

California State Auditor

B U R E A U O F S T A T E A U D I T S

Department of Health Services:

*Its Licensing and Certification Division Is
Struggling to Meet State and Federal Oversight
Requirements for Skilled Nursing Facilities*



April 2007
2006-106

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CALIFORNIA STATE AUDITOR

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April 12, 2007

2006-106

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol

Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Health Services' (Health Services) oversight of skilled nursing facilities.

This report concludes that Health Services did not always follow state and federal laws and regulations and its own policies governing the oversight process. In particular, we found that Health Services has struggled to initiate and close complaint investigations and communicate with complainants in a timely manner. In addition to timeliness issues, Health Services did not correctly prioritize certain complaints it received and understated the severity of certain deficient practices it identified at skilled nursing facilities. It also has yet to implement an Internet-based inquiry system as required by state law to provide consumers with accessible public information regarding skilled nursing facilities.

Further, Health Services needs to improve some of its business practices. In particular, we identified weaknesses in controls over the integrity of data in the complaint-tracking system that could allow erroneous data to be entered into the system without being detected. We also found that, even though Health Services has completed its recent federal recertification workload within federally required time frames, the timing of some recertification surveys are more predictable than others, which diminishes the effectiveness of these reviews. In addition, Health Services has weak controls over its disbursements of funds from the Health Facilities Citation Penalties Account, which limits its ability to ensure the funds are used for necessary purposes.

Finally, Health Services' assertion that staffing shortages have contributed to many of its oversight problems has merit. Although the Legislature authorized an additional 115 facility evaluator positions in fiscal year 2006-07, Health Services continues to struggle to actually fill these positions and faces challenges in training new facility evaluators. Health Services' primary reliance on staff that are registered nurses is also problematic with the current nursing shortage and higher salaries offered elsewhere in state service.

Respectfully submitted,

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SUMMARY

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) oversight of skilled nursing facilities revealed the following:

- Health Services has struggled to initiate and close complaint investigations and communicate with complainants in a timely manner.*
- Health Services did not correctly prioritize certain complaints and understated the severity of certain deficient practices it identified at skilled nursing facilities.*
- Health Services has yet to implement an Internet-based inquiry system as required by state law to provide consumers with accessible public information regarding skilled nursing facilities.*
- The system Health Services uses to track complaint investigations regarding skilled nursing facilities has weak controls over data integrity that could allow erroneous data to be entered into the system without being detected.*

continued on next page . . .

RESULTS IN BRIEF

The Department of Health Services (Health Services) is responsible for protecting and enhancing the health of the State's citizens. With an annual budget of roughly \$38 billion and a staff of more than 6,000 in fiscal year 2006–07, Health Services works toward achieving its mission by administering a broad range of health programs, such as the California Medical Assistance Program, and overseeing various health care professionals and facilities, such as administrators and health care providers employed at skilled nursing facilities. Citizens whose primary needs are for ongoing nursing support rely on more than 1,200 skilled nursing facilities for care each year.

To operate a skilled nursing facility in California, or to receive federal funding under Medicaid or Medicare, a skilled nursing facility administrator must obtain Health Services' continued approval. As part of its approval process, Health Services must ensure that residents of skilled nursing facilities are receiving quality care. Health Services' key oversight functions include investigating complaints from facility stakeholders, such as physicians and concerned relatives of residents, and conducting recurring inspections of skilled nursing facilities to determine whether they continue to comply with state and federal program requirements.

Our review of Health Services' oversight of skilled nursing facilities revealed that it has not consistently followed state and federal laws and regulations and its own policies governing the oversight process. In particular, we found that Health Services has struggled to investigate and close complaints promptly and make timely communications with complainants. The Health and Safety Code requires Health Services to initiate investigations of all but the most serious complaints within 10 working days. Additionally, according to its policy, Health Services' goal is to complete a complaint investigation within 45 working days of receiving the complaint. To measure how promptly Health Services initiated and closed complaint investigations, we used data from its complaint-tracking system. We found that data related to the dates Health Services received complaints, initiated investigations, and closed complaints were of undetermined reliability. The data were of undetermined

- ☑ *The timing of some federal recertification surveys is more predictable than others, which diminishes the effectiveness of these reviews.*
 - ☑ *Health Services has weak controls over its disbursements of funds from the Health Facilities Citation Penalties Account, which limit its ability to ensure that funds are used for necessary purposes.*
 - ☑ *Despite efforts to increase staffing, Health Services has struggled to fill its vacant facility evaluator positions with registered nurses. This reliance on registered nurses is also problematic because of the current nursing shortage and higher salaries offered elsewhere in state service.*
-

reliability primarily because of weaknesses in application controls over data integrity. According to these data, Health Services received roughly 17,000 complaints and reports of incidents that facilities self-reported between July 1, 2004, and April 14, 2006. Although not every complaint Health Services receives and reviews warrants an investigation, we found that Health Services promptly initiated investigations for only 51 percent of the 15,275 complaints for which it began investigations and promptly completed investigations only 39 percent of the time.

Our audit also noted that Health Services' staff could not demonstrate that they have consistently communicated with complainants promptly. Program statutes require Health Services to acknowledge its receipt of complaints within two working days and inform complainants in writing of the results of their investigations within 10 working days of completing their work. For 21 of the 35 complaints we reviewed, the files contained copies of the initial letters to the complainants. In seven of these 21 cases, we found that Health Services notified the complainant beyond the two-working-day time frame. For the most delayed case, it took Health Services 104 days to notify the complainant. Similarly, for all 22 cases that contained copies of the second letter, we found that Health Services notified the complainant of the results of the investigation beyond the 10-working-day time frame. In the most delayed case, it took Health Services 273 days to provide this notification to the complainant. The main cause for delays in providing the second notice appears to be Health Services' practice of waiting for the facility to first submit its plan of correction, which can take another 10 to 15 days beyond the date the facility was notified, before informing the complainant of the investigation results. By failing to consistently meet deadlines for communicating with complainants, Health Services unnecessarily exposes complainants to continued uncertainty about the well-being of residents at skilled nursing facilities.

