action.

Finally, survey and certification agencies have a number of staffing constraints. The overall number of surveyors varies by State, thereby affecting the number of standard, follow-up, and complaint surveys each team can conduct. For example, the number of standard surveys on the 10 States ranges from 12 to 26 per year. State directors also express concern about high staff turnover rates, difficulties replacing staff once they leave, and limited surveyor training. They additionally report weaknesses in coordination between their staff and ombudsman staff. Surveyors received 13 percent of all Ombudsman program abuse complaints per month in 1997.

While the Ombudsman program is well designed, inadequate resources limit its capacity

The Ombudsman program has several functions to promote and monitor quality of care in nursing homes, including identifying and resolving complaints, making regular visits to nursing homes, and engaging in a variety of different advocacy activities. Discussions

with State and local ombudsmen, as well as State Aging Unit Directors, emphasize the uniqueness of this program. In contrast to other programs, ombudsmen lack enforcement and regulatory oversight authorities. As independent advocates, they work solely on behalf of residents and are often the only voice residents have in their own care. An ongoing, routine nursing home presence is therefore essential to the ombudsman role. In fact, most State ombudsmen (6 of 10) believe this presence is the most important part of their program. This presence provides ombudsmen with the opportunity to develop personal and confidential relationships with residents and enables them to identify and address individual issues before they become larger, systemic problems.

Nevertheless, the overall capacity of the Ombudsman program is limited by inadequate resources, including inadequate staffing. Paid staffing and volunteer levels among the 10 States vary considerably, ranging from 4,618 nursing home beds per paid staff in one State to 1,115 beds per paid staff in another. While no minimum staffing ratios are required by law, a 1995 Institute of Medicine study on the Ombudsman program recommends a standard staffing ratio of 1 paid Ombudsman staff person per 2,000 long term care facility beds; only 1 in the 10 sample States, Massachusetts, meets this standard. Furthermore, a majority of State and local Ombudsmen identify insufficient program staffing and an inadequate number of volunteers as obstacles which detract from their program's effectiveness.

Inadequate program staffing is particularly evident in the limited extent to which ombudsmen make regular nursing home visits. In the nine States that make such visits, volunteers are generally assigned to just one nursing home and visit this home on a weekly basis. However, most nursing homes in the 10 States do not have volunteers assigned to them, and these homes are usually visited by paid staff just once or twice a year for no longer than one to three hours. In fact, in four States there are nursing homes that are never visited by volunteers or paid staff.

Other limitations affect the Ombudsman program's overall capacity. Lacking a common standard for complaint response and resolution, ombudsman staff in some States are not consistently handling complaints in a timely manner. Ombudsman staff also devote varying amounts of time to outreach and advocacy activities, with some spending relatively little time on community education, work with the media, work on laws and policy, and nursing home staff training. Also, half of State and local ombudsmen believe their program's lack of support in the State diminishes its capa ity and limits their ability to influence nursing home policies. Lastly, they believe b ter collaboration is needed with the survey and certification agency.

State systems to safeguard nursing home residents from abuse are inconsistent and unreliable

Based on findings from a recent OIG audit, "Safeguarding Long Term Care Residents," (A-12-97-0003) it appears that some weaknesses exist in State efforts to safeguard nursing home residents from abuse. This audit revealed great diversity in the way States systematically identify, report, and investigate suspected abuse. While no Federal requirement exists for criminal background checks of nursing home staff, 33 States do mandate that such checks occur. However, the methods used to identify individuals who pose a risk of abuse and the criteria followed for prohibiting employment vary widely among these States. Furthermore, not all States systematically report convictions to central databases, such as the certified nurses aide registry. It therefore appears that there is no assurance that individuals who may pose a risk to residents are systematically identified and barred from nursing home employment.

A more in-depth audit of Maryland also found problems with nursing home hiring practices in that State. In particular, this audit found that five percent of employees in eight nursing homes had criminal records. It also noted that some of these individuals were not reported in the State or Federal systems used for criminal background checks, despite the fact that they had been convicted of elder abuse.

Public awareness and access to nursing home survey results is limited

Two-thirds of 155 families interviewed in eight sample cities did not know that the results of Federal and State nursing home inspections are available on request. Half were also unaware that such inspections are required. Only 15 of the 155 individuals we interviewed had ever requested a copy of the survey results, and of the 11 who obtained a copy, 6 said the results were not based on a recent survey conducted within the past 15 months.

Most of the 32 sampled nursing homes visited by staff from the Office of Inspector General did not fully meet the requirements for making survey results available. In a majority of these homes, the notice identifying the location of the survey results was not posted and/or the survey results were in locations directly observed by staff, contrary to regulations. Staff from the OIG had to ask for the survey results in 24 of the 32 homes they visited. While most (27) did ultimately make the survey results available, the OIG staff had an advantage over other members of the public since they were aware of what to look for and how to ask for it.

The HCFA has recently established a more easily accessible version of nursing home survey results with an internet site entitled *Nursing Home Compare.* For families with access to the internet, this is a promising development. When staff from the OIG located this site, they found it easy to understand. Most of the families interviewed said it could be very helpful in providing useful nursing home information.

New initiatives based on law enforcement approaches are being considered

Initiatives to strengthen nursing home law enforcement are relatively new. Particularly noteworthy is the formation of nursing home task forces at the local, State, and national levels, comprised of representatives from the Department of Justice, HCFA, OIG, and other agencies. These groups will examine and develop action plans for several enforcement strategic areas and will address the full range of nursing home enforcement issues. They will collaborate with Medicaid Fraud Control Units, the State Attorneys General, State survey agencies, and other oversight agencies. Among the strategic areas targeted are: improving the handling of civil monetary penalty referrals; reviewing patient abuse and neglect legislation for model State legislation; recommending possible new legislation for prosecuting abuse and neglect; reviewing current services available to abuse victims; and identifying emerging quality of care and fraud problems in nursing homes.

By targeting key strategic areas and coordinating among the various agencies responsible for nursing home enforcement, these initiatives appear promising. If successful, they should strengthen enforcement of nursing home problems. However, it is too soon to determine the full impact of these enforcement initiatives. Some of the task forces and action plans will not be fully developed until early 1999, and at the earliest, preliminary results will not be available until later in that year.

Nursing home reforms established by OBRA 1987 have not been systematically assessed

The nursing home reforms created by OBRA 1987 impacted both nursing home systems and nursing home care. First, these reforms essentially changed the focus from a nursing home's *ability* to provide care to the *quality* of the care actually provided. The OBRA 87 requires nursing homes participating in Medicare and Medicaid to comply with extensive standards. These standards include ensuring various resident rights, rights related to admission, transfer and discharge, and the right to be free from restraints and abuse. The OBRA 87 also requires nursing homes to promote residents' quality of life, conduct periodic resident assessments, and provide the necessary care needed for residents to maintain the highest practicable physical, mental, and psychosocial well-being.

Additionally, OBRA 87 requires nursing homes to provide certain services, including nursing, dietary, physician, rehabilitative, dental, and pharmacy services. Finally, several administrative standards were also established, including requirements for nurse aide training, a medical director, and clinical records.

The OBRA 87 also changed nursing home enforcement and survey procedures. Among these changes are: the development of the Resident Assessment Instrument (RAI), which is a standardized assessment instrument for nursing home residents; a more outcome oriented survey that emphasizes gathering information by observing and interviewing residents; and new intermediate enforcement remedies that augment existing options for noncompliant nursing homes.

While it has now been more than a decade since OBRA 1987 was first passed, there has been no systematic assessment of its extensive agenda and no methodical evaluation of whether or not the reforms it intended are actually working. In its 1998 Report to Congress, HCFA attributes positive changes in the use and outcomes of resident assessment instruments and psycho-pharmacological medications to OBRA 87. The HCFA also concludes that new enforcement and survey regulations have been effective. Other studies have addressed additional OBRA reforms, including OIG reports on nursing home prescription drug use and resident abuse. Furthermore, data from survey and certification and Ombudsman program reporting systems suggest the OBRA requirement that residents be free from restraints is having some effect; deficiencies on restraints and ombudsman restraint complaints have been decreasing over the past several years. Nevertheless, the success of this major legislation has not yet been established. A definitive assessment of the extent to which OBRA reforms have bettered conditions in nursing homes is therefore needed.

AN AGENDA FOR CONTINUING IMPROVEMENT IN NURSING HOME CARE

Since OBRA 1987 was first passed, real improvements have been made in nursing home care. More recently, considerable attention has been paid to addressing persisting concerns about nursing home conditions and systems. In particular, we commend the Health Care Financing Administration (HCFA) for its extensive nursing home initiative since it addresses many of these persisting problems. This initiative includes many individual action items which should result in positive changes. Additionally, the Administration on Aging (AoA) has been taking steps to enhance the Ombudsman program, including improving the program reporting system and conducting annual training of ombudsman staff.

The problems we describe in this report will require continuing attention, possibly for several years. The broad outline of an effective strategy would include actions to:

- enhance the survey and certification process;
- strengthen the Ombudsman program with increased resources;
- improve nursing home staffing levels; and
- improve coordination between State survey agencies and ombudsmen.

We also believe that further evaluation and progress measurement would make an important contribution to efforts to advance nursing home care. We specifically suggest:

- a systematic assessment of OBRA 1987; and
- the creation of a periodic report card on conditions in nursing homes.

We have incorporated action items from HCFA's nursing home initiative, AoA's Ombudsman program activities, recommendations for additional steps to be taken, current OIG work, and areas requiring further evaluation into one comprehensive, long term agenda to continue improvements in nursing home care. This agenda consists of a three stage approach of immediate action, research and evaluation, and continued progress measurement. It is outlined below.

I. Immediate Action

We believe immediate action should be taken to strengthen the capacity of systems designed to oversee nursing home care. We also believe improvements should be made in nursing home staffing levels, since this directly impacts on the care residents receive.

Survey and Certification	
Survey enforcement efforts. Strengthen survey enforcement efforts by: making surveys more timely, effective, and unpredictable; increasing the number of night and weekend surveys and surveys at chronically substandard homes; focusing on specific problems, such as pressure sores; eliminating grace periods for homes with repeat serious violations; proposing new civil monetary penalties; and placing survey results on the internet.	Addressed in HCFA initiative
Enhanced monitoring. Enhance monitoring of special focus facilities.	Addressed in HCFA initiative.
Surveyor training. Provide additional training and assistance to State surveyors.	Partially addressed in HCFA initiative
Surveyor staffing. Evaluate State surveyor staffing to assure adequate staffing is available.	Action under consideration by HCFA
Surveyor coordination. Provide a forum for surveyors to meet and discuss common issues.	Action under consideration by HCFA
Abuse. Add survey task to look at provider's abuse intervention system, develop national abuse intervention campaign, and promote prosecution of egregious violators.	Addressed in HCFA initiative
Ombudsman Program	
Visibility. Develop guidelines for minimum levels of Ombudsman program visibility, including criteria for frequency and length of regular visits and staffing ratios.	Partially addressed by AoA through annual training

Volunteers. Formulate strategies for recruiting, training, and supervising more ombudsman volunteers.	Partially addressed by AoA through annual training and Ombudsman Resource Center
Complaint response and resolution. Develop guidelines for ombudsman complaint response and resolution times.	Not currently addressed
Reporting system. Continue to refine and improve the Ombudsman program's data reporting system.	Continuing attention by AoA
Coordination with Survey and Certification. Establish ways to enhance coordination between survey and certification and Ombudsman programs.	Continuously addressed
Resident Abuse Safeguards	
Employment safeguards. Improve the safety of residents and strengthen safeguards against employment of abusive workers.	Addressed in HCFA initiative
Nursing Home Staffing	
Staffing standards. Develop staffing standards for registered nurses and certified nurse assistants in nursing homes to assure sufficient staff on all shifts to enable residents to have proper care.	Currently being studied by HCFA
Care Guidelines	
Malnutrition and dehydration. Develop best practice guidelines for malnutrition and dehydration care and national campaign to increase awareness of these problems.	Addressed in HCFA initiative
Drug usage. Develop guidelines and protocols for using effective drugs.	Addressed in HCFA initiative
Family Involvement	
Family awareness and access. Promote and facilitate greater awareness and access to survey results by strengthening existing avenues for receiving information and identifying new avenues.	Action under consideration by HCFA

II. Research and Evaluation

We also propose the development of a research and evaluation program to assess the

quality of care in nursing homes, including a systematic look at each of the legislative reforms established with OBRA 1987 and other quality of care issues. In the following table, we indicate where the OIG is conducting or planning work. As the Office of Inspector General, we have a particular interest in assuring that the standards mandated by OBRA 1987 are being met. Since we do not expect to address all of the nursing home requirements and issues we have identified, we invite others to join us in this evaluation.

OBRA 1987	
Prescription Drugs. Assess the extent and appropriateness of prescription drug use by nursing home residents and describe consultant pharmacists' concerns about drug use.	OIG report issued
Resident assessment. Determine the systems used by nursing homes to conduct periodic resident assessments and plans of care and evaluate how this impacts reimbursement.	OIG study underway
Nurse aide training. Evaluate nurse aide training	In OIG workplan
Abuse reporting. Examine the extent to which States have implemented abuse reporting requirements.	In OIG workplan
Medical director. Examine the role medical directors play in assuring quality of care.	In OIG workplan
Resident rights. Assess the extent to which nursing homes are assuring resident rights.	
Admission rights. Assess the extent to which nursing homes are assuring admission, transfer, and discharge rights.	
Restraints and abuse. Assess whether rights to be free from restraints and abuse are being met.	
Quality of life. Assess whether or not nursing homes are providing care which promotes each resident's quality of life.	
Resident well-being. Determine if nursing homes are providing care and services to maintain the highest levels of residents' physical, mental, and psychosocial well-being.	
Nursing home services. Determine if nursing home staffing levels are adequate to provide required nursing, dietary, physician, rehabilitative, dental, and pharmacy services.	
Physical environment. Determine if nursing homes are maintaining a healthy and safe physical environment.	

Other Quality of Care	
Resident satisfaction. Determine the level of resident satisfaction with nursing home care.	OIG study underway
Immunizations. Examine the obstacles to immunizing 80% of nursing home residents against pneumoccocal disease and influenza.	OIG study underway

III. Progress Measurement

Finally, an independent, continuous assessment is needed to measure the progress made in raising the standard of nursing home care.

Periodic Assessments	
Periodic report card. Conduct periodic evaluations describing conditions in nursing homes based on deficiency trends, ombudsman complaints, resident satisfaction, and insiders' perspectives.	Under consideration by OIG

AGENCY COMMENTS

This report is based primarily on a series of recent studies conducted by the Office of Inspector General on nursing home care. They are:

Nursing Home Survey and Certification: Deficiency Trends, OEI-02-98-00331;
Nursing Home Survey and Certification: Overall Capacity, OEI 02-98-00330;
Long Term Care Ombudsman Program: Complaints Trends, OEI-02-98-00350;
Long Term Care Ombudsman: Overall Capacity, OEI-02-98-00351;
Public Access to Nursing Home Survey and Certification Results, OEI-06-98-00280; and
Safeguarding Long Term Care Residents, A-12-97-0003.

We received detailed comments from HCFA, AoA, and the Assistant Secretary for Planning and Evaluation on the above reports. We made modifications in each report to respond to the comments received and to reflect the actions already being taken to improve nursing home conditions. This overview report also incorporates many of these modifications. We encourage everyone to read the individual reports and the comments we received on them. The comments are included in each report.

The CHAIRMAN. Mr. Grob, we are going to wait for Dr. Scanlon and then we will ask questions of both of you. Dr. Scanlon.

STATEMENT OF WILLIAM SCANLON, M.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE

Dr. SCANLON. Thank you very much, Mr. Chairman. We have been very happy to work with you and the committee on this important topic. I do not think there is anything that we are working on that we think rises to the level of importance and that we can personally understand the significance of as this issue. Today I would like to highlight in my remarks the findings from the report that we prepared at your request and released today on the complaint investigation process for nursing home care.

This process is intended to provide nursing home residents, their families and friends and nursing home staff with an outlet for lodging concerns about the quality of care. In addition, I will summarize the report that we released to you and other requesters last Thursday on the effectiveness of the Federal enforcement process, which is intended to ensure that those nursing homes that failed to comply with Federal nursing home quality standards correct their deficiencies and are appropriately sanctioned.

Before turning to these two very recent reports, though, it might help to put some of these findings into the larger context. As you mentioned, last July, we reported to the committee on the quality of care issues in California nursing homes, prompted by allegations of inappropriate deaths in 1993. You asked us to examine those allegations and beyond that to determine how well Federal and state agencies had done more recently in identifying and correcting care problems in California's homes.

As you recall, we identified problems not only in the State of California but also more broadly in HCFA's oversight of the Federal and state nursing home program, and I would like to just briefly recap some of the highlights of those findings. Despite the considerable Federal and state oversight program and infrastructure in place, we found that one-third of California nursing homes had been cited by state surveyors for serious violations of Federal and state standards. These violations included improper care leading to death or life-threatening harm to residents. Other serious violations involved improper care and in falsifying or omitting key information from medical records. These problems were identified through the state's annual surveys of nursing homes and through complaint investigations.

Despite the seriousness and prevalence of these identified problems, we believe them to be understated. The predictable timing of the onsite reviews by state surveyors, the questionable accuracy and completeness of medical records and the limited number of residents whose care was reviewed in each home likely shielded some problems from state surveyors' scrutiny. Our work indicated that these systemic issues with the survey process applied more than just in California. Moreover, even when California surveyors did identify serious deficiencies, we found that HCFA's enforcement policies were not effective in ensuring that the problems were corrected and remained corrected.

HCFA's policy of granting a grace period to correct deficiencies regardless of past performance allowed most homes to evade any consequences of their poor performance. Only a few homes that posed the greatest danger were not provided such a grace period. Concerned about these findings, you have asked us to broaden our scope and determine how widespread these problems might be elsewhere. Unfortunately, our findings are not positive.

In many cases, neither complaint investigations nor enforcement practices are being used effectively to assure adequate care to nursing home residents. As a result, allegations or verified incidents of serious problems such as inadequate prevention of pressure sores, failure to prevent accidents and avoidable fractures, and failure to assess residents' needs and provide appropriate care often go uninvestigated and uncorrected. Even when problems are documented and corrected, they too often reoccur.

For serious complaints alleging harm to residents, our review in 14 States reveals that the combination of inadequate state efforts and limited HCFA guidance and oversight have often resulted in a system that does not provide for a quick or adequate response to allegations of serious problems. We saw at least three reasons for this. First, state policies or practices may actually discourage complaints from being filed. Two States we visited encourage people who call in to submit their complaint in writing. While these States' policy is to help prepare a written complaint if the caller is unable or unwilling to do so, we found conflicting information as to whether this actually happens.

In contrast, another State that we visited readily accepts and acts on phone complaints without encouraging the written follow-up. This State has a substantially higher volume of complaints than the other two.

Second, serious complaints alleging harmful situations are often not given a high priority for investigation and consequently are not investigated promptly. One State we visited did not classify any complaint received during a 1-year period as having the potential for immediate jeopardy of residents. Such a classification would have triggered a Federal requirement for investigation within two work days. Another state assigned over 90 percent of its complaints to a priority category that would allow up to 45 days for an investigation. Beyond this, even though States frequently give complaints a priority allowing a delay before an investigation, most investigations were still not done by the assigned deadlines. Some complaints that alleged serious risks to residents' health and safety remained uninvestigated for several months.

To illustrate these issues, our report includes an appendix that chronicles the backlog of complaints in three major cities, Baltimore, Detroit and Seattle, for nursing homes that had three or more complaints that had not yet been investigated within the deadline specified by the State when we visited last December and January. Let me cite just two examples to make this point more concrete.

One complaint alleged that during a 16 month period, a resident who was 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. This complaint was

uninvestigated after 111 days despite being assigned a 45 day investigation priority. Three other serious complaints regarding the home's care were also still pending. They had been made between 140 and 293 days before our visit.

In another case, the State's practice was to give complaints low priority if the resident was no longer at the nursing home when the complaint was received, even if the resident had died or had been transferred to a hospital or another nursing home due to care problems. One complaint received in July 1998 alleged that a diabetic resident died because the home did not properly manage his insulin or perform blood sugar tests. Just 10 days prior to receiving this complaint, the State had completed a second visit to that home, subsequent to its standard survey. The monitoring and treatment of diabetic residents had been an issue during those survey visits, but at the second revisit, the State gave the home a clean bill of health, concluding it was in compliance with all standards.

Despite this allegation of death just 10 days after the State's visit and the home's history of a problem with diabetic care, the State did not investigate the complaint until March 12, 1999, 8 months after it had been lodged. It is hard to understand why the State did not investigate this complaint sooner given that the resident died and the home had previously documented deficiencies related to diabetic care.

Now I would like to turn to our work on the effectiveness of the Federal and state enforcement process to respond to those nursing homes that have been found to have serious deficiencies. Among other things, we analyzed the enforcement record for a sample of homes with serious and repeated problems on the premise, or on the hope, that the system would be more effective or more aggressive about responding to those inarguably poor quality homes. However, our analysis of these 74 homes in four States showed a yo-yo pattern of compliance and non-compliance. HCFA would give notice to impose a sanction such as denial of payment for new admissions, a civil monetary penalty or even termination. The home would then correct its deficiencies, HCFA would rescind the sanction, and a subsequent survey would find that serious problems had returned. The threat of sanctions appeared to have little effect on the home.

It did not deter them from falling out of compliance because they apparently knew they would continue to avoid the sanction's effect as long as they kept temporarily correcting their deficiencies. What explains these failings? Beyond the role of nursing homes and the States as the first and second line of defense, HCFA bears a portion of the responsibility for the weaknesses in the complaint and enforcement practices.

For example, except for one requirement to investigate an allegation of immediate jeopardy within two work days, HCFA has left it to the States to determine the priorities and timeframes for investigating complaints. Moreover, HCFA's guidance on how to conduct investigations has been developed for States' optional use and thus has not widely been adopted. And HCFA's monitoring reviews of state nursing home surveys rarely include complaint investigations. For enforcement actions, the manner in which some sanctions have been implemented have limited their effectiveness. Civil

monetary penalties, which can bring up to $10,000 per day in fines, have a potentially strong deterrent effect because theoretically they could not be avoided simply by taking corrective action. And the longer the deficiency remains, the larger the penalty can be.

However, the effectiveness of such penalties has been hampered by the growing backlog of administrative appeals which now stands at over 700 cases awaiting action. This backlog encourages HCFA to settle appealed cases, reduce the size of some fines, and delay the effective fines even if they are ultimately upheld after appeal. The deterrent effect of monetary penalties seems to largely be lost.

Our reports have contained several specific recommendations for HCFA and the Administrator has generally concurred with these recommendations and has already taken steps to act on some of them. In closing, I would like to acknowledge that HCFA is giving this issue a priority, even among its other pressing priorities. The Administrator's response to our findings has been consistently swift and specific, but in responding to and in correcting the problems identified today and in our earlier work, it will take a continuing and increasing commitment on the part of HCFA as well as many other varied players and stakeholders. We believe continued vigilance and support from the Congress will be essential to ensure that the real reform takes place and to better ensure that the health and safety of America's nursing home residents are protected. Thank you, Mr. Chairman. I would be happy to answer any questions you have.

[The prepared statement of Dr. Scanlon follows:]

United States General Accounting Office
GAO
Testimony

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U.S. Senate

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NURSING HOMES

Stronger Complaint and Enforcement Practices Needed to Better Assure Adequate Care

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-89

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our findings on the effectiveness of complaint and enforcement practices, which are an integral part of the federal-state process to protect nursing home residents and to ensure that homes participating in Medicare and Medicaid comply with federal standards. The nearly 1.6 million elderly and disabled residents living in nursing homes are among the sickest and most vulnerable populations in the nation. They are frequently dependent on extensive assistance in basic activities of daily living like dressing, grooming, feeding, and going to the bathroom, and many require skilled nursing or rehabilitative care.

The federal government, which will pay nearly $39 billion for nursing home care in 1999, plays a major role in assuring that residents receive adequate quality of care. Based on statutory requirements, the Health Care Financing Administration (HCFA) defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The federal government has the authority to impose sanctions, such as fines, if homes are found not to meet these standards.

In hearings before this Committee last year, we reported that unacceptable care was a problem in many California nursing homes, including 1 in 3 where state surveyors found serious or potentially life threatening care problems. We also concluded that federal and state oversight was not sufficient to guarantee the safety and welfare of nursing home residents.[1] The information I am presenting today updates and expands upon the information presented last year with the results of our work on two recently completed projects conducted for this committee and several other requesters. In a report issued today, we examine the effectiveness of states' complaint practices in protecting residents.[2] In this report, we also assess HCFA's role in establishing standards and conducting oversight of states' complaint practices and in using information about the results of complaint investigations to assure compliance with nursing home standards. In the second report, issued last week, we analyze national data on the existence of serious deficiencies in nursing home compliance with Medicare and Medicaid standards. Further, we assess HCFA's use of sanction authority for homes that failed to maintain compliance with these standards.[3]

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[1]See California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations (GAO/T-HEHS-98-219, July 28, 1998) and California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

[2]See Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, March 22, 1999). We examined Maryland, Michigan, and Washington as well as 11 other states reviewed by state auditors -- Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin.

[3]See Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, March 18, 1999). The scope of this review included analysis of

In brief, we found that neither complaint investigations nor enforcement practices are being used effectively to assure adequate care for nursing home residents. As a result, allegations or incidents of serious problems, such as inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care, often go uninvestigated and uncorrected. Our work in selected states reveals that, for serious complaints alleging harm to residents, the combination of inadequate state practices and limited HCFA guidance and oversight have often resulted in:

- Policies or practices that may limit the number of complaints filed;
- Serious complaints alleging harmful situations not being investigated promptly; and,
- Incomplete reporting on nursing homes' compliance history and states' complaint investigation performance.

Further, regarding enforcement actions, HCFA has not yet realized its main goal – to help ensure that homes maintain compliance with federal health care standards. We found that too often there is a yo-yo pattern where homes cycle in and out of compliance. More than one-fourth of the more than 17,000 nursing homes nationwide had serious deficiencies – including inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care – that caused actual harm to residents or placed them at risk of death or serious injury. Although most homes corrected deficiencies identified in an initial survey, 40 percent of these homes with serious deficiencies were repeat violators. In most cases, sanctions initiated by HCFA never took effect. The threat of sanctions appeared to have little effect on deterring homes from falling out of compliance because homes could continue to avoid the sanctions' effect as long as they kept temporarily correcting their deficiencies.

HCFA has taken a number of recent actions to improve nursing home oversight in an attempt to resolve problems pointed out in earlier studies. These initiatives include staggering annual surveys to lessen their predictability and more vigorously prosecuting egregious violations. We are making several additional recommendations to HCFA that should strengthen its standards for and oversight of states' complaint practices and improve the deterrent effect of enforcement actions, including the use of fines and terminations. We are also recommending that HCFA improve its management information systems to more completely include complaint investigation results and to be able to more effectively identify and respond to homes with recurring problems. Last week, the Administrator

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HCFA's nationwide database of periodic inspections and detailed work in four states – California, Michigan, Pennsylvania, and Texas.

generally concurred with these recommendations and announced new initiatives to address these issues.

SOME STATES' COMPLAINT PRACTICES ARE LIMITED IN THEIR ABILITY TO PROTECT RESIDENTS

Investigations of complaints filed against nursing homes can provide a valuable opportunity for determining if the health and safety of nursing home residents are threatened. Complaint investigations are typically less predictable than annual surveys and can target specific areas of potential problems identified by residents, their families, concerned public, and even the facility itself. However, we found that complaint investigation practices do not consistently achieve their full potential.

Some States' Policies or Practices Limit the Filing of Complaints or Quick Response

Some states have practices that may limit the number of complaints that are filed and investigated. For example, both Maryland and Michigan encourage callers to submit their complaints in writing. In contrast, Washington readily accepts and acts on phone complaints without encouraging a written follow-up. This practice would appear to contribute to Washington's much higher volume of complaints than in either Maryland or Michigan.

When a complaint is received, the state agency ascertains its potential seriousness. HCFA requires states to investigate complaints that may immediately jeopardize a resident's health, safety, or life within 2 workdays of receipt. For other serious complaints, states are permitted to establish their own categories and timeframes for investigation. Some states permit relatively long periods of time to pass between the receipt of these complaints and their investigation. For example:

- Michigan's statute allows 30 days, but Michigan's operating practice in 1998 allowed 45 days;
- Tennessee allows 60 days; and,
- Kansas allows 180 days.

Other states, however, such as Maryland, Pennsylvania, and Washington, have additional priority levels that categorize other serious complaints to be investigated within shorter timeframes, such as 10 workdays.

Some States Assign Low Priority Levels to Serious Complaints

We found that some states classify few complaints in high-priority levels that would require a prompt investigation. For example, in the 1-year period from July

1997 to June 1998, Maryland did not classify any complaints as having the potential to immediately jeopardize residents and thereby requiring a visit within 2 workdays. Maryland most frequently classified complaints as not requiring a visit until the next on-site inspection – which could be as long as a year or more away. Similarly, Michigan categorized nearly all of its complaints between July 1997 and June 1998 as not requiring a visit for 45 days or until the next annual survey. In contrast, Washington determined that 9 out of 10 complaints should be investigated within either 2 or 10 workdays.

Several states have explicit procedures or operating practices that do not place serious complaints in high priority categories for investigation. A Maryland official, for example, acknowledged reducing the priority of some complaints since the agency recognized that it could not meet shorter timeframes due to insufficient staff. Michigan gave some complaints low priority if the resident was no longer at the nursing home when the complaint is received – even if the resident had died or been transferred to a hospital or another nursing home due to care problems. 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 his insulin injections or perform blood sugar tests. The state had recently investigated the home and determined that previous problems with treatment of diabetic residents had been corrected. However, the state did not investigate the complaint until this month as part of the most recent annual survey – nearly 8 months after the complaint was received – and state investigators did not identify any problems with treatment of diabetic residents. We question why the state agency did not investigate this complaint sooner given that the resident died and the home had previous deficiencies related to diabetic care. Michigan also delayed investigating certain non-immediate jeopardy complaints against nursing homes undergoing a federal enforcement action. Officials told us that they adopted this practice to avoid potential confusion that may result from having two enforcement actions pending simultaneously. This practice, however, 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 that raise questions about why they were not considered as involving potential immediate jeopardy and thereby requiring a visit within 2 workdays. Examples of these allegations include:

- A resident was found dead with her head trapped between the mattress and the siderail 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 siderail problems.

- 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 an "unprecedented rapid decline (in his condition)." A

member of the ambulance crew transporting the resident to the hospital reported 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... I personally feel he was not being properly cared for." The state eventually determined that the nursing home had harmed the resident, but only after categorizing this complaint as not needing an investigation until the next on-site inspection that was more than 4 months after receipt of the complaint.

Some States Not Conducting Complaint Investigations in Timely Manner

Further, we found that states often did not conduct investigations within the timeframes they assigned complaints, even though some states frequently placed complaints in priority categories that would 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. For example, Maryland only met its timeframes for 21 percent of complaints assigned to the 10 workday category and for 69 percent of complaints assigned to the 45 workday category. Michigan met its timeframes in about one-fourth of cases. Washington, which assigned most complaints to the category requiring a visit within 10 workdays, met its timeframes in slightly more than half (55 percent) of all complaints.

During our visits to Maryland, Michigan, and Washington, we asked the states to provide copies of all complaints in the Baltimore, Detroit, and Seattle areas that had not yet been investigated and that exceeded the assigned timeframe. Baltimore and Detroit metropolitan areas had over 100 such complaints and there were 40 in the Seattle area. For example, in Baltimore we identified a nursing home that had three complaints alleging neglect or abuse that had not yet been investigated and had been pending for at least 3 or 4 months. These allegations included a resident who was not fed for nearly 2 days and was hospitalized with dehydration, pressure sores, and an infection; a resident whose condition deteriorated, including losing 10 percent of her body weight in 2 months, and suffered from poor hygiene; and a resident who was improperly transferred and suffered 2 fractured legs. In Detroit, a nursing home had four pending complaints that had not been investigated for between 2 and 8 months and that alleged neglect and abuse of residents in the home's care. These allegations included a resident who died after the home allegedly failed to send her to the hospital promptly and who the hospital's physician determined was dehydrated and malnourished; a resident with an uncared-for cut that became infected and resulted in heel amputation; an unattended resident who was found outside the home with injuries from a fall; and a resident who was verbally abused by a staff member.

Failure by states to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions. As a result of delayed investigations, situations in which residents are harmed are

permitted to continue for extended periods. For example, we found a complaint in Michigan alleging inadequate care for pressure sores and fractures due to falls that was not investigated for over 7 months. When the state did investigate, it found that the nursing home had a pattern of deficiencies of inadequate care that actually harmed residents.

APPLICATION OF SANCTIONS DOES NOT ENSURE NURSING HOMES MAINTAIN COMPLIANCE

Based on our analysis of nationwide survey data, we found that more than 1 in 4 nursing homes have serious and often repeated deficiencies that resulted in immediate jeopardy or actual harm to residents. While HCFA's initiation of actions typically brought homes into at least temporary compliance, they were often ineffective in ensuring that homes maintained compliance over time with federal standards.

Many Nursing Homes Incur Repeated Serious Deficiencies

Surveys conducted since the July 1995 implementation of stronger enforcement tools showed that, each year, more than 4,700 homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. The most frequent violations causing actual harm included inadequate prevention of pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care. Although most homes were found to have corrected the identified deficiencies, subsequent surveys showed that problems often returned. About 40 percent of the homes that had such problems in their first survey during the period we examined (July 1995 to October 1998) had them again in their last survey during the period.

Sanctions Often Do Not Take Effect or Result in Only Temporary Corrections

Our work in four states and four HCFA regions showed that HCFA-initiated sanctions against non-compliant nursing homes did not take effect in a majority of cases and generally did not ensure that the homes maintained compliance with standards.[4] Our review of 74 homes that states had referred to HCFA for federal enforcement action, as a result of serious or uncorrected deficiencies, showed that the threat of sanctions often helped bring the homes back into temporary compliance but provided little incentive to keep them from slipping back out of compliance. Based on state recommendations, the most common sanctions HCFA initiated for these homes were denial of payments for new admissions, civil

[4]The four states were California, Michigan, Pennsylvania, and Texas that combined account for 23 percent of nursing homes nationwide. The HCFA regions we reviewed included San Francisco, Chicago, Philadelphia, and Dallas that are responsible for overseeing states with 55 percent of nursing homes nationwide. Within these 4 states, we chose a judgmental sample of 74 nursing homes that had deficiencies of sufficient severity that states had referred the homes to HCFA for 241 separate federal enforcement actions.

monetary penalties, and termination.[5] States had referred these homes to HCFA for possible sanctions an average of about 3 times each. Because many homes corrected their deficiencies before the effective date of the sanction, HCFA often rescinded the sanction before it took effect. For example, sanctions did not take effect in 55 percent of cases where denial of payments were recommended; in 68 percent of cases for civil monetary penalties; and 72 percent of cases for recommended termination.[6]

However, the threat of sanctions only temporarily induced homes into correcting identified deficiencies, as many were again out of compliance by the time the next inspection was conducted. Of the 74 homes we reviewed that faced possible sanctions, 69 were again referred for sanctions after being found out of compliance once more—some went through this process as many as 6 or 7 times. For example, twice in 1995, and again in 1996 and 1997, Michigan cited one home for causing actual harm to residents. Deficiencies included failure to prevent the development of pressure sores in several residents and failure to prevent accidents, which resulted in a broken arm for one resident and a broken leg for another. In another example, Texas surveyors cited one nursing home for placing residents in immediate jeopardy and actual harm twice in 1995—including failure to prevent choking hazards, provide proper incontinent care, and prevent or heal pressure sores. On the next annual survey, surveyors again found quality of care deficiencies that caused harm to residents, including failure to provide adequate nutrition.

This yo-yo pattern of compliance and noncompliance could be found even among homes that were terminated from Medicare, Medicaid, or both. Termination is usually thought of as the most severe sanction and is generally done only as a last resort.[7] Once a home is terminated, however, it can generally apply for reinstatement if it corrects its deficiencies and has demonstrated "reasonable assurance" that they will not recur. Of the 74 homes we analyzed, 13 were terminated at some point; however, the pattern of noncompliance returned for 3 of 6 homes that were reinstated. For example, a Texas nursing home was terminated from Medicare for a number of violations that included widespread deficiencies causing actual harm to residents. About 6 months after the home was terminated, it was readmitted under the same ownership. Within 5 months, state surveyors again identified a series of deficiencies involving harm to residents, including failure to prevent avoidable pressure sores or ensure that residents received adequate nutrition.

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[5]Other sanctions, including increased state monitoring, appointment of a temporary manager to oversee the home while it corrects its deficiencies, and state-directed plans of correction, have been infrequently used.

[6]The relatively small number of civil monetary penalties that have taken effect is a reflection of the large number of fines under appeal. As appeals are settled, a higher proportion of the fines imposed may take effect.

[7]When a home is terminated, it loses any income from Medicare and Medicaid payments, which for many homes represents a substantial part of operating revenues. Residents who receive support from Medicare or Medicaid must be moved to other facilities.

FURTHER HCFA OVERSIGHT AND ENFORCEMENT NEEDED

Given these weaknesses in many states' complaint practices and the current inadequacy of enforcement actions to maintain homes' compliance with federal standards, one would expect HCFA to be more proactive in overseeing states and enforcing sanctions when nursing homes do not maintain compliance with its standards. HCFA, however, has exercised limited oversight or guidance of states' complaint practices. In addition, while HCFA has some tools to address the cycle of repeated noncompliance among some homes, it has not used them effectively.

HCFA Oversight of Complaints is Limited

Although federal funds finance over 70 percent of complaint investigations nationwide, HCFA plays a minimal role in providing states with direction or oversight regarding these investigations. HCFA has left it largely to the states to determine which complaints are so serious that they must be investigated within the federally mandated 2 workdays. Until last week, HCFA had no formal requirements for the prompt investigation of serious complaints that could harm residents but were not classified as potentially placing residents in immediate jeopardy. Moreover, 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 had not been widely adopted.

- Federal monitoring reviews of state nursing home inspections primarily focus on the annual standard survey of nursing homes, with very few 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 states we reviewed complaint processes were addressed superficially or not at all.

In response to our findings and concerns raised by advocates for nursing home residents, HCFA announced last week several initiatives intended to strengthen its standards for and oversight of states. For example, HCFA will now require states to investigate complaints alleging actual harm to residents within 10 workdays.

HCFA Policy Limits Enforcement Sanctions' Effectiveness

Regarding enforcement actions, the manner in which some sanctions have been implemented limits their effectiveness. For example, civil monetary penalties have a potentially strong deterrent effect because they cannot be avoided simply by taking corrective action, and the longer the deficiency remains, the larger the

penalty can be. However, the effectiveness of civil monetary penalties has been hampered by a growing backlog of appeals. Nationwide, a lack of hearing examiners has created a growing backlog of over 700 cases awaiting decision as of February 1999, with some cases dating back to 1996. HHS estimated that each year at least twice as many appeals would be received as would be settled and has requested additional funds for fiscal year 2000. This appeals backlog creates a bottleneck for timely collections. As of September 1998, only 37 of the 115 monetary penalties imposed on the 74 homes we reviewed had been collected. This backlog of appealed civil monetary penalties encourages HCFA to settle appealed cases, often reducing the size of the fine, and delays the imposition of the fine even if it is ultimately upheld after appeal. As a result, it is not surprising that some nursing home owners routinely appeal imposed penalties. For example, we found that one large Texas chain appealed 62 of the 76 civil monetary penalties imposed on its nursing homes between July 1995 and April 1998. These 62 potential penalties totaled $4.1 million.

Since July 1998, HCFA has taken or proposed several initiatives to improve nursing home oversight. These initiatives include staggering annual survey schedules to reduce the predictability of surveyors' visits, revising the definition of a poorly performing facility to broaden the criteria for taking immediate enforcement action, and prosecuting egregious violations of care standards. While these are important steps, it is too early to gauge their effect in resolving earlier identified problems. HCFA's initiatives do not, however, address some weaknesses identified in our most recent work. For example:

- HCFA does not require states to refer homes for sanction in all cases where identified deficiencies contributed to the death of a resident. We identified examples where investigation of a resident's death found that the deficient practice had ceased at the time of the investigation, thus resulting in a finding of actual harm. Under HCFA policy, states are not required to refer homes with this level of deficiency for sanction.

- In addition to the need to better demonstrate reasonable assurance that violations will not recur prior to reinstating a terminated home, HCFA's policy prevents state agencies from considering a reinstated home's prior record. This policy effectively gives the home a "clean slate" and produces the disturbing outcome that termination could actually be advantageous to a home with a poor compliance history.

HCFA's Management Information Systems are Inadequate

Finally, our work points to weaknesses in HCFA's management information systems that have limited its effectiveness in addressing both nursing home complaints and enforcement. HCFA reporting systems for nursing homes' compliance history and complaint investigations do not collect timely, consistent, and complete information. Having full and accurate information on a nursing home's compliance and enforcement history, including the results of complaint

investigations, would improve HCFA's ability to identify nursing homes in need of further enforcement sanctions. Further information system weaknesses pertain to the inability to centrally track enforcement actions or to identify nursing homes under common ownership.

CONCLUSIONS AND RECOMMENDATIONS

As Congress, HCFA, and the states seek to better assure adequate quality of care for nursing home residents, our work has demonstrated that key components of complaint investigations and enforcement actions need to be strengthened to better protect the growing number of elderly and disabled Americans who rely on nursing homes for their care – one of the nation's most vulnerable populations. Absent such improvements, many federal and states' policies and practices continue to result in serious complaints that allege harm to residents not being investigated for weeks or months. In addition, HCFA's ineffective use of common enforcement sanctions, such as fines, denial of payments, and termination, leads to nursing homes temporarily correcting deficiencies that recur all too often.

Our reports contain several specific recommendations to HCFA. The Administrator has already concurred and has started taking steps to act on them. Broadly, these recommendations call for HCFA to:

- Develop additional standards for the prompt investigation of serious complaints and strengthen its oversight of state complaint investigations;
- Improve the effectiveness of enforcement actions, including reducing the backlog of appeals of civil monetary penalties, and strengthen policies regarding terminated homes such as requiring reasonable assurance periods of sufficient duration and maintaining the home's pre-termination history.
- Develop better management information systems to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other members of the Committee may have.

(101813)

The CHAIRMAN. Thank both of you for your outstanding report and your outstanding work that is being released here today. I will start with Mr. Grob. Your presentation indicates that serious nursing home quality of care deficiencies have been increasing. How many years have these trends been in evidence?

Mr. GROB. The data we saw was for the four last surveys for Survey and Certification data and for the ombudsman reports go back to 1989.

The CHAIRMAN. OK. If the quality of care is deteriorating, do your studies indicate whether this is happening in the entire universe of nursing homes?

Mr. GROB. It is a combination. There are some nursing homes that have much more serious problems, but the serious problems extend beyond just the repeat performers. Let me try to give an indication of that. In the individual top ten survey deficiencies that we show in our report, they range between ten and 16 percent of nursing homes that had problems with any single one of those or with each one.

If you were to try to compute, well, how many had a problem with at least with one of those, it would be considerably more than that, perhaps as many as a quarter or so. However, 6 percent of our nursing homes had the same serious deficiencies 4 years in a row, the same deficiency. And 10 percent of our nursing homes had problems with all top ten of the deficiencies that we cited.

The CHAIRMAN. Yes. We have some very good apples in nursing homes.

Mr. GROB. Yes.

The CHAIRMAN. And we have some very rotten applies.

Mr. GROB. Yes.

The CHAIRMAN. I Think that is what you want to tell us.

Mr. GROB. Exactly.

The CHAIRMAN. And these bad apples are not an indictment of all the good nursing homes.

Mr. GROB. That is absolutely right.

The CHAIRMAN. But there are a few rotten apples that are giving everybody else a bad reputation?

Mr. GROB. There are some that are really rotten and there are a lot of them that are really good and there are some other ones I would not buy.

The CHAIRMAN. OK. In light of—again, Mr. Grob—in light of this worsening quality of care situation and along the lines we just demonstrated, would it be reasonable to draw from the data that some nursing homes are not improving the quality of care and that the systems and remedies that we have in place to bring homes into compliance with quality standards are not working as intended?

Mr. GROB. Absolutely.

The CHAIRMAN. Will the HCFA initiatives from last July have a positive effect on these systems and remedies that are not working and before you answer that, have you seen any indications of such positive effect in light of the activities HCFA has commenced since July? And I did hear what Dr. Scanlon just said about HCFA and I feel encouraged by what he said. Go ahead.

Mr. GROB: I do agree. I think that HCFA is to be commended for their response to the work of this committee and the earlier GAO reports. I found their responses, first of all, to match the findings that we and the General Accounting Office have come up with. I think their responses are quite specific. They are public. There is a commitment to it, and I detect a lot of energy in their preparing their action plan. In terms of any results, I would say it is too soon to tell and I can tell you that we do intend to stay on the case for a long time, hoping to contribute in some ways to bring the quality of care in the nursing homes up to where it should be.

The CHAIRMAN. OK. Also to you, Mr. Grob, according to your report from January 1997 to July 1998, OSCAR data reported 4,707 nursing home resident abuse complaints in the ten States that you reviewed. Of these complaints, 1,569 were substantiated. According to your report, no action, plans of correction, or other remedies were applied to 1,412. That would be 90 percent of these substantiated complaints. Does this mean that there was no action at all?

Mr. GROB. For the complaints for which we said there was no action, there was no action on those substantiated complaints. Now for complaints that were not substantiated, it does not mean that there was not a problem. It could be that the complaint did not have merit, but it could also be that the investigators simply did not have the opportunity to tell whether there was any merit to the case, perhaps because they were delayed in reaching the nursing home.

The CHAIRMAN. Would some resolution of these complaints have been effected without the imposition of citation or some other action that was not recorded in the OSCAR data?

Mr. GROB. Yes. In fact, this is a good opportunity for me to talk just briefly about the complaint system to tell you that it is rather complicated and there are both good and bad effects of the phenomena that there is more than one way to make a complaint. A person can contact the Survey and Certification office in the State, could call the ombudsman in their area, could call the local police, for example, and there are other places that could be called, and these complaints are handled in a variety of different ways.

The strength is that there are several venues for people to register a complaint. The disadvantage is that you are not really sure what happens to them after they are registered. So it is true that some complaints can be resolved, for example, by the ombudsman. However, I need to tell you this. If the complaint ends up with the State Survey and Certification Agency and it records it, then it is required to follow up and take action on that complaint.

The CHAIRMAN. OK. Now, in my State of Iowa, the ombudsman's office often addresses and resolves problems onsite and as a result it is not necessary to impose a remedy as an example, and that is what you were saying.

Mr. GROB. Yes.

The CHAIRMAN. Does that fact in any way distort the statistics we are basing some of our decisions on?

Mr. GROB. I think, first of all, in our reports and I think this is true for the reports of the General Accounting Office as well, the statistics are quite clear in relating them to the survey and certifi-

cation complaints so that the comparisons that are being made are quite accurate in that regard to the extent that they are recorded.

Now, in our report, we also talk about complaints that come into the ombudsman office, and you are absolutely right, that in that case many of those complaints can be addressed through the good offices of the ombudsman who is familiar with the nursing home. So you can look at it two ways. On the positive side, there is another way to solve the problem. On the negative side, it is another indication that there are more complaints to deal with.

The CHAIRMAN. Yes. Senator Breaux, and then I will complete my questioning on the second round.

Senator BREAUX. Thank you very much for both of your work on this. Before I ask some specific questions, how certain can you be that this snapshot approach that you all have taken because you have looked at about what—13, 14 States, I guess—how certain can we be that this is consistent with the rest of the country or did you just happen to pick out the 14 worst States or, heaven forbid, that this was the 14 best States? I mean how typical is what you are reporting to Congress over the rest of the country?

Dr. SCANLON. We did not select the sample of States to try and be representative of the full country. What we did try to do was to select a range in terms of practices that States used in trying to assure quality and to try and include different regions of the country so there were different HCFA regional offices involved, since they play an important role in this process, so that we could understand what impact those practices might have. The conclusion that we take from this is that there is a significant enough problem in enough States that we as the Federal Government should be concerned about this.

Second——

Senator BREAUX. Do you agree with that, Mr. Grob?

Mr. GROB. I would go further. We picked the ten States because they were the largest ones. We also picked only ten so that we could do a complete study of all ten of those. So we bring not only one source of data, not just the survey and certification data, but the ombudsman data. We also looked at our own exclusions of people from programs. We looked at other forms of complaint data and we interviewed people from the survey and certification offices, from the ombudsmen's offices, who were inside the nursing homes and could see and tell us what was happening there.

So we tried to get a cross-section of data from every source that we could get to make sure that we were getting the consistent story, and when we did the ten largest States so that we could get this full picture, whenever we could compare that data to national data through the computers, we did so. And every time we did we found that what was happening in those ten largest States was largely happening in the Nation as a whole. So I am pretty comfortable in saying that what we have done here is describe something that is pretty much across the country.

Senator BREAUX. All right. Let me ask you some more specific concerns that have been expressed at least by the Louisiana Nursing Home Association. I have a letter from them that said that the inspection process is broken. It needs to be fixed. We need to work together to create a system that measures quality of care and qual-

ity of life and makes another suggestion, but they have some specific complaints about the reports and I would like you to comment on them.

They say that the administration and this committee, the Senate Aging Committee, are working from a report which premises and conclusions are flawed. These conclusions hinged on alleged severe, level G or greater, deficiencies, and poor performing change. And then they give some examples. And this is what I want you to comment on. For example, for instance, the report says—I hate those lights. I want to shoot them out.

The CHAIRMAN. OK. We have got time.

Senator BREAUX. Only got two of us.

The CHAIRMAN. We can ignore it.

Senator BREAUX. We can ignore all these other members that want to talk?

The CHAIRMAN. Yeah. Go ahead. [Laughter.]

Senator BREAUX. OK. For instance, the report says that if a facility cancels an activity such as a painting class, the facility has committed a severe violation. Another example, the government has changed the definition of a severe deficiency to include isolated events that are unfortunate but not a sign of severe problems, things like a nurse's aide's failure to knock before entering a patient's room. Another example of policy they point out that threatens quality according to the government is when regulators threaten to decertify a facility for a technical violation during Hurricane Georges, which hit down in my area. They said chief among the violations that the government regulator cited for what they call actual harm was that no morning newspaper was delivered to a patient. That does not sound like real severe problems to me. I mean are these some of the things that actually appear in one of your reports?

Dr. SCANLON. They do not appear in our report. In fact, if they are examples of G violations, which are violations that involve actual harm to a resident or a small group of residents, they are in our mind, inappropriately cited at that level. Now we have heard these types of complaints from the industry and examples such as those as well as others and they often have said that this is what the inspector cited. One of the things that we know about the process is that the inspector citations are not always upheld when the inspection is turned over to the State licensing and certification agency and then reviewed after appeal by the home.

The data that we are using are the data that come after those appeals are completed so that a violation of this type might be reduced from actual harm to the potential for harm.

Senator BREAUX. Do any of your investigations focus on these type of allegations, Mr. Grob?

Dr. SCANLON. Our investigations have primarily focused on a different type of allegation which is the quality of care allegation as opposed to the quality of life deficiencies which I think most of the ones that you have indicated would fall into the quality of life category. HCFA has tabulated for the committee information on the number of violations in the G category that fall into these different groups. About 7 percent fall into the quality of life category and

about two-thirds to three-quarters fall into the quality of care category.

The kinds of things that we are talking about and have in our reports are serious care problems in terms of pressure sores, poor nutrition, et cetera, can be G category violations. Those are the ones that we are concerned about. We think there is a sufficient volume of those that there is a need for a response. We would not want to effect a response over some of the issues that you just identified.

Senator BREAUX. Mr. Grob.

Mr. GROB. We were even more specific. There are 185 separate types of deficiencies in the Survey and Certification system. And they are divided into subcategories. Three of the subcategories are called "substandard quality of care" deficiencies and they relate to: resident behavior and facility practices such as the use of restraints, abuse and staff treatment; and quality of life matters such as related to residents having freedom to make decisions for themselves and accommodating their special needs; and then a third, quality, of which there are 25, called "quality of care" deficiencies. These 25 are the ones that we were most interested in, and it was 13 of those 25 very serious quality of care deficiencies related to medical care that we found increasing. These related to pressure sores, accident hazards, the dignity of the patient, housekeeping and maintenance, care necessary for the highest practical well being, freedom from restraints, accommodating needs, drug regimens, freedom from unnecessary drugs, treatment of incontinence, and proper care for people who need special help with activities of daily living. These do not at all sound like the kind of things that——

Senator BREAUX. So what do I say when I respond to this letter? That this is not—what do I say? If you had gotten this letter being the inspector for GAO and an inspector for HHS and you got this kind of letter, what is wrong with it?

Mr. GROB. I would say that we understand that there are times when people who are trying to do a good job running a nursing home might find themselves bothered by what they regard as an unfair finding. But I do need to say that we were extraordinarily careful in this regard. We did not want to come and present to you any matters that you would then find were trivial or were unimportant. We tried our darnedest.

Senator BREAUX. So your report is not based on these type of examples that I gave you?

Mr. GROB. Not at all. Not at all.

Senator BREAUX. OK. Final question. They point out to me that presently the government has quote "a no collaboration" policy. And as an obstacle to ongoing improvements in quality, this policy prohibits nursing home inspectors from supplying information that could help solve problems. What do they mean by that? Is there any truth to that and if so what can we do about it?

Dr. SCANLON. During the course of surveys today there is much less information provided by surveyors to homes in accord with the notion that these are meant to be independent assessments of a facility's care and operations. In the past, there was a more active involvement in terms of providing what you might call technical as-

sistance to the facility. The feeling is that these facilities should be very strong entities capable of delivering care and that we do need an independent assessment.

There is always a fear that when someone does an assessment if one is actively engaged or collaborating with the person or the body being assessed, that it is going to influence your assessment. So that is why this policy has been put into place. Recognize it is a change from the practices of the past. We may need to find ways in order to provide the type of technical assistance that the facilities are talking about, but we also need an independent assessment.

Senator BREAUX. What we are saying is that inspectors do not share what they found deficient with the people they are inspecting?

Dr. SCANLON. No, they share what they find is deficient. They may not suggest practices to remove the deficiency, which is what the facilities are complaining about.

Senator BREAUX. OK. I have some additional questions later.

The CHAIRMAN. Oh, no. Go ahead.

Senator BREAUX. No, we will alternate. I get tired of hearing myself.

The CHAIRMAN. OK. Following up a little bit where Senator Breaux left off, Mr. Scanlon, I would like you to address a matter that is currently causing some concern among nursing home administrators and the community. These are issues that they bring to us, which are legitimate to bring their concerns to us just as well as advocates for patients bring their concerns to us about nursing homes. And this is in regard to HCFA's plan to use G level deficiencies on two consecutive surveys as a criteria to trigger stiffer sanctions on any nursing facility.

Many nursing home administrators have written to me to complain that the G level deficiencies are often not particularly serious in their judgment and that it is very easy to incur them. It has been alleged in a recent press release by the American Health Care Association that they include things like canceling a painting class. So the administrators argue that this policy runs the risk of lumping good facilities that have only isolated problems in with the real problem facilities. Now I am not justifying the cancellation of that painting class. I do not know whether that is real. I am just telling you what was written to me. Can you start by defining for us what a G-level deficiency is?

Dr. SCANLON. HCFA classifies facilities along two dimensions: the scope and the severity of the deficiency. In terms of the severity, a G level deficiency is one in which there is actual harm caused to residents. It is harm less serious than harm that is either life threatening or causes death, but it is still not considered minor harm. And furthermore, the G deficiency is defined in terms of scope by having occurred to a limited number of residents. It is not necessarily a single resident. It could be four or five or six residents that are affected by this. This is where these two, the scope and severity, define the G violation.

The CHAIRMAN. OK. Now looking at the charts, I guess both right and left, one list—what I understand would be substantiated G level deficiencies from your report. The other list, what I am told

are also G level deficiencies which do not appear as consequential. Now which chart—over here—yes, that is what I thought. This last list comes to us from one of the multi-facility nursing home companies and I want to come back to them after you finish your comments about these issues.

Dr. SCANLON. In terms of looking at these two charts, and I did have the opportunity to see them in the other room, I would note that in the chart that is on the left that is provided by the Manor Care chain, it is often referred to as what the surveyor found. In the process of the determination of the actual level of offense, there is a process by which States will review surveyor's findings. There are often changes made to those findings, most typically downgrading them from one level to a lower level.

Second, this is something we have not investigated for you, but we will be happy to pursue, it is important that we do have a good boundary between what we regard as a serious G level violation and something that would not rise in the minds of reasonable people to the level of severity that we would want to call this a poor performing facility.

The disturbing thing that we have found in terms of looking at G level information in the data that are available is that it is too easy to find things that we not only actual harm, we would think of them potentially as worse than actual harm within that G level category. Those are the things that we are trying to focus on. We are trying to encourage HCFA to get into place a system that will deal with these serious violations. We have encouraged them simultaneously to make sure they are not wasting resources pursuing things that are not as serious as these.

The CHAIRMAN. OK. Read one that is more serious and one that is less serious so that everybody has an understanding of what falls into the categories.

Dr. SCANLON. I will read the first one off of each chart so as not to be suggesting that I am skewing this in any way. In terms of the more serious chart, the resident had caked feces all over his body, dried blood under his fingernails and on his hand, and pressure sores all over the body. A member of the ambulance team that transported the resident to the hospital questioned whether the home properly cared for the resident. This was found to be actual harm in an isolated instance.

The first example from the Manor Care list is that a resident arrived at the hospital with a 6.5 centimeter blister on the right heel. The nurse erred in documenting the ulcer as 6.5 inches. Once the error was discovered, the facility remeasured the wound and found the size to be the same. This was cited as an isolated instance of actual harm.

The CHAIRMAN. Is it fair to conclude that your analysis shows that the G level deficiencies tend to be more serious kinds listed on the excerpt from the table in your report rather that what appears to be less serious kind?

Dr. SCANLON. We were confident that in selecting the examples for the report that these were more typical of the findings of the G level deficiencies that were identified. Furthermore, in our report on complaints, what we did was we printed all of the complaints that apply to the facilities with three or more complaints that had

not been investigated so that there was no selection on our part and we allow the reader to judge whether or not those complaints rise to the level in which you would have hoped that an investigation of that facility had been done.

The CHAIRMAN. OK. But does it also imply that the deficiencies used to trigger more severe and immediate sanctions should be more tightly focused than they would be were HCFA to continue using the two consecutive G level deficiencies as is currently under consideration?

Dr. SCANLON. We think that that trigger should be very tightly focused, but we are sort of leery of making this kind of simple comparison because we do not know if these ultimately end up as G level violations. And it is also possible for a facility to have multiple G level violations on a single survey and that is not going to be counted as a double G in the parlance of this trigger. That would be counted as having a G violation in a survey. But if you had several of them in different areas, there may be one or more that would rise to the level that again we reasonably find to be severe enough that you would want the trigger to apply to that facility.

The CHAIRMAN. Yes. Your testimony, Mr. Grob, states that the inadequate staffing in nursing homes may be a cause of the quality of care problems that we reportedly see. What incentives in the system could be causing nursing home administrators to understaff and just why understaff?

Mr. GROB. It is really hard to tell. It was almost universal from everyone we talked to and the data we looked at that there seemed to be a problem with the staffing in the nursing homes. It was an opinion rendered by the people that we interviewed, and if you look at the ombudsmen complaints you see that some of the major complaints are due to that having inadequate staffing levels.

I gave some thought to what is involved here. There are different things that one could consider. A person running a nursing home would have adequate staff if their mind were really set on ensuring the quality of care. That is something that motivates many, many people in the business. An opposite incentive could be the desire to have larger profits and reduce expenses. In the middle, though, there are administrative steps. For example, right now, there are no standards or ratios for what kind of staffing should be in a nursing home for what kind of patients. There is no consensus or agreement on this and it requires some study.

There are no penalties that are related to the staffing levels as such, only to the ultimate outcome of not having the proper penalties. And finally there are questions that relate to the conditions of work in the nursing homes. There is a very high turnover rate among these staff. The work is hard. People need to be trained often. It is a difficult thing to do. So there would be some concern for those running nursing homes as well to do their best, to make sure that conditions are as good as can be, and that they can help their staff through those conditions.

The CHAIRMAN. It seems to me starting with our hearings last July, and what we have heard since, including some of the things that each of you have found that it is in the very elementary type care, the hands-on care, the nurse's aide type care that I think of—

maybe that term is not quite right, nurse's aide, but at least not the registered nurse and not the administrators and the other people—where we have problems because getting enough water into a patient's body so they do not dehydrate, enough food, not that the food might not be good, because it probably is good, but getting it into the body, so to stop malnutrition. And just the simple things of turning people adequately.

Dr. SCANLON. I think one of the very striking things about the things that we found is that one does not need to have clinical training to know that this is not appropriate care for these individuals. One wonders about the need for consultants when you are talking about issues of keeping someone clean, keeping someone dry, giving someone adequate nutrition and water. These are so basic that that is what has been startling about the work that we have been doing.

Mr. GROB. If I could comment as well, we drew our conclusion about the staffing on three things. One is that the insiders told us that this was a problem. Second, when people complained to their ombudsman, that is what they complained about, and you heard that in the earlier testimony. And the third thing is that the conditions are the kind of things that are related to the hands-on care that you were talking about, and I think it is worthwhile noting that if you are in a nursing home, the person that will be rendering care to you, the person that you will be dealing with, is not the administrator, it is that person who is in your room giving you care. That is why it is important.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. I think that some day we ought to have a hearing on things that are good that are happening. A lot of times we complain about the evening news, that the evening news is always about bad things, and there is never any good news. It seems like most of our hearings always focus in on the bad things that are happening in society. And I understand the necessity for that because we are trying to correct those problems.

But it would seem sometimes encouraging to let the American public also know that good things are happening. There are literally thousands of skilled nursing facilities that are out there that every day 24 hours a day provide the attention, the love, and the affection for the patients who are there that many times they do not even get from family members, and that we do not have hearings on.

I am not being critical of the chairman. I think that you could probably cite every committee in Congress, whatever jurisdiction we have, it is always dealing with a problem area and something that is not working. And would you agree? I mean there is another side of this coin. I mean everyday, 24 hours a day, in some very difficult situations, nursing homes many times provide the type of quality care that is lacking even in our own homes dealing with our own parents.

Mr. GROB. I could cite something very specific here. The very first words that appear in our very first finding are that overall the deficiencies are declining. It was some deficiencies, albeit the more serious ones, that were on the increase, and it was on a smaller

number of nursing homes that that was happening. But overall the citation of deficiencies was declining.

We have also seen other work that indicates some progress being made, for example, in eliminating the improper use of restraints; and although it is not anywhere near perfect, there seems to be some improvement of the review of drug use. And finally OBRA 1987 does exist and it does provide a pretty good framework for what ought to happen. So at least there is a map to follow. So there are some good things that have been happening, too.

Senator BREAUX. Dr. Scanlon.

Dr. SCANLON. We concur. While we have been trying to focus on how to improve the survey and certification system to deal with, as Senator Grassley has indicated, the bad apples, we have been trying to focus on that small subset of truly bad apples, the people that have repeat serious deficiencies, and we looked at two surveys and came up with a number of 9 percent. Mr. Grob used four and came up with a number closer to 5 percent. We do not give enough credit to the fact that 90 percent did not fall into our category and 95 percent did not fall into Mr. Grob's category.

We know, therefore, that someone has managed to find a way to provide better care than the type of care that we are saying is unacceptable here today and, therefore, we need to be able to move this 5 percent or this 9 percent in the direction of this better care. There is no question about that and we should never lose sight of that.

Senator BREAUX. Now you two probably know as much about the deficiencies in this area as any two human beings in the United States. Would either of you decline or refuse to recommend the use of a skilled nursing facility for either a member of your family or a parent or a close member of your family knowing what you know?

Dr. SCANLON. Knowing that there are circumstances under which the use of a nursing home is absolutely essential, the answer is no. At the same time, and this is both personal experience of family as well as from friends, a real effort to try and identify which homes are known to provide better care is an essential portion of using a nursing home.

The CHAIRMAN. Know what you buy.

Dr. SCANLON. Knowing what you are buying.

Senator BREAUX. Mr. Grob.

Mr. GROB. I would say the same thing and I would urge that the last two witnesses gave good advice that people should listen to, which is to go and see for yourself. Visit, talk, ask people who are there. I think that people need to know what is happening not in nursing homes in general but what is happening in nursing homes in particular, in the one that they want to go. And if there is anything that the government can do at any level, Federal, state, local, whatever, to help the beneficiaries figure that out, then I think it should be done for them.

Senator BREAUX. Let me ask one final substantive question. We have talked about this before and we do not inspect hospitals like this; do we? We do not use the inspecting system to inspect hospitals?

Dr. SCANLON. No.

Mr. GROB. We basically do have survey and certification system for some hospitals, but we rely mostly on the accreditation of the Joint Commission on Accreditation of Health Care Organizations.

Senator BREAUX. Could not that type of system and if not, why not, be implemented for the skilled nursing facilities in the country of which there are thousands? There are some who would argue that the government certified private inspectors could provide more inspectors and therefore a better quality of inspection if it was done like we do it for the nation's hospitals. Do you have any comment on that?

Dr. SCANLON. I believe that the situation is really very different because of the nature of hospital care versus the nature of nursing home care. In the hospital in addition to having the Joint Commission or other accreditation bodies looking at the hospital, there is tremendous involvement on the part of the physicians who are on staff in that hospital. They really perform an incredible quality assurance role in that they know they are practicing in that institution and that their own liability is a function of how well that institution performs. And so therefore they are always keeping the facility honest as well.

The same thing is not true in nursing homes. We have much too little physician involvement in the care of nursing home patients and therefore we feel that there is a stronger need to have a body that will be an effective overseer. Now the issue that has come up in the past in thinking about whether that overseer should be some private body or a public body is that we have not reached the point where we can stop worrying about the issue of enforcement. And the private bodies, the Joint Commissions, et cetera, do not have any sanction authority available to them other than withholding their accreditation.

Senator BREAUX. Well, that is a pretty big sanction.

Dr. SCANLON. Well——

Senator BREAUX. If you are not accredited, you are not going to participate in Medicare. I mean what kind of hammer is that?

Dr. SCANLON. But that is a hammer of last resort. And that is one of the things we are finding trouble with using them today. When we talk about cutting off admissions or terminating a facility from the program, we often find that that is going to have an unacceptable price for the residents of the facility and therefore we stop short. We would have that same dilemma if we were to have a private body doing this as well.

Senator BREAUX. You mentioned the fact that the hospitals have doctors. Do not doctors make routine calls on nursing home patients that are under their care?

Dr. SCANLON. Not with the frequency that is probably needed in order to have a really strong quality assurance presence.

Senator BREAUX. Mr. Grob, what about the concept of doing it like we do for hospitals?

Mr. GROB. To be honest with you, I am a little reluctant to embrace that as a substitute at this point. I do believe that the circumstance in a hospital is much more open. I think there are more people coming and going. There is a lot more going on there. A lot of people who are involved in all kinds of aspects of the quality of care. It is not just the facility, but it is the kind of medical care

that you receive there. There is just a lot more that is going on there.

There is another thing, too, that I think is important, which is that the care in the hospitals and the care that physicians render have evolved over very, very many years, and there is a very long tradition that goes back into the approval of the care in those facilities. In the nursing home situation, we found some very serious problems that preceded the enactment of the OBRA 1987 reforms. They were quite serious and the reforms, I think, tried to identify what those are and provide a structure that could deal with them.

I would think that the conditions that were in the nursing homes prior to OBRA 1987 did not in any way correspond in terms of quality to the conditions that were in the hospitals at that time. So I really think that there is a way to come yet before you could use exclusively an accreditation system instead of a survey and certification system. Perhaps in the future some combination of the two might be very helpful.