In addition to timeliness issues, we found that Health Services may not have correctly prioritized complaints it received against skilled nursing facilities. For 12 of the 35 complaints we reviewed, Health Services may have understated the priority of complaints that, according to requirements, would have warranted more urgent investigations. We also found that Health Services may have understated the severity of the deficiencies it identified for nine of the 35 recertification surveys we reviewed. When Health Services does not classify

deficiencies at a sufficiently severe level, the enforcement actions Health Services imposes on skilled nursing facilities may not be adequate, and facility stakeholders may form misperceptions about the quality of care offered at those facilities. It has also yet to implement an Internet-based inquiry system as required by statute to provide consumers with accessible public information regarding skilled nursing facilities. This inquiry system must provide information to consumers regarding a skilled nursing facility of their choice, including its location and owner, number of units or beds, and information on state citations assessed.

Our audit also revealed that Health Services could improve some of its business practices. We found that the system Health Services uses to track complaint investigations for skilled nursing facilities has weak application controls. We also found that Health Services did not record complaint data consistently and some complaint records contained data that is potentially inaccurate. These data problems limit Health Services' ability to effectively manage and accurately report its activities. Further, our audit found that although Health Services completes its recertification workload within federally required time frames, the timing of some recertification surveys is more predictable than that of others, depending on the region in which the skilled nursing facility is located. The more predictable the timing of Health Services' recertification surveys, the greater the opportunity for skilled nursing facilities to mask deficient practices.

We also found that Health Services has weak controls over its disbursements of funds from the Health Facilities Citation Penalties Account (citation account). Between fiscal years 2001–02 and 2005–06, Health Services spent more than \$14.7 million from the citation account. Although most of those funds paid for temporary management companies—firms appointed by Health Services to take control over a skilled nursing facility that fails to comply with federal and/or state requirements—we found that Health Services did little to ensure that the payments it made were necessary or reasonable. In particular, Health Services disbursed more than \$10.5 million to one temporary management company based primarily on the company's e-mails requesting funds. Without firm controls over expenditures, Health Services cannot be sure that citation account funds are used for necessary purposes.

Health Services cited staffing shortages as the cause of many of its oversight problems. We believe that Health Services' explanation has some merit. Our review of the staffing levels within the Field Operations Branch (branch) of the Licensing and Certification Division indicated that securing adequate staffing has been a problem. In the fiscal year 2005–06 budget, the Legislature approved funding for 485 positions within the branch, of which 397 were facility evaluator positions. During the same year, the branch reported it was able to fill 426 of these approved positions, of which 347 were facility evaluators. Most of these facility evaluators are registered nurses, accounting for 78 percent of the 397 health facility evaluator positions authorized in fiscal year 2005–06. Annual vacancy rates for these positions averaged about 16 percent between fiscal years 2002–03 and 2005–06 but have declined slightly each year since fiscal year 2003–04. Health Services primarily focuses on hiring candidates that are registered nurses; however, a nursing shortage and higher salaries elsewhere make filling these positions problematic.

RECOMMENDATIONS

To proactively manage its complaint workload, Health Services should periodically evaluate the timeliness with which district offices initiate and complete complaint investigations. Based on this information, Health Services should identify strategies, such as temporarily lending its staff to address workload imbalances occurring among district offices.

To ensure that it fully complies with state law regarding communication with complainants, Health Services should reassess its current practice of delaying notification to complainants about investigation results until after it receives acceptable plans of correction from cited skilled nursing facilities. If Health Services continues to support this practice, it should seek authorization from the Legislature to adjust the timing of communications with complainants accordingly.

To ensure that it can provide the public access to complete and accurate information regarding skilled nursing facilities as the Legislature intended, Health Services should continue in its efforts to implement an Internet-based inquiry system and take steps to ensure that the data it plans to provide through the system are accurate.

To improve the accuracy of complaint data used to monitor its workload and staff performance, Health Services should develop strong application controls to ensure that its data are accurate, complete, and consistent. This process should include validating the data entered into key data fields, ensuring that key data fields are complete, and training staff to ensure consistent input into key data fields, such as the field designed to capture the date on which the investigation was completed.

To reduce the predictability of its federal recertification surveys, Health Services should institute a practice of conducting surveys throughout the survey cycle, ensuring that each facility has a greater probability of being selected at any given time.

To ensure that it can adequately justify the expenses it charges to the citation account, Health Services should take steps to gain assurance from temporary management companies that the funds they received were necessary. This should include reviewing the support behind temporary management companies' e-mails requesting payments.

To fill its authorized positions and manage its federal and state workloads, Health Services should consider working with the Department of Personnel Administration to adjust the salaries of its staff to make them more competitive with those of other state agencies seeking similarly qualified candidates. In addition, Health Services may want to consider hiring qualified candidates who are not registered nurses. Finally, if these options prove unsuccessful, Health Services should develop additional strategies, such as temporarily reallocating its staff from district offices that are less burdened by their workloads to those facing the highest workloads.

AGENCY COMMENTS

Health Services agreed with our recommendations and indicated it is taking action to address them. ■

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INTRODUCTION

BACKGROUND

The mission of the Department of Health Services (Health Services) is to protect and improve the health of all Californians. With a \$38 billion annual budget and more than 6,000 employees in fiscal year 2006–07, Health Services strives to achieve that mission by administering a broad range of public and environmental health programs, as well as the California Medical Assistance Program (Medi-Cal), which is the State’s Medicaid program for providing health care services to eligible low-income persons and families. Health Services is also responsible for regulating the quality of care in approximately 7,000 public and private health facilities, clinics, and agencies throughout the State.

THE LICENSING AND CERTIFICATION DIVISION PERFORMS THE TASKS REQUIRED TO OVERSEE SKILLED NURSING FACILITIES

Health Services plays a critical role in overseeing California’s skilled nursing facilities, which provide nursing and support to residents whose primary need is having skilled nursing care available on an ongoing basis. Specifically, Health Services is responsible for licensing health care facilities operating in the State, including skilled nursing facilities; for recommending to the federal government certification for facilities that have met the requirements to receive funding under the Medicare and Medi-Cal programs; and for conducting recertification surveys of facilities already federally certified. Health Services has assigned the tasks required to fulfill these responsibilities to its Licensing and Certification Division (division). With the number of skilled nursing facilities statewide exceeding 1,200, Health Services has the budgetary authority to employ more than 400 staff to evaluate skilled nursing facilities (facility evaluators) for fiscal year 2006–07.

Working out of Health Services’ 14 district offices, teams of facility evaluators periodically inspect skilled nursing facilities to ensure that they meet applicable state and federal requirements. Since 1993, under prescribed circumstances, state law has allowed skilled nursing facilities that are certified for participation in Medicare and Medi-Cal to be exempt from

state licensing inspections. Health Services still conducts federal certification surveys at skilled nursing facilities, the requirements for which are established by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services. Federal requirements are generally grouped into key compliance categories that include quality of care, quality of life, residents' rights, and staffing. State law currently allows recertification surveys to substitute for required state licensing inspections. However, because state and federal requirements are not always the same, facility evaluators do not routinely inspect for compliance with some state-specific requirements when performing recertification surveys. Recently, the governor has approved legislation mandating that the division incorporate both federal and state requirements into the State's federal certification survey process, effective July 1, 2007.

In addition to conducting recertification surveys, facility evaluators are charged with investigating the complaints of facility stakeholders, which include physicians, residents and their families, and other concerned citizens. When the results of an on-site investigation reveal an instance of noncompliance with a federal or state requirement, Health Services notifies the skilled nursing facility to take corrective action. If the noncompliance is severe, such as a resident being harmed through negligence, Health Services can issue a citation with a monetary penalty; appoint a temporary management company to take control of the facility; or recommend that the CMS impose a fine, deny Medicare and Medicaid payments to the facility, or terminate the facility's Medicare provider certification.

The division's headquarters in Sacramento has seven branches: Administration and Program Application Support; Professional Certification; and five field operations branches for the Coastal, Northern, Southern, and Bay Area regions and Los Angeles County. At each of Health Services' 14 district offices, a district manager has operational responsibility for the licensing and certification of facilities within the district office's jurisdiction as shown in Figure 1 on the following page. In addition to these 14 district offices, Health Services relies on the Los Angeles County Department of Health Services (LACDHS) to serve that county on Health Services' behalf. Health Services contracts with the LACDHS to perform the duties of a district office, with the chief of LACDHS's Health Facilities Division as the principal contract coordinator. For fiscal years 2005–06 through 2007–08, Health Services has executed a contract with LACDHS for these services at an annual cost of approximately \$18 million.

FIGURE 1

**Health Services' Licensing and Certification Division
District Offices and Service Areas**



Source: Auditor prepared based on the Department of Health Services' Web site.

Note: We visited the indicated district offices during our review. Los Angeles is managed under a contract with the Los Angeles County Department of Health Services (LACDHS). During our review, we visited two of LACDHS's five offices that oversee skilled nursing facilities.

Health Services is responsible for the certification and licensing of various types of health care facilities other than skilled nursing facilities—for example, general acute care hospitals, home health agencies, and psychology clinics. According to its recent report estimating license fees for fiscal year 2007–08, Health Services indicated that more than 60 percent of the division’s annual workload involves long-term care facilities, of which skilled nursing facilities are a major subset. Table 1 shows the staffing and workload levels maintained by the district offices to fulfill the responsibilities related to licensing and certifying skilled nursing facilities.

TABLE 1

**Health Services’ Licensing and Certification Division’s
District Office Staffing and Workload Levels**

District Office	Skilled Nursing Facilities and Nursing Facilities in Service Area (Fiscal Year 2005–06)	Complaints and Facility Incident Reports Received (Calendar Year 2005)	Facility Evaluators* Allocated (Fiscal Year 2006–07)
Bakersfield	33	338	15
Chico	50	642	22
Daly City	49	361	23
East Bay	110	1,279	34
Fresno	55	750	23
Los Angeles†	367	1,639	‡
Orange County	77	358	27
Redwood Coast/Santa Rosa	72	741	35
Riverside	52	712	27
Sacramento	116	1,232	46
San Bernardino	55	779	34
San Diego North	48	726	27
San Diego South	35	621	23
San Jose	67	952	31
Ventura	47	254	21

Source: Department of Health Services’ workload reports (unaudited).

* Positions to be filled by registered nurses.

† Los Angeles County operated out of many offices. Los Angeles County offices pertaining to our audit of skilled nursing facilities include: North, West, East, Central, and San Gabriel.

‡ Los Angeles County independently allocates facility evaluators for this district.

According to the division's assistant deputy director, Health Services has an established hierarchy of activities that directs district offices in prioritizing their workloads. On a weekly basis, headquarters also monitors district offices' progress in addressing high-priority tasks and complaints. Within these management control structures, each district office creates its own schedule—a practice that, according to the assistant deputy director, is necessary because of the “unique environments in which the district offices function.” The assistant deputy director explained that headquarters has recently focused on addressing other problems, such as its recruiting, hiring, and training needs for facility evaluators.