Senator BREAUX. All right. Final question is, suppose somebody just says, look, I mean we are hearing all these complaints from the inspections the way they are being done now. And this is a program that has billions of dollars of Federal tax dollars paying for the care of patients and nursing homes. In my own State of Louisiana, it is probably 70 percent federally funded, 30 percent state match. So let us just tell the States you are not going to have to do it anymore or at least that you will have 70 percent Federal inspections and 30 percent state inspectors or the inspectors would relate to the match between the Federal contribution and the state contribution. So there would be a Federal involvement here directly.

If a State is a 50/50 Medicare/Medicaid, half the inspectors would be paid for by the State, half by the Federal Government. In my State, it would be 70 percent Federal inspectors paid by the Federal Government and 30 percent by the State, to try and get more help financially to get this done. I mean does that make any sense at all or is that off the wall?

Dr. SCANLON. Well, there already is a considerable Federal financing of this. In fact, for complaint investigations, 70 percent of the money is coming from the Federal Government. That, in fact, is one of our concerns. In financing the majority of this licensing and certification activity, the Federal requirements or standards for this activity have been very, very minimal. I do not think we necessarily want to substitute Federal employees for state employees, but we would certainly like to provide some minimum guidance to assure that these are adequate surveys and then allow states to go beyond that at their choice.

Senator BREAUX. Do we need any more laws? Do we need to clarify the current set of rules and regulations? I mean should Congress, should Senator Grassley introduce a bill tomorrow to help fix this problem or is it bigger than that?

Dr. SCANLON. At this stage, we have not identified the need for any legislation to try and correct this. What we have identified is a number of steps in the process of implementation of OBRA 1987 that HCFA has embraced. We are looking at other portions of this process. We anticipate that we may find other aspects that could

be modified that will improve the process as well. At this point, though, none of those have been legislative fixes.

Senator BREAUX. Well, I thank both of you for your help and assistance, your involvement. I mean this is a very important issue. I mean the fact that Senator Grassley is having these hearings and we have done it before last year and will continue to try and monitor what is happening out there, and your help and assistance is invaluable, and we appreciate it very much. Mr. Grob, how did you manage to get up here? I mean you are Department of Health and Human Services.

Mr. GROB. Oh, I am with the Inspector General's office, sir.

Senator BREAUX. Snuck in on a side door?

Mr. GROB. Well, we speak our minds whenever we need to.

Senator BREAUX. Could not stop you?

Mr. GROB. Yes.

Senator BREAUX. Congratulations.

Mr. GROB. Thank you. [Laughter.]

The CHAIRMAN. Maybe just following up a little bit where Senator Breaux left off. First of all, in regard to Federal enforcement and Federal regulations and Federal law versus any other approach including an accrediting commission, I think it is important to remember that it has just been 3 years since the Federal enforcement regulation has been written and that was 8 years after the law was passed. So I do not know whether we have enough time to determine whether or not the present process is the right process. I think we better enforce existing laws and get that carried out before we draw a conclusion that something else is better.

And as I recall, the president's 900 page HCFA page was kind of a self-indictment of its own enforcement efforts. The president raised a lot of questions about the joint commission's recommendations as to both their methodology and their approach, whether or not that would be the right—am I right on that in their recommendations? Did they not raise questions about the joint commission's recommendations?

Mr. GROB. The report that HCFA submitted in response to the congressional request that there be a study on that drew the conclusion that the survey and certification approach, at least for now, is certainly by far the best one today.

The CHAIRMAN. Yes. Now when it comes to good news versus the bad news, I would say that if this represents the good news and this represents the bad news—maybe I better hold it this way——

Senator BREAUX. Is that an Iowa apple?

The CHAIRMAN. Well, I do not know what State they came from, but the point that I want to make is if these are on a scale——

Senator BREAUX. Maybe Denmark.

The CHAIRMAN [continuing]. I think without a doubt the good apples outweigh the bad apples numerically.

Mr. GROB. Yes.

The CHAIRMAN. But if you look at good news, good news versus bad news, you have the bad news, the minority, outweighing the good news tremendously because there are some very serious problems out there. And I think that our first two witnesses made that very clear. And your work of a year and a half has made that very clear, and your work, Mr. Grob, substantiates that as well. And so

I think what we are trying to do is not just rely upon just government regulation and government enforcement at the Federal level to make sure that all of these problems corrected.

To some extent, as was indicated by the industry at their July participation in our hearing, they admitted that there are tremendous problems, and they were not going to disagree with what had been found in California and that it had to be corrected. And I got a clear message from the industry that they were going to be part of helping us take care of the bad apples. And I look forward to that much more than I look forward to government regulation doing it and to the benefit of everybody.

Mr. Grob, if I could follow up on something at last July's hearing, we had witnesses testify about the weaknesses that characterize the OSCAR data base, particularly in regard to information it captures.

Mr. GROB. Yes.

The CHAIRMAN. Your report states that quote "while generally satisfied with OSCAR data, more than half of state directors and surveyors believe that it, meaning OSCAR, is not a true indicator of nursing home quality of care since it only portrays the situations of the nursing home at the time surveyors are physically conducting the survey." Do you agree with that assessment? Is OSCAR data giving us an accurate picture of nursing home quality? And would you comment on this—I would like to have Dr. Scanlon also comment on this.

Mr. GROB. Yes, there are shortcomings in the data. I do not think it describes it precisely. I think it describes it generally and I think we have to accept the fact that it is not completely accurate. Now with that in mind, what we tried to do was to see what it would look like no matter how we looked at it, because all data systems are flawed and these certainly are.

So what we tried to do is to compensate for that by approaching it from several different angles. So we looked at the survey and cert data, we looked at the ombudsman data. We interviewed people who actually go inside the nursing homes—the ombudsmen, the survey and certification staff—and we asked them what they thought. We looked at the complaints that we were receiving. We looked at the people that we were excluding. All of these analyses told more or less the same story despite the reservations.

I think what they were saying is, do not rely on this data set alone. So we did not. We did not rely on one data set alone. And I think the General Accounting Office brought lots of examples, and as Dr. Scanlon said let them speak for themselves. These were the complaints. They are described here. People can see for themselves what we are talking about here. So I do believe that there are significant imprecisions in the data, but overall I believe the story is correct.

The CHAIRMAN. Yes. In your report you identified 463 homes that have been cited with the same deficiencies over the last four surveys. You identified these homes using OSCAR data. How does that impact on your report? And I wanted to ask you that before Dr. Scanlon responded.

Mr. GROB. Right. Again, I would say that as long as we all understand that you cannot accept something just on one data source,

then I think we can say that these repeat deficiencies that we are seeing here are an indication of a serious problem. Is it possible that the percentage of repeat deficiencies, four surveys in a row, with the same serious deficiency 4 years in a row, could be a higher or a lower percentage than we found if the data were absolutely precise? Yes. That is possible.

But certainly we see here a not insubstantial number of nursing homes that 4 years in a row are having the same serious problem. So I think it still indicates a serious problem.

The CHAIRMAN. Dr. Scanlon.

Dr. SCANLON. We agree that the information in OSCAR from the complaint process are not going to give us a precise measure of the quality of care in nursing homes. But they do give us a strong indicator that we have enough of a problem with quality of care in some nursing homes that we need to look to see whether the system is in place that is going to try to correct and prevent these problems.

This is how we have approached the use of the OSCAR data, how we have approached the information that we have gotten out of the complaint systems, recognizing if anything the potential biases are in direction of understatement rather than overstatement. As we told you last July, surveyors have a difficult time even on that day that they are in the facility and the day the OSCAR data are generated in detecting all the care problems that may exist in a facility. So given that, I think we need to take the OSCAR data and use it cautiously. But we have seen from the OSCAR data as well as other sources that there is a sufficient enough problem that we need to act.

The CHAIRMAN. All right. Dr. Scanlon, several sections of your report are dedicated to illustrating the various state policies and guidelines regarding allowable timeframes for investigating complaints of a serious nature. The implication is that this wide variance among States is a result largely of HCFA's minimal guidance and oversight of state complaint practices. Will HCFA's new policy that was announced last week at the news conference by the administrator improve the promptness of the response to serious complaints?

Dr. SCANLON. We think it will. The policy in the past of only having the one criterion which was that if a complaint involved immediate jeopardy to residents that it be investigated within 2 days and no standard for any other complaint was obviously inadequate. The new requirement that there be at least one more category for any claim or complaint that involves actual harm to be investigated within 10 days is an improvement over that prior system.

The key here, though, is going to be two things. One is that States are effective in terms of their classification of complaints so that all potential actual harm complaints are categorized as such, and then that the target for the investigation is 10 days. Second, it is going to be key that these investigations do get carried out within 10 days. We have seen in both instances a failure to adequately classify complaints and then a failure to meet the deadlines that are imposed even by the State themselves.

The CHAIRMAN. I have got so many more questions and the time is running a little bit late. I wonder—I am going to submit some

questions to each of you for answering in writing. I want to thank you for participating in today's hearing and I would ask you to respond if you can in a couple of a weeks.

I also was wondering is there somebody here from HCFA? Nobody is here from HCFA? If you are, I would like to have them come up here and answer some questions for me. [Laughter.]

OK. Well, since nobody is here from HCFA, I would like to summarize that it is quite obvious to everybody that we have heard some disturbing testimony this afternoon. And I want to thank each of our witnesses, especially the first panel, as it was very difficult for them to come and testify, to revisit situations that bring about very painful memories. We owe a debt of gratitude to each of them for their moving and impassioned testimony. We learned a great deal today.

First, complaints must be responded to quickly and effectively. Family members who file complaints deserve a timely response from the State. Furthermore, these complaints deserve a very thorough investigation. Second, enforcement must be applied consistently so that similar problems are identified and corrected in the same way and only HCFA can put rules in place to ensure this. And the reason for this is clear: residents deserve the same quality of care wherever they may stay. Poor performing nursing homes should not appear to be high quality facilities because enforcement is irregular and I think that that happens fairly regularly. Similarly, high performing homes should not be suspect because the enforcement system is inconsistent.

And third, punishment for violations must be applied swiftly and evenly so that violators are punished and standards are maintained. Again, one standard should be fairly applied across the board. Punishment where justified should sting and be swiftly applied so that it is an effective deterrent. In addition, the backlog of more than 700 cases before the appeal board is really an absurd situation. The guilty obviously evade punishment. Wrongly accused parties will have a cloud over their head and families will not have a timely and accurate picture of the quality of nursing home care.

Finally, the public must have ready access to timely and consistent information on nursing homes so that they can make informed decisions about which home to trust when they advocate for a family member. When one has to make a decision whether or not to put a loved one in a nursing home, I think in most cases that is a pretty traumatic one, traumatic not just for the patient but traumatic for the family members to do that as well. With all of the Federal and state dollars that are flowing through Survey and Certification, determining whether a facility has provided good care or has a record of poor service ought to not be a guessing game.

And many good nursing homes do, in fact, exist. We have made that very clear today. In fact, I visited many of these in my State of Iowa. I make a point of visiting many nursing homes every year. Families should be able to see who they are based upon current and consistent information when they have a bad nursing home so that they can then select good nursing homes.

Before I adjourn this hearing, I want to thank the GAO for all the time and energy that has gone into this nursing home work for the past 8 months as well as all the time that you and your staff,

Dr. Scanlon, have devoted to this all throughout 1998. I know how much work was dedicated to the report of the General Accounting Office, particularly the one that you made to the committee last July, and the fact that the General Accounting Office has delivered now two new reports within a week, I think, is extraordinary.

The General Accounting Office has done much to help me and other policymakers in Congress understand the complexities and weaknesses of a system that was designed to oversee and ensure that high quality care can be delivered to our nation's nursing home residents. So I thank Dr. Scanlon and your team that I understand included Kathy Allen, John Dicken, MaryAnn Curran, Chic Walter, Gloria Eldridge, Peter Schmidt, Jack Brennan, and I hope I did not miss anybody. If I did, we will add them to the record.

Dr. SCANLON. OK.

The CHAIRMAN. I also thank Mr. Grob and your team at HHS Inspector General's Office that I understand included Renee Dunn, Demetra Arapakos, Vincent Greiber, Ellen Vinkey, Lucillo Cop, Danielle Fletcher, Daniel Ginsberg, Steve Shaw, Patricia Banta, Leah Bostick, Nancy Juhn, Nancy Watts, Felicia White, and Suan Burbach for their dedicated efforts, and I find most of the work most inspectors general in many departments being what it ought to be. Once in awhile I find one where I think they are too responsive to the bureaucracy that they are a part of and compromise its intent. But I think you have shown today that in your instance, your office has not done this, and because there is very valuable information from the six reports that you released today, that is going to be very helpful to us as a committee as we continue our oversight of HCFA and what they are doing.

I would also want to reiterate that the GAO's recommendations are very solid, they are tough, and they make sense, and despite HCFA's absence here today, I urge the agency to respond appropriately and to heed the General Accounting Office's very good advice, and I request that HCFA add these recommendations to those already included in the monthly reports that are submitted to the committee and that will be read by me and my staff and critiqued and questions followed up, and again I would thank HCFA for their cooperation in that regard.

I thank everybody very much and the hearing is adjourned.

[Whereupon, at 3:32 p.m., the committee was adjourned.]

APPENDIX

RESPONSE TO COMMITTEE QUESTIONS ON COMPLAINTS AND ENFORCEMENT REPORTS FROM GAO

Question. The GAO report includes an in-depth look at the system's weaknesses that stem from weak Federal guidance and oversight. In particular, the report tells us that HCFA does not provide 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. Furthermore, the lack of an effective data collection system gives HCFA little to rely on for oversight purposes. To what extent does HCFA's recent guidance to States regarding complaints address the inadequacies you pointed out?

(A) Will HCFA's new policy announced last week improve the promptness of response to serious complaints?

(B) Will HCFA's new guidance address the understating or downgrading of complaints upon receipt by the State? If not, what can be done to help ensure that complaints are appropriately evaluated so that follow-up activities are appropriately conducted?

Answer. HCFA announced three specific actions that directly respond to GAO's recommendations related to complaint investigations: (1) states must investigate complaints alleging actual harm to a resident within 10 workdays, (2) states must record confirmed violations in HCFA's database that tracks nursing home compliance, and (3) HCFA will develop additional minimum Federal standards for states complaint investigations and identify ways to better oversee states' performance.

These initiatives, while responsive, may not resolve other problems GAO found. Some States' practices may discourage the filing of complaints or result in understating their importance which in turns delays their investigation. Unless these state practices are reformed, HCFA's initiative will have little effect. While HCFA's response should help improve prompt response to serious complaints, ensuring that states meet these timeframes also requires clear criteria on how to categorize allegations that may pose immediate jeopardy or actual harm to residents, and stronger Federal oversight to ensure that states are meeting these requirements.

Question. Once HCFA's new policies regarding the complaint process have been implemented, how will we know if improvements are achieved? In other words, what should Congress look to as a means of monitoring improvements in this area?

Answer. Improved Federal oversight is critical to assess states' progress in improving their complaint investigation practices. HCFA's recently announced initiative includes a complaint improvement project intended to strengthen Federal monitoring of state complaint processes. As yet, the details of this program remain unclear. However, examples of specific performance measures should include (1) additional priority levels for states that do not have them, (2) appropriate assignment of priority levels to complaints, (3) timely investigation within established priority levels, and (4) timely reporting of validated complaints into HCFA's database. As part of HCFA's oversight of state performance and to assess whether changes in state practices have resulted from the new complaint policies, HCFA could either require States to report this data to HCFA or review data currently maintained in state data systems.

Question. The GAO report regarding the complaint investigation process, particularly the table on page 6 of this report, seems to indicate that requiring or encouraging that complaints be submitted in writing leads to substantial under-filing of complaints. The table indicates that the State of Washington, which accepts non-written complaints, has about four times the number of complaints received by one of the other States that you studied, and even more when compared to the third State. Is that presumption correct? Do systems that require written complaints lead to a substantial under-filing of complaints? Furthermore, does that mean that the extent of quality problems in nursing facilities is underestimated?

Answer. Although States may not require complaints to be written, our experience in two of the three States visited shows that written complaints were strongly encouraged. These States prefer written complaints because they provide additional documentation and details that may assist investigating the allegations. However, a State's failure to establish a user-friendly complaint process, such as readily accepting telephone complaints, may discourage some legitimate complaints. Washington's policy of accepting phone complaints without encouraging a written follow-up contributed to a substantially greater number complaints received (336 per 1,000 nursing home beds) relative to Maryland and Michigan (21 and 45 per 1,000 nursing home beds, respectively). The volume of complaints may also be affected by how proactively states publicize their complaint process and the public's perception of how promptly and effectively the state will respond to their concerns. To the extent that potential complaints are not filed and investigated, some quality problems in nursing homes may not be promptly identified.

Question. A recurring Issue in the complaint report, as well as the enforcement report, is the significance of HCFA's weak data systems. Ideally, an up-to-date system would allow surveyors to quickly assess a facility's performance track record, and be equally important for HCFA central and regional staff for oversight purposes. Please elaborate on the problems you identified in the data reporting systems, particularly the disconnect between what States are investigating and reporting as state deficiencies, which perhaps should be recorded in the Federal database, but are not reaching HCFA's system.

Answer. In our 1998 and 1999 reports to the Committee on nursing home quality, we found several important weaknesses in HCFA's data systems. These include:

- The information in HCFA's Online Survey, Certification, and Reporting (OSCAR) system was incomplete and inaccurate because States and HCFA have not consistently entered data into OSCAR. During our work in California last year, we found instances of missing information in 282 of the 1,370 homes in our analysis.
- HCFA does not require States to cite violations of Federal standards if the deficiencies were found during complaint surveys.
- HCFA's OSCAR system does not include all information about Federal and state enforcement actions. HCFA regions and States that we visited maintain and use their own systems to monitor enforcement actions.
- There is a lack of data about homes with common ownership that are having severe compliance problems.

The form HCFA uses for States to report the results of complaint investigations was created for a single complaint but some States use it to report multiple complaints, resulting in inaccurate and incomplete information.

There is a time lag of as much as 6 months in States reporting complaint investigation information into Federal data systems.

Question. What do we know about the level of understanding on the part of families and advocates about the process of filing a formal complaint?

Answer. The three States we visited used a variety of techniques to inform the public of the complaint process, including brochures, posters, and the publication of a toll-free phone number. However, we did not examine their effectiveness in informing consumers of the process for filing a formal complaint.

Question. Did you find other practices that might help consumers when filing complaints, such as hotlines or 1–800 numbers? If so, how effectively did they seem to work?

Answer. Maryland, Michigan, and Washington each have a toll-free "800" phone number that they make available for the concerned public and nursing homes to use in reporting complaints. For example, nursing homes in Maryland are required to display a sign with the 800 number and Michigan distributes a flier telling consumers how to submit complaints, including the 800 number.

Our calls to these 800 numbers indicated that some are less consumer-friendly than others are. The message on the Maryland 800 number indicated that it is for complaints regarding home health with no mention of nursing homes. Also, neither Maryland nor Michigan's 800 phone number is accessible by out-of-state family or friends who may have concerns about a resident's care. In addition, the direct (non-800) phone number that Maryland publicizes was not answered, and did not provide a message, when we called it several times during non-business hours. Finally, as noted in our report, Maryland and Michigan strongly encourage callers to follow-up their calls regarding serious complaints with a letter documenting their problems, which may discourage some complainants.

In contrast, Washington's 800 number is accessible both in and out of state, clearly states that it is for complaints regarding nursing homes and other settings, pro-

vides clear automated menu options, and promises to call the complainant back during business hours to confirm receipt of the complaint.

Question. What are the resource implications at both the state and Federal level regarding the recommendations of this report? In particular, what resource implications are there for a state interested in implementing an effective telephone complaints system? Are there steps that can be taken to make the system better without requiring substantial new resources?

Answer. We did not assess the resource requirements for an effective state complaint process. Nonetheless, our work indicates that states that commit more resources to their complaint process have a more effective system for responding to complaints. In many respects, Washington may be considered a good example for effective complaint investigation practices. Compared to other States we reviewed, Washington received a much higher volume of complaints, conducted more complaint investigations per home, prioritized most complaints within its two highest categories, and was more timely in conducting investigations. But to achieve this system, Washington spent nearly 2½ times the national average on complaint investigations per certified bed in fiscal year 1998. In contrast, Maryland spent less than one-fourth the national average and Michigan spent about 70 percent of the national average in fiscal year 1998. In their comments on a draft of our report, both states highlighted resource constraints as contributing to their problems with complaint investigations.

Some improvements could be realized without substantial additional funding such as improving messages for toll-free phone numbers and clarifying states' proper use of the form used to record information about completed complaint investigations. On the other hand, States that seek to investigate more complaints in a more timely manner—including complying with HCFA's new 10-day requirement for investigating complaints alleging actual harm to residents—win likely require additional resources.

Congress and HCFA have recognized the need for additional funding to improve oversight of nursing home quality in support of HCFA's 1998 initiatives. In fiscal year 1999, Congress appropriated an additional $4 million, and HCFA reallocate another $4 million from other sources, for nursing home survey and certification The Administration has requested a $33 million increase in survey and certification funding for fiscal year 2000.

Question. HCFA has been extremely active implementing the GAO and HCFA initiatives since last July. How would you characterize the agency's efforts—are they pertinent, constructive, well aimed? Are they making improvements to the system, which will ensure that it works better and reduces the incidence of problems?

Answer. HCFA's July 1998 initiatives to improve nursing home quality of care are generally well directed and constructive. Some initiatives, such as reducing the predictability of recertification surveys and requiring onsite revisits for homes with recurring serious deficiencies, have already been implemented or are expected to be implemented shortly. Others, such as reducing the backlog of administrative appeals and redesigning its management information systems, will take HCFA more time to accomplish. We are currently reviewing the progress HCFA is making in implementing all of these the initiatives. We expect this review to be completed in May, and we will report our findings to the Committee at that time.

Question. Some nursing home industry representatives complain that the current enforcement system can't improve the quality of care. Has the enforcement system been used in the way it was designed to be used? In other words, has it really been tried and tested?

In our view, nursing home enforcement system has not yet been fully implemented as intended. The enforcement system's design includes sanctions to encourage homes to correct deficiencies and to maintain compliance to avoid penalties. Until recently, implementation policies and practices have made it too easy for nursing homes to evade penalties if they came into compliance within a few months of a survey, especially those homes with a history of serious and repeat deficiencies. As a result, homes have had little incentive to avoid future deficiencies.

Question. Do you have any evidence which indicates that the quality of care is better when enforcement is more rigorously practiced?

Answer. Data were not available to make such a comparison. First, HCFA has no reliable data system that tracks imposition and disposition of its enforcement cases. Second, because sanctions actually take effect infrequently we were not able to isolate a pattern of rigorous enforcement in our sample cases to separately study. Nevertheless, we believe that providing an incentive for homes to achieve and maintain compliance with quality of care standards to be an appropriate and likely effective goal of HCFA's enforcement system.

Question. The current enforcement system has been criticized as not distinguishing between minor infractions and major problems. The implication of this criticism is that nursing facilities can incur serious penalties for what are minor infractions. Please comment on this criticism.

Answer. HCFA's system for categorizing its deficiencies is designed to make important distinctions between minor infractions and major problems. The distinction is made on the scope of the deficiency (number of residents affected) and the severity of the deficiency (the level of harm actually or potentially affecting residents). In addition, HCFA's scheme for sanctioning deficient nursing homes is geared specifically to the scope and severity of identified deficiencies. HCFA considers deficiencies that have potential for causing only minimal harm to residents to be minor infractions and as such the home to be in substantial compliance. Homes in substantial compliance are not subject to sanctions.

Question. Your report identifies critical areas in HCFA's enforcement that continues to be unresolved. Sanctions can, and should, deter home from violating standards of care. If, as you state, sanctions generally appear to have little success in ensuring that nursing homes maintain compliance with standards, where is the breakdown?

Answer. We found that intermediate sanctions did provide encouragement for homes to correct deficiencies, but that such sanctions did not appear to deter homes from future violations. We believe that this is because nursing homes could often avoid most of the more serious sanctions, such as denial of payments for new admissions, by returning to compliance before the sanction became effective. Similarly, actual payment of an assessed civil monetary penalty could be avoided, diminished—or at least postponed-by appealing it, and thus tying the case up in the long appeals backlog. Thus, homes have little incentive to correct systemic problems that may be the root cause of its repeat non-compliance.

Question. Sanctions without teeth, without imposition, are meaningless. What's blocking sanctions from taking effect?

Answer. We found that HCFA's policy of giving almost all homes-even those which were found to have repeatedly harmed residents-a grace period to correct deficiencies before imposition of a sanction, was the major problem with preventing sanctions from taking effect. HCFA has taken a major step to correct this problem by eliminating the grace period for homes found to have repeatedly harmed residents since the previous recertification survey. Another significant problem is the long backlog of appeals of civil monetary penalties. HCFA has addressed this problem by requesting additional funds for clearing up the backlog for the fiscal year 2000 budget. But even if Congress approves these funds, it will take some time for the additional resources to be put in place and have some effect on reducing the backlog.

Question. The report states that most sanctions achieved corrective action but not continued compliance. How can corrective action be taken by a nursing home yet compliance NOT achieved in the future? How can this be considered "corrective action" if it is ineffective in preventing a recurrence of the problem?

Answer. We used the term "corrective action" as defined by HCFA. That is, the problem has been addressed for the moment. However, we share your skepticism that this should be our objective, and thus have shifted the discussion to "maintain compliance-where problems are eliminated and state eliminated. Unfortunately, the corrective actions taken by nursing homes are often temporary. Unless the most severe deficiencies exist, a home has up to 6 months to correct deficiencies before being terminated from the program. Corrective action within this period is almost always accomplished. However, we found that 40 percent of those homes found to have harmed residents in one survey also harmed residents in a subsequent survey.

Question. The GAO report suggests that civil monetary penalties should be used more often and more effectively. However, one drawback is that they are not paid while under appeal. Many facilities appeal at every level and these appeals can take years to adjudicate. Your report noted that there is currently a backlog of some 700 cases in the Department of Health and Human Services. How can CMPs be made more effective given that nursing homes can overwhelm the appeals process with their appeals?

Answer. Our recommendation recognizes the need to reduce the backlog of civil monetary penalties and increase the capacity to resolve appeals more quickly so that they can be useful in deterring future non-compliance. HHS has requested additional funds in its fiscal year 2000 budget request that would more than double the number of staff working to resolve these appeals. Subsequent analysis could indicate whether this increase is sufficient to resolve appeals in a timely manner.

Question. How realistic is the threat of termination-and how wise is its imposition-since terminating a facility requires that its residents be moved and such movement may result in transfer trauma?

Answer. We believe that termination should be reserved as a last resort, when other sanctions have failed to bring a home into compliance. Terminations may be rare if the other sanctions are used to their fullest extent. However, a strong termination sanction must also be available for use in such extreme cases to assure that residents are appropriately protected. In addition, it should be noted that termination does not have to result in relocation of residents and closure of the facility. Currently, the facility is often rapidly readmitted to Medicaid and Medicare and, because of the provision permitting 30 days payment after termination may only lose a few days reimbursement. While residents do not have to move if the facility is readmitted with the same ownership and no action taken to address the deficiencies taken on a long-term basis, this is very troubling. Readmission should occur only when the management, operational, and ownership changes necessary to assure adequate care have occurred.

Question. The GAO report concludes that the denial of payment for new admissions is not an effective enforcement tool because a facility can come back into compliance before the penalty takes effect. Is there a way to fix this flaw?

Answer. Denial of payment for new admissions appears to encourage nursing homes to return to compliance. We have noted, however, that it does not appear to deter future non-compliance because the nursing home can easily avoid it by returning to compliance after it receives the notice of future imposition, generally 3 months after the deficiency has been identified. As long as notice is required in advance of the sanction taking effect, its value as a deterrent to future non-compliance would be limited. Imposing this sanction earlier in the enforcement period, particularly for homes with serious and repeat deficiencies, could be one means of achieving the desired result.

Question. Finally, don't we have an enforcement dilemma? What would work?

Answer. While enforcing nursing home quality standards presents challenges, we do not consider them to be insurmountable. Rather, there is strong potential for some of the OBRA sanctions, such as civil monetary penalties, to act as a deterrent to future noncompliance. We believe that HCFA's implementation of our recommendations could significantly increase the effectiveness of the enforcement system, especially for homes with serious and repeat deficiencies.

Question. One of the complaints made by the nursing home industry is that state inspectors have an adversarial relationship with them. They argue that state inspectors should provide more guidance on how to fix problems. In your report, you mention a project underway in the State of Michigan, which involves using a consultant on contract with the state to help deficient facilities achieve sustained compliance. Sanctions still may be imposed if a facility is unable, even with the technical assistance of a consultant, to come into compliance. Please elaborate on this project. Would this method provide the technical assistance nursing homes want, without compromising the relationship between inspectors and facilities? Should this method be more widely used?

Answer. In implementing the current enforcement system, HCFA recognized the Institute of Medicine's concerns about the potential conflict between the consulting and the regulatory roles of state surveyors. As such, under current procedures HCFA considers the homes to be responsible for establishing internal quality control systems and practices that ensure continuous compliance with Medicare/Medicaid standards. State surveyors in practice provide an independent review of whether the facility is meeting the standards. If state surveyors did not significantly limit their role as a consultant, this independence could be jeopardized. However, the state survey agency is not precluded from establishing other mechanisms to provide facilities with needed technical assistance.

As such, in 1998, Michigan established a system that uses an independent nonprofit organization to provide technical assistance to homes with recurring and/or serious compliance problems. In essence, homes are required to pay for this service and their performance may be monitored for an extended period. While the program may provide some promise, it is still too early to tell the extent to which it will help homes to maintain compliance with the standards over the long term. The results of future surveys will be needed to assess the program's success.

Question. HCFA's plan to use a G-level deficiency on two consecutive surveys as the criteria to trigger stiffer sanctions on a nursing facility is currently causing some concern in the nursing home community. Many nursing home administrators have complained that G-level deficiencies are often not particularly serious and that it is very easy to incur them. It has even been alleged in a recent press release by the American Health Care Association that they include things like canceling a

painting class. Administrators argue that this policy runs the risk of lumping good facilities—that have only isolated problems—in with the real problem facilities.

(A) Is it fair to conclude that the GAO's analysis shows that the G-level deficiencies tend to be of the more serious kind (as identified in the table in the GAO complaints report on pages 13–14) rather than what appears to be the less serious kind?

(B) Does it also imply that the deficiencies used to trigger more severe and immediate sanctions should be more tightly focused?

Answer. We acknowledge that a wide variety of deficiencies can be included as a level G deficiency. Most of the actual harm deficiencies we reviewed include serious care problems such as inadequate prevention of pressure sores, failure to prevent accidents, failure to assess residents needs and provide appropriate care, and failure to maintain acceptable nutrition status. (See our enforcement report, GAO/HEHS–99–46, table 4, pp. 11–12.) HCFA data show that about two-thirds of G-level deficiencies include these types of quality of care issues. Only about 7 percent of G-level deficiencies are for quality-of-life concerns, typically including issues such as resident's privacy and dignity, grooming, verbal abuse, or exposing the resident in public.

Our complaint report includes summaries of all 22 actual harm deficiencies that resulted from nearly 300 complaints filed in Maryland, Michigan, and Washington in early 1998. (See complaints report, GAO/HEHS-99–80, table 6, pp. 13–14.) Seventeen of these 22 (77 percent) were G level (isolated actual harm). These 17 deficiencies range from verbal abuse to inadequate care for pressure sores and a fatality due to faulty bed side-rails. They also include physical abuse by other residents or staff, an unattended resident who left the home and died of hypothermia, inadequate prevention of accidents such as falls, improper positioning or transfers, and the improper drawing of blood or insertion of an IV. As a result of many of these deficiencies, residents suffered from bruises, cuts, fractured or dislocated bones, poor nutrition or hydration, pressure sores, or (in 2 cases) death. Further, while state investigators categorized these deficiencies as being isolated, in some cases they affected several residents.

Our reviews of many specific cases with deficiencies did not find any examples of trivial G-level deficiencies in isolation that have been highlighted by the nursing home trade associations (such as cancelled painting classes). As I noted during my testimony, deficiencies proposed by surveyors undergo a thorough review at the state level before being assigned a final severity category. As a result, deficiencies initially proposed at the G level, which may sometimes be considered "trivial," are likely often reduced in severity before being included in HCFA's data.

However, we recognize that there is ongoing dialogue between the industry and HCFA regarding the proposed expansion of the definition of "poor performing" nursing homes to include those with two consecutive G level deficiencies. To ensure that this category truly reflects homes that repeatedly have serious deficiencies, HCFA should give careful consideration to the types of problems identified at the G-level. It is also important to recognize that state investigators vary widely as to how frequently they cite homes at different deficiency levels, and it would be unfortunate to discourage states from appropriately citing homes for deficiencies that are harming one or several residents. We intend to continue examining the extent to which G-level deficiencies reflect serious care problems and the impact of the proposed expansion of the poor-performing category.

HCFA'S RESPONSES TO QUESTIONS

HCFA'S RESPONSIBILITIES

Question. At the Special Committee on Aging hearing in July, the following question, which can be found at page 276 of the Committee report, was posed to HCFA: ". . . [Does HCFA dispute the fact that it is the agency that has primary responsibility for ensuring that care is acceptable in those nursing homes for which $30 billion of the taxpayers' money was spent last year and not the States? Mr. Hash, the HCFA representative, responded in the following manner: "I want to answer that in the strongest possible way I can. Our whole initiative is predicated, I believe, on the premise that enforcement is our (HCFA's) responsibility."

In light of that testimony, please clarify the inconsistency evident between HCFA's July testimony and the statements in HCFA's March 22, 1999 testimony and letter sent to the Committee on March 30, 1999. Specifically, please elaborate on the following: "We (meaning HCFA) are committed to working with states, which have the primary responsibility for conducting inspections and protecting resident safety." (March 22, 1999, Written Testimony) and "states, by law, have the primary

responsibility for conducting onsite inspections, enforcing regulations, and protecting residents . . . [We at HCFA have a responsibility to ensure the law is fairly and vigorously enforced and that state agencies are accountable for their performance." (March 30, 1999 letter).