Health Services' district offices send teams of facility evaluators to skilled nursing facilities to investigate complaints and perform recertification surveys. The team size varies for these activities. Factors contributing to the size of a team include the experience levels of the facility evaluators assigned, the complexity of allegations within a complaint, the size of the facility, and the number of residents living at the facility. Most of Health Services' facility evaluators are employed in positions that require them to possess the legal requirements to practice as a registered nurse in California. Further, these specific facility evaluators must have one year of professional nursing experience, including a minimum of at least six months of experience in an administrative position, such as a shift supervisor or lead nurse. As of the end of fiscal year 2005–06, Health Services had budget authority to employ 397 facility evaluators in its Field Operations Branch (branch), of which 308 were positions for registered nurses.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits (bureau) to conduct an audit assessing Health Services' oversight of skilled nursing facilities. Specifically, the audit committee requested that the bureau evaluate Health Services' guidelines and practices for investigating consumer complaints and self-reported incidents related to skilled nursing facilities. In particular, the audit committee asked the bureau to assess Health Services' compliance with laws and regulations governing complaint intake, investigation, and enforcement; the timeliness of completing these investigations; and the process of communicating with complainants. The audit committee also asked the bureau to determine whether Health Services'

oversight, certification, and enforcement policies comply with applicable laws and regulations. Specifically, the audit committee asked us to review and evaluate practices or mandates that address quality of care, quality of life, staffing, and residents' rights. In addition, the audit committee asked us to determine whether any laws exist that require Health Services to use certain automated systems and whether these systems comply with applicable laws and regulations. Further, the audit committee requested that we determine how Health Services tracks and measures its district offices' effectiveness. In particular, the audit committee asked us to determine whether district offices' inspections of skilled nursing facilities were predictable in timing and process and whether inspection findings comply with federal and state laws and regulations. The audit committee also asked us to determine whether Health Services used funds from the Health Facilities Citation Penalties Account (citation account) for allowable purposes. Finally, the audit committee asked the bureau to determine how Health Services determines its resource needs for enforcement activities and establishes workload priorities for its staff.

In order to assess Health Services' oversight of skilled nursing facilities, we reviewed the laws, regulations, and policies relevant to Health Services' oversight functions. Specifically, we reviewed Health Services' contract with CMS, identifying the CMS's expectations for the workload it expects Health Services to accomplish. We also reviewed the CMS's various state operations manuals to identify its expectations as to how Health Services should conduct complaint investigations and periodic recertification surveys of skilled nursing facilities for licensure under Medicare and Medicaid (Medi-Cal in California). In order to assess how it complies with the above requirements, we also obtained and reviewed Health Services' policies and procedures manual for its division.

The U.S. Government Accountability Office (GAO), whose standards we follow, requires us to assess the reliability of computer-processed data. We tested data from Health Services' complaint-tracking system for the purposes of determining how quickly it had initiated and concluded its complaint investigations. Based on our review, we found that Health Services' data were of undetermined reliability, since the accuracy and completeness of its data could not be verified. (See the text box for the definitions of data reliability.) Specifically, Health Services' documentation of when it had received complaints, and when it closed complaint investigations, was

Definitions of Data Reliability

Sufficiently Reliable Data—Based on audit work, an auditor can conclude that using the data would not weaken the analysis nor lead to an incorrect or unintentional message.

Not Sufficiently Reliable Data—Based on audit work, an auditor can conclude that using the data would most likely lead to an incorrect or unintentional message and the data have significant or potentially significant limitations, given the research question and intended use of the data.

Data of Undetermined Reliability—Based on audit work, an auditor can conclude that use of the data could lead to an incorrect or unintentional message and the data have significant or potentially significant limitations, given the research question and intended use of the data.

Source: Assessing the Reliability of Computer-Processed Data from the U.S. Government Accountability Office.

often based solely on the data whose reliability we were trying to assess. Further, our review of the complaint-tracking system's application controls over data integrity revealed a lack of controls that would prevent erroneous data from being entered or that would detect errors or omissions in its system. We discuss the system control weaknesses we identified in Chapter 2. As a result, we found the data to be of undetermined reliability.

To evaluate Health Services' practices for investigating complaints, we judgmentally selected a sample of 35 complaint investigation files for review, focusing on those cases for which Health Services took more than 75 days to complete its investigation. Our sample comprised five complaint files from each of the seven district offices we reviewed. Our selection of the seven district offices was based on the geographic and workload characteristics of those particular district offices. The seven district offices we reviewed are

shown in Figure 1 on page 9.

To better evaluate the entire process, we chose only complaints that the complaint-tracking system indicated were ultimately substantiated and for which Health Services assessed a priority level just below immediate jeopardy. We considered this priority level to contain the highest risk of misclassification because it is just below the level that would require a 24-hour response as opposed to a response within 10 working days. For our sample of 35 complaint investigation files, we limited our review to consumer-reported complaints, since Health Services is not required to adhere to the complaint investigation timelines prescribed under the Health and Safety Code, Section 1420, for entity self-reported incidents. Further, we believe that entity self-reported incidents present a lower risk to residents of skilled nursing facilities, since the management of these facilities, who report these incidents to Health Services, is presumably highlighting the problematic conditions or events and what it is doing to remedy them. To assess whether Health Services appropriately prioritized the 35 complaints, we compared the complaint allegations as recorded in the complaint-tracking system to examples of immediate jeopardy shown in Health Services' policy and procedures manual and federal guidelines for determining immediate jeopardy.

To evaluate whether Health Services promptly communicated with complainants, we initially tried to use data from Health Services' complaint-tracking system. However, Health Services informed us that the "acknowledged date" and "date acknowledged" fields were not sufficiently reliable, since its staff did not always enter data in these key data fields and these fields are used for different types of acknowledgments. As a result of concluding that these two fields were not sufficiently reliable, we used the sample of 35 complaint investigation files previously described to evaluate the timeliness and content of Health Services' communications with complainants.

To evaluate whether Health Services' policies and procedures comply with applicable laws and regulations, we used the same sample of 35 complaint investigation files and another sample of 35 federal recertification files for review. We selected our sample of 35 recertification surveys following a similar methodology as that used for our sample of complaint files. Specifically, we judgmentally selected 35 federal recertification surveys, five from each of the seven district offices we reviewed. We limited our 35 federal recertification surveys to those for which Health Services had reported a deficiency that was at a level 2 severity. Table 4 in Chapter 1 provides the various federal severity levels and their corresponding levels of required enforcement actions. Since any higher deficiency level would have required stricter enforcement actions by Health Services, this sample allowed us to assess whether Health Services had missed opportunities to pursue stronger enforcement remedies against noncompliant skilled nursing facilities. In addition, to assess whether Health Services categorized instances of noncompliance at the appropriate severity level, we reviewed the circumstances for the most severe deficiencies it cited on the 35 recertification surveys, based on the findings and conclusions Health Services wrote on the statements of deficiencies it sent to the facilities. Following the GAO standards for the use of computer-processed data mentioned previously, we tested data from Health Services' recertification survey-tracking system for the purposes of identifying the severity levels of the deficiencies it had found between fiscal years 2004–05 and 2005–06. Based on our tests, we determined that the data were sufficiently reliable for this purpose.

To determine whether Health Services is required to use certain automated databases, and whether existing databases comply with state law, we interviewed Health Services' staff to understand their previous efforts towards establishing such

systems. In addition, we reviewed state laws requiring Health Services to develop an on-line inquiry system for consumers, as well as Health Services' previous and current feasibility studies regarding the inquiry systems' requirements and proposed implementation schedules.

To evaluate how Health Services' management reviews and tracks the performance of its various district offices, we interviewed Health Services management and reviewed the quality of the performance data in its complaint and survey tracking systems.

To determine whether Health Services' federal recertification surveys were predictable, we used data from its survey-tracking system to measure the time elapsed between a skilled nursing facility's last two surveys. This allowed us to assess whether Health Services has complied with federal guidelines regarding survey frequency. Following the GAO standards for the use of computer-processed data mentioned previously, we tested data from Health Services' recertification survey tracking system for the purposes of determining whether it had performed recertification surveys within the time frames prescribed by the CMS. We determined that these data were reliable for our purposes. By identifying and comparing the dates Health Services physically left a skilled nursing facility during its prior two recertification surveys, performed prior to July 1, 2006, we were able to calculate the time that had elapsed between these two reviews.

To determine whether Health Services used funds from the citation account for allowable purposes, we reviewed accounting records and identified all expenditures between fiscal years 2001–02 and 2005–06. We also identified the Legislature's appropriations of citation account funds over this same time period. To understand the criteria governing Health Services' use of citation account funds, we reviewed the applicable sections of the Health and Safety Code. To understand Health Services' internal controls regarding the disbursement of citation account funds, we interviewed Health Services' management and reviewed documents indicating Health Services' approvals for the expenditures it recorded.

To determine how Health Services determines its resource needs, we interviewed Health Services' management and reviewed its recent efforts at increasing its numbers of facility evaluators. Specifically, we reviewed Health Services' fiscal year 2006–07

budget change proposal, in which it sought an additional 115 facility evaluators. We also reviewed Health Services' testimony before the Legislature and in court proceedings describing its staffing shortages. To assess the magnitude of Health Services' staffing shortage, we calculated Health Services' vacancy rates between fiscal years 2002–03 and 2005–06 for those facility evaluator positions that must be filled by registered nurses. As described in Chapter 3 of the audit report, registered nurses make up the majority of facility evaluator staff within Health Services' branch. We calculated vacancy rates based on the authorized positions shown in the governor's budget to our own calculation of "filled" positions. Using data from the payroll system at the State Controller's Office, we estimated the number of filled positions by identifying the number of months in which registered nurses received more than \$1,000 in regular pay and divided that number by 12. We assessed the reliability of these data by relying on our testing of payroll transactions performed during our annual financial audit of the State. In addition, we identified employees with less than one year of experience by comparing the number of employees that received at least \$1,000 in regular pay during June 2006 to the number that received at least \$1,000 in regular pay during June 2005.

To determine how Health Services establishes workload priorities for its staff, we reviewed the workload guidance from the CMS and interviewed Health Services' management to assess the level of autonomy district offices have in completing their assigned workloads. We also interviewed district office managers and Health Services' management to identify their strategies for coping with staffing shortages while trying to accomplish their mandated oversight activities. Finally, we interviewed a representative from the CMS to identify the potential penalties California may face if it does not satisfy the CMS's workload expectations. ■

CHAPTER 1

The Department of Health Services Has Had Difficulty Meeting Its Oversight Responsibilities for Skilled Nursing Facilities

CHAPTER SUMMARY

The Department of Health Services (Health Services) has not always complied with laws, regulations, and policies related to its oversight of skilled nursing facilities.

We found that it failed to meet various time requirements related to its processing of complaints against skilled nursing facilities. In particular, Health Services had difficulty initiating and completing complaint investigations on time and has not promptly communicated with complainants as required. By failing to meet these requirements, Health Services caused delays in the remedial actions skilled nursing facilities needed to take, and facility stakeholders, including physicians and residents' family members, remained uninformed about the safety and well-being of residents on whose behalf they raised concerns.

We also found that Health Services may have understated the priority levels of complaints it received and the severity levels of deficient practices it identified during recertification surveys. As a result, it may not have responded to complaints as promptly as conditions warranted and may have imposed enforcement actions inconsistent with the severity of its findings at the cited skilled nursing facilities. Finally, we noted that Health Services has yet to implement an on-line inquiry system for consumers in accordance with the Health and Safety Code. Health Services hopes to finish implementing the system by February 2008.

MEETING SOME TIME REQUIREMENTS HAS PROVED DIFFICULT FOR HEALTH SERVICES

Our audit found that Health Services has been unable to initiate and close its complaint investigations promptly. According to its complaint-tracking system, between July 1, 2004, and April 14, 2006, Health Services received

roughly 17,000 complaints from facility stakeholders and reports of incidents from facilities themselves. Although not every complaint Health Services receives and reviews warrants an investigation, we found that Health Services promptly initiated investigations for only 51 percent of the 15,275 complaints for which it began investigations and promptly completed investigations only 39 percent of the time. In addition, based on our assessment of the reliability of computer-processed data, as required by the U.S. Government Accountability Office, we found Health Services' complaint-tracking system data to be of undetermined reliability. We use this data because it is the only source available to assess timeliness at a department-wide level. However, the use of these data for the purpose of determining how quickly Health Services initiated and concluded its complaint investigations could lead to an incorrect or unintentional message. We reached this determination because the accuracy and completeness of its data could not be verified and the system lacks strong application controls, as discussed in Chapter 2.