Answer. The statements in HCFA's March 22, 1999 testimony and March 30, 1999 letter correctly stated that states, by law, have the primary responsibility for conducting onsite inspections, enforcing regulations, and protecting residents and are accountable for their performance. However, the accountability of states' responsibilities ultimately lies with HCFA to ensure that the States are meeting the letter of the laws.

Question. In written testimony for the March 22, 1999 hearing, HCFA agrees with the GAO that complaint investigations need to be watched more closely by the Federal Government. Please elaborate and clarify that statement. Does this mean HCFA will be watching complaint investigations more closely? How?

Answer. HCFA is strengthening complaint investigation requirements because some state investigations of allegations have lagged. States are already required to investigate complaints alleging immediate jeopardy to residents within 2 days and all other complaints in a timely manner. As of March 16, 1999, HCFA is requiring States to investigate within 10 working days whenever a complaint alleges harm to a resident. States also must now add confirmed violations to HCFA's data base that tracks compliance in nursing homes. We will develop minimum Federal standards for States to conduct complaint investigations and will identify ways to better oversee states' performance. And we are working with the Association of Health Facility Survey Agencies to expand guidance on prioritizing and scheduling of other complaint investigations as well as provide appropriate training.

Question. HCFA's written testimony reads "states must adequately respond to complaints or we can and will contract with other entities to conduct surveys and enforce regulations." Given that HCFA is ultimately responsible for the performance of this system, what recourse does Congress have if HCFA is unsuccessful with the States? Does HCFA have a contingency plan to assume the operations of surveys and enforcement if a State fails to adequately fulfill its duties and responsibilities?

Answer. We believe that in the exercise of its oversight and legislative authorities, Congress has the opportunity to establish national policy direction for nursing homes and to hold Federal agencies accountable for the execution of these policies.

In regard to our oversight of State operations, HCFA has an agreement with each State called the " 1864 Agreement" which spells out consequences for inadequate survey performance. The agreement provides for canceling all or part of the agreement and seeking another entity to perform these duties.

NURSING HOME INITIATIVES

Question. HCFA's testimony outlines a number of activities the agency will initiate to address the problems discussed at the March 22, 1999 hearing. Has HCFA done an internal analysis to determine why these problems arose? What caused the administrative lapse? Please make this analysis available to the Committee so the GAO and I can review it to ensure that we can put the same level of confidence in your diagnosis and prescription as you do.

Answer. Protecting nursing home residents is a priority for this Administration and our agency. We have the responsibility of ensuring quality of care and quality of life is assured for our most vulnerable beneficiaries who reside in nursing homes. In our own Report to Congress, the series of reports by the General Accounting Office (GAO), and your Congressional hearings on the quality of care for nursing home residents, highlighted several areas where improvement was needed. We have made marked improvements since 1995, but clearly more needs to be done. These mediums provided analyses of problem areas and we have done our best to meet these challenges. During our process of identifying new initiatives, we found that insufficient standards, funding and oversight have contributed to the administrative lapses in some of our processes. For example, complaint investigations that are not addressed by statutory requirements have not received the same priority by States as mandatory annual surveys. We have recently clarified the importance of this function and are adjusting our resource allocation.

Question. HCFA's testimony indicated that the agency has monitored the nursing home resident protections announced in July 1995 and the initiatives announced in July 1998 and that these efforts are bringing about marked improvements. Given the problems with management information systems—specifically OSCAR—and the disconnect between the complaint process and the enforcement process, what justifies your confidence?

Answer. In July 1995, the Clinton Administration implemented the toughest nursing home regulations ever, and they brought about marked improvements recognized by our own reports and by the GAO reports. One measure of the impact of nursing home reform is the number of sanctions applied to poor-performing nursing homes. Working with States, who have the primary responsibility for conducting onsite inspections, assuring that they are effective and timely, and recommending sanctions, we have sharply increased the number of sanctions levied on poor quality nursing homes.

We are confident the new initiatives announced in July 1998 (especially our new enforcement and complaint procedures and our OSCAR redesign) will bring marked improvements, but it is too early for us to make a judgment at this time. States are still in the process of implementing many of them and we look forward to receiving data and feedback regarding these initiatives. Overall, we believe we have made significant progress in implementing the nursing home initiative to which we are committed.

Question. HCFA's long list of initiatives is a clear indication that things are not working well. Has the agency performed a critical self-assessment to determine why the system isn't working?

Answer. We have been using the "continuous improvement" approach for nursing home enforcement for a number of years. We identify problem areas and implement "corrective actions" as appropriate. Our latest initiative in improving the enforcement of nursing home standards began in July, 1998. It is still too early for us to make any judgments on it's impact. We plan to begin an assessment of the impact as more data becomes available.

COMPLAINT GUIDANCE TO THE STATES

Question. Will HCFA's new guidance address issues raised in the General Accounting Office (GAO) report on the state complaint investigation process? Particularly, does it address the understating or downgrading of complaints upon receipt by the State?

If not, what can be done to help ensure that complaints are appropriately evaluated so that follow-up activities are appropriately conducted?

Answer. Effective March 16, 1999, any complaint that alleges actual harm to an individual in a certified nursing home must be investigated within 10 working days of receipt. This is in addition to the existing requirement of a 2-day investigation for cases alleging immediate jeopardy. Where investigations reveal noncompliance with conditions of participation, the State agency must process the complaint in accordance with HCFA's State Operations Manual.

In addition, HCFA is planning to supplement its Federal Monitoring System procedures to permit the selection and inclusion of a much larger sample of complaint surveys. The Federal Oversight and Support Surveys will be used to evaluate how well state surveyors are performing the survey functions (including complaint investigations) and the information will be used to evaluate overall State performance and identify instances where complaints are downgraded or otherwise not adequately addressed in carrying out its oversight role for the Federal Government.

Question. The GAO complaint report includes an in-depth look at the complaint investigations systems' weaknesses that stem from weak Federal guidance and oversight. In particular, the report tell us that HCFA does not provide 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. Furthermore the lack of an effective data collection system gives HCFA little to rely on for oversight purposes.

To what extent does HCFA's recent guidance to States regarding complaints address the inadequacies pointed out in this report?

Answer. In addition to our recent guidance to States, HCFA is undertaking a Complaint Improvement Project which will 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 compliant 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.

Question. Once new policies regarding complaint processes have been implemented, how will HCFA and Congress know if improvements are achieved? What measures has HCFA put into place to monitor the success of these new policies?

Answer. Currently, we have routine meetings with senior level staff within HCFA to monitor the various elements of the initiative that began last July. In addition, we provide a monthly report to the Senate Aging Committee, GAO, and others. We plan to make a complete review of our efforts as more data becomes available over the next several months. Information from this review will be shared with Congress as it becomes available.

In addition, we are continuing to improve the OSCAR data system to strengthen our management information system. By June 1999, we will also begin using Quality Indicators (QIs) in conjunction with our Nursing Home Minimum Data Set (MDS) data base to both enhance the survey process and provide us with information about nursing home quality when we are not onsite. The QIs and the wealth of MDS data will allow us to continually examine quality of care, and assist nursing homes in identifying opportunities for continuing quality improvement.

"IN WRITING" REQUIREMENTS FOR COMPLAINT SUBMISSIONS

Question. The GAO complaint report seems to indicate that requiring or encouraging that complaints be submitted in writing leads to substantial under-filing of complaints. The table on page 6 of the report summary indicates that the State of Washington, which accepts verbal complaints, has about four times the number of complaints received by one of the other States the GAO studied, and even many more than that compared to the third State.

Please comment on this inference. More specifically, would a system that encourages only written complaints lead to a substantial under-filing of complaints, and hence underestimation of the extent of quality problems in nursing facilities? If this is the case, please comment on the consequences of failure to address what, in many cases will be serious problems.

Answer. It may well be that requiring or encouraging complaints be submitted in writing leads to substantial under-filing of complaints; however, we want to further investigate GAO's findings on this. We expect our Complaint Improvement Project will assist in determining whether this is a problem. We will incorporate GAO findings into our Complaint Improvement Project as well. We have seen evidence with the State of Washington which "readily accepts complaints by phone" having the highest rate of complaints. However, Michigan which requires a written complaint had over twice the complaint rate of Maryland which has a policy to "accept and act on a complaint by phone." It is also possible that written complaints may ultimately provide a more identifiable record and subsequently result in more substantiated complaints than complaints received by phone.

ENFORCEMENT SYSTEM

Question. Some nursing home industry representatives complain that the current enforcement system cannot improve the quality of care. Has the enforcement system really been used in the way it was designed to be used? In other words, has it really been tried? Is there any evidence that would indicate that the quality of care is better where enforcement is more rigorously practiced?

The GAO enforcement report indicates that most sanctions achieved corrective action but not continued compliance. How can corrective action be taken by a nursing home yet compliance NOT be achieved in the future? How can this be considered "corrective action" if it fails to prevent a recurrence of the problem?

Answer. We believe that our enforcement system meets the intent of OBRA–87. As with the intent of the OBRA–87 nursing home law, the 1995 nursing home regulations brought about more consistency on how deficiencies are rated and how sanctions are applied. We have been applying this authority since 1995. Our current initiative is the first major evaluation of these regulations and policy guidance since the 1995 regulations. Adjustments to these regulations and policies are being made to ensure they are effective and in fact conform to the original intent of OBRA–87.

Some of our other nursing home initiatives have been demonstrated to improve the health and safety of nursing home residents. In our Report to Congress in 1998, improvements were seen with the reductions in the use of anti-psychotic drugs, in the inappropriate use of restraints, and in the inappropriate use of indwelling uri-

nary catheters. The report also showed us that more needed to be done. We expect our current initiative to address these issues.

While we believe effective enforcement is a key variable to ensure an improved quality of care, we also believe there are other interventions needed to focus on the quality of care. Current remedies are structured in such a way that they are designed to deal with a specific set of facts at a date certain time. The remedies themselves will not ensure continuous compliance, therefore additional tools are needed, such as retooling the survey process, to promote continuous compliance.

Question. If the quality of care in nursing homes is deteriorating, is this happening in the entire universe of nursing homes? Are quality of care deficiencies concentrated in homes that have been chronically out of compliance? In other words, do repeat offenders account for the great majority of these deficiencies?

Answer. There are many high quality of care and reputable nursing homes across our nation. We do not feel the quality of care is deteriorating in all homes. Recent examples, brought forth by the GAO reports, the Senate Special Committee on Aging hearings, and in our own Report to Congress, made clear that while progress has been achieved more needs to be done to improve the quality of care in our nursing homes. Some facilities clearly are far more problematic than others. As part of the process to improve quality of care in nursing homes, we now require States to conduct regular surveys twice as often for certain homes that have chronic out-of-compliance histories. We've also ordered States to stop letting problem nursing homes avoid sanctions by fixing problems during a grace period. The nursing home initiatives we expect, will promote continual compliance and further ensure that nursing home residents get the quality of care they deserve.

Question. The current enforcement systems have been criticized as not distinguishing between minor infractions and major problems. The implication of this criticism is that nursing facilities can incur serious penalties for minor infractions. Please comment on this criticism.

Answer. The OBRA–87 nursing home law, that forms the basis for our existing survey and certification policies, required that all deficiencies be addressed. HCFA's enforcement regulations, developed with input from industry, consumers, and advocates, include sanctions that increase in seventy as the seriousness of the deficiency 'increases. We continue to believe this is the best approach to ensuring that quality care is maintained in nursing homes.

THE DOUBLE G-TRIGGER

Question. HCFA's plan to use a G-level deficiency on two consecutive surveys as the criteria to trigger stiffer sanctions on a nursing facility is currently causing some concern in the nursing home community. Many nursing home administrators have complained that G-level deficiencies are often not particularly serious and that it is very easy to incur them. It has even been alleged in a recent press release by the American Health Care Association that they include things like canceling a painting class.

Administrators argue that this policy runs the risk of lumping good facilities—facilities with only isolated problems—in with the real problem facilities. The GAO complaint report includes a table on pages 13 and 14 which details examples of serious isolated complaints that have been substantiated through investigation. In your review of this issue, has your analysis shown G-level deficiencies tend to be of the more serious kind listed on the GAO table rather than what appears to be the less serious kind?

Answer. We believe that G-level deficiencies represent serious problems in a nursing home. The regulations describe G-level deficiencies as isolated instances of actual harm to nursing home residents. We also believe that a facility that has a second survey with G-level deficiencies should have a more immediate implementation of sanctions. The so-called "double G" is a good trigger.

KINDS OF SANCTIONS

Question. The GAO enforcement report suggests that civil monetary penalties (CMPs) should be used more often and more effectively. However, one drawback is that they are not paid while under appeal, and many facilities appeal at every level so that the appeals can take years to adjudicate. The GAO report noted that there is currently a backlog of more than 700 cases in the Department of Health and Human Services. How can CMPs be made effective given that nursing homes can overwhelm the appeals process with their appeals?

Answer. A nursing home's right to appeal is clearly within their legal authority. The Department is committed to nursing home enforcement and in the President's fiscal year 2000 budget has asked Congress for additional funds for the Depart-

mental Appeals Board, HCFA and the Office of the General Counsel to fully implement its Nursing Home Quality Initiative. This includes hiring additional administrative law judges, lawyers, and other legal staff to improve the appeals process. HCFA appreciates your commitment to ensuring that the Departmental Appeals Board has the necessary resources for adjudicating enforcement actions in an efficient, effective, and timely manner.

However, the most serious cases of resident endangerment does not affect the pace of the appeals. That's because in these types of cases, where HCFA may terminate the facility's provider agreement or deny payment for new admissions, the sanctions are put in place without regard to the pursuit of appeals.

Question. How realistic is the threat of termination—and how wise is its imposition—since terminating a facility requires that its residents be moved and moving them can cause transfer trauma, which can kill the resident?

Answer. Termination from participation in the Medicare/Medicaid programs is a necessary remedy of last resort. A menu of remedies is available to the States and HCFA to attempt to bring about facility compliance with Federal regulations. Some States have additional remedies available under their own licensure programs. But in accordance with a statutory mandate, termination is required if a facility remains out-of-compliance with regulations 180 days after the finding of deficient practices. Normally, during an out-of-compliance period, HCFA and the State work together by way of proposing and imposing appropriate remedies to bring about compliance of the facility. Payments for new admissions may be stopped to further assure the facility that non-compliance is serious and costly. Under some scenarios, we may impose a running civil monetary penalty of up to $ 10,000 a day until compliance is achieved.

Neither the President's initiatives, nor the GAO reports have increased the number of facilities terminated involuntarily by HCFA. The number of involuntary terminations of nursing homes for the preceding years and for the fiscal year 99 to-date are:

Involuntary Terminations	
Fiscal year 1996	37
Fiscal Year 1997	31
Fiscal Year 1998	33
FY 1999 to Date	16

HCFA must have "termination from the program" as a sanction option for homes that fail to fix problems and properly care for residents. Otherwise, we would not be fully able to meet our obligation to ensure that residents' lives are not in danger and that they are receiving proper care. Termination is very serious and difficult, especially for residents and their families. Regretfully, sometimes termination is the only option left; but once that decision is made, we recognize that we have the responsibility to ensure an orderly relocation of these vulnerable citizens to a qualified facility. We do take great care to work with residents and their families to ensure a safe transfer.

Question. The GAO report concludes that the denial of payment for new admissions is not an effective enforcement tool because a facility can come back into compliance before the penalty takes effect. Is there a way to fix this flaw?

Answer. In response to GAO's findings, HCFA is drafting manual guidance that encourages States to use the denial of payment for new admissions sanction more often and more quickly in the enforcement process. While the statute only mandates imposition of the sanction after 3 months of continued non-compliance, our draft suggests that States can impose at their option, denial of payment by itself or in combination with other remedies in order to encourage quick compliance. This guidance is under development and will be sent to providers and consumer advocates for comment before it is final.

In addition, HCFA has expanded the State's current ability to impose certain remedies on non-compliant facilities, with HCFA's approval, to include the denial of payment sanction. This means that States are authorized by HCFA to impose this remedy on our behalf so they are able to respond more quickly to facility noncompliance and therefore, maximize the benefit of the sanction.

Question. Finally, it appears that we have an enforcement dilemma. What would work?

Answer. We believe that actions we are taking are working. We will have a better idea of this later this year as more data comes available.

TECHNICAL ASSISTANCE

Question. One of the complaints made by the nursing home industry is that state inspectors have an adversarial relationship with nursing facilities. They argue that state inspectors should provide more guidance on how to fix problems.

The GAO enforcement report mentions a project underway in the State of Michigan which involves using a consultant on contract with the state to help deficient facilities achieve sustained compliance. Sanctions may still be imposed if a facility is unable, even with the technical assistance of a consultant, to come into compliance. Please comment on this project. Would this method provide the technical assistance nursing homes want, without compromising the relationship between inspectors and facilities? And should this be a method that is more widely used?

Answer. The State of Michigan is just now embarking on this project, and we look forward to evaluating whether or not this is an effective arrangement. However, the Institute of Medicine's report in 1986, which provided the underpinning of the nursing home reform in 1987, specifically mentioned tension between technical assistance and inspection, opining that HCFA should not be a consultant but a regulator. Their report states, "There is a potential conflict between the consulting and regulatory roles of a survey agency. The compliance-oriented consulting role, combined with professional attitudes of surveyors trained in the helping professions such as nursing and social work, can lead surveyors to be too understanding and lenient toward substandard providers."

WEAKNESSES IN DATA SYSTEMS

Question. At the Special Committee on Aging hearing last July, witnesses testified about the weaknesses that characterize the OSCAR data base, particularly in regard to the information it captures. A nursing home overview report from the Office of the Inspector General (OIG) (OEI–02–99–00060) states that "while generally satisfied with OSCAR data, more than half of state directors and surveyors believe it [OSCAR] is not a true indicator of nursing home quality of care since it only portrays the situation of the nursing home at the time surveyors are physically conducting the survey." Do you agree with that assessment? Is OSCAR data giving us an accurate picture of nursing home care quality?

Answer. It is true that the annual certification surveys maintained in OSCAR record only information about compliance or quality of care during those annual surveys (up to four annual surveys are retained). However, the OSCAR system also maintains a record of findings for all complaint surveys conducted at any Wine since the mid–1980's. Moreover, by June, 1999, we will begin using Quality Indicators (QIs) in conjunction with our Nursing Home Minimum Data Set (MDS) data base to both enhance the survey process and provide us with information about nursing home quality when we are not onsite. The QIs and the wealth of MDS data will allow us to continually examine quality of care, focus survey resources on identified problems in a facility, and assist nursing homes in identifying opportunities for continuing quality improvement.

Question. A recurring issue in the GAO complaint report, as well as the GAO enforcement report, is the significance of a weak data system. Ideally, an up-to-date system would be a valuable tool for surveyors to quickly access a facility's performance track record, and equally important for HCFA central and regional staff for oversight purposes.

The disconnect between what States are investigating and reporting as state deficiencies, which may also be deficiencies that should be recorded in the Federal data base but are not being appropriately reported, is disturbing. It seems evident that improvements are necessary to ensure a complete and accurate data reporting system. Do you agree? What actions has HCFA taken to address this problem?

Answer. HCFA agrees that we must improve our data on complaint investigations and enforcement actions. As noted 'in the reports, States are too often handling complaints and enforcement actions under their own systems (both Medicaid surveys and State licensure reviews) and not reporting them to HCFA. We will issue updated instructions to the States and Regional Offices emphasizing that all actions related to a violation of Federal requirements must be promptly reported to HCFA systems, regardless of additional actions taken under State law. We also have a workgroup currently working on short term changes to the data collected by our present nursing home enforcement data system to more accurately reflect actions taken (e.g., multiple sanctions). In addition, HCFA is undertaking a longer term initiative to redesign the OSCAR system. This project will include improving the complaint and enforcement data collection content and process, and the value of reports based on those data.

STAFFING

Question. Inadequate staffing in nursing homes may be a cause of the quality of care problems we repeatedly see. What incentives in the system could be causing nursing home administrator to under staff? Additionally, please comment on the status of the staffing study which is currently under contract with AM Associates.

Answer. We are conducting a staffing study and expect that it will provide answers concerning (1) whether minimum nurse staffing ratios are appropriate; and, (2) the potential cost and budgetary implications of minimum ratio requirements. It is likely that the incentive to reduce costs impacts staffing patterns since labor costs are the largest category of nursing home expenses.

We have met with, and secured input from, consumer, union, and industry representatives regarding this report. We have also established an external Technical Expert Panel to advise us on the analysis. Our evaluation contractor on this study, Abt Associates, will be delivering a draft final report at the end of the calendar year. We expect to have the report completed by early next year.

RESOURCES

Question. Please elaborate on the resource implications at both the state and Federal level regarding the recommendations included in the GAO complaint and enforcement reports, as well as the OIG nursing home overview report. In particular, what resource implications are there for a state interested in implementing an effective telephone complaints system? Are there steps that can be taken to make the complaint investigation and enforcement systems better without substantial new resources?

Answer. Clearly, some of our nursing home initiatives have significant resource implications. Changes to our revisit policy as well as requiring all allegations of serious harm to be investigated within 10 days will require, all other factors being equal, additional resources. We have established a workgroup to develop methods to operationalize these policy changes within existing resources. Our recently initiated Complaint Improvement Project (CIP) will identify best practices for complaint investigations and the resource implications of those practices.

We have included an increase 'in the President's fiscal year 2000 budget for the overall nursing home initiative and are examining opportunities to re-allocate existing resources to support our enhanced activities. While it is likely additional resources will be needed, our CIP will evaluate best practices and whether there are resource implications for the states.

Statement of

MIKE HASH

DEPUTY ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

on

NURSING HOME ENFORCEMENT

before the

SENATE SPECIAL COMMITTEE ON AGING

MARCH 22, 1999

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Testimony of
MIKE HASH, DEPUTY ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
on
STATE NURSING HOME COMPLAINT INVESTIGATIONS
before the
SENATE SELECT COMMITTEE ON AGING
March 22, 1999

Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting me to discuss our continuing efforts to improve protections for nursing home residents. I would also like to thank the General Accounting Office (GAO) for its important evaluations of State responses to consumer complaints about nursing homes and of additional steps needed to strengthen enforcement of Federal quality standards. And I would like to thank the Office of the HHS Inspector General for its reports on nursing home issues, as well.

We have made substantial progress in improving nursing home resident protections. The GAO's new reports, *Complaint Investigation Process Inadequate to Protect Residents* and *Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards,* look at States where problems are most serious over a time period before we had implemented most provisions of the nursing home enforcement initiative that we announced last July. We undertook our nursing home enforcement initiative in response to intolerable situations that have caused our most vulnerable citizens to suffer. The initiative includes several steps to:

- address preventable problems such as bedsores and malnutrition,
- crack down on repeat offenders,
- strengthen State inspections, and
- improve Federal oversight.

The new GAO reports again document intolerable situations, and make clear that we must take additional steps to protect nursing home residents. We must ensure that States improve responses to and tracking of consumer complaints. We must also improve consistency in handling terminations of facilities. These and other new steps must be incorporated into our proactive initiative to ensure that nursing homes comply with care and safety requirements.

We generally concur with the GAO's recommendations, and are already taking actions to address them. Specifically, we

- directed all State survey agencies to investigate any complaint alleging harm to a resident within 10 working days;
- reiterated to States that complaints alleging immediate jeopardy to residents must be investigated within two days;
- stressed to States that they must enter complaint information into our data system promptly;
- published a regulation last week allowing States to impose fines for each instance of a violation, and
- will now have Regional Office staff conduct surveys to verify nursing home resident complaints when necessary.

HCFA Administrator Nancy-Ann DeParle and I both met last week with the Board of Directors of the Association of Health Facility Survey Agencies, which represents State survey agencies, to discuss the problems with complaint investigations and stress the urgency of improving all enforcement efforts.

We will take additional steps to address problems identified by the GAO, and to ensure that nursing home residents are safe and receive quality care. We will continue to work with the States, Congress, residents and their families, resident advocacy groups, and nursing home providers to ensure that nursing home care and safety standards are met and the vulnerable residents are protected.

BACKGROUND

Protecting nursing home residents is a priority for this Administration and our agency. We are committed to working with States, which have the primary responsibility for conducting inspections and protecting resident safety. Some 1.6 million elderly and disabled Americans receive care in approximately 16,800 nursing homes across the United States. Through the

Medicare and Medicaid programs, the federal government provides funding to the States to conduct on-site inspections of nursing homes participating in Medicare and Medicaid and to recommend sanctions against those homes that violate health and safety rules.

In July 1995 the Clinton Administration implemented the toughest nursing home regulations ever, and they brought about marked improvements. We monitored those protections as they were implemented to see what else needed to be done. We and the GAO found that many nursing homes were not meeting the requirements, and many States were not sufficiently monitoring and penalizing facilities that failed to provide adequate care and protection for residents. In July 1998, President Clinton announced a broad and aggressive initiative to improve State inspections and regulation enforcement. Those efforts are bringing about marked improvements as well.

The GAO reports examined events through December 1998. Since that time period we have implemented many aspects of our new enforcement initiative. We are grateful that Congress has provided essential funding for this initiative, and we look forward to working with you to secure the $60 million increase for this initiative in the President's fiscal 2000 budget, as well as our legislative proposal to require background checks of potential nursing home employees and establish a national registry.

STATE COMPLAINT INVESTIGATIONS

Consumer complaints are a valuable and unique source of information about the health and safety of nursing home residents. We have been concerned about problems with State survey agency responses to complaints, and in 1995 we developed complaint investigation protocols for States in order to foster improvement. However, the GAO report makes clear that these protocols are not sufficient.

We therefore have taken two new actions. First, we directed all State survey agencies to investigate any complaint alleging actual harm to a resident within 10 working days. We also stressed that States must promptly enter complaint information into our data system. We will

56-728 - 99 - 6

monitor State reporting of complaint information more closely to make sure they comply.

Second, we initiated a Complaint Improvement Project to identify key elements of the complaint process, address resident and consumer concerns about the process, and develop standards for prioritizing complaints and determining appropriate time frames for investigations. We will work to address concerns of residents, their families, consumer representatives, and representatives of the Administration on Aging's Ombudsman program in this project.

SPECIFIC GAO RECOMMENDATIONS

As stated above, we generally concur with the recommendations in the GAO reports, and are taking action to address them. We agree that:

- we need stricter standards for prompt investigation of serious complaints;
- we need more stringent Federal oversight of State complaint investigations;
- Federal officials must have access to complaint investigation results;
- fines must be more certain and the appeals process must be faster;
- termination of repeat offenders from Medicare and Medicaid must be used more consistently and effectively;
- States must do a better job of telling us when homes are cited for a deficiency that contribute to a resident's death; and
- we must develop better management information systems to integrate results of complaint investigations, track deficiencies, and monitor enforcement actions.

Standards for Prompt Investigation

The GAO found that States categorize serious complaints alleging situations that harm residents as less than a complaint about immediate jeopardy to residents. The GAO also found that States do not always investigate these complaints promptly, or at all. Its report calls for new standards for prompt investigation that include maximum allowable time frames for investigating serious complaints and for complaints that are deferred until the next survey schedule.

Therefore, effective immediately, any complaint that alleges actual harm to an individual in a certified facility must be investigated within 10 working days of its receipt. We also stressed to States that all complaint data must be entered in a timely fashion into our On-line Survey, Certification and Reporting data system (OSCAR). We will develop more standards and long-term improvements as we further analyze complaint investigation processes. We believe that States have the resources they need to meet these new standards. If additional resources are needed, however, we will re-examine our priorities, or the Administration will work with Congress to make sure the funds are there to do the job right.

Our new Complaint Improvement Project will help us to understand the key elements of the complaint investigation and resolution process. We believe these key elements include:

- informing consumers of their right to make complaints and how to do so;
- the complaint intake process, including how complaints are received, classified and scheduled for investigation;
- the investigation process, including the training, knowledge, attitudes, and case load of investigators;
- the resolution process, for determining whether a complaint is substantiated;
- the administrative hearing process, including back-log of cases;
- the compliance or response process for addressing substantiated complaints, including the range and actual use of remedies and back-log of actions; and,
- interactions between complaint investigations and licensure and certification systems, the legal system, and facility-level grievance or continuous quality improvement processes.

Using this analysis, we will develop Federal minimum standards and produce a manual for States describing each element of a model complaint investigation process, how States should implement the process, and necessary training and staffing levels.

In addition, we will specify measures we can use to strengthen Federal monitoring and audits of State performance, including the elements that should be included in a Federal complaint investigation reporting system and database. And we will explore other changes needed to

strengthen Federal oversight, enhance the responsiveness of the complaint investigation process, and ensure the welfare of beneficiaries.

Oversight of State Complaint Investigations

We agree with the GAO that investigations need to be watched more closely by the Federal government, and that States are not sufficiently setting priorities for investigating complaints. Importantly, as mentioned above, we will now have Regional Office staff conduct surveys to verify nursing home resident complaints when necessary. This means that a complaint from a resident now can directly trigger a standard survey by Federal surveyors.

We are improving Federal oversight of State complaint investigations. We are now outlining actions we will take when States do not meet their survey responsibilities. We will specifically evaluate how well States respond to consumer complaints and how promptly and thoroughly they report investigation results to us to determine whether they meet their survey responsibilities. And, as part of our Complaint Improvement Project, we will identify the most effective ways for us to monitor State processing of complaints.

HCFA regional offices are now required to maintain logs 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 correct this omission.

As part of the Nursing Home Quality Initiative, we made it clear that States will lose Federal funding if they fail to adequately protect residents. States must adequately respond to complaints, or we can and will contract with other entities to conduct surveys and enforce regulations.

Federal Access to Complaint Investigation Results

The GAO found that States are not reliably reporting results of complaint investigations to us, and that these findings are therefore not taken into account when considering other actions. States are currently required to report this information, and we are taking action to ensure that they comply.

We have directed the States to immediately enter all current and backlogged complaints into the OSCAR data system regardless of whether the complaint is entered into a State licensure system. We will closely monitor States to ensure that the information currently required is actually entered into HCFA's database. We will include reporting of complaints as a new performance evaluation element for States. And we will revise the current complaint form so it provides the information needed to facilitate Federal monitoring of State performance, prioritization, and timeliness.

Improving Effectiveness of Fines

The GAO found that fines are not always an effective enforcement tool. We agree that appeals must be processed more quickly so fines can be collected more quickly. Fines need to be imposed for each instance of a violation. And they need to be imposed for serious problems even if the problems are quickly corrected.

We support the President's efforts to speed appeals and collections by the Health and Human Services Departmental Appeals Board, which operates separately from HCFA. Providers are entitled to a hearing before fines can be collected. Increased enforcement efforts have resulted in a large number of cases awaiting appeal hearings. The President's fiscal year 2000 budget proposal would double the number of Administrative Law Judges that can hear appeals cases in order to speed the appeals process and ensure that fines and other sanctions are adjudicated in a timely manner.

As announced last July, we have developed a new regulation to enable States to impose fines for each instance of a violation regardless of the amount of time the facility was out of compliance with requirements. This regulation was published in the *Federal Register* on March 18, 1999, and is effective 60 days after publication. This additional enforcement option will give States greater flexibility to assess penalties quickly.

Strengthening Use of Terminations

Terminating homes from Medicare and Medicaid is an essential last resort enforcement tool for

facilities that fail to correct problems and provide adequate care and safety to residents. We agree with the GAO, and current policy now requires, that Medicaid payments to terminated facilities continue for up to 30 days after a facility is terminated if and only if the home and State Medicaid agency are making reasonable efforts to find another nursing home for those residents. (Medicare also makes funds available but does not explicitly require a State's effort to transfer residents.)

We will study transfer procedures in the 30 involuntary terminations that took place last fiscal year. We will explore whether States applied oversight and payment policies appropriately and consistently, if not why not, and whether facilities closed and transferred residents, stayed open and paid for care of residents not transferred, were sold to third parties, etc.

We are concerned, however, that there could be unintended consequences from the GAO's recommendation to use longer "reasonable assurance periods" in all cases before allowing homes that have been terminated to reenter Medicare. Current guidance to State inspectors includes several examples to assist in setting reasonable assurance periods, but there must be flexibility in determining appropriate reasonable assurance periods. Excessive reasonable assurance periods may not be in the best interest of the nursing home residents, particularly in regions with limited access to care.

It is important to note that reasonable assurance periods are rarely used. More than 95 percent of nursing homes given initial notice of termination correct problems and remain open. Last year only 30 of the more than 8300 facilities given initial notice of termination were in fact terminated. It is also important to note that reasonable assurance periods apply only under Medicare. The requirement was removed from the Medicaid statute in 1987. Most nursing homes participate in both Medicare and Medicaid. Therefore, reasonable assurance periods now can result in a facility being certified for Medicaid but not for Medicare until a reasonable assurance period is satisfied. We are prepared to work with Congress to restore reasonable assurance to the Medicaid program so the two programs are consistent.

We will subject terminated facilities to extra scrutiny and stiffer sanctions for problems if and when they are allowed to reenter Medicare and Medicaid. Current Federal regulations allow consideration of a facility's prior history of noncompliance. However, past problems have not been routinely reviewed when assessing new sanctions. And previously terminated nursing homes have been able to re-enter Medicare or Medicaid with a "clean slate." As such, they have been treated less aggressively than problem-prone facilities that have not been terminated, and this has created a perverse advantage to termination that will no longer exist.

We will therefore make explicit in our instructions to States that previously terminated facilities are automatically subject to immediate sanctions if problems recur. States and our regional offices track termination information, and we will work to ensure that this information is used systematically when subsequent enforcement actions are considered. We will further consider applying this policy to previously terminated homes that re-enter under new ownership.

Improving the Referral Process

The GAO report cites appalling cases which document our concern that States have not been consistently referring cases for sanction, even when violations resulted in a resident's death. We are therefore requiring States to refer all cases that result in harm to residents. We also now will require States to report to us when they do not recommend sanctions in cases where regulations have been violated and a nursing home resident died.

Current guidelines do authorize referral and imposition of fines for egregious violations, such as those that contribute to a resident's death, even if the problem has been corrected. Also, as mentioned above, we last week published a regulation making nursing homes subject to additional penalties or fines for each specific incident, such as an instance of abuse or neglect, that contributes to a resident's death. Under this new regulation, even if the nursing home corrects the violation quickly, it would still face fines when a resident suffers harm due to a serious violation.