We also noted that Health Services could not always demonstrate that it communicated promptly with complainants in acknowledging that complaints were received or communicating the results of its investigations. Further, Health Services informed us that the data in its complaint-tracking system was not sufficiently reliable for the purpose of monitoring key time requirements related to its communications with complainants. Therefore, the use of this data would most likely lead to an incorrect or unintentional message. Health Services frequently cited staffing shortages, an issue we discuss in Chapter 3, as the primary cause for its performance problems.

Long Delays in Initiating Complaint Investigations Limit Health Services' Ability to Ensure Quality Care

The Health and Safety Code requires Health Services to investigate a complaint regarding a skilled nursing facility within 10 working days of receipt, unless it determines that the complaint is willfully intended to harass the facility or lacks a reasonable basis. In Appendix B we specify the time requirements related to initiating complaint investigations and other key steps in the oversight process. When a complaint allegation is sufficiently severe, as when there is threat of imminent danger of death or serious bodily harm, statutes require Health Services to initiate a complaint investigation within 24 hours. According to data in its complaint-tracking

According to data in its complaint-tracking system, Health Services has had difficulty initiating complaint investigations in a timely manner.

system, Health Services has had difficulty initiating complaint investigations in a timely manner. Table 2 summarizes the time Health Services needed to begin investigating complaints it received between July 1, 2004, and April 14, 2006, measured by the number of calendar days between the date the complaint was received and the date the on-site investigation started. For complaint investigations required to be initiated within 10 working days, we considered those that exceeded 14 calendar days to be late, which allows for weekends and holidays. As we describe in Chapter 2, we found these data to be of undetermined reliability because we were unable to perform accuracy and completeness testing and because the lack of strong application controls shows the potential for errors in the data.

TABLE 2

Health Services' Initiation of Complaint Investigations

Calendar Days	Highest Priority (Initiation Required Within 24 Hours)	Percentage of Total	All Other Complaints (Initiation Required Within 10 Working Days)	Percentage of Total
Within 1	902	90.8%	2,176	15.3%
2-14	66	6.6	4,789	33.5
15-30	9	0.9	2,043	14.3
31-60	8	0.8	1,800	12.6
61-90	2	0.2	1,088	7.6
More than 90	7	0.7	2,385	16.7
Totals	994	100.0%	14,281	100.0%

 Complaint investigations initiated timely in accordance with statutes.

Source: Department of Health Services' (Health Services) complaint-tracking system as of September 5, 2006.

Notes: We identified 17,042 records for which the complaint-received dates were between July 1, 2004, and April 14, 2006. We found these data to be of undetermined reliability because we were unable to perform accuracy and completeness testing and because the lack of application controls, as discussed in Chapter 2, shows the potential for errors in the data. The use of these data for the purpose of determining how quickly Health Services initiated its complaint investigations could lead to an incorrect or unintentional message.

Further, the 17,042 records represent individual complaints or reports of incidents from facilities themselves; however, in some cases multiple complaints may be submitted for the same incident. Although each complaint and incident report are tracked separately, an incident is usually only investigated once. We excluded from this table 1,115 records that had complaint-received dates but did not have investigation start dates, and 652 records in which the investigation start dates preceded the complaint-received dates. According to Health Services, the latter occurs when it receives a second complaint about an incident that is already under investigation and links the two complaints together under the same investigation.

Table 2 indicates that Health Services was late in initiating investigations for about 9 percent of the highest-priority cases and for more than 51 percent of all other complaints. In

When Health Services is late responding to complaints, it is not adequately meeting its responsibility to ensure that skilled nursing facilities are providing the best care possible.

addition, although delays in starting to investigate any type of complaint are problematic, Health Services was much more prompt at beginning its investigations of its 994 highest-priority complaints. Nevertheless, investigations of 26 (about 3 percent) of these most serious cases took longer than 14 days to initiate. However, the delays related to all other complaints were more severe, with Health Services taking longer than 90 days to start investigating 2,385 (about 17 percent) of these complaints. When Health Services is late responding to complaints, it is not adequately meeting its responsibility to ensure that skilled nursing facilities are providing the best care possible.

According to a former Health Services' manager who was responsible for reviewing Health Services' compliance with time requirements, Health Services made the policy decision to postpone investigations of all but the highest-priority complaints until staff visited those facilities for their annual recertification surveys because it was experiencing critical staffing shortages. In Chapter 3 we discuss the staffing challenges Health Services is facing in more detail. We observed this policy in practice, noting that six of the 35 complaints we reviewed were not investigated until the skilled nursing facilities underwent their federal recertification surveys. Although for two of these six complaints, Health Services began the investigation on time, it was late in starting investigations for the other four, which took more than 100 days to initiate. Health Services' practice of waiting to start all but the most critical complaint investigations can adversely affect its ability to investigate the specific conditions and residents involved with the complaint. In fact, for one of the four complaints in which the investigation was delayed for more than 100 days, the resident was no longer residing in the facility. In another of the four long-delayed cases, the documentation shows that Health Services was not able to validate the complaint allegation but did identify other unrelated violations during the on-site visit.

Concerns over Health Services' inability to initiate complaint investigations of skilled nursing facilities within the prescribed time frames led the California Advocates for Nursing Home Reform (advocates for nursing home reform) to request the San Francisco Superior Court to issue an order, requesting that it require Health Services to initiate complaint investigations within the 10-working-day period specified under law. In July 2006 Health Services informed the court that 9,463 of 17,210 complaints were initiated within 10 working days, with 1,071 complaints still to be initiated. Although Health

Court-Mandated Milestones for Health Services

By January 12, 2007

- Conduct initial on-site investigations within 10 working days for 80 percent of new complaints received between September 27, 2006, and December 29, 2006.
- Conduct initial on-site investigations for 40 percent of all complaints received before September 27, 2006 (backlog).