Improving Management Information Systems

We are already undertaking a major redesign of our data systems that will allow us to integrate results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions adequately. We will release software this summer that will make it easier to track the status and history of deficiencies at the State level. This software will also automate the current requirement for State collection of ownership information. We will make further improvements as soon as our Year 2000 computer work allows.

It is important to note that many States investigate complaints for regulations that exceed Federal requirements and we have no authority to require them to report these data. As we redesign our management information system we will work to make sure that these data are fully integrated with other information on facility performance.

HHS INSPECTOR GENERAL FINDINGS

The HHS Inspector General has produced six reports on nursing home enforcement issues which echo our own concerns and underscore the need for our ongoing efforts to help States improve enforcement efforts. Many of the Inspector General's recommendations are already incorporated into the nursing home initiative announced by the President in July 1998, including:

- making surveys more timely and effective;
- changing survey schedules to make surveys more unpredictable;
- increasing the number of night and weekend surveys;
- increasing the number of surveys in facilities with chronic quality of care problems;
- focusing on specific problems such as pressure sores, dehydration, and malnutrition; and
- providing additional training to State surveyors.

We have research underway that will help us respond to the Inspector General recommendation for staffing standards for registered nurses and certified nurse assistants in nursing homes. Last September we awarded a contract to Abt Associates to assist us in a comprehensive study of nursing home staffing, with results due back to us this fall.

We strongly support the Administration on Aging's Ombudsman Program, which is absolutely critical in maintaining quality of care in nursing homes. Ombudsmen make regular visits to nursing homes, act as advocates for residents, and help in enforcing nursing home standards and ensuring that all nursing home residents are treated with dignity and compassion. We agree with the Inspector General that this program should have more visibility, including criteria for frequency and length of regular visits to facilities. It also needs guidelines for complaint response and resolution times, further refinements to its data reporting system, and more volunteers.

Though progress has been made in improving the quality of care in nursing homes, we need to continually build upon it. To this end, HCFA is willing to work with the Administration on Aging to increase their effectiveness and to facilitate communications between the Administration on Aging and State survey agencies to better serve nursing home residents.

ENFORCEMENT INITIATIVE PROGRESS

We have made solid progress since the President announced our nursing home enforcement initiative last July. We have taken several steps to improve inspections by States, who have the primary responsibility for conducting on-site inspections and recommending sanctions for care and safety violations. These steps will help ensure faster sanctions when problems are found, increase oversight for the worst offenders in each State, and enhance the quality of care by targeting preventable problems.

We have expanded the definition of facilities subject to immediate enforcement action without an opportunity to correct problems before sanctions are imposed. New guidance to States will make clear that a facility should automatically get such "grace periods" only if violations do not cause actual harm to residents and if the facility does not have a history of recurring problems.

We have identified facilities with the worst compliance records in each State, and each State has chosen two of these "special focus facilities" for frequent inspection and intense monitoring, and monthly status reports. Through closer scrutiny and immediate sanctions, we will work to

prevent "yo-yo" compliance, in which problems are fixed only temporarily and are cited again in subsequent surveys.

This spring we will implement a wide range of initiatives to detect and prevent bed sores, dehydration, and malnutrition. We are working with outside experts to develop a systematic, data driven process to identify problems and provide focus for in-depth on-site assessments. We will take interim steps this year, and expect to complete the new system by the end of 2000. We are also working with the American Dietetic Association, clinicians, consumers and nursing homes to share best practices for preventing these problems. And we will begin a national campaign to educate consumers and nursing home staff about the risks of malnutrition and dehydration and nursing home residents' rights to quality care this year.

We will this summer implement a new survey protocol we developed with a national abuse and neglect forum for evaluating nursing homes' abuse and neglect prevention processes. We will launch a national consumer education campaign on preventing and detecting abuse this year.

We will provide training and guidance to States this Spring on enforcement, use of quality indicators in surveys, medication review during surveys, and prevention of pressures sores, dehydration, weight loss, and abuse.

We also have:

- made clear that States will lose federal funding if they fail to adequately perform surveys and protect residents because we can and will contract with other entities, if necessary, to make sure those functions are performed properly;
- established a new monitoring system for evaluating State survey teams' adherence to Federally mandated procedures and policies;
- formally reminded States that they must enforce sanctions for serious violations and may not lift them until an on-site visit verifies that problems are fixed;
- required States to sanction facilities found guilty more than once for violations that harm

residents, with no option to avoid penalties by correcting problems during a grace period;

- required States to conduct more frequent inspections for nursing homes with repeated serious violations while not decreasing their inspections for other facilities;
- required States to stagger surveys and conduct a set amount on weekends, early mornings and evenings, when quality and safety and staffing problems often occur;
- instructed States to look at an entire chain's performance when serious problems are identified in any facility that is part of a chain, and begun developing further guidelines for sanctioning facilities within problem chains;
- developed new regulations to enable States to impose civil money penalties for each serious incident and supplement current rules that link penalties only to the number of days that a facility was out of compliance with regulations; and

We have taken additional steps to help consumers choose facilities, help facilities improve care, and help our law enforcement partners prosecute the most egregious cases. We have:

- created a new Internet site, Nursing Home Compare, at *www.medicare.gov*, which allows consumers to compare survey results and safety records when choosing a nursing home, and which has so far had more than 826,000 page views;
- posted best practice guidelines at *www.hcfa.gov/medicaid/siq/siqhmpg.htm* on how to care for residents at risk of weight loss and dehydration;
- begun planning national campaigns to educate residents, families, nursing homes and the public at large about the risks of malnutrition and dehydration, nursing home residents' rights to quality care, and the prevention of resident abuse and neglect;
- begun a study on nursing home staffing that will consider the potential costs and benefits of establishing minimum staffing levels; and
- worked with the Department of Justice to prosecute egregious cases where residents have been harmed, and to improve referral of egregious cases for potential prosecution.

Budget

The Clinton Administration's fiscal year 2000 budget includes proposals to:

- require nursing homes to conduct criminal background checks of prospective employees;
- establish a national registry of nursing-home workers who have abused or neglected residents or misappropriated residents' property; and
- allow more types of nursing-home workers with proper training to help residents eat and drink during busy mealtimes.

The cost of background checks and querying the national registry will be financed through user fees. The Administration will put forward additional proposals as needed for additional legislative authority to further improve nursing home quality and safety.

We are grateful that Congress provided us with a total fiscal 1999 survey and certification budget of $171 million for our increased nursing home enforcement efforts, including $4 million earmarked for the new initiative. We thank you, Mr. Chairman, for your continued support in meeting the resource needs required by our increased oversight efforts. We are requesting an additional $60.1 million for fiscal year 2000 to enable us and other HHS components to fully implement all provisions of the Nursing Home Initiative. This includes $35 million for HCFA to strengthen State inspection and enforcement efforts, $15.6 million in mandatory Medicaid money to supplement State inspection and enforcement efforts, and $9.5 million to ensure adequate resources for timely judicial hearings and court litigation.

CONCLUSION

We have made substantial progress in improving protections for vulnerable nursing home residents. We are doing a better job of making sure nursing homes provide adequate care and protection. We greatly appreciate the evaluation and advice of the GAO, the HHS Inspector General, and this Committee in these efforts. Clearly there is much more that we need to do. The new GAO and HHS Inspector General reports and this hearing will help us focus on specific areas that we must address. We are committed to continuing our progress and doing everything we can to ensure that nursing homes comply with care and safety rules. We look forward to continuing to work with you, the GAO, the HHS Inspector General, residents, their families, advocates, and providers as we proceed. And I am happy to answer your questions.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia WA 98504-5000

March 18, 1999

The Honorable Charles E. Grassley
The Honorable John Breaux
United States Senate
Special Committee on Aging
Washington, D.C. 20510-6400

Dear Senators Grassley and Breaux:

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.

We agree that states should have procedures that encourage the filing and tracking of complaints; that states should have the ability to appropriately prioritize complaints based upon the risk to residents; and, that serious complaints are investigated promptly. These goals can not be achieved without the investment of adequate resources, and a true philosophical commitment to nursing home residents and the public.

A strong relationship between the state agency and Health Care Financing Administration (HCFA) is also crucial to a successful system. Washington State has experienced a close and ongoing partnership with the HCFA Regional Office (Region X). Region X has assisted Washington in recognizing the role that complaint investigation can play in overall quality assurance and the value of consistent, resident focused program standards. This state has a partnership that is noteworthy, worth replication, and of significant benefit to the public. Similarly a working relationship with the Long-Term Care Ombudsman results in better resident service.

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 firm foundation 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.
- We have extensively published the complaint intake number, and maintain an on-going positive partnership with stakeholders and advocates.
- Washington conducts more on-site complaint investigations per 1,000 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.
- Washington's timeliness in initiation of complaint investigations is not adequately captured, due to limitations of the federal data systems.
- Washington believes that with increased Federal investment of resources, the complaint system could perform at an even greater level of effectiveness.

Thank you for the opportunity to comment.

Sincerely,

Lyle Quasim
Secretary, Washington State
Department of Social and Health Services

cc: Ralph W. Smith, Assistant Secretary
Aging and Adult Services Administration
Patricia K. Lashway, Director
Residential Care Services Division
Joyce Pashley Stockwell, Administrator
Washington State Nursing Home Quality Assurance
Jan Shinpoch, Director
Washington D.C. Office of the Governor

State of Michigan
John Engler, Governor

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

G. Mennen Williams Building
P.O. Box 30004
Lansing, Michigan 48909-7504
517-373-1820

March 17, 1999

The Honorable Charles E. Grassley, Chairman
Senate Special Committee on Aging
SDG-31 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Grassley:

Thank you for the opportunity to provide input to the Special Committee on Aging, especially as you study and review the two recent General Accounting Office (GAO) reports on nursing home regulation in the United States and the relationship between the Health Care Finance Administration (HCFA) and state regulators. Let me first comment on the GAO enforcement report.

Governor John Engler has encouraged the Michigan Department of Consumer and Industry Services to improve the quality of care provided in Michigan's nursing homes. Because of that, Michigan has been at the forefront in updating their nursing home enforcement process during the past 18 months.

Following four months of meetings with nursing home providers, advocates, and representatives of the Health Care Finance Administration (HCFA), Michigan developed the Resident Protection Initiative (RPI). The RPI initiated some new computer models. Most importantly, we established a model which allows us to identify poor performing nursing homes sooner so we can initiate action to hopefully rehabilitate those homes. We believe the majority of homes do want to provide high quality care.

We retain the right to issue civil monetary fines as well as other penalties such as bans on admissions and denial of payment for new admissions. However, the Michigan experience has shown us that civil monetary fines do not achieve improvements in quality care. Most fines are either paid quickly with no change in care standards or fines are appealed and often take years to resolve.

That is why Michigan adopted a new model - a collaborative model. When homes in trouble are identified by our computer auditing system, we require certain remediation to occur. We have the authority to place Temporary Managers to basically run a home until required improvements are effectuated. We can require training on a specific citation problem which needs correction or require a plan of correction along with a variety of other corrective actions. Homes pay for any

and all of these required remedies which we feel is a much more effective tool than civil monetary penalties.

Recognizing we could not "do it all", Michigan established a contract with the Michigan Public Health Institute (MPHI) to serve as the temporary managers in homes or the consultants who can provide the on-site training or help write the Corrective Action Plans. As an example, in the past year Michigan has sent MPHI into over 100 different homes across the state to remediate issues discovered by our computer auditing system. We have found that in 85% of these facilities, systemic changes have occurred based on compliance at the first revisit.

We consider our collaboration with the MPHI and the nursing homes in Michigan a success and one we plan to build on. However, make no mistake that Michigan has also closed four nursing homes in 1998. These are the first nursing homes closed in Michigan in about 12 years. We will not tolerate homes which either do not wish to be rehabilitated or simply cannot be saved.

The second GAO report focuses on complaint investigations. Let me first say that Michigan must do better. Our record of timeliness on reviewing complaints is unacceptable.

I have initiated a 30-day independent study of our nursing home complaint process to not only identify why we have such a significant delay in conducting investigations, but also to make recommendations to resolve it. I expect Michigan will have a new system in place by May 1 of this year to address complaints in Michigan nursing homes on a more timely basis.

We have faced some challenges in this area. While this is not the complete story, it is part of it. Michigan government had an early retirement program in 1997 which resulted in the loss of 11 trained surveyors who were involved in complaint investigations. Each of these individuals has now been replaced and are either performing duties or are in the final stages of training.

In addition to replacing early retirees, the Michigan Legislature authorized eight additional surveyors in the current fiscal year. Of these, seven have been hired and are in training and the eighth will soon be employed.

We expect these additional resources and changes made will begin to reduce the current complaint backlog and will prevent it from reoccurring. In the month of January 1999, the backlog was reduced by 7% from 394 files to 368.

In 1999, we have also initiated the following program revisions to assure that complaints are responded to quickly and effectively:

- Effective January 1999, we have changed our survey scheduling procedures to give higher priority to all complaints, regardless of their categorization.

- Initiated off-hour and weekend complaint investigations when the matter involves off-hour or weekend conditions.

- Published a booklet on How to File a Complaint to aid citizens and residents in making complaints. This booklet is required to be available in the lobby of all nursing homes.

- Reviewing current Michigan law that requires a complaint be in writing to determine if revisions are appropriate.

I must also tell you that new demands placed on our surveyors by HCFA have increased their workload significantly. For example, the new HCFA policy increasing the need for revisits by 30% involve surveyors who might otherwise be investigating complaints. In the same way, a HCFA policy to reduce the backlog of administrative appeals of fines will involve the use of surveyors as witnesses in hearings and will further reduce their availability for complaint investigations. These mandates come at a time when the federal money continues to decrease. We urge the federal government to adequately fund our program so that ALL federal priorities can be addressed at the same time.

In your letter, you ask what Michigan would recommend to improve the existing relationship between the State of Michigan and HCFA. In response, we would ask for flexibility. Michigan is taking innovative, effective steps to improve the quality of care in our nursing homes, especially with the implementation of the Resident Protection Initiative. In order for our work to continue, HCFA needs to allow us to do that.

Second, if HCFA continues to force more mandates on the states, the mandates must be accompanied by appropriate funding.

Protecting nursing home residents is critical. It is also costly to be able to conduct timely surveys, conduct complaint investigations, participate in hearings and conduct off-hour visits to nursing homes.

Again, thank you for the opportunity to share our thoughts on nursing home regulation.

Sincerely,

Kathleen M. Wilbur

Kathleen M. Wilbur
Director

MICHIGAN DEPARTMENT
OF
CONSUMER & INDUSTRY
SERVICES

Nursing Home Initiative

1999

CIS

Serving Michigan...Serving You

Michigan Nursing Homes At-a-Glance

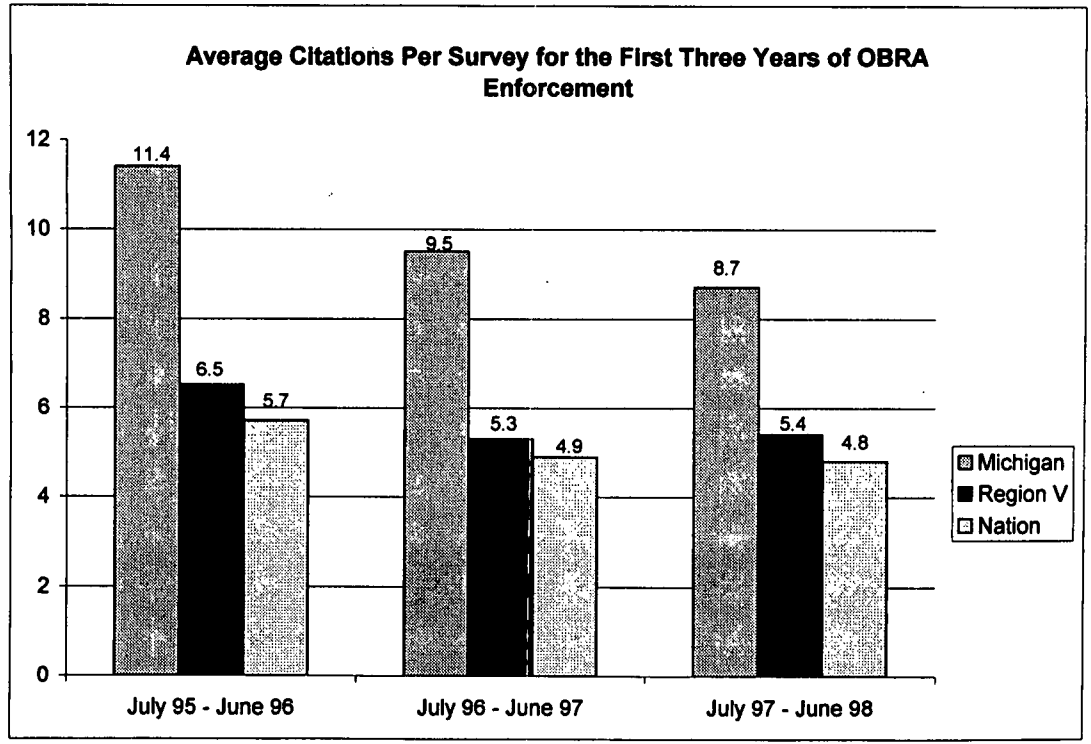
- 458 Nursing Homes
- 52,271 Residents
- Unannounced Inspections Conducted Annually (9-15 months)
- Of the 2,500 or so complaints received annually, approximately 25 percent are substantiated
- CIS required by statute to refer all abuse, neglect and fraud cases to the Attorney General
- Offices in Detroit, Lansing and Gaylord
- 97 surveyors spread regionally
- Six regional teams consist of nurses, pharmacists, sanitarians, social workers and dieticians
- Complaint Hot Line and Emergency Reporting System operational 24 hours a day
- CIS has been committed to keeping this area fully staffed -- no positions were cut due to early retirement
- Eight new field positions have been added for FY1999

MICHIGAN NURSING HOME SURVEYS
FY 97 AND FY 98

Survey Summary Totals		
	FY97	FY98
	10/1/96-9/30/97	10/1/97 - 9/30/98
Total LTC Facilities	459	458
Visits:		
Standard Surveys	428	403
Complaint Visits	910	1075
Survey and Complaint Revisits	369	473
Total Onsite Visits	1707	1951
Onsite Visits per Facility	3.72	4.26

Standard Survey Results		
	FY97	FY98
	10/1/96 - 9/30/97	10/1/97 - 9/30/98
Standard Survey Results:		
Standard survey citations	3522	3583
Average cites per survey	8.39	9.14
Surveys with no citations	14	15
Surveys with substandard care	12	30

SURVEYS.LTC/February 4, 1999



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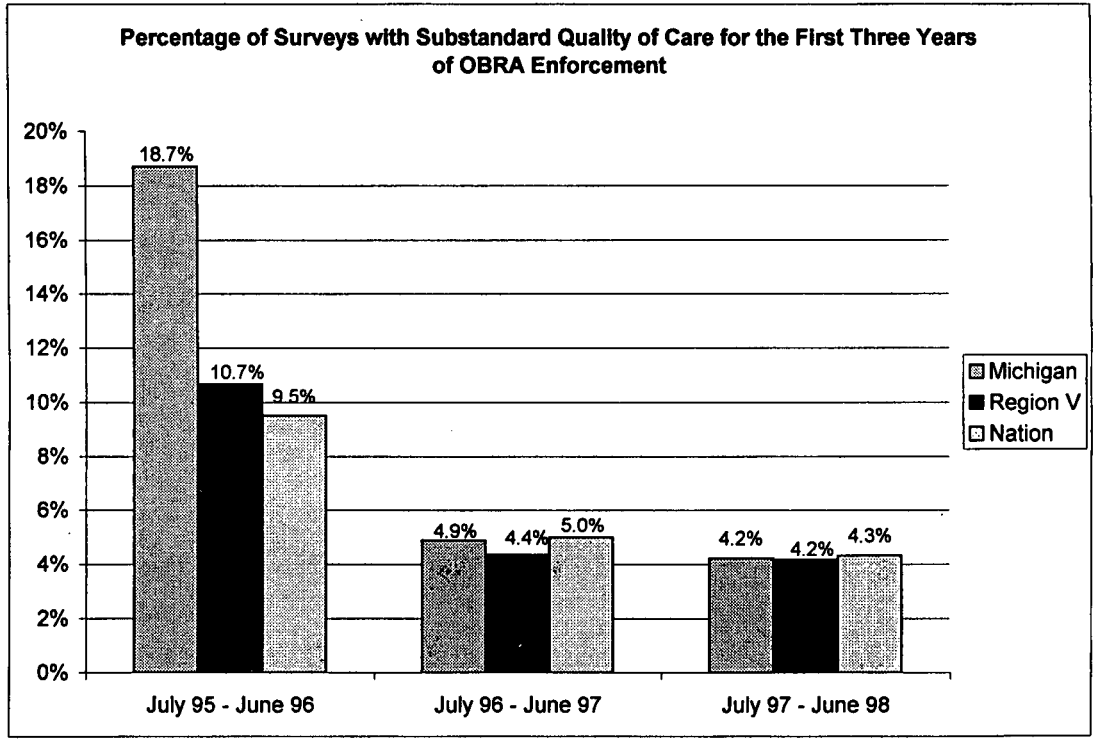

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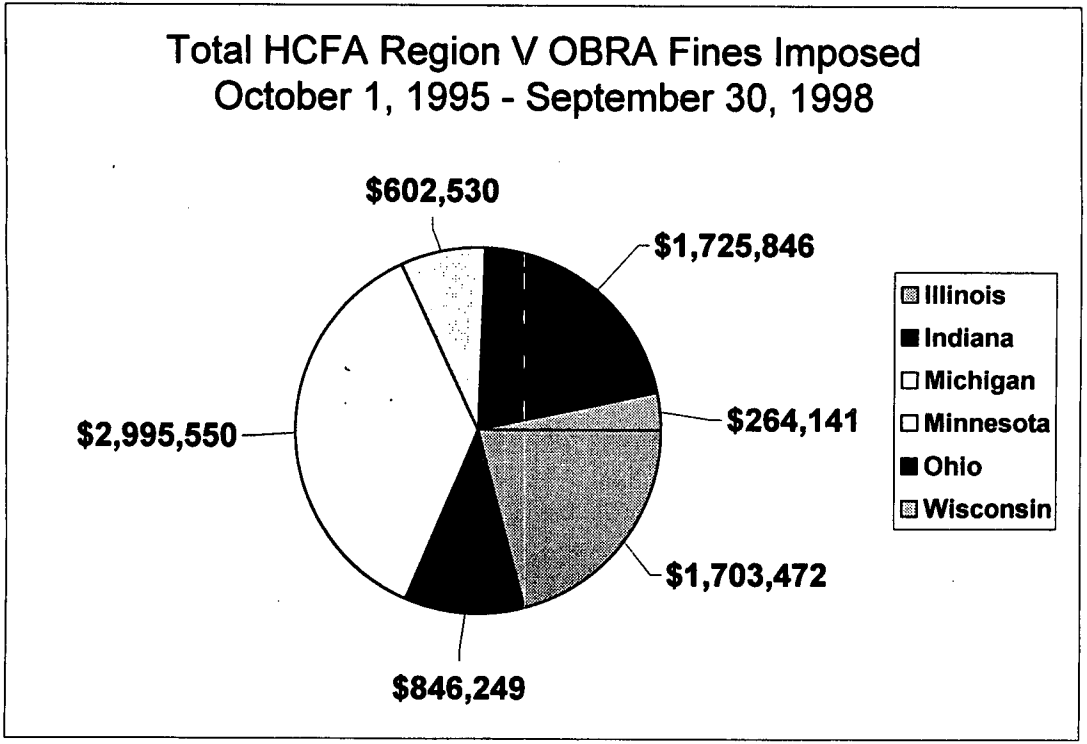

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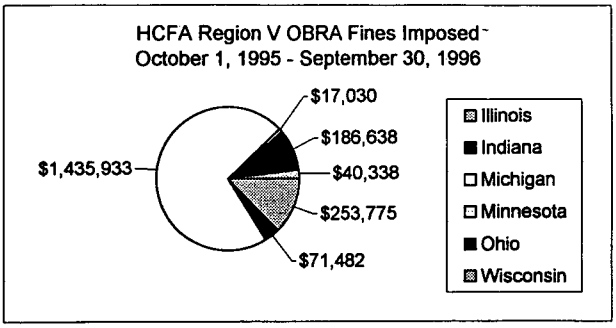
HCFA Region V OBRA Fines Imposed
October 1, 1995 - September 30, 1996
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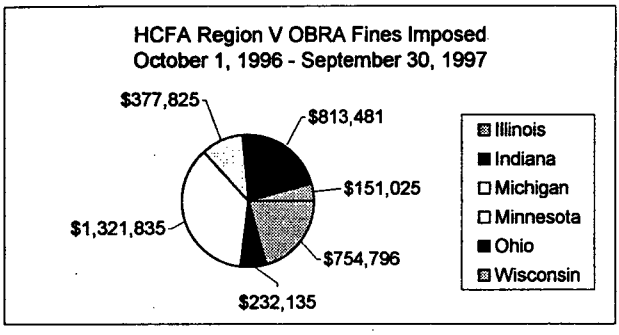
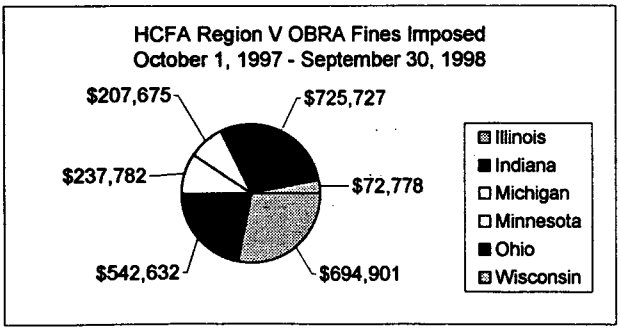
$186,638
$40,338
$253,775
$71,482
$1,435,933
Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin


HCFA Region V OBRA Fines Imposed
October 1, 1996 - September 30, 1997
$377,825
$813,481
$151,025
$754,796
$232,135
$1,321,835
Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin


HCFA Region V OBRA Fines Imposed
October 1, 1997 - September 30, 1998
$207,675
$725,727
$237,782
$72,778
$542,632
$694,901
Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

Region V CMP Summary Totals					
RO V Report Date: January 19, 1999 ; CO Data: January 19, 1999					
State	# of Cases	Total Amount Due	Medicare Paid	Medicaid Paid	Total Amount Paid
Michigan	49	$1,435,932.50	$130,551.87	$736,110.02	$866,661.89
Illinois	28	$253,775.50	$62,202.94	$151,272.56	$208,507.50
Ohio	9	$186,637.50	$11,468.88	$175,304.23	$186,773.11
Indiana	4	$71,482.50	$19,514.84	$51,967.66	$71,482.50
Wisconsin	2	$40,337.50	$0.00	$22,587.50	$22,587.50
Minnesota	1	$17,030.00	$681.20	$16,348.80	$17,030.00
FY 1995-1996 Totals	93	$2,005,195.50	$224,419.73	$1,153,590.77	$1,373,042.50
Illinois	83	$754,796.00	$94,184.77	$548,063.48	$642,248.25
Ohio	39	$813,480.50	$100,439.34	$661,331.97	$761,771.31
Michigan	42	$1,321,835.00	$169,556.30	$664,412.68	$833,968.98
Indiana	17	$232,135.00	$17,593.93	$128,241.07	$145,835.00
Minnesota	11	$377,825.21	$36,195.76	$341,629.45	$377,825.21
Wisconsin	10	$151,025.00	$15,257.70	$135,767.30	$151,025.00
FY 1997 Totals	202	$3,651,096.71	$433,227.80	$2,479,445.95	$2,912,673.75
Illinois	100	$694,900.50	$111,514.81	$533,367.50	$644,882.31
Ohio	51	$725,726.75	$57,663.91	$622,230.73	$679,894.64
Indiana	45	$542,632.00	$61,441.37	$139,797.10	$201,238.47
Wisconsin	12	$72,778.00	$8,356.96	$58,871.04	$67,228.00
Michigan	15	$237,781.82	$38,490.14	$132,495.02	$170,985.16
Minnesota	6	$207,675.00	$25,072.45	$183,684.34	$208,756.79
FY 1998 Totals	229	$2,481,494.07	$302,539.64	$1,670,445.73	$1,972,986.37
Cumulative Totals	524	$8,137,786.28	$960,187.17	$5,303,482.45	$6,258,701.62

MICHIGAN DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

Resident Protection Initiative

Established June, 1997

1. **In May 1997, Michigan established a distinct enforcement unit to oversee and coordinate federal and state nursing home enforcement actions.**

   - *The unit was upgraded to Division status on January 25, 1999.*

2. **In June 1997, Michigan implemented a new enforcement data system to track facility performance and streamline enforcement activities.**

   - *Complaint scheduling was integrated with the standard survey scheduling.*
   - *Federal enforcement actions and time frames are now tracked with State enforcement actions.*

3. **In January 1998, Michigan initiated a computer-based formula to identify facilities for early enforcement.**

   - *The system analyzes a facility's past and current compliance and complaint history and compares it to all other facilities to identify problem homes.*
   - *Facilities identified as poor performers by the system receive early oversight and enforcement action. It is in addition to the federal definition of poor performers.*

4. **On January 19, 1998, Michigan instituted a new Medicaid Bulletin which officially coordinated state and federal enforcement and mandates early intervention for poor performers.**

   - *The Bulletin reflects the state scoring system and increases the types of remedies available. The system is now being promulgated as a formal administrative rule.*
   - *Michigan also uses this early intervention and remedy system for its recommendations to HCFA regarding dual Medicare/Medicaid providers.*

5. Michigan has expanded the monitoring and rehabilitation of problem nursing homes by working with the private sector.

- *Michigan has contracted with the Michigan Public Health Institute (MPHI) to provide long-term oversight and correction of deficiencies.*
- *MPHI has a list of 36 trained consultant-remediators as of January 1999, and continues to identify more.*
- *The system provides for long-term oversight of facilities by state approved experts, and enables the permanent correction of deficiencies.*
- *In 1998, MPHI provided 65 Directed Plans of Correction; 28 directed In-Service Trainings; 15 administrative/clinical advisors; 8 temporary managers and 39 resident/family education programs.*
- *Michigan closed two nursing homes in 1998, one in 1999 and managed the orderly transfer of residents to other nursing facilities.*

6. Michigan has established a timely and objective Informal Deficiency Dispute Resolution (IDDR) process with the assistance of the Michigan Peer Review Organization (MPRO).

- *A panel of 5 federally trained reviewers provides quick resolution of disputes involving citations.*

June 1997

Poor care facilities targeted

Under new program, state will find them, respond to repeat problems

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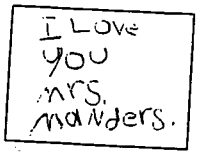


Desirae Brewer, 5, wrote this card for Marie Manders, who taught for the last time on Thursday.

Above: Manders, 73, holds students at McDowell Elementary: Deloria Sweatt, left, Desirae Brewer and Ashley Langman, all 5. Left: Manders walks students to gym.

Photos by CRAIG PORTER/Detroit Free Press

BY DAWSON BELL
Free Press Staff Writer

LANSING — State nursing-home regulators unveiled an enforcement plan Thursday that they said will help them zero in on homes that provide chronically poor care.

The system will rely on computer analysis of violations to find chronic problems, and add programs to solve them and resolve disputes between the state and the homes, said Kathy Wilbur, director of the Department of Consumer and Industry Services.

"The current system doesn't focus on chronic poor performance," Wilbur said. The department will target homes that fail repeatedly with "frequent, rapid response," she said.

Michigan nursing homes have been under increased scrutiny because of high numbers of violations of resident-care standards — double the national average, according to state officials. The problems were highlighted in a 1996 Free Press series on nursing-home conditions.

Thursday's announcement was met with guarded optimism from state nursing-home operators and a consumer-watchdog group.

Reginald Carter, executive vice-president of the Health Care Association of Michigan, a group of for-profit nursing-home operators, said the changes were "a first real step in the right direction."

"We felt that the whole industry has been tainted by a few" chronically troubled homes, Carter said. Nursing-home operators also have bristled at what they consider capricious enforcement of regulations.

Dorothy Collins, regional administrator of the federal Health Care Finance Authority, which oversees nursing homes, said she was glad to see Michigan "taking a leading role" in nursing-home oversight, attributable to the high "noise level" created by the number of violations.

Hollis Turnham, long-term-care ombudsman for the watchdog agency Citizens for Better Care, said she, too, thought the plan had promise.

"There are some things in their proposal, that if fully implemented and they have the staff ... will be improvements," Turnham said.

"We remain concerned that the department doesn't have sufficient staff to respond in a timely fashion."

Wilbur said the department is working on its staffing levels, and plans to replace inspection and oversight staff that retired early.

Maura Campbell, spokeswoman for the Consumer and Industry Services Department, said on-site inspections will not be curtailed.

Wilbur said about 40-50 of the state's 458 nursing homes are considered chronically troubled.

She said penalties assessed on homes in violation will not change, but that increased emphasis will be placed on correcting deficiencies and preventing problems.

TO READ MORE

You can find "Who Cares?" the award-winning Free Press report on Michigan nursing homes, on the Web at **www.freep.com/nursing/index.htm**

State sets to improve care homes

Tighter enforcement, partnership aim to weed out bad facilities

By Kathy Barks Hoffman
Associated Press

In an effort to weed out or improve the state's worst nursing homes, state officials said Thursday they would tighten enforcement and ask a public-private partnership to help bad nursing homes get better.

"We want to make sure that people are provided the highest quality care they can get in a nursing home," said Kathy Wilbur, state Consumer and Industry Services director.

"We know we have some very good nursing homes in the state," Wilbur said. But all agree that the numbers of nursing homes cited for poor care are too high, she said.

Walter Wheeler of the Bureau of Health Systems, which oversees inspections of the state's 458 nursing homes, said a computerized system will be in place by July to let the state track inspections and alert officials to the worst offenders.

"What this system is supposed to do is ring a bell," he said. He estimates the state has 40 to 50 nursing homes that chronically have problems.

The computer program will track inspection survey results since 1995, the number and severity of citations the home has received during inspections, the number of complaints the state has received and how quickly the facility fixed problems after the last inspection.

The worst offenders will be monitored more closely both by a new state enforcement unit and by people working for a public-private collaborative remediation project that will monitor improvements, correct care problems and provide consumer education.

The state plans to hire the Michigan Public Health Institute to handle the remediation project. Money for the contract will come from fines assessed against bad nursing homes and from the nursing home industry, Wheeler said.

The state already has signed a $30,000 contract with the Michigan Peer Review Organization to review about 500 disputes a year over deficiencies found by state inspectors, Wilbur said.

The state lost many of its 89 nursing home inspectors through the early retirement program offered this spring, but Wilbur said all will be replaced.

The new initiative was drawn up after a working group of consumers, nursing home providers and government agencies worked for six months reviewing why Michigan has a higher number of nursing homes cited for deficiencies than the national average and what improvements could be made.

The initiative has the blessing of federal Health Care Financing Authority, which oversees nursing homes that receive federal health care money.

"Michigan is probably taking the most innovative approach" to improving its nursing homes among Midwest states, said Dorothy Burk Collins of the federal agency's regional office in Chicago.

Facts about state nursing homes

- Michigan has 458 nursing homes that care for 52,271 residents.
- In 1996, state officials conducted 790 nursing home inspections and investigated 2,615 complaints and reports of poor care.
- Each nursing home is inspected every nine to 15 months.
- The state plans to hire new employees to bring its inspection staff back up to 89 inspectors after losing some to early retirement.
- To file a complaint about a nursing home, call 1-800-882-6006.

House approves some help for state roads

Coordination of Michigan Enforcement Activities

Division of Enforcement Training and Evaluation

Michigan has created a central division to provide overall direction and coordination of nursing home enforcement actions, including the following responsibilities:

- Assure requests for enforcement are consistent with policies and properly documented.
- Monitor non-compliance with enforcement orders and develop appropriate responses to violations.
- Assure that required documents are approved by the Attorney General and expert witnesses are obtained when needed.
- Arrange for informal and formal hearings necessary to provide due process related to enforcement actions.
- Represent the Bureau in discussions with health facilities and organizations that are the subject of specific compliance actions.
- Maintain the Michigan Enforcement Data System for tracking and evaluation of enforcement actions.
- Provide liaison with the Office of Legal and Legislative Affairs, the Michigan Department of Attorney General and HCFA.
- Provide enforcement training and information to other Bureau programs and interested organizations. Develop training materials and presentations on enforcement and documentation.
- Process Bureau responses to litigation, including answers to interrogatories and subpoenas; including arranging for staff involvement in litigation when required as witnesses.

Coordination of Michigan Enforcement Activities

Michigan's Enforcement Data System

In 1997, Michigan expanded its data system to include information on state and federal enforcement actions. The new data system provides for:

- Coordination of state and federal enforcement actions. The state and federal compliance and enforcement history of each facility will be electronically integrated and tracked.

- Integration of Michigan poor performer identification program. At the time of the annual survey, the data system will automatically update facility status, considering the most recent survey information, substantiated complaints since the last survey, and compliance history. The information will be quantified and compared to the performance of other nursing homes to determine whether poor performance exists.

- Electronic production of enforcement forms and linkage to relevant survey documents. This will help the paperwork flow, and will reduce the time between the completion of a survey and the initiation of enforcement action, if required.

- Accessibility by the Enforcement Unit of the primary survey documents (Federal ASPEN report; HCFA Form 2567; and state licensing forms) as soon as they are prepared, as well as the Scope & Severity grid related to any survey or complaint investigation.

- Continuous updating of a facility's federal compliance record as it moves through the enforcement process and retain as part of the electronic facility file.

- Tracking of critical dates in enforcement, including any required federal compliance date ("Date Certain"), the federal termination date and the date a facility achieves "Substantial Compliance" for federal purposes. The system will also track State remedies, the effective and end dates for each remedy and a calculation of fines, if any.

-- Tracking of state enforcement remedies, such as bans on admissions, compliance orders, license limitations or denials, facility monitors or managers, lockout status and civil fines assessed for patient rights violations.

-- Tracking of pending administrative hearings or conferences related to state enforcement actions and judicial appeals of state enforcement actions.

Michigan's Facility Performance Audit System

1. **Current Standard Survey Score**

A numeric score has been determined with points assigned for each citation as follows:

A, B and C	= 0		
D	= 2		
E	= 4		
F	= 6	FSQoC	= 10
G	= 10		
H	= 20	HSQoC	= 25
I	= 30	ISQoC	= 35
J	= 50	JSQoC	= 75
K	= 100	KSQoC	= 125
L	= 150	LSQoC	= 175

Point values assigned to standard survey deficiencies are weighted to reflect increased scope and severity. In addition, deficiencies which constitute substandard quality of care receive additional weight.

2. **Complaint History**

Point values (Refer to Table in Item 1 above) are also assigned to each deficiency cited as a result of a substantiated complaint. At the time of a standard survey, the data system reviews the facility's complaint activity of the previous survey cycle. Points are assigned for all substantiated complaints, as above, and the total complaint score is added to the current raw standard survey score.

Note: Survey findings, which result from substantiated complaint activity, receive equal weight, in the determination of "poor performance", as do findings of the standard survey.

3. **Extended or Protracted Non-Compliance**

Point values are also assigned for the number of revisits which were required in the facility's previous survey cycle to achieve substantial compliance. The flat point assignment is:

1st Revisit	=	0 points
2nd Revisit	=	50 points
3rd Revisit	=	75 additional points
4th Revisit	=	100 additional points

Termination (non-compliance for a period of 180 days) = 250 points

4. **Total "Performance Score"**

Raw Survey Score + Complaint Score + Extended Non-Compliance Score = Total Performance Score.

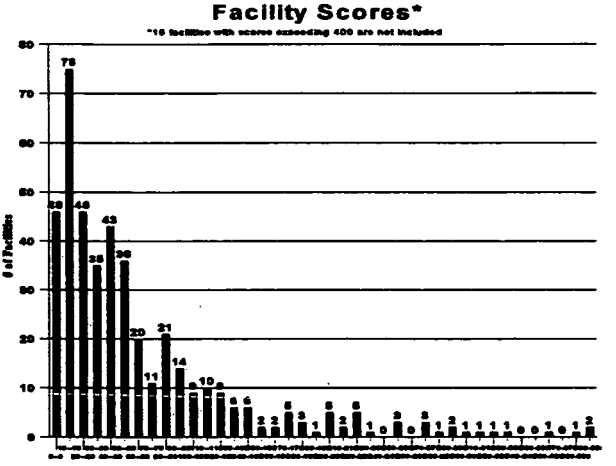
5. **Establishing and Applying a Trigger Score**

The computer program examines the total performance score of every facility surveyed in the last complete quarter. The last complete quarter in the data system is two quarters before the current quarter because it takes time for the system to be updated to take account of informal deficiency review (IDDR) results.

The total performance scores are added together and averaged and standard deviations from the average score are determined. A "trigger" score is set at one standard deviation from the average total score at the beginning of each calendar quarter.

Facilities whose total performance score exceeds the trigger score are automatically identified in the enforcement data system and receive early review.

Typical Performance Score Distribution



Typical Score Distribution

SELECTION CRITERIA FOR ENFORCEMENT ACTION

A facility's survey findings and compliance history are analyzed by survey team managers to select and recommend enforcement remedies for imposition. Selection criteria are listed below:

- Staff Instability (Facility Management).
- Repeat Quality Indicator Citations from previous standard survey cycle.
- Poor Performance previous cycle.
- Ineffectiveness of enforcement actions in previous standard survey cycle.
- Inability to sustain compliance since last standard survey cycle.
- Scope/Severity of citations at revisit has increased.
- Minimal progress has been made in correcting citations.
- Non-implementation or ineffective implementation of Plan of Correction.
- Repeat Quality Indicator Citations (within current survey cycle).
- New citations.
- History of facility's inability to achieve compliance.
- History of facility's inability to sustain compliance.
- Previous enforcement actions ineffective.
- Results of reports from CRP, if any available.
- Refusal to accept remediation approach.
- Resistive to CRP intervention.
- Other.

Remedies and Sanctions

June 12, 1997

State and Federal Enforcement Actions for Poor Performance

Immed. Jeopardy	[J] **Menu 6** **POC Required**	[K] **Menu 6** **POC Required**	[L] **Menu 6** **POC Required**
Actual Harm, but no Immed. Jeopardy	[G] **Menu 4** **POC Required**	[H] **Menu 5 (if SqoC)** **or** **Menu 4** **POC Required**	[I] **Menu 5 (if SqoC)** **or** **Menu 4** **POC Required**
No actual Harm-Potential for more than Minimal Harm-No Immed. Jeopardy	[D] **Menu 4** **POC Required**	[E] **Menu 4** **POC Required**	[F] **Menu 5 (if SqoC)** **or** **Menu 4** **POC Required**
No Actual Harm-potential for no more than Minimal Harm	[A] No Remedies	[B] POC Required	[C] POC Required
	Isolated	Pattern	Widespread

When more than one menu is indicated by the survey findings, the highest appropriate menu will be applied.

Menu 6: If "Immediate Jeopardy" is found at ANY[1] Survey:

Federal Enforcement Remedies (§488.408)

Category 1 (optional):
- Directed Plan of Correction[2];
- Directed In-Service Training[2];
- State Monitoring

Category 2 (optional):
- Denial of Payment for New Admissions

Category 3 (required):
- Civil Money Penalty ($3,050 - $10,000)

and

23 Day Termination of Provider Agreement/s

Other:
- Nurse Aide Training Lockout[3]

State Enforcement Remedies (Public Act 368 of 1978):
- Emergency Order Limiting, Suspending or Revoking a License (Section 20168);
- Letter of Intent to Revoke Licensure;
- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements (Section 20162 or 21799b; BOA Policy of 10/1/90);
- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
- State Patient Rights Penalties, if applicable (Section 21799(c)(4));

Validation of removal of Immediate Jeopardy counts as a revisit.

Menu 5: If Substandard Quality of Care (SQoC) less than immediate jeopardy is found at ANY survey:

Federal Enforcement Remedies (§488.408)

Category 1 (optional):
- -- Directed Plan of Correction[2] ;
- -- Directed In-Service Training[2];
- -- State Monitoring

Category 2 (required):
- -- Denial of Payment for New Admissions
- -- Civil Money Penalty ($50 - $3,000 per day)

Other:
- -- Nurse Aide Training Lockout[3]

State Enforcement Remedies (Public Act 368 of 1978):
- -- Letter of Intent to Revoke Licensure;
- -- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements (Section 20162 or 21799b; BOA Policy of 10/1/90);
- -- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
- -- State Patient Rights Penalties, if applicable (Section 21799(c)(4));

If the "SQoC" is not resolved by the first or subsequent revisit:

- -- Denial of Payment for New Admissions (required federal remedy if noncompliance past the 90th day) §488.412(3)(c)
- -- Initiate Receivership Sale (Section 21751);
- -- Additional enforcement action from Menu 5.

Menu 4: If "Substantial Compliance" is not found at standard or abbreviated survey:

Federal Enforcement Remedies (§488.408)

Category 1 (optional for F and G; required for D and E):
-- Directed Plan of Correction[2] ;
-- Directed In-Service Training[2];
-- State Monitoring

Category 2 (required for F and G; optional for D and E):
-- Denial of Payment for New Admissions

Other:
-- Nurse Aide Training Lockout[3]

State Enforcement Remedies (Public Act 368 of 1978):
-- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements (Section 20162 or 21799b; BOA Policy of 10/1/90);
-- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
-- State Patient Rights Penalties, if applicable (Section 21799(c)(4));

If "Substantial Compliance" is not achieved at the first or subsequent revisit:

-- Letter of Intent to Revoke License;
-- Denial of Payment for New Admissions (required federal remedy if noncompliance past the 90th day) (§488.412(3)(c))
-- Additional enforcement action from Menu 4.

If "Substantial Compliance" is not achieved by 180 days:

-- Termination, if required by federal law;
-- Initiate Receivership Sale (Section 21751).

Notes:

Denial of Payment for New Admissions and State Monitoring will be imposed when a facility has been found to have provided substandard quality of care on three (3) consecutive standard surveys.

NOTICE OF TERMINATION for failure to achieve substantial compliance within 180 days is always included with notification of alternate remedies.

Footnotes:

[1]ANY survey means an annual standard survey, abbreviated survey or revisit survey. A standard survey includes both the health survey and life safety code survey findings.

[2]Options: Facility developed or CRP referral

[3]Federal law, as specified in the Social Security Act at Section 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Remedies and Sanctions
June 12, 1997

State and Federal Enforcement Actions for Other Surveys

Immed. Jeopardy	[J] Menu 3 POC Required	[K] Menu 3 POC Required	[L] Menu 3 POC Required
Actual Harm, but no Immed. Jeopardy	[G] Menu 1 POC Required	[H] Menu 2 (if SqoC) or Menu 1 POC Required	[I] Menu 2 (if SqoC) or Menu 1 POC Required
No actual Harm-Potential for more than Minimal Harm-No Imm. Jeopardy	[D] Menu 1 POC Required	[E] Menu 1 POC Required	[F] Menu 2 (if SqoC) or Menu 1 POC Required
No Actual Harm-potential for no more than Minimal Harm	[A] No Remedies	[B] POC Required	[C] POC Required
	Isolated	Pattern	Widespread

When more than one menu is indicated by the survey findings, the highest appropriate menu will be applied.

Menu 3: If "Immediate Jeopardy" is found at ANY survey:

Federal Enforcement Remedies (§488.408)
Category 1 (optional):
-- Directed Plan of Correction[2] ;
-- Directed In-Service Training[2];
-- State Monitoring

Category 2 (optional):
-- Denial of Payment for New Admissions

Category 3 (required):
-- 23 Day Termination of Provider Agreement/s

Other:
-- Nurse Aide Training Lockout[3]

State Enforcement Remedies (Public Act 368 of 1978):
-- Emergency Order Limiting, Suspending or Revoking a License (Section 20168);
-- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements (Section 20162 or 21799b; BOA Policy of 10/1/90);
-- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
-- State Patient Rights Penalties, if applicable (Section 21799(c)(4));

Validation of removal of Immediate Jeopardy counts as a revisit.

If "Substandard Quality of Care" remains at the first revisit or thereafter:

Federal Enforcement Remedies (§488.408)
Category 1 (optional):
-- Directed Plan of Correction[2] ;
-- Directed In-Service Training[2];
-- State Monitoring
Category 2 (required)
-- Denial of Payment for New Admissions
Other
-- Denial of Payment for New Admissions (required federal remedy for noncompliance past the 90th day)

Menu 3: If "Substandard Quality of Care" remains at the first revisit or thereafter, cont.:

State Enforcement Remedies (Public Act 368 of 1978):
- -- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
- -- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific requirements (Section 20162 or 21799b; BOA Policy of 10/1/90);
- -- State Patient Rights Penalties, if applicable (Section 21799(c)(4));
- -- Letter of Intent to Revoke License.

If "Substantial Compliance" is not found at the first revisit or thereafter:

Federal Enforcement Remedies (§488.408)

Category 1 (optional):
- -- Directed Plan of Correction[2] ;
- -- Directed In-Service Training[2];
- -- State Monitoring

Category 2 (Required for F and G levels; optional for D and E levels)
- --Denial of Payment for New Admissions

Other
- --Denial of Payment for New Admissions (required federal remedy for noncompliance past the 90th day)

State Enforcement Remedies (Public Act 368 of 1978):
- -- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
- -- State Patient Rights Penalties, if applicable (Sec. 21799(c)(4));
- -- Other remedial enforcement actions appropriate to the specific case, which may include Correction Order or Notice To Discontinue Admissions or Readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific requirements (Sections 20162 or 21799b; BOA Policy of 10/1/90).

Menu 2: If "Substandard Quality of Care" is found at ANY survey:

Federal Enforcement Remedies (§488.408)
Category 1 (optional):
-- Directed Plan of Correction[2] ;
-- Directed In-Service Training[2];
-- State Monitoring
Other:
-- Nurse Aide Training Lockout[3]

State Enforcement Remedies (Public Act 368 of 1978) (Immediate Imposition):
-- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
-- State Patient Rights Penalties, if applicable (Section 21799(c)(4));
-- Ban On Admissions if Consistent With Dept. Policy of 10/1/90;

If "Substandard Quality of Care" remains at the first revisit or thereafter:

Federal Enforcement Remedies (§488.408)
Category 1 (optional):
-- Directed Plan of Correction[2] ;
-- Directed In-Service Training[2];
-- State Monitoring

Category 2 (required):
-- Denial of Payment for New Admissions

Other:
-- Nurse Aide Training Lockout[3]
-- Denial of Payment for New Admissions (required remedy for noncompliance past the 90th day)

State Enforcement Remedies (Public Act 368 of 1978):
-- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
-- Correction Order or Notice To Discontinue Admissions or readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific requirements (Sections 20162 or 21799b; BOA Policy of 10/1/90);
-- State Patient Rights Penalties, if applicable (Section 21799(c)(4));
-- Letter of Intent to Revoke License.

If "Substantial Compliance" is not found at the first revisit or thereafter:

Federal Enforcement Remedies (§488.408)

Category 1 (required for D and E levels; optional for F, G, H and I levels):

-- Directed Plan of Correction[2] ;

-- Directed In-Service Training[2];

-- State Monitoring

Category 2 (required for F, G, H and I levels; optional for D and E levels)

--Denial of Payment for New Admissions

Other

--Denial of Payment for New Admissions (required federal remedy for noncompliance past the 90th day)

State Enforcement Remedies (Public Act 368 of 1978):

-- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)

-- State Patient Rights Penalties, if applicable (Section 21799(c)(4));

-- Other remedial enforcement actions appropriate to the specific case, which may include Correction Order or Notice To Discontinue Admissions or Readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific requirements (Sections 20162 or 21799b; BOA Policy of 10/1/90).

Menu 1: If "Substantial Compliance" is not found at standard or abbreviated survey:

No remedies; date certain opportunity to correct is given.

If "Substantial Compliance" is not achieved at the first revisit or thereafter:

Federal Enforcement Remedies

Category 1 (required for D and E levels; optional for F, G, H and I levels):

- Directed Plan of Correction[2] ;
- Directed In-Service Training[2];
- State Monitoring

Category 2 (required for F, G, H and I levels; optional for D and E levels)

- Denial of Payment for New Admissions

Other

- Denial of Payment for New Admissions (required federal remedy for noncompliance past the 90th day)

State Enforcement Remedies (Public Act 368 of 1978):

- Appointment of a Temporary Manager/Advisor (by referral to Collaborative Remediation Project)
- State Patient Rights Penalties, if applicable (Section 21799(c)(4));
- Other remedial enforcement actions appropriate to the specific case, which may include Correction Order or Notice To Discontinue Admissions or Readmissions; Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific requirements (Sections 20162 or 21799b; BOA Policy of 10/1/90).

Notes:
Denial of Payment for New Admissions and State Monitoring will be imposed when a facility has been found to have provided substandard quality of care on three (3) consecutive standard surveys.

NOTICE OF TERMINATION for failure to achieve substantial compliance within 180 days is always included with notification of alternate remedies.

Footnotes:
[1]ANY survey means an annual standard survey, abbreviated survey or revisit survey. A standard survey includes both the health survey and life safety code survey findings.

[2]Options: Facility developed or CRP referral

[3]Federal law, as specified in the Social Security Act at Section 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Michigan Abstinence Partnership
Michigan Commission on Genetic Privacy & Progress
Fetal Infant Mortality Review
Violence Prevention: Michigan Medical Examiner Reporting
Data Base
Local Public Health Accreditation
Cancer Policy Studies
Cardiovascular Disease Resource Center
Alzheimer's Disease Community Support
Long term Care Quality Improvement Program
Nutrition Project
Child Death Review
Domestic Elder Abuse Research
Drug Policy-Safe Schools Evaluation Training
Pediatric AIDS
Health Systems Development in Child Care
Maternal and Infant Support Services Evaluations
Infant & Toddler Early Intervention system
Senior Volunteer Evaluation
Sexual Assault and Rape Prevention
Firearm Injury Reduction Education
PBB Endocrine Survey
Immunization Registry
Recidivism in Drunk Driving Evaluation
Tobacco Data & Evaluation

"The mission of MPHI is to maximize positive health conditions in populations and communities through collaboration, scientific inquiry, and the application of scientific health practices. MPHI will carry the voice of communities to health policy makers, scientists, purchasers, and funders. MPHI activities will advance community capacity to improve health and to reduce disparities among population groups and geographic areas."

Michigan Public Health Institute
2436 Woodlake Circle, Suite 300
Okemos, MI 48864
517/324-8300 Fax: 517/381-0260
www.mphi.org

MICHIGAN PUBLIC HEALTH INSTITUTE

People and partnerships
to advance community health

"The Michigan Public Health Institute has earned recognition as a trusted, honest broker between communities, government and academic partners. This role of "intermediary" is very important in making meaningful advances in community health."

—Glenn Kossick, Executive Director,
Metro Health Foundation,
MPHI Board of Directors

MPHI: People & Partnership

The Michigan Public Health Institute (MPHI) is a private nonprofit research and health policy institute that promotes and carries out projects that foster community health. The institute has offices in Okemos, Ann Arbor, and Detroit, and receives all of its funding on a project basis. In FY 97, MPHI managed 120 projects, with annual revenues of $16 million.

MPHI began in 1990 as a partnership of four institutions: Michigan State University, the University of Michigan, Wayne State University, and the Michigan Department of Community Health. It has evolved, and is a trusted voice in the dialogue between communities, policy-makers, funders, and academia. MPHI also provides hands-on technical support to communities so that they can incorporate science and best-practice information into decisions about community health and prevention.

MPHI has earned the trust of communities by strictly adhering to values of collaboration, excellence in science, neutrality, and integrity. It is that trust, built over time, which has enabled MPHI to emerge as an effective intermediary between parties working to advance community health.

Our Major Initiatives

DATA SYSTEMS, EVALUATION, AND TRAINING
40+ staff build data systems, conduct survey research, provide education and training, conduct evaluation, and support community health assessment with a wide variety of clients.

SYSTEMS REFORM
Reforming Michigan's supportive systems for infants, toddlers, and families through technical assistance, evaluation, and training.

COMPREHENSIVE COMMUNITY HEALTH MODELS OF MICHIGAN
A foundation/community partnership to demonstrate local community decision-making processes and develop comprehensive, integrated health delivery systems.

MICHIGAN COMMUNITY HEALTH LEADERSHIP INSTITUTE
Year-long leadership development program for mid-career and senior community health professionals from the public and private sectors.

INTERACTIVE LEARNING CENTER
State-of-the-art videoconferencing, satellite downlinking, and conference facility serving MPHI projects, clients, and non-profit, government, and corporate clients.

MICHIGAN COMMUNITY HEALTH ELECTRONIC LIBRARY
Growing resource for electronic access to community health data, literature, and search capabilities for MPHI projects, clients, and interested community health professionals.

LONG TERM CARE REMEDIATION
Collaborative partnerships to improve the quality of long term care services in Michigan.

CHILD AND ADOLESCENT HEALTH
Advancing Michigan capacity to prevent fetal, infant and child death and support positive child adolescent health behaviors and health services.

HEALTH PROMOTION AND DISEASE PREVENTION
Support to communities and state government in health promotion and in preventing, detecting and treating cancer, heart disease, dementia, violence, addictions and other conditions.

A Sample of 1997 Projects

Alzheimer's/Dementia

The purpose of this program is to expand the knowledge and referral of dementia information and to coordinate local and state dementia resources.

Alzheimers Disease Community Support

This project, housed at the University of Michigan Alzheimer's Disease Research Center in Ann Arbor, provides six Michigan communities with community assessment, community organization, educational intervention, and support services for Alzheimer's disease diagnosis, treatment, and community services.

BCFS Training

Provides high quality training on a variety of clinical topics and to local agencies that currently run Division of Family & Community Health Maternal and Child Health programs to providers and organizations selected under the Comprehensive Health Plan and agencies that subcontract with these providers.

Cancer Control Support

Provides technical assistance and support for the coordination of cancer control efforts of state and local public health agencies as well as private and non-profit agencies and community organizations in their joint efforts to reduce morbidity and mortality through strategies to prevent cancer, or detect it early. Also, enables timely and appropriate treatment and rehabilitative care or assure access to palliative care.

Cancer Epidemiology Services

This project provides epidemiological services for the Michigan Department of Community Health Cancer Section Breast and Cervical Cancer Program and the Michigan Cancer Consortium Initiative.

Cancer Policy Studies

Conducts policy and evaluation studies and provides expert consultation and technical support for cancer prevention and control. Project activities include consultation on cancer related curricula in Michigan's primary care medical residency programs, analysis of organizational and enrollee personal characteristics associated with variation in rescreening rates within Michigan's BCCCP, developing plan for evaluating Michigan's new Cancer Control Initiative, providing expert consultation and technical support to the BCCCP including the development of evaluation studies as needed, and other projects related to cancer policies to support the Cancer Section's cancer control planning team.

Cardiovascular Disease Resource Center

The Resource Center for Cardiovascular Health (RCCH) is a collaborative effort between the Michigan Department of Community Health and MPHI. It is a resource for local agencies and health professionals involved in the statewide cardiovascular disease prevention program to use in reducing cardiovascular disease. It provides training and consultation, develops and disseminates educational materials on cardiovascular health-related topics, coordinates demonstration projects, and conducts research and outreach activities in various communities in Michigan.

2436 Woodlake Circle Suite 300
Okemos MI 48864
517-324-8301

Child Death Review

Establishes ongoing capacity at the local level in all 83 counties for determining and studying the causes of child death in Michigan, and establishes a state advisory panel for child death review. Technical assistance is provided to local Child Fatality Review Teams. Goals of the project include accurate identification and uniform documentation of the cause of every child death; coordination of efforts among participating agencies; improvement of criminal investigation and prosecution of child abuse homicides; design and implementation of cooperative protocols for investigation of certain categories of child deaths; improve communication among agencies and more timely notification of agencies when a child dies; and identification of needed changes in legislation, policy, and practices.

Collaborative Remediation in Long Term Care

A three project program focused on promoting quality care and services in the long term care setting. The Collaborative Remediation Project assists long term care facilities with short-term and extended development and implementation of corrective action toward regulatory compliance. The Continuous Quality Improvement Project provides assistance to the State Medicaid Agency in the review, evaluation, and on-site validation of the Continuous Quality Improvement Incentive Program in which over 400 Michigan nursing homes participate annually. The Resident/Family Education Project is a program of consumer education and information, covering various aspects of Long Term Care regulatory policy, payment sources, and care/service quality. It is delivered to consumers statewide.

Comprehensive Community Health Models

The Comprehensive Community Health Models of Michigan initiative was launched in 1992 by the WK Kellogg Foundation. Major assumptions to be tested by the project are that 1) communities can identify their health care needs and manage the health care resources to address them, and 2) consumers, payers, and providers of health care need to be more engaged in joint decision making related to the allocation of resources supporting the delivery of health care services. Three Michigan communities—Calhou Muskegon, and St. Clair Counties—were invited to join in a partnership to implement the CCHMs Model. Core objective of the project include establishing a community decision-making process, achieving community-wide coverage, and developing a comprehensive, integrated delivery system. The communities are currently implementing activities such as a school health initiative, health purchasing alliance, pilot projects to expand access to the uninsured, neighborhood health links, health promotion activities, teen sexuality surveys, and many others to achieve these objectives.

Crime Victims Services Comm

This project will develop a technical support role to assist the Crime Victims Services Community in creating more efficient systems for collecting and synthesizing better quality information and data.

Domestic Elder Abuse Research -Violence Prevention

The purpose of this project is to look at the hidden and serious issue of male-to-female relationship violence among intimate partners age 50 and over.

Drug Policy-Safe Schools Evaluation Training

Provides assistance to local districts in planning and evaluating a comprehensive program for safe schools, using a systematic program planning and evaluation model, such as a logic model. The project will support Michigan's prevention plan that emphasizes local choice and community involvement and includes expansion of school-community relationships in the area of 1) needs assessment, 2) coalition building, 3) program planning, and 4) evaluation of specific prevention programs.

Electronic Library

MPHI will provide technical assistance and support in the development of all aspects of delivery of library information electronically to users.

Evaluation of the Infant Support Services Program

The Infant Support Services (ISS) program is designed to provide support and case coordination services to at-risk infants and their families in order to help reduce infant mortality, morbidity, and abuse and neglect. This evaluation examines the extent to which Infant Support Services is meeting its intended objectives and the effects the program has on the lives of the clients it serves. Six hundred of the women and teens who were interviewed for the evaluation of the Maternal Support Services program, a companion program that provides support services to at-risk pregnant women, will be contacted at least one year after their babies are born to request their participation.

Evaluation of the Maternal Support Services Program

The purpose of Phase II of the evaluation of the Maternal Support Services (MSS) program is to finalize the master datafile developed over Phase I of the evaluation. The master datafile includes findings from interview data and medical record data compiled from over 1,000 women and teens who delivered babies in eight hospitals in six counties throughout the state; key information from the hospital charts, selected information from the birth certificate worksheets; claims data from Medicaid files and records from agencies that served the MSS client included in postpartum interview. The evaluatio examines the needs, behaviors, attitudes, and birth outcomes of three subgroups of women interviewed: (1) those who participated in Maternal Support Services, (2) those who were eligible for Medicaid, and (3) those who did not participate in MSS or Medicaid.

Fetal Infant Mortality Review

Provides state level technical assistance to enhance existing FIMRs in Michigan and expand efforts to encourage communities to establish FIMRs, in an attempt to improve systems of care that impact healthy birth outcomes.

Firearm Injury Reduction Education - Violence Prevention

The Firearm Injury Reduction Education (FIRE) program is a comprehensive community-based initiative aimed at reducing the number of firearm injuries and deaths in Michigan. The FIRE program is a multifaceted intervention that includes (1) videotaped testimonials; (2) radio public service announcements and promotional campaign, and (3) pamphlet distribution. In all cases, target audience members have an opportunity to receive a free gun trigger lock.

HIV/AIDS Continuum of Care Symposia

Facilitate and administer four, one-day symposia, and a closing consensus Symposium Meeting in February 1998. The symposium will include national and state experts, persons with AIDS, managed care, and AIDS service providers presenting on topics such as the Lazarus Effect, Vocational Rehab and Job Training for Persons with AIDS, and HMO Creative Strategies and Innovative Approaches for Low-Cost Health Care. An MPHI facilitator will lead a consensus building discussion to form recommendations for program development.

Health Systems Development in Child Care

Work with the Child Care Coordinating Council of Detroit-Wayne County in devising strategies for promoting safe and healthy environments for children in family child care settings. Over three years the project will seek to (1) identify children, families, and child care providers to target for immunization services, insurance coverage, safety information and violence prevention; (2) link children, families and child care providers with direct immunization services; (3) enroll eligible individuals in Medicaid or other health care service coverage; (4) link families with safety information and devices for improving the safety of child care homes; and (5) provide training for families and child care providers on skills needed for reducing family and community violence and how to access available prevention services.

Infant & Toddler Early Intervention System

Implement and manage technical assistance and training as part of the comprehensive system of personnel development for "Early On." The project will also improve delivery of early intervention services to infants and toddlers with disabilities and their families.

Juvenile Justice Grants Unit Technical Assistant

This is a state-wide, multi-site demonstration project designed to reduce risks and enhance protective factors associated with delinquency and youth violence. MPHI provides technical assistance to communities in utilizing the federally-developed Community Self-Evaluation Workbook, and in developing and implementing independent (site-specific) evaluation components.

The project has expanded in its third year to include technical assistance to 25 sites, up from 14. The project has an added collaborative component with the national evaluation of Title V, being conducted by Caliber Assoc. in Alexandria, VA.

Michigan Community Health Leadership Institute

Coordinate and administer the Michigan Community Health Leadership Institute, a year-long leadership development program for mid-career and senior community health professionals from the public and private sectors.

Local Health Department Accreditation

Administer funds and provide technical assistance for development and implementation of a local health department accreditation system to evaluate compliance with program standards established for the required and allowable cost shared services pursuant to Michigan's Public Health Code.

MAP Evaluation - MI Abstinence Partnership

Evaluation of the Michigan Abstinence Partnership program which seeks to positively impact adolescent health by promoting abstinence from high-risk behavior, including early sexual activity and use of drugs, alcohol, and tobacco. A comprehensive approach involving coalitions, communities, media, and curriculum is being used. The project is in its fourth year.

MAP Technical Support - MI Abstinence Partnership

A major state initiative to promote abstinence for 10-14 year olds. MPHI provides technical assistance to the communities which are funded to develop local abstinence programs for 10-14 year olds. Communities are implementing a wide range of innovative programs, including curricula, special events, after school programs and parent support. The MPHI team of 5 consultants helps communities plan, implement and evaluate their programs.

Michigan Prevention Partners

Supports the activities of 11 substance abuse prevention community partnerships and coalitions throughout the state. Support includes training and technical assistance in substance abuse prevention, managed care and sustainability. MIPP assists community-based prevention groups with development of local policies which will lead to decreased use of alcohol, tobacco and other drugs by youth and adults. MIPP also plays an important role in collaborating with other substance abuse prevention organizations to coordinate prevention activities in Michigan.

Nutrition Project

Promotes the reduction of nutrition-related chronic disease risks identified by Michigan's critical health indicators. It provides grant funding to stimulate and test innovative community-based nutrition programs, teaches health professionals to evaluate the effectiveness and impact of nutrition interventions, and collaborates with experts across health and science disciplines to seek new solutions to risky eating behaviors.

Opening Doors

Stimulates development of innovative strategies that reduce barriers to services for individuals considered to be "hard to reach" for family planning services. MPHI will provide consultation and technical assistance to funded agencies and is monitoring agency performance. A final report will document lessons learned and implications for family planning policy and service delivery.

PBB Endocrine Project

A survey research project sponsored by Center for Disease Control and Emory University, gathering self-reported data from women in the Michigan Long Term PBB Registry regarding hormone functioning.

Pediatric AIDS

Evaluates the effectiveness of the Ryan White Title IV Pediatric AIDS program to provide comprehensive services to women and children with AIDS in Southeast Michigan.