By May 12, 2007

- Conduct initial on-site investigations within 10 working days for 80 percent of all complaints received between December 29, 2006, and April 27, 2007, and 100 percent of all complaints received after May 12, 2007.
- Conduct initial on-site investigations for all backlogged complaints.

Services argued that it was making progress toward reducing its backlog, the court ultimately issued the order requested by the advocates for nursing home reform, which established the performance benchmarks shown in the text box. By May 12, 2007, the court expects Health Services to have cleared its backlog of complaints, defined as those received before September 27, 2006, and to begin investigating all new complaints within 10 working days in accordance with state law. We did not review Health Services' performance toward meeting these benchmarks since the mandated time for compliance with the court order, May 12, 2007, occurs outside the time period of our review.

In addition to the benchmarks shown in the text box, the court required Health Services to provide quarterly reports on its progress toward complying with the court order. Health Services' first report to the court, covering the period between mid-August and mid-November 2006, indicated that it had reduced its backlog of complaints to 374 and that it was investigating 95 percent of new complaints within 10 working days.

Closing Complaints on Time Has Also Been a Problem

Although no federal or state time requirements exist for closing complaints, Health Services' policy is to reach closure within 45 working days of receiving a complaint. This includes 40 days for facility evaluators and supervisors to complete the investigation and five days for support staff to close out the complaint file. Health Services considers the investigation complete when it receives an acceptable plan of correction from the facility. Similar to its struggles to initiate complaint investigations promptly, Health Services has had difficulty meeting its timeline for closing complaints. Table 3 on the following page shows the time Health Services needed to close the complaints it received between July 1, 2004, and April 14, 2006. Based on data in Health Services' complaint-tracking system as of September 5, 2006, closure is measured by the number of calendar days between the date the complaint was received and the date the file was closed. To allow for weekends and holidays, we considered complaints to be late if

they took longer than 75 calendar days to close. According to the table, Health Services failed to close more than half of its complaint cases within its 45 working-day policy goal.

TABLE 3

Health Services' Closure of Complaint Investigations

Calendar Days	Highest Priority (45 Working-Day Goal)	Percentage of Total	All Other Complaints (45 Working-Day Goal)	Percentage of Total
Within 75	404	46.9%	5,003	38.8%
76–100	89	10.3	1,607	12.5
101–200	215	24.9	3,609	28.0
201–300	92	10.7	1,529	11.9
301–400	39	4.5	660	5.1
More than 400	23	2.7	478	3.7
Totals	862	100.0%	12,886	100.0%

 Complaint investigations initiated timely in accordance with statutes.

Source: Department of Health Services' (Health Services) complaint-tracking system as of September 5, 2006.

Notes: We identified 17,042 records for which the complaint-received dates were between July 1, 2004, and April 14, 2006. We found these data to be of undetermined reliability because we were unable to perform accuracy and completeness testing and because the lack of application controls, as discussed in Chapter 2, shows the potential for errors in the data. The use of these data for the purpose of determining how quickly Health Services closed its complaint investigations could lead to an incorrect or unintentional message.

Further, the 17,042 records represent individual complaints or reports of incidents from facilities themselves; however, in some cases multiple complaints may be submitted for the same incident. Although each complaint and incident report is tracked separately, an incident is usually only investigated once. We excluded from this table 3,253 records that had complaint-received dates but did not have investigation-closed dates, and 41 records in which the investigation-closed dates preceded the complaint-received dates. According to Health Services, the latter occurs when it receives a second complaint about an incident that is already under investigation and links the two complaints together under the same investigation.

To assess why it takes Health Services so long to close complaints, we reviewed five complaints at each of seven district offices that the complaint-tracking system indicated were substantiated. For a majority of the complaints, we were able to determine the time between the start of the investigation and the date the facility was notified of the investigation results, based on evidence in the files. These files included investigation reports, now called summary reports, and letters to the complainant or facility. We found that for 18 of the 35 complaints, just the time it took between starting an on-site investigation and notifying the facility in writing of the results equaled or exceeded the 45-working-day policy for closing complaints. The time lags for completing this stage in the process varied, with the two fastest complaint cases taking 45 working days and the slowest complaint case taking 379

working days. For 14 of the 18 complaints, the time lag exceeded 100 calendar days. The actual hours facility evaluators spent performing their on-site work was minimal, based on our review of the workload reports generated from the complaint-tracking system included in 17 of the 18 case files; one file did not have a workload report. Specifically, the number of hours that facility evaluators spent performing on-site investigations ranged from a low of two hours to a high of 29.5 hours for the 17 case files that contained workload reports.

Health Services stated that sometimes its facility evaluators need additional information or need to interview staff not at the facility's location, causing a months-long gap between the first visit to the facility and the exit conference.

Our review of the investigation reports found that the delays for 15 of the 18 complaints were attributable to the hours facility evaluators needed to complete their work and for supervisors to review and approve the complaint files. Health Services' staff indicated that sometimes a months-long gap occurs between the time when facility evaluators first visit the site and when they return to conduct the exit conference, at which they share the results of the investigation with the facility. The staff further indicated that this delay happens if the facility evaluators need additional information or need to interview other staff not at the facility's location.

According to Health Services' policy, facility evaluators must complete an investigation report, along with a statement of deficiencies summarizing the results of the investigation. The investigation report has a signature and date block that the facility evaluator and the supervisor sign before submitting the file to support staff, who then send a notice providing the investigation results to the facility. For the three remaining complaints that took 45 or more working days to close, we could not pinpoint when the facility evaluators and supervisors completed their work because the investigation reports for two of the complaints were completed after Health Services notified the skilled nursing facilities about the results, and one case file did not have a copy of the investigation report.