Pregnancy Risk Assessment Monitor Survey

The Pregnancy Risk Assessment Monitoring System, which surveys 1,600 African-American and White women postpartum about their experiences during pregnancy and involvement in health and risky behaviors, has been run historically by the Michigan Department of Community Health. As of October 1, 1997, MPHI will be responsible for administering the survey. The survey includes a written questionnaire, telephone follow-up calls to non-respondents, and in-hospital postpartum interviews. Basic frequency distributions of responses will be tabulated and included in an annual report of findings.

Recidivism in Drunk Driving Evaluation

Develop a thorough understanding of current and prior evaluations of recidivism for drunk driving. Identify research programs that are thought to be effective in other states. Critique the appropriateness of evaluations and assessment instruments. Develop profile of recidivist groups in Michigan. Develop comprehensive list of programs in Michigan that judges use for referral. Determine which programs judges believe are successful and how these judges decide a program has been successful.

SEMHAC HIV/AIDS Needs Assessment

Identify and prioritize the extent and type of current and future services needed for persons living with HIV/AIDS in the Detroit Metropolitan Area through the use of survey and other assessment techniques.

Senior Volunteer Evaluation

Provides technical assistance to State Office of Services to the Aging on the evaluation of its senior volunteer programs including: development of two survey instruments (volunteers and agencies), design of sampling and data collection procedures, and training in data collection. Work includes technical assistance in formulating appropriate outcome measures to determine program impact.

Sexual Assault and Rape Prevention

MPHI, in collaboration with the University of Illinois at Chicago, provides evaluation technical assistance and training to 35 agencies across the state which received grants for rape prevention and/or rape crisis service delivery.

Statistical and Technical Assistance to Blue Care Network

Develop and review sampling designs; selected review, analysis and interpretation of data; develop and provide training and training materials in basic principles and uses of statistics for policy decision making and consultative advice for software selection for use in biostatistical analysis.

Strong Families/Safe Children

Lead the efforts to evaluate the Strong Families/Safe Children Initiative and increase the capacity of communities to evaluate collaborative initiatives.

Substance Abuse Project

Provides training to service providers and administrators on ways to implement smoke-free policies and nicotine addiction treatment in substance abuse treatment agencies.

Telecommunications – TIIAP Immunization Registry

The goal is to improve greater Detroit-area immunization rates through implementation of a Childhood Immunization Information Network that links private and public caregivers and administrators in southeast Michigan. Networking technologies will be matched to end user preferences and will include interactive voice response, client-server, and other options. Private-sector buy-in is being encouraged through support for immunization tracking software selection, installation, and training.

Tobacco Data & Evaluation

The purpose of this project is to monitor and make accessible current data on Michigan-specific tobacco use, the effects of tobacco use, impact of tobacco reduction strategies, and to provide feedback on the impact of Michigan-specific strategies to reduce tobacco use.

Violence Prevention: Medical Examiner Reporting

Medical examiner investigations produce valuable information useful to public health officials, the criminal justice system, and families of the deceased. The goal of the Michigan Medical Examiner Database Project is to standardize and electronically collect data from each of the 83 county-based medical examiner offices. Michigan will be one of the first states with a county-based system to have a state-wide, voluntary medical examiner database and a leader in utilizing the Internet for this type of data collection.

Vision Project

Determines the efficiency of a new vision test in screening school children's vision, data from pilot regions of 80,000 children in the experimental group and 70,000 children in the comparison group will be collected and analyzed.

Collaborative Remediation Agency Project

I. Background

Nursing homes and hospital long term care units are subject to state licensure standards as a condition of operation. These facilities are also subject to Medicare and Medicaid provider conditions of participation if they participate in those reimbursement programs. Standards are monitored through on site surveys by the Department and enforced through the imposition of penalties and remedies as provided by state and federal law.

The Collaborative Remediation Project is intended to study the possibility of improved quality of care and compliance through increased public-private collaboration in oversight and assistance to providers with compliance problems; education for long term care residents and their families; and the promotion of continuous quality improvement efforts by providers.

II. Project Description

This is a two year study of collaboration between state government, health service providers, consumers and private organizations involved in quality assurance for nursing homes and hospital long term care facilities. The Project began in 1997. The Project involves the establishment of a Collaborative Remediation Project to (1) assist long-term care providers in the achievement and maintenance of compliance with licensure and certification requirements; (2) provide education to residents and their families regarding appropriate care and rights; and (3) establish and administer criteria for the Continuous Quality Improvement Program (CQIP) which awards providers with significant quality improvement initiatives.

Start-up funding comes from fines already collected at the state and federal levels under Medicare and Medicaid. In addition, the project will be authorized to charge a fee to providers for the actual cost of services provided. The Michigan Public Health Institute will undertake a pilot project to initiate and evaluate the merits of increased public/private collaboration.

The provider oversight and assistance portion of the Project will have at least the following characteristics: (1) The Project will utilize only advisors who meet minimum state requirements; (2) the Project will use standards which are equivalent to state provider requirements; (3) the fees charged for advisor services do not exceed costs as determined by the Department; (4) the Project will be capable of providing objective, consistent and timely

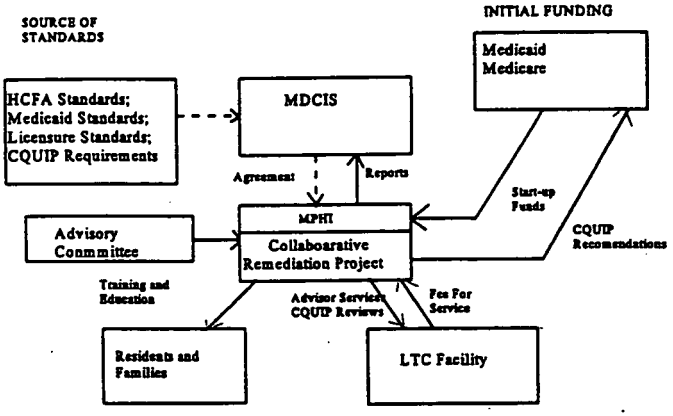
reports to the Department on the activities of its advisors; (5) the Project will agree to participate in reporting requirements sufficient to evaluate the performance of its advisors; (6) the Project will have a broad-based advisory body to assist in policy development; and (7) the Project will agree that all reports and records related to this pilot project will be available to the public unless prohibited by law.

For the period of the pilot project, the Department will utilize referral to the designated Collaborative Remediation Project as an alternative remedy in its enforcement processes.

The Project will also develop and promote training and education for long term care residents and their families to increase the level of understanding regarding the quality of care and residents' rights.

In addition, the Project will adopt criteria, receive applications and verify provider eligibility for CQIP grants which will be recognized by the Medicaid Program for its CQIP awards.

Project Organization



Michigan Public Health Institute **January 12, 1999**
Project Final Report

Venoy Nursing Home Closure
66-66105-000
May 1, 1998 – December 18, 1998

I. CRP Activity

At the request of the MDCH and MCIS, the CRP served as the temporary closure agency at Venoy Nursing Center in Detroit, Michigan. CRP staff responded to the request and arrived on-site on May 4, 1998. Several staff members assisted FIA and on-site staff with the transfer of residents from May 4 through May 15, the day the last resident was transferred from the facility. CRP has retained detailed accounts of its activity on-site and off-site during this transition period. These records continue to be available in the LTCQIP office.

Subsequently, CRP staff were required by client agency staff to seize, duplicate (upon written request) and safely store all resident records involved in the transfer during the given time period. Also, CRP staff worked closely with legal representatives to petition the bankruptcy court for employment records in an effort to process payroll for employees on-site during the temporary closure period. On December 18, 1998, LTCQIP staff released payroll checks to these individuals and original resident records were released to the Mali Corporation's legal representative in Detroit. LTCQIP staff witnessed the transfer of these records.

The CRP staff have concluded their activity with regards to the Venoy Nursing Center closure. The only outstanding issues identified at this time are any expenditures for legal services not billed as of this date, or any request for CRP Temporary Management team members to testify in any criminal or civil actions taken against the owner by the State Attorney General.

Michigan Public Health Institute **January 12, 1999**
Final Project Report

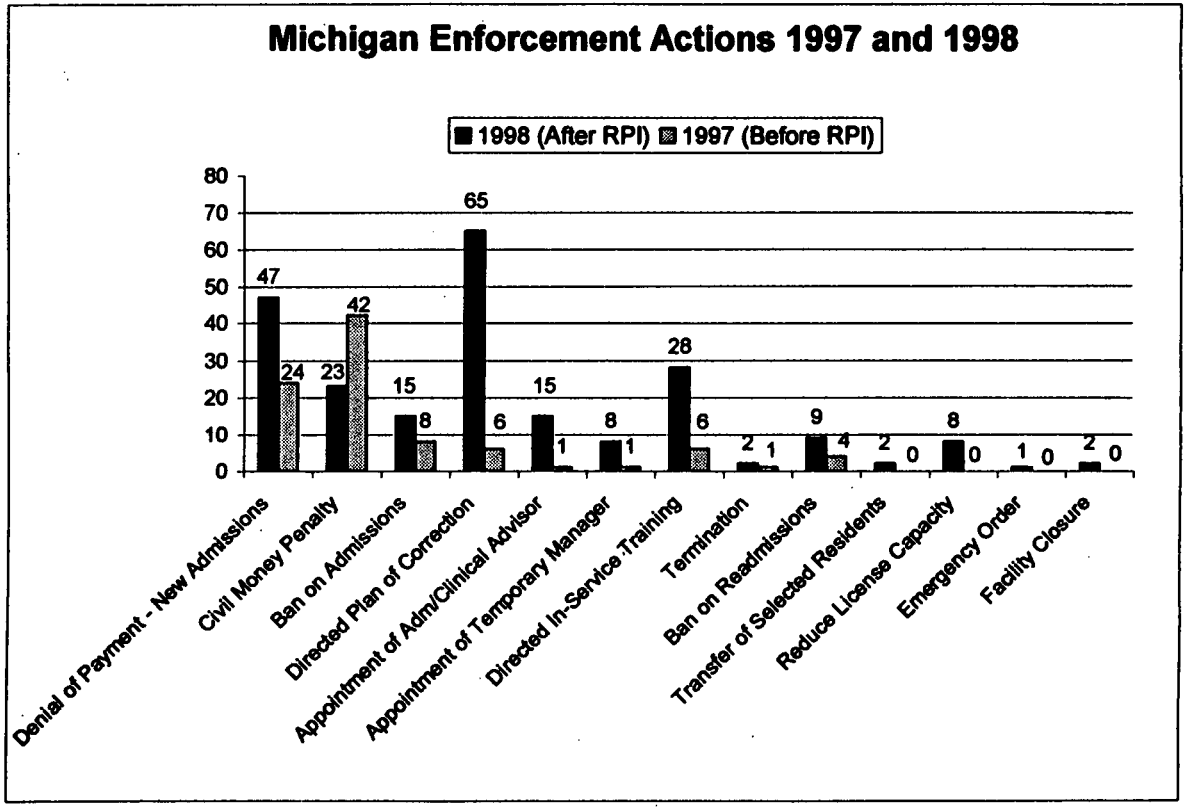
L & L Nursing Center
96-96107-000-000
October 7, 1998 – December 31, 1998

I. CRP Activity

At the request of the MDCH and MCIS, the CRP served as the temporary closure agency at L & L Nursing Center in Detroit, Michigan. CRP staff responded to the request and arrived on-site on October 7, 1998. Several staff members assisted FIA and on-site staff with the transfer of residents on October 7, 1998. All residents were transferred from the facility on October 7. CRP staff returned to the facility on October 8, 1998 to assure the safety and accounting of all resident belongings. The responsibility of the facility management was returned to the owner late on October 8, 1998, concluding an on-site investigation by MDCH staff. The CRP has retained detailed accounts of its activity on-site and off-site during this transition period. These records continue to be available in the LTCQIP office.

Subsequently, CRP staff were required by client agency staff to seize, duplicate and safely store all resident records involved in the transfer. Copies of all resident records were delivered to receiving facilities on Monday, October 12, 1998. The original records were returned to the owner's legal representative on October 14, 1998. On December 18, 1998, all copies of resident records obtained during the closure were destroyed as no requests for additional information had been received. LTCQIP staff witnessed the destruction of these records on December 18, 1998.

The CRP staff have concluded their activity with regards to the L & L Nursing Center closure. The only outstanding issues identified at this time are any expenditures for legal services not billed as of this date, or any request for CRP Temporary Management team members to testify in any criminal or civil actions taken by the State Attorney General.


Michigan Enforcement Actions 1997 and 1998
1998 (After RPI)
1997 (Before RPI)
80
70
60
50
40
30
20
10
0
47
24
23
42
15
8
65
6
15
1
8
1
28
6
2
1
9
4
2
0
8
0
1
0
2
0
Denial of Payment - New Admissions
Civil Money Penalty
Ban on Admissions
Directed Plan of Correction
Appointment of Adm/Clinical Advisor
Appointment of Temporary Manager
Directed In-Service Training
Termination
Ban on Readmissions
Transfer of Selected Residents
Reduce License Capacity
Emergency Order
Facility Closure

NEW INITIATIVES

- Additional Surveyors
- Increased Off-Hour and Weekend Surveys - 1998-99
- HCFA Required Increased Revisits - 1998-99
- Governor's Quality Care Awards
- Reconvening Nursing Home Task Force
- Web Page Improvements -- Publishing Survey Reports
- Joint Provider/Surveyor Training

  January 1998 - Prevention of Pressure Sores
  October 1998 - Quality Assurance

- Anticipate $10,000,000 Budget Increase for Long Term Care Improvements
- Nursing Home Consumer Guide

Michigan's Survey Budget
FY 1998-99

Michigan's nursing home enforcement budget for FY 1998-99 authorizes 8 new nursing home surveyors for a total of not less than 97 inspectors to survey the care and services delivered in nursing homes under state law and federal law.

The budget act also requires that complaints alleging poor care and services occurring on nights or weekends, will be investigated on-site on nights and weekends in keeping with the severity of the allegations.

MICHIGAN SURVEYOR STAFF

Regions	Positions Filled as of:			Positions Authorized as of:
	3/2/98	*12/31/98*	*2/22/99**	*12/31/98*
Lansing	45	54	56	57
Gaylord	9	10	10	12
Detroit	26	26	28	28
Total	**80**	**90**	**94**	**97**

*(4) New staff hired; start date of 2/22/99.

Michigan Department of Consumer & Industry Services
Bureau of Health Systems
-prepared 2/6/99

OFF-HOUR SURVEYS

Michigan has already implemented off-hour and weekend surveys. The following is a summary of this activity from October 1, 1998 to February 3, 1999.

Off-Hour Standard Surveys:	11
Off-Hour Complaint Investigations:	12
Off-Hour Site Visits in Response to 24-Hour Emergency Hotline:	2

NUMBER OF REVISITS UNDER NEW POLICY

The number of revisits has significantly increased under the new federal policy.

6/98 - 9/98 (4 months prior to change)	10/98 - 1/99 (4 months after change)
107	128 (20% increase)

Announcing Michigan's first-ever awards program devoted to recognizing those who provide quality licensed care to Michigan's youngest, oldest and special citizens.

March 1998

Dear Friend,

Michigan has a proud history of care and concern for its valued citizens: its youngest, its oldest, and those whose individual needs call for those special places and programs that will provide the quality of health and life we all want for our loved ones.

It is my privilege and pleasure to announce the first-ever Governor's Quality Care Awards to recognize those individuals and those licensed facilities across the state that have gone beyond the ordinary to truly enhance the quality of life for those under their care.

Whether it be a day care center for children, a home for the aged, a nursing home, or a special needs adult foster care facility-we know there are places where the individual comes first, where special programs enrich the days, and where the unique atmosphere created by caring individuals is truly a model of excellence.

I call on each person who has a child, a parent, a relative, or who personally has experienced this kind of place or who has known a special individual who has truly given "quality care" to take the time to nominate by March 30 your choice for the Governor's Quality Care Awards. Together we can give those caring providers and special facilities the recognition they deserve, and make their style of care the "quality standard" for Michigan.

Sincerely,

John Engler
Governor

"He who would pass his declining years with honor and comfort, should, when young, consider that he may one day become old, and remember when he is old, that he has once been young."

—Joseph Addison

Rules:

- Only licensed providers will be considered.
- No self-nominations. Nominations must be made by a resident, family member of a resident, another provider, or, for a child, a parent or guardian.
- This is a joint-award. While either a facility or individual may be nominated, all nominations must include name of both facility and at least one individual/employee.
- Only nominations **postmarked by March 30** will be considered.
- Finalists will be notified by Mid-April.
- Finalists will be asked to provide a community reference from an elected official, clergy member or neighbor.
- Judges will tour all finalists to determine winners.
- Awards will be based on size, geographic location and type of provider (long term or daycare.) and will be presented at a gala event in Lansing in May.

Nomination Process:

On this form or on a separate sheet of paper please answer the following questions:

1. Why should this facility or individual be considered?

2. What unique/special care or service sets this facility or individual apart?

3. What does this facility or individual do to enhance the highest quality of life?

Name of Licensed Provider being nominated: _____
Name of Licensed Provider/Individual being nominated: _____
Address of Provider: _____
Provider Phone Number: _____
(nursing home, day care, adult foster care, home for the aged)
Type of Care: _____
Nominator's Name: _____
Relationship to Provider: _____
(resident, family member, parent/guardian)
If a facility is nominated, please include names of at least one individual. If an individual is nominated, include facility name: _____

The Governor's Quality Care Awards are sponsored by the Michigan Department of Consumer & Industry Services, in cooperation with leading Michigan child care and long term care associations and advocates. CIS licenses child care homes and centers and a number of long term care providers including adult foster care, homes for the aged, and nursing homes in the State of Michigan.

All Nominations must be postmarked by March 30, 1998

Please mail to:

Nancy Dixon
Consumer & Industry Services
P.O. Box 30018
Lansing, MI 48909-7518
(517) 241-9219
(517) 241-9280-fax

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Authority: DCIS DIRECTOR
Total Copies - 22,500; Total Cost - $2531.25; Unit Cost - $.1125

THE U.S. GENERAL ACCOUNTING OFFICE (GAO) VISITS TO MICHIGAN STATE SURVEY AGENCY

Representatives of the GAO visited Michigan during the week of June 15, 1998 to review long term care enforcement. A second visit during the week of January 11, 1999 focused on complaint investigations.

1998 GAO Visit

The focus of the review was on enforcement and the key areas are as follows:

- To understand the types of noncompliance (scope).
- To review types of enforcement in response to noncompliance.
- To determine if the Health Care Financing Administration's (HCFA) enforcement systems are adequate.
- To recommend changes in the system to HCFA or recommend to Congress proposed changes to the law.

Twenty five questions (25) were submitted to Michigan prior to the visit. The responses and documentation to the questions were compiled. Members of the staff were also interviewed.

1999 GAO Visit

The focus of the second visit was on complaint investigations with emphasis on the following:

- Michigan's complaint handling process.
- Medicare Budget and complaint costs associated with Long Term Care.
- Michigan's response to the State Agency Quality Improvement Program (SAQIP)-- a HCFA mandated quality assurance program for performance data.

The GAO submitted a request for a chronological listing of all complaints filed during 1997 and 1998; Michigan's procedures for handling complaints; the data dictionary from the state's data system (CareNet); a list of enforcement cases generated out of complaints; Michigan's Medicare budget for 1997 and 1998,

SAQIP reports, a copy of Michigan's 1864 signed agreement; and Michigan's statutory references to complaint investigations for nursing homes.

The GAO representatives visited the Lansing and Detroit offices to review actual complaint files. Copies of the material were provided. Members of staff were interviewed.

QUESTIONS FOR STATE SURVEY AGENCIES
Lansing, Michigan -- June 16 -19, 1998

Enforcement Tracking:

1. Describe the Michigan process for tracking enforcement actions, from the beginning of the process when deficiencies are identified, to the end (termination or compliance). How does the tracking system handle federal and state enforcement actions, and enforcement actions related to deficiencies found during complaint surveys?

2. Describe your use of OSCAR.

3. How many facilities have been terminated since July 1995? How many of these facilities have re-entered the system?

PPF:

4. How do you track the compliance history of nursing facilities to determine which providers meet the federal definition of a PPF (poorly performing facility)? What is your current definition of a PPF? How has this definition changed since July 1995? Please supply a list of PPFs identified since July 1995.

State Program:

5. If Medicare certification of a facility is terminated, what standards does the state agency require for readmission to Medicaid? Is there a state mandated waiting period?

6. How does the Michigan enforcement program differ from other state programs?

Use of State Remedy:

7. Under what circumstances do you use remedies available under your state licensing authority in preference to federal remedies for NFs/SNFs? Why do you prefer state remedies?

8. Please provide a copy of the Michigan state authority to sanction nursing home providers.

9. Are state remedies effective in achieving compliance? Maintaining compliance? How do you measure effectiveness?

10. Please provide a list of how many providers received only state enforcement action, how many were referred to HCFA, and how many received no sanctions since July 1995.

Compliance History:

11. Is a provider's compliance history considered at the time of licensure, re-certification, or change of ownership?

Effectiveness of "Date Certain" Process:

12. What is Michigan's policy regarding facilities which are offered a chance to correct, but fail to correct by the 'date certain.' What is your understanding of HCFA's policy? Please supply a list of facilities which have missed their 'date certain' since July 1, 1995, with remedies proposed, imposed, and current status.

Complaints:

13. How do you integrate complaint surveys into your NH compliance process? Can complaint surveys be used as a basis for defining PPF?

Incident Reporting:

14. Does Michigan have laws which require nursing homes or nursing home personnel to report serious incidents of substandard care to the state?

Definition of Widespread:

15. In a "clarification memo" of 09/12/96, HCFA "clarified" the definition of the term "widespread" as it related to HCFA's scope and severity grid. What is your present understanding of the requirements which must be met before a deficiency at a facility may be cited as "widespread"? What effect has this had on the ability of SAs to cite problems as deficiencies?

HCFA Guidance:

16. Please supply all communications (including oral communications, if you have a record) from HCFA related to nursing home survey and enforcement subsequent to state operations manual transmittal 273, June, 1995, Survey & Enforcement Process for SNFs and NFs.

Ombudsman:

17. What is the role of the state Ombudsman office in the survey process?

Program Evaluation:

18. Is enforcement data used to monitor trends in compliance, non-compliance, and enforcement?

19. How do you ensure consistency in enforcement actions?

20. What are the reasons for variation among the states in program outcomes, such as average number of deficiencies cited, number of enforcement actions taken, use of the appeal system, and number of terminations?

21. What, in your opinion, has been the effect of HCFA's decision to reserve CMPs for only the most serious offenses on the effectiveness of federal enforcement?

22. Does the enforcement system work for the most poorly performing providers? Does it motivate them to come into compliance? To stay in compliance?

23. Does the enforcement system work for repeat violators?

24. How about the "middle-of-the-road" providers -- does the enforcement system work to keep them in compliance? Does it improve the quality of nursing home care?

25. What do you see as the strengths and weaknesses of the current nursing home enforcement process?

Case-specific Information:

In addition to the facility specific information requested above, it is anticipated that we will need more information on specific cases, such as PPFs and facilities that failed to meet date certain deadlines. We would like to review selected facilities with enforcement personnel to determine any special information related to these facilities, such as their compliance history, ownership history, and current status.

GAO
United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

December 21, 1998

Ms. Gladys Thomas
Director
Division of Health Facility Licensing and Certification
Bureau of Health Systems
525 Ottawa
P.O. Box 30664
Lansing, MI 48909

Dear Ms. Thomas:

At the request of Senators Charles Grassley, Chair, and John Breaux, Ranking Minority Member, of the Special Committee on Aging, GAO is reviewing states' processes and federal oversight relating to nursing home complaints. As part of this review, GAO is visiting several states to further examine their nursing home complaints process. As we discussed on the telephone earlier today, we would like to visit the Michigan Division of Health Facility Licensing and Certification from January 4 through January 8, 1999.

In addition to discussing Michigan's complaints handling procedures during the first day of our visit, we would like to review complaints files for 1997 and 1998. To prepare for our visit, we have requested a chronological listing of all complaints received during these two years (see attached list). We would also like to receive a copy of the data dictionary that defines the fields available in your data system. During our visit, we will review and copy files documenting information from the intake and investigation of selected complaints. In addition, we would like to request an electronic copy of your complaints database, including complaints received in 1997 and 1998.

Thank you and your staff for your assistance in regards to this request. If you have any questions regarding our study or visit, please contact John Dicken, Assistant Director, at (202) 512-7043 or Gloria Eldridge, Evaluator, at (202) 512-3624.

Sincerely yours,

John Dicken
Assistant Director

Enclosure

Initial Data Request from Michigan Division of Health Facility Licensing and Certification

List of nursing home complaints (SNF, NF, SNF/NF dually certified, and SNF/NF distinct parts) listed chronologically by the date the complaint was received from January 1, 1997 to the present.

For each complaint, list the following:

1. Date complaint received (complaints will be listed chronologically from this date starting with 1/1/97)
2. Complaint ID # (MI internal tracking number)
3. Facility Name
4. Facility Medicare #
5. District Office (Lansing, Detroit, Gallard, etc.)
6. Priority level
7. Complaint referred by (Referred to Licensing/Certification by)
8. Complaint referred to (Referred from Licensing/Certification to)
9. Date complaint investigated
10. Complaint Investigated by*
11. Status (Substantiated, Unsubstantiated, Unable to Verify)
12. Complaint Code(s) (Patient Care, Abuse, Resident Rights, Billing, etc.)
13. Federal deficiencies cited
14. State citations or deficiencies cited
15. Follow-up (Revisit) Required
16. Date referred to HCFA Regional Office for enforcement
17. Date complaint closed

* Complaint may have been investigated by a staff member within Michigan Licensing & Certification, Ombudsman, the Facility, the Police, or a combination of these and others)

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
11030 Ables Lane, Dallas, TX 75229. 214/243-2272. Fax 214/484-2720

WRITTEN TESTIMONY ON NURSING HOME QUALITY OF CARE
SENATE AGING COMMITTEE
(HEARING HELD3/22/99)
Provided by the American Association for Respiratory Care

The American Association for Respiratory Care (AARC), a 36,000-member professional association of respiratory therapists welcomes the opportunity to submit written testimony to the Senate Special Committee on Aging's hearing on the quality of care in nursing homes.

Respiratory therapy services are provided by respiratory therapists to patients with disorders of the cardiopulmonary system. These services include diagnostic testing, therapeutics, monitoring, rehabilitation and patient, family, and consumer education. These services are provided in all health care facilities and in the home. Respiratory therapists are the only health care providers who undergo formal education and competency testing in the delivery of these services. Indeed, the national medical standard is for these services to be provided by credentialed and licensed respiratory therapists. This standard has existed for decades.

Respiratory Therapy under PPS

The implementation of a Prospective Payment System (PPS) for Medicare Part A Skilled Nursing Facility (SNFs) has unintentionally created an unsafe environment for Medicare beneficiaries requiring respiratory therapy. Nursing home providers have always had the responsibility to determine how the clinical needs of the patient will be met and which health care provider will be responsible for rendering the care. But now, because PPS fails

to accurately recognize costs for respiratory therapy services; nursing homes have a powerful financial incentive to use caregivers who may not be qualified and are not tested for competency in the provision of respiratory therapy services. Since no minimum competency standards exist, some nursing home providers, faced with lower rates of reimbursement, are substituting respiratory therapists with unqualified caregivers. In effect, these facilities are eliminating the only professionals who posses education and competency evaluation in this specialty.

In a letter to HCFA, Gail Wilensky, chairman of MedPac, stated that the PPS system, as designed, could lead to lower quality of care. Dr. Wilensky states, "the shift from cost-based payment to prospective rates also creates financial incentives for SNFs to stint on the care they furnish . . ." and that the system creates "incentives to . . . deny admission to patients who appear to have special needs." How can Medicare assure patient safety if caregivers are not tested for competency in the provision of respiratory therapy?

The Danger to Patients

Patients under the care of respiratory therapists consist of a disproportionately sicker population of patients. Moreover, respiratory therapists have responsibility for control of life support equipment such as ventilators. Therefore, respiratory therapy services rendered by individuals who have not documented their competency presents a very real danger to the patients and has resulted in numerous negative clinical outcomes ranging from the inappropriate to the deadly. Respiratory therapy, when provided by persons without competency testing has resulted in:

1. Services that are inappropriate for the patient's condition.
2. Services that are unnecessary.
3. Increases in hospital readmission due to pulmonary complications.
4. Longer and more costly lengths of stay.
5. Increased morbidity.
6. Death of the patient.

The following examples illustrate the harm that has come to Medicare beneficiaries who have received respiratory therapy services from individuals who have not have to document their competency in respiratory therapy services.

Information provided in a letter from a respiratory therapist in New Jersey.

A respiratory therapist who had previously been employed to provide respiratory therapy services to patients in a nursing home was informed that her services with no longer be required as a caregiver. The nursing home contracted for her services to train nurses on oxygen administration and pulse oximetry, a diagnostic tool for assessing a patient's blood oxygen level. The therapist informed the nurses that if a patient's blood oxygen level fell below 70 percent the situation constituted a life-threatening crisis, requiring the use of 100 percent oxygen through a mask attached to a powerful source of oxygen. This source of oxygen needs to be an oxygen tank, not an oxygen concentrator. An oxygen concentrator is appropriate for patients who suffer with a limited shortness of breath, which would require only small amount of additional oxygen. This information was provided by the respiratory therapist in written form for each of the nursing staff for reference and for study. Furthermore a copy of the instructions was posted at the nurses station. Later, on a routine visit for an inventory check, the therapist was pulled aside by the nursing staff. A patient was having labored breathing and the staff requested the assistance of the respiratory therapist. A pulse oximetry check showed the patient's blood oxygen level was only 69%. He needed intensive oxygen therapy at 100 percent oxygen at 12 liters per minute via mask from an oxygen tank. The director of nursing thanked the therapist for her assistance, and said that had she not been there at that time, the nurses would have set the patient up on two liters of nasal oxygen attached to an oxygen concentrator. In the opinion of this therapist, with may years of clinical experience, had the patient only received two liters of oxygen via a concentrator, the beneficiary would have suffered cardiac arrest and probably died.

Information taken from a letter from a respiratory therapist in Arizona

A Medicare beneficiary in a nursing home had a tracheostomy, i.e., a surgically opened hole the neck from which to breathe. The respiratory therapist was requested to provide services to the patient on a Wednesday, at which time she suctioned the mucus from the airway. Thereafter, the therapist was informed that her services would not be required again, as the nursing staff was capable of caring for the respiratory needs of the patient. Thirty-six hours later, the therapist was called by a nurse to assess the patient's breathing status. His fingers were blue and his breathing was extremely labored. The therapist noticed that the suction canister was empty, indicating that he had not been suctioned in the 36 hours since she had done the procedure. A pulse

oximetry reading showed a blood oxygen level of 59 percent. The therapist immediately began to suction the patient, retrieving nearly a cup of mucus. The next day, the patient was dead. Probable cause of death: an occluded airway.

HCFA staff reporting on a delinquency at a California nursing home, Jan. 23, 1997.

"In conclusion, the facility's nursing staff failed to provide adequate respiratory services to residents who were severely compromised. Nurses were administering oxygen therapy based on what they thought shortness of breath meant and if the resident with turning 'blue'. To one nurse interviewed, shortness of breath was 'if someone is breathing for 20 breaths per minute'. For another nurse, shortness of breath was 'if someone is breathing for 30 breaths per minute'.

"Rarely was oxygen administered based on the resident's oxygen saturation. In most cases, no repeat oxygen saturations were done by the nursing staff to see if the resident was getting enough oxygen after the oxygen was administered. The nursing staff also failed to obtain physician orders for oxygen once it was started in a number of cases. In two cases, the nursing staff administered oxygen per face mask at low liter flows, thereby jeopardizing residents whose respiratory status was already compromised. There were few long assessments done for residents with acute and chronic respiratory symptoms.

"Observations of the nurses administering respiratory treatments, whether metered dose inhalers or hand-held nebulizers, revealed that they were not given according to the standards of practice or per the facility's own policies and procedures."

The only way to assure the safe and effective delivery of respiratory therapy is to test care providers for competence. And the only way to ensure care providers are tested for competence is to insist on minimum competency standards for all health care providers. It is that simple.

No objective evidence exists supporting the competency of health care personnel in the provision of respiratory therapy other than respiratory therapists.

The AARC has attempted to work with the Health Care Financing Administration (HCFA) to incorporate minimum competency requirements in the current regulations. After 18 months of discussion HCFA staff informed the AARC that the agency did not have the regulatory authority to expeditiously insert competency requirements into the

regulations governing nursing home operations. HCFA staff advised the AARC that legislation was the only alternative.

While the efforts of both the respiratory therapy and consumer community continue to advocate for minimum competency standards, the health and safety of Medicare beneficiaries currently residing in nursing homes remains in jeopardy. The AARC commends the efforts of the Select Committee on Aging to improve the quality of nursing home care for this nation's elderly. We hope that you might move the issue of competency testing forward so that Medicare beneficiaries can receive the standard of care that other Americans now receive.

TESTIMONY of CAROL BENNER, SC.M., DIRECTOR
LICENSING AND CERTIFICATION ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE OF MARYLAND

BEFORE
THE SENATE SPECIAL COMMITTEE ON AGING

MARCH 22, 1999

Thank you for the opportunity to provide this written testimony for this most important hearing. Effective and responsive complaint investigation and enforcement systems are vitally important and indeed integral to high quality nursing home care for our frail, vulnerable and elderly citizens. It is my hope that my comments and suggestions which follow will encourage the States, Congress, and HCFA to work together to improve the complaint investigation and enforcement systems and, as a result, increase quality.

Recently much has been said and written about the failure of the current system to adequately protect our nation's elderly citizens. The State Agencies are blamed for the inability to carry out their responsibilities; Congress for the lack of adequate funding, and HCFA for the lack of direction. However, we should not forget that we have made great strides in significantly improving the quality of nursing home care in this country in the past ten years. In Maryland, since the beginning of the decade, we have repeatedly targeted nursing homes with records of poor performance to either bring them into compliance or, through appropriate sanctions, to protect the health and safety of the residents. This effort has been well documented.

As you well know, in mid-1998 in this continuing effort to improve quality in nursing homes, President Clinton and Congress substantially revised the nursing home regulation enforcement system. Though seemingly well-intentioned, this initiative had a direct and palpable impact on Maryland's survey activities and ability to carry out those activities. The diminished flexibility of the enforcement penalty protocols, implemented as part of the initiative, has resulted in more nursing homes facing the possibility of termination from the Medicare and Medicaid programs. Consequently, because more nursing homes are facing termination, our surveyors are performing more frequent and extensive re-visits to those nursing homes. Despite the substantial increase in staff time in performing these re-visits, inadequate resources and staff have been provided. Unfortunately, the natural consequence of this increased workload for our survey staff is delayed or postponed annual and complaint surveys of other nursing homes. While we make every effort possible to prevent annual or complaint survey delays, we nonetheless recognize that delays inevitably have occurred.

To illustrate the consequences of this enforcement focus shift under the new initiative, Maryland has had three nursing home closures within the past three months. Prior to January of this year, nine nursing homes had closed in Maryland in the past eight years. While these three closures were ultimately in the best interest of the residents, the survey and follow-up activities, performed before the closures, consumed an untold number of staff hours. Immediately prior to the closures, in order to safely and sensitively relocate the residents of the homes, our professional survey staff was needed to plan, implement and monitor the resident relocation. At some points,

staff was available in the nursing homes on a 24-hour a day basis. For just one of these nursing home closures alone, we calculated that 650 person hours of survey staff time were spent in relocation efforts and activities. We recognize that the time spent in relocation activities is essential to a safe and orderly transfer of residents; however, when so much time is spent performing these functions, we cannot spend as much time as we believe is necessary on annual or complaint surveys. Unfortunately, it comes down to a question of priorities and, faced with the very real possibility of nursing home closures, these activities are taking precedence.

On March 16, 1999, days after the current draft GAO report was sent to HCFA, HCFA issued a new complaint policy. If implemented, this new complaint policy will only serve to divert resources from the Clinton initiative. Furthermore, in these past few months when assistance and direction in the new initiative has been most needed, it has been difficult to discern HCFA's enforcement policies. In particular, HCFA Region III has changed the re-visit policy several times since August, 1998. Additionally, HCFA's policy concerning nursing home terminations for low level ("D" and "E" level) deficiencies remains unclear. Now with this new complaint policy, states will have a third area of concern.

Within this atmosphere in which our survey unit must function, it should not be surprising that, while Maryland remains committed to investigating complaints and believes that a strong complaint investigation unit is vital to nursing home regulation enforcement, complaint surveys have, nonetheless, been postponed or delayed. However, this situation need not continue and can be swiftly corrected with two vital tools -- resources and clear direction.

First, as Maryland's situation illustrates, the states need additional survey staff to handle the increased responsibilities and functions HCFA and Congress expect the states to perform. The more surveyors we have in the field, the more complaints will be investigated and, consequently, the more quality will improve. The states cannot be expected to continue adding staff to respond to the federal initiative; therefore, federal money to fund positions 100% for additional staff is essential to effective quality oversight of nursing homes.

Second, HCFA needs to communicate to states a clear, reasonable and fair policy on nursing home enforcement actions and re-visits. Our surveyors cannot keep returning to nursing homes three and four times for follow-up surveys after a finding of non-compliance. HCFA must decide when and under what circumstances allegations of compliance will be accepted and, in addition, must set a policy for maximum number of re-visits that may occur within the six month survey cycle. Only with clear and decisive direction from HCFA will consumers, states and the nursing home industry be able to have confidence in the survey system and know what to expect from that system.

Again, I appreciate this opportunity to provide input to your committee on these serious issues that affect the health and safety of nursing home residents. This testimony, though perhaps candid, is an effort to state the problem in as clear and concise terms as possible. I am confident that with additional resources for staff and with direction from HCFA on a reasonable enforcement policy, we can continue to assure good quality nursing home care to our most vulnerable citizens.

National Senior Citizens Law Center
1101 14th Street, NW, Suite 400 • Washington, DC 20005 • (202) 289-6976 • FAX (202) 289-7224 • http://www.nsclc.org

Burton D. Fretz
Executive Director
Washington, DC

Gerald McIntyre
Directing Attorney
Los Angeles, CA

SENATE AGING COMMITTEE
"RESIDENTS AT RISK? WEAKNESSES PERSIST IN NURSING HOME COMPLAINT INVESTIGATION AND ENFORCEMENT"

March 22, 1999

STATEMENT OF THE NATIONAL SENIOR CITIZENS LAW CENTER

Last week, the General Accounting Office released a report reaffirming what it found last summer: that the federal enforcement system for nursing facilities, put in place by the Health Care Financing Administration in July 1995, fails to assure that nursing facilities provide high quality of care and high quality of life to the nation's 1.6 million residents.[1] Instead, the GAO reported, the federal enforcement system tolerates abusive and neglectful care – more than one-quarter of facilities nationwide had deficiencies causing actual harm to residents or placing residents at risk of death or serious injury – and deficiencies often continue year after year – 40% of facilities that were cited were cited repeatedly. Although federal law authorizes a broad range of remedies when federal or state agencies cite these deficiencies, few remedies are ever actually imposed. Last summer, the GAO reported that 98% of California facilities cited with deficiencies between July 1995 and April 1998 were given a reprieve; nationally, 99% of facilities with deficiencies were granted a grace period under the federal government's lenient system of enforcement.[2]

While the GAO has identified the shocking inadequacy of the public enforcement system, its four recommendations are far too restrained to correct these abuses. For example, the GAO suggested that HCFA require states to refer facilities to the federal government "for possible sanction . . . if they have been cited for a deficiency that contributed to a resident's death."[3] The regulatory system must intervene at an earlier

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[1] General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, GAO/HEHS-99-46 (Mar. 1999).

[2] General Accounting Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 26, GAO/HEHS-98-202 (Jul. 1998).

[3] General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 24, GAO/HEHS-99-46 (Mar. 1999).

Los Angeles Office: 2639 S. La Cienega Blvd. • Los Angeles, CA 90034 • (310) 204-6015 • FAX (310) 204-0891

time to *prevent* bad outcomes for residents that are avoidable.

If a bad outcome occurs that could have been avoided if the facility had provided proper care, a variety of legal remedies exists against the facility's owners, management, and staff: criminal prosecution, wrongful death litigation, and civil liability under the Federal False Claims Act, to name a few. In contrast to these legal remedies, which punish bad outcomes that have already occurred, the public regulatory system has as its goal and purpose *preventing* avoidable bad outcomes.

The California Supreme Court affirmed the importance of prevention in a 1997 ruling on the state's nursing home regulatory system. Rejecting an argument by the nursing home industry that residents could enforce their rights through the tort system, the California Supreme Court held that suggesting that residents assume responsibility for enforcing state law "is to abrogate the most basic and traditional police power of the state -- the oversight of public health and safety. . . . Relying on the threat of a personal injury lawsuit to impose compliance with health and safety regulations defeats the very purpose of the statutory scheme, i.e., *preventing* injury from occurring."[4]

The regulatory goal of prevention cannot occur if the regulatory system fails to act until death or serious harm to a resident has occurred.

The problems identified by the GAO lie in large part in HCFA's implementation of the nursing home reform law. While the law and HCFA's final rules call for strong enforcement at the federal and state levels, HCFA's implementation in July 1995 and afterwards has failed to carry out the Congressional mandate. Through the State Operations Manual issued in 1995 and a series of changes made to the manual after that date, HCFA weakened states' and the federal government's ability to identify and cite deficiencies and to impose appropriate sanctions for noncompliance with federal standards of care. HCFA effectively reinstated the enforcement system that Congress had rejected and replaced in the 1987 reform legislation.

The President's Nursing Home Initiative, announced on July 21, 1998 and reaffirmed on March 16, 1999, has begun to reverse that pattern and to make a number of changes to the federal survey and enforcement systems. One of the strongest actions to date is publication of new final rules on March 18, 1999 that give states and HCFA expanded authority to impose per instance civil money penalties of $1000 to $10,000 for deficiencies, without regard to whether actual harm has already occurred and without first giving facilities an opportunity to correct.[5] In its written response to last week's GAO report, HCFA said it would revise its guidance on enforcement: "The guidance will

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[4] *California Association of Health Facilities v. Department of Health Services*, 940 P.2d 323, 65 Cal.Rpts. 872, 885, *quoting Kizer v. County of San Mateo*, 53 Cal.3d 139, 150 (1991) [emphasis supplied].

[5] 64 Fed. Reg. 13,354 (Mar. 18, 1999).

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."[6] This is another step in the right direction. But more needs to be done.

Recommendations

Additional changes to the public regulatory system are needed to strengthen the regulatory system and to make facilities more accountable for the quality of care they provide:

- Congress must direct HCFA to rewrite the State Operations Manual to require and assure the swift and effective imposition of remedies; to reduce the excessive complexity and unnecessary paperwork in the existing system; and to assure a more meaningful and appropriate relationship between the state survey agencies and the federal government. Such revisions would make HCFA's guidance conform the manual to the mandates of the 1987 reform law.

- HCFA must use the full range of intermediate sanctions, earlier and more effectively, instead of relying on termination.

- Congress must appropriate more money for survey and enforcement activities at both the state and federal levels;

- More administrative law judges must be hired and must be given comprehensive training to hear nursing home cases (there are only 3.5 administrative law judges at present to hear cases for the entire country and a 10-year backlog in hearings involving civil money penalties); and

- HCFA must strengthen the complaint investigation system so that it operates quickly and effectively to identify and sanction care problems. In particular, complaint investigators need training to learn how to validate and substantiate complaints when they do not personally witness deficiencies.

Conclusion

We thank the Members of Congress who requested that the General Accounting Office conduct a comprehensive evaluation of the federal nursing home enforcement system and the complaint system. We congratulate them for bringing attention to continuing serious problems of quality of care and quality of life in nursing facilities and to the need to strengthen public oversight and enforcement activity. We also thank the President

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[6] General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 35, GAO/HEHS-99-46 (Mar. 1999) [emphasis in original].

for his Nursing Home Initiative last summer that recognized the shortcomings in the existing enforcement system and called for substantial and fundamental changes to strengthen it. The Initiative has begun to bring about some of the changes that are needed, but many more changes are necessary.

We are hopeful that the continued attention brought to these concerns at last week's briefing on the GAO report and at today's hearing will lead to a strengthened public regulatory system, to increased federal funding for these important regulatory activities, and ultimately, and most importantly, to better lives for our nation's million and a half nursing home residents.

Toby S. Edelman

NUTRITION SCREENING INITIATIVE

THE AMERICAN DIETETIC ASSOCIATION

1010 Wisconsin Avenue, NW Suite 800 Washington, D.C. 20007 202/625-1662

April 13, 1999

Senator Chuck Grassley
Chairman
Senate Special Committee on Aging
105 Hart Senate Building
Washington, DC 20510

Dear Senator Grassley:

On behalf of the Nutrition Screening Initiative (NSI), a project of the American Academy of Family Physicians, the American Dietetic Association, and the National Council on the Aging, thank you for including this letter and the attached fact sheets in the Congressional Record pertaining to the March 22nd Senate Special Committee on Aging hearing, "Residents at Risk: Weaknesses Persist in Nursing Homes; Complaint, Investigation and Enforcement."

NSI applauds the Senate Special Committee on Aging for its persistence in calling attention to the needs of elders in nursing facilities. While we agree that federal oversight and enforcement of existing quality care standards is critical, we hope the Committee will look for practical solutions to improve the provision of routine nutrition care inside nursing facilities. Furthermore, we urge the Committee to devote at least as much attention to promoting model nursing home programs as it has to exposing the problems.

We would like to call the Committee's attention to NSI's recent work to develop a new educational tool: the *Nutrition Care Alerts*. NSI is creating this tool in collaboration with an advisory board of long-term care organizations whose members are responsible for the care of nursing facility residents. Our objective is to raise awareness about the risk factors and interventions appropriate for nursing facility residents with certain nutrition-related conditions, including those identified in the most recent GAO report, "Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards."

Specifically, the *Nutrition Care Alerts* will help front-line caregivers identify on a daily basis residents at risk for — or already suffering from — unintentional weight loss, dehydration, pressure ulcers, and tube feeding complications. The tool will also provide suggested interventions that could be implemented by members of the interdisciplinary care team (i.e., nurses, dietitians, physicians,

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pharmacists, etc.), since improving and maintaining the nutritional health of elders is often a formidable task that requires the skills of health professionals across several disciplines. We plan to begin distributing the *Nutrition Care Alerts* this Summer.

In addition to the *Care Alerts*, The American Dietetic Association's Long Term Care Task Force is developing nutrition risk assessment and intervention tools. These tools will be used by nutrition professionals to identify nursing home residents at nutritional risk and provide appropriate multidisciplinary intervention strategies.

The *Nutrition Care Alerts* and the ADA's risk assessment and intervention tools represent just one step in the process of creating and sharing practical solutions to the challenges of providing quality care to nursing home residents. It is essential that these efforts and others like them receive support from the Committee and the agencies that regulate nursing home care. Additionally, we ask the Committee to bear in mind the serious challenges facing nursing homes and the professionals who care for the aging population as we work to develop and implement solutions.

These challenges include:

1. The demands of caring for an older and sicker population are becoming increasingly complex. For many areas of care, such as nutrition care, new standards of quality care and practice guidelines must be integrated in OBRA regulations, accreditation standards, reimbursement policies, and training of professionals and volunteers caring for elders in nursing facilities. Currently, the Minimum Data Set collects patient information; it does not assess patient status or measure quality care.

2. Studies have observed 54% to 85% of elders are malnourished when they enter nursing facilities. Nutrition screening, assessment and the incorporation of medical nutrition therapy and other nutrition interventions into patient care plans must become routine for every nursing home resident.

3. Nutrition care is more than feeding. It encompasses nutrition screening, assessment and, most importantly, a range of interventions that include enteral and parenteral nutrition therapy when necessary, as well as medications management, psychological and social counseling, physical therapy, and dental treatment. Attention must be paid not only to staffing of patient feeding programs but to insuring that dietitians and nurses provide nutrition care, before nutrition-related health problems reach crisis levels.

4. Poor nutritional status can be an unavoidable, albeit an undesirable consequence of natural disease progression. Therefore, weight loss does not always indicate poor quality care. Weight loss which goes undetected however, is an indicator of poor quality care. Again, we encourage you to recommend that nursing facilities routinely conduct nutrition screening and be held accountable for incorporating medical nutrition therapy into patient care plans when appropriate. Reimbursement policies should be changed to ensure this vital care is provided. Specifically, reimbursement for oral supplementation with medical nutritional products and

increased reimbursements for enteral tube feedings, including disease-specific products, are essential.

5. While most pressure ulcers can be prevented, even the most vigilant nursing care may not prevent the development and worsening of ulcers in some very high-risk individuals. In those cases, intensive therapy must be aimed at reducing risk factors, at preventive measures, and at treatment. However, when an individual is in the latter stages of a terminal illness, the primary goal of therapy may be to promote comfort and prevent pain. In this case, strategies to prevent pressure ulcers may not be consistent with the goal of promoting comfort.

Enclosed are several fact sheets providing an overview of the nutritional status of both institutionalized and non-institutionalized older Americans and the challenges poor nutritional status presents the nation's health care system. These fact sheets clarify that in order to maintain the nutritional status of elders in nursing facilities, not only must we strengthen current regulations related to nutrition care, but we must also support collaborative efforts like the *Nutrition Care Alerts* and the ADA's risk assessment and intervention tools that will help care providers prevent nutrition-related conditions. Furthermore, nutritional status must be monitored, appropriate interventions must be provided, and reimbursement must be adequate to assure that quality of care and quality of life are achieved for our nation's elders living in nursing facilities.

Thank you for your consideration.

Sincerely,

David Smith
Director

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A Profile of Nursing Facility Residents: Vulnerable to Malnutrition and Nutrition-Related Health Problems

Among persons aged 65 years, about 40% can expect to enter a nursing facility at some time. Slightly half of these older adults are expected to stay in a facility for at least 1 year and about one-fifth may stay at least 5 years. (Reuben)

The most rapidly growing segment of the population is the age group 85 years of age or older; this age group also has the highest rate of institutionalization, approximately 25%. (Reuben)

Between one-quarter and one-third of nursing facility residents have a low Body Mass Index, while 10 - 14 % experience significant weight loss. A low BMI and severe weight loss are sometimes unavoidable symptoms of clinical conditions such as end stage renal disease, chronic obstructive pulmonary disorder, cancer, or congestive heart failure, or the result of a resident's end-of-life directives to refuse artificial nutrition and hydration. (Hawes)

Approximately 70% of nursing facility residents have some type of organic brain disorder usually accompanied by dementia. (AARP)

Confusion, the single most common symptom of brain disorder, affects 44% of residents. These residents may also suffer from anorexia and involuntary weight loss, conditions that occur more frequently outside the long-term care facility (66%) before their admission. (Bartlett)

As many as 50% of Americans have lost all their teeth by the age of 65. Poor oral health can contribute significantly to nutritional decline. (Fisher)

It is estimated that 40% to 60% of older adults in long-term care facilities may experience dysphagia during eating. Nutrition restrictions, coupled with sensory losses, may result in limited food enjoyment and compromised food intake. (The American Dietetic Association)

As many as 50% of nursing facility residents need help with 4 or more activities of daily living. (Fisher) As Medicare and Medicaid eligibility criteria become more stringent, only the sickest patients will be admitted to nursing facilities, causing the patient populations to be even more debilitated and medically unstable. (Fisher)

The incidence of eating disability in nursing facilities is high. One survey documented that 50% of skilled nursing facility residents require eating assistance. (Varma)


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Among older adults in nursing facilities, development of pressure ulcers are associated with a greater risk of death within one year. (Thomas) Although pressure ulcers have multiple causes, nutritional status is a contributing factor. One study found that time to healing was significantly reduced in patients who had a good nutritional status. (van Rijswijk)

One significant predictor of death due to nonvascular causes in a malnourished patient in a nursing facility is a low cholesterol level. (Raiha)

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Nutrition-Related Health Problems Among The Elderly: Expensive & Preventable

Older Americans, due to the many environmental, social, economic and physical changes of aging, are at disproportionate risk of poor nutrition that can adversely affect their health and vitality. The American population will increase by almost 50 percent from 1995 to 2050, while the 65 and older age group will increase by 135 percent. There are currently over 3 million Americans over 85. This number is expected to reach over 8 million by 2030, and over 18 million by 2050. The population of Americans age 85 and over will increase by 401 percent from 1995 to 2050. (AAHSA)

Even though older Americans currently make up only 13% of the population, they consume 36% of the country's health care resources. Maintaining the good health and independence of this population is critically important to the stability of the U.S. health care system. (US Department of Health and Human Services)

Randomized, controlled clinical trials have shown that malnourished older Americans have increased medical and surgical complications (Gallagher-Allred), higher rates of morbidity and mortality (Quesenberry), increased functional dependence (Jensen), and higher rates of hospital readmission (Sullivan).

In 1993, a national survey commissioned by the Nutrition Screening Initiative of 750 geriatric doctors, nurses and administrators of hospitals, nursing homes and home care agencies reported that *one in four* of their elderly patients suffer from malnutrition as do *one half* of elderly hospital patients and *two in five* nursing home residents. (Hart)

Poor nutritional status among America's seniors includes not only nutritional deficiencies, dehydration, undernutrition, and nutritional imbalances, but also obesity and other excesses such as alcohol abuse. In addition, inappropriate dietary intakes for conditions that have nutritional implications and the presence of an underlying physical or mental illness with treatable nutritional implications are common treatable problems. (US Preventive Services Task Force)

A report of the U.S. Senate Committee on Education and Labor stated that "85% of the older population have one or more chronic conditions that have been documented to benefit from nutrition interventions." (US Congress, Committee on Education and Labor)


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Nutrition-Related Health Problems Among The Elderly: Expensive & Preventable – page 2

In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, nutrition screening was emphasized as a necessary, routine component of primary care because so few physicians or other health professionals ask about nutrition. (US Public Health Service)

As a component of nutrition care, nutrition screening makes early intervention possible, thus ensuring timely access to health services, preventing serious nutrition-related health problems and promoting management of chronic diseases and good health. (Coombs)

The Lewin Group projects the net cost of extending coverage of medical nutrition therapy to all Medicare beneficiaries at less the $370 million over seven years, when savings are considered. After the third year of coverage, the study estimates that savings would be greater than costs. The study projects that the initial investment required to Medicare Part B, which covers outpatient care, will yield significant savings to Medicare Part A, which covers inpatient costs. The total savings to the Medicare program come from reduced hospital admissions and reduced complications requiring a doctor's visit. (Lewin Group)

A 1996 study conducted by the Barents Group of Peat Marwick documents that the consistent and appropriate use of medical foods for hospitalized patients prevents complications in the treatment of those critically ill and injured. The study estimated the routine provision of medical foods would save $1.3 billion in health care dollars by the year 2002. Nutrition intervention for a wide variety of diseases and conditions including hip fracture, cardiovascular diseases, pulmonary and renal infections, and endocrine and metabolic disorders were found to be clinically and cost effective. (Barents Group)

Federal programs to combat hunger and food insecurity reach only one-third of needy older adults. (Burt)

The cost of providing nutritious home-delivered meals to a person for 1 year equals the cost of one in-hospital day. (The American Dietetic Association)

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Older Americans: Disproportionately at Risk for Poor Nutritional Status

Risk factors for poor nutritional status are characteristics or occurrences which indicate that someone is at risk for or is already in a poor nutritional state. Risk factors for older Americans include: inappropriate food intake; poverty; social isolation; poor mental health; poor oral health; dependence/disability; acute/chronic disease or conditions; medication use; and advanced age. The greater the number of these risk factors, and the longer they persist, the greater the likelihood that poor nutritional status will ensue. (Dwyer)

In 1993, a national survey commissioned by the Nutrition Screening Initiative of 750 geriatric doctors, nurses and administrators of hospitals, nursing homes and home care agencies reported that *one in four* of their elderly patients suffer from malnutrition as do *one half* of elderly hospital patients and *two in five* nursing home residents. (Hart)

About 9.4 million older people live alone. Nearly half of Americans over the age of 85 live alone. (AAHSA) Being with people daily has a positive effect on morale, well-being and eating.

As many as 50% of Americans have lost all their teeth by the age of 65 years. Poor oral health can contribute significantly to nutritional decline. (Fisher)

One of every five older persons has trouble walking, shopping, buying and cooking food. (Nutrition Screening Initiative)

An evaluation of the Elderly Nutrition Program of the Older Americans Act (congregate and home delivered meals) indicates that 67 % to 88 % of the participants are at moderate to high nutritional risk. One survey found that almost two-thirds of those responding had a weight outside the healthful range and that 18 % to 32 % had involuntarily gained or lost 10 pounds within 6 months before the survey. (Ponza)

41% of congregate and 59% of home-delivered meal participants reported having three or more diagnosed, chronic illnesses or conditions. (Ponza)

It is estimated that 40% of older adults have inappropriate dietary intakes of 3 or more nutrients. Poorly nourished adults have higher morbidity and mortality rates than do their optimally nourished counterparts. (White)

Only 13% of older adults eats the minimum amount of fruit and vegetables recommended by the Food Guide Pyramid. (Nutrition Screening Initiative)


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Older Americans: Disproportionately at Risk for Poor Nutritional Status - page 2

Approximately 3.7 million (11.7%) elderly persons live below the poverty level. Another 2.2 million (7%) of older Americans are considered "near poor." (AAHSA)

National projections from local surveys by the Urban Institute indicate that 2.5 - 4.9 million older adults experience food insecurity, the inability to access a nutritionally adequate, culturally compatible diet. (Burt)

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A Profile of Nursing Facilities: A Record of Problems and Progress

As defined by the American Health Care Association, long-term care services target persons who have lost the capacity to function on their own as a result of chronic illness or conditions that require intervention for an extended period. Assisted living, sub-acute rehabilitative care facilities, and nursing facilities all fall within the rubric of long-term care. There are 16,995 nursing facilities in the US.

1.6 million increasingly frail Americans live in long-term care facilities, a number that will rise sharply as the country ages.

Since 1985, the number of nursing facilities decreased by 13 % while the number of beds increased by 9%. The number of nursing facility residents was up only 4 % between 1985 and 1995, despite an 18 % increase in the population aged 65 years and over. Many older adults receive care at home, leaving only the most frail elders to reside in nursing facilities.

Enacted by Congress in 1987, the Omnibus Budget Reconciliation Act (OBRA) reforms made substantial ongoing changes to the rules that apply to facilities that receive Medicare and/or Medicaid funding. Among the problems addressed in OBRA are deficiencies in food service, sanitation and attention to the nutritional needs of residents.

OBRA-87 reforms sought to shift the survey process from focusing on a facility's paper compliance to focusing on resident-centered outcomes. The new monitoring systems were expected to provide more accurate information on the day-to-day lives of residents and a more accurate picture of the adequacy of a facility's performance.

The mandated resident assessment inventory (RAI) includes a multi-page Minimum Data Set (MDS) that assesses resident's health status including oral and nutritional status. In addition, for residents with nutritional risk factors or problems identified on the MDS, the RAI suggests that additional, highly focused assessments and resident assessment protocols (RAPs) be completed to identify reversible or treatable causes of nutritional problems and guide care plan decisions.

OBRA-87 reforms also specified the development and implementation of an enforcement system that was intended to provide the states and federal government with tools that would encourage facilities to attain and maintain compliance with the quality of care standards.


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The percentage of facilities cited for deficiencies under the regulations covering 1.) dietary services, and 2.) and nutritional adequacy of meals have dropped from 15% of the facilities in 1991 to 9% and 5%, respectively in 1996.

Since the implementation of OBRA-87, there have been overall improvements and improvements in the quality of nutritional care and in related resident outcomes. A greater proportion of residents with nutritional problems or risk factors now have some type of care plan in place to address malnutrition and dehydration. And somewhat fewer residents are malnourished now, compared to the period prior to OBRA-87.

Variations still exist among facilities in the proportion of residents with potential nutrition-related problems. While some variation may be associated with differences in resident case mix, it is extremely unlikely that great disparities are associated only with the underlying mix of residents. It is much more likely that these disparities represent real differences in the quality of care and services provided. It suggests that the care practices provided in the best scoring facilities can reasonably be applied more broadly, and improved nutritional status can be realized for many nursing home residents.

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Definitions of Nutrition Care

Poor Nutritional Status includes not only deficiency, dehydration, undernutrition and nutritional imbalances, but also obesity and other excesses such as alcohol abuse. In addition, inappropriate dietary intakes for conditions that have nutritional implications and the presence of an underlying physical or mental illnesses with treatable nutritional implications are included. Finally, it also encompasses evidence that nutritional status may be deteriorating over a patient's life. Such evidence may be derived from clear-cut objective clinical signs, by nonspecific clinical evidence, by responses to direct, specific questions about diet and nutrition (even if complaints are not volunteered), and by reliable reports from third parties (family, friends, caregivers, and social workers).

Risk Factors of Poor Nutritional Status are characteristics that are associated with an increased likelihood of poor nutritional status. They include the presence of acute or chronic diseases and conditions, inadequate or inappropriate food intake, poverty, dependence/disability, and chronic medication use.

Indicators of Poor Nutritional Status are generally quantitative and provide evidence that poor nutritional status is present. Indicators include dietary, clinical, anthropometric, and biochemical parameters, as well as the existence of nutrition-related conditions or diseases. Changes in indicators are usually quantifiable, and, if abnormal to a certain defined extent, mandate consideration of nutritional factors. Minor indicators are less specific and/or quantifiable, and include some individual specific nutritional deficits.

Nutrition Screening is the process of identifying characteristics known to be associated with dietary or nutritional problems. Its purpose is to differentiate individuals who are at high risk of nutritional problems or who have poor nutritional status. For those with poor nutritional status, screening reveals the need for an in-depth nutrition assessment which may require medical diagnosis and treatment as well as nutrition counseling, as a specific component in a comprehensive health care plan.

Nutrition Assessment is the measurement of indicators of dietary or nutrition-related factors to identify the presence, nature, and extent of impaired nutritional status of any type, and to obtain the information needed for intervention, planning and improvement of nutritional care.

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Definitions of Nutrition Care – page 2

Nutrition Intervention is an action taken to decrease the risk of or to treat poor nutritional status. Nutrition interventions address the multifactorial causes of nutritional problems and therefore include actions that may be taken by many different health and social service professionals as well as family and community members. A wide range of intervention actions, from utilization of congregate meal programs and home care services, to dental services and pharmacist advice, to nutrition education and nutrition counseling, to specialized medical and/or dietary treatment, e.g. enteral nutrition therapy, are all examples of nutrition interventions.

Medical Nutrition Therapy is a part of a patient's overall medical care. It is the process that dietitians , physicians and other trained health professionals use to assess the patient's nutritional status and optimize nutrient intakes, either through diet modification and counseling or specialized medical feeding. Medical nutrition therapy may, but does not always, include the use of medical foods.

Nutrition Education imparts information about foods and nutrients, diets, lifestyle factors, community nutrition resources and services to people to improve their nutritional status.

Nutrition Counseling provides individualized guidance on appropriate food and nutrient intakes for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychological factors. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size, or composition of meals; to modify food textures; and, in extreme instances, to change the route of administration - from oral to feeding tube to intravenous.

Nutrition Support is the alteration of usual food intake by route of administration modification of nutrient content, nutrient density or food consistency. Nutrition support always includes nutrition counseling; it often includes the use of medical nutritional supplements which may be given orally, and the provision of enteral or parenteral nutrition. Individuals who may benefit from nutrition support are those who can not, should not or will not eat a nutritionally adequate diet. It is especially important when dietary intakes are inappropriate for conditions that have nutritional implications especially when underlying physical or mental illnesses with treatable or nutritional implications are present.

Enteral Nutrition involves the administration of nutrients via feeding tubes in people with functional GI tracts; as opposed to *parenteral nutrition* (also known as intravenous feeding) which involves the direct administration of nutrients into the blood stream.

Medical Foods are a specific form of specialized therapy administered orally or through feeding tubes under a physician's supervision for the dietary management of a medical disorder, disease or condition. Some medical foods are disease specific and may provide levels of certain nutrients that aid in the treatment of specific diagnoses.

References

American Association of Retired Persons, A Profile of Older Americans. Administration on Aging. 1992:2-4.

American Association of Homes and Services for the Aging. http://www.aahsa.org/ members/aging.htm

American Dietetic Association. Position of The American Dietetic Association: Liberalized diets for older adults in long-term care. Journal of the American Dietetic Association. February, 1998.

Barent's Group. The Clinical and Cost-Effectiveness of Medical Nutrition Therapy: Evidence and Estimates of Potential Medicare Savings from the Use of Selected Nutrition Interventions. Nutrition Screening Initiative, 1996.

Bartlett BJ. Characterization of anorexia in nursing home patients. Educ Geron. 1990, 96:361-369

Bart MR. Hunger among the elderly: Local and national comparisons. Washington, DC, The Urban Institute, 1993.

Coombs J. Nutrition screening and intervention programs meet challenges to provide quality and cost-effective care for geriatric patients. Man. Care Quarterly. 6(2):1-00.

Dwyer JT. Screening Older American's Nutritional Health: current and future possibilities. Nutrition Screening Initiative, Washington, DC. 1991.

Fisher J, Johnson M. Low body weight and weight loss in the aging. J Am Diet Assoc. 1990;90:1697-1706.

Fowles DG. A Profile of Older Americans: 1995. Washington, DC, American Association of Retired Persons and USDHHS Administration on Aging. 1995.

Gallagher-Allred CR, Voss AC, et al. Malnutrition and clinical outcomes: the case for medical nutrition therapy. J Am Diet Assoc. 1996; 96:361-366.

Hart Research Associates. National survey on nutrition screening and treatment for the elderly. Washington, DC 1993.

Hawes C. US Senate Special Committee on Aging, October 22, 1997.

Jensen GL, Kita K, Fish J, et al. Nutrition risk screening characteristics of rural older persons: relation to functional limitations and health care charges. Am J Clin Nutr. 1997; 66:819-828.

Lewin Group. Significant Medicare savings with medical nutrition therapy. RDs improve health care and reduce costs. Chicago: ADA Courier, May, 1997.

Nutrition Screening Initiative. DETERMINE Your Nutritional Health Checklist.

Ponza M, Ohls JC, Millen BE. Serving elders at risk: the older Americans act nutrition programs, National evaluation of the elderly nutrition program, 1993 - 1995. Washington, DC: Mathematica on Policy Research, Inc; 1996.

Position of the American Dietetic Association: cost-effectiveness of medical nutrition therapy. J Am Diet Assoc. 1995;95:88-91.

Quesenberry CP jr, Caan B, Jacobson A. Obesity, health services use, and health care costs among members of a health maintenance organization. Arch Intern Med 1998;158:466-472.

Raiha I, Marniemi J, Puukka P, et al: Effect of serum lipids, lipoproteins, and apolipoproteins on vascular and nonvascular mortality in the elderly. Arterioscler Thromb Vasc Biol. 1997; Jul;17(7): 1224-32.

Reuben D. Chronic Care Initiatives in HMOs, American Association of Health Plan. Medical Affairs Issues Reports. 1997.

Sullivan DH. Risk factors for early hospital readmission in a select population of geriatric rehabilitation patients: the significance of nutritional status. J Am Geriatr Soc. 1992; 40:792-798.

Thomas DR; Goode PS, Tarquine PH, Allman RM: Hospital-acquired pressure ulcers and risk of death. J Am Geriatric Soc. 1996; Dec: 44(12): 1435-40.

US Congress, Committee on Education and Labor. May 16, 1995

US Department of Health and Human Services, Washington, DC: 1990.

US Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Williams & Wilkins, Baltimore, pp. 794-796, 1996.

US Public Health Service. Healthy People 2000: National Disease Prevention and Health Promotion Objectives. 1994.

van Rijswijk L, Polansky M: Predictors of time to healing deep pressure ulcers. Ostomy Wound Manage. 1994; Oct;40(8):40-2,44,46-8 passim.

Varma RN. Risk for drug-induced malnutrition is unchecked in elderly patients in nursing homes. J Am Diet Assoc. 1994;94:192-194.

White JV. The Role of Nutrition in Chronic Disease Care. Nutrition Screening Initiative. Washington, DC. 1997.

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