In providing perspective regarding the 45-working-day policy, division managers told us that the policy originated with former federal guidelines that recommended completing complaint investigations within 40 days. They also noted that although federal guidelines no longer include this recommendation, the December 2006 draft of the division's revised policies and procedures includes the 40-day time frame. However, the policies do not establish any further guidelines for timely completion of the various stages in the process. For example, there is no expectation established for facility evaluators

regarding how many days they are allowed after starting the investigation to deliver the completed complaint documentation to the supervisor for review. In addition, it is unclear how much time should be allotted for supervisory review. Without timelines for individual steps in the complaint investigation process linked to the parties responsible for performing them, Health Services cannot be sure its objectives are being met and will have difficulty holding staff accountable for the timely completion of work.

Communications With Complainants Did Not Always Occur Within Required Time Frames

The Health and Safety Code requires Health Services to communicate with complainants on two separate occasions. First, it must respond to a complainant within two days of receiving a complaint. Although statutes do not specifically require it, Health Services' practice is to provide this initial communication in writing. Second, Health Services must inform the complainant in writing of the results of its review within 10 working days of completing its investigation. These requirements assure concerned stakeholders that Health Services has heard and is addressing their concerns about skilled nursing facilities. Our review of 35 complaint files revealed that Health Services did not always retain sufficient documentation to demonstrate that they provided complainants with these required notices. In addition, we found that even when Health Services documented the notices, it did not always communicate with complainants in a timely manner.

Health Services did not always retain sufficient documentation to demonstrate that they provided complainants with required notices.

Of the 35 complaints we reviewed, four were submitted anonymously. In addition, one was an incident self-reported by a facility that had been misclassified as a consumer complaint. Further, one complaint was submitted by a local public health official to update Health Services on the status of an earlier complaint that Health Services and the public health official were working on together. For these six complaints, we did not expect to see any evidence of communications with complainants. However, for the remaining 29 complaints, we did expect the case files to contain letters proving that Health Services had communicated with the complainants on two separate occasions. For the initial communication, we found that eight letters were missing from the files. In responding to our questions about the missing letters, district office managers told us that the complainants for four of the eight cases did not provide Health Services with their addresses,

so no letters were sent. However, they indicated that staff called the complainants in three of these cases. To determine whether the initial communication with complainants was timely, we compared the date the complaint was received, based primarily on faxes, letters, and other handwritten notes, to the date on the 21 letters we found in the complaint files. For seven of the 21 cases, we found that Health Services notified the complainant after the two-working-day time frame had passed. For the worst case, it took the district office 104 days to notify the complainant that it had received the complaint.

Similarly, we expected to find letters in the complaint files to prove that Health Services had communicated a second time with complainants within 10 working days of completing its investigations for 29 of the 35 complaints we reviewed. However, we found that these letters were missing for seven of the 29 cases. For the 22 files that did contain these letters, we determined whether the communication with complainants was timely by comparing the date the investigation was completed, according to data generated from the complaint-tracking system, to the date on the letter we found in the complaint file. For most of the complaint files, we were unable to find any additional documentation to corroborate the date shown in the complaint-tracking system for the completion of the investigation. For all 22 cases, we found that Health Services notified the complainant beyond the 10-working-day time frame. In the worst case, it took the district office 273 days to notify the complainant of the results of the investigation.

The main cause for delays in notifying complainants about the results of investigations appears to be Health Services' interpretation of the Health and Safety Code, Section 1420(a). Under this statute, Health Services is required to notify the complainant and the facility in writing of the results of the investigation within 10 working days after it has determined the results of its investigation. In practice, Health Services notifies the facility first and waits for it to submit a plan of correction, which can take at least another 10 to 15 days beyond the date the facility was notified, before informing complainants of the results. Therefore, depending on how long a skilled nursing facility takes to prepare and submit its plan of correction, a complainant may not learn of the investigation's results until much later than necessary.

The main cause for delays in notifying complainants about the results of investigations appears to be Health Services' interpretation of the Health and Safety Code.

Health Services acknowledged that it is not in strict compliance with the Health and Safety Code, Section 1420(a), but believes that it meets the spirit of the law. Specifically, it believes that the delay in written communication is better for the complainant because it provides finality to the process by letting them know exactly how the facility has changed its practices to remedy the deficiency. Health Services generally allows facilities up to 15 calendar days to submit plans of correction once they receive written notice of the deficiencies. In our review of the 35 complaints, we found that a number of skilled nursing facilities submitted their plans of correction late. For a majority of the complaints, we were able to calculate these delays by comparing the date on the letters to the facilities to the date-stamp on the plans of correction returned by the facilities. We noted that the facilities submitted 12 of the 35 plans more than 15 calendar days after being notified, with four taking 30 or more calendar days to submit their plans. Although these delays are less significant than others highlighted in this section, they effectively prevent Health Services from promptly informing complainants about the results of the investigations.

HEALTH SERVICES MAY HAVE UNDERSTATED THE PRIORITY LEVELS OF COMPLAINTS RECEIVED AND THE SEVERITY LEVELS OF DEFICIENCIES IDENTIFIED DURING RECERTIFICATION SURVEYS

We question whether Health Services could have prioritized 12 of the 35 complaints we reviewed at higher severity levels when it received them. Had it done so, Health Services would have been required to investigate the 12 complaints within 24 hours instead of the 10 working days allowed by state statutes for complaints assessed at lower priority levels. We also question whether Health Services should have categorized nine of the 35 deficiencies we reviewed from its recertification surveys at higher severity levels, resulting in more severe penalties for the noncompliant skilled nursing facilities. We acknowledge that Health Services' staff use their professional judgment in reaching these decisions; however, if Health Services understates the severity of complaint allegations and noncompliant practices, it might underplay the need for skilled nursing facilities to correct their deficiencies and could put residents at risk of receiving poor quality care.

If Health Services understates the severity of complaint allegations and noncompliant practices, it might put residents at risk of receiving poor quality care.

Some Complaints May Have Been Prioritized at Levels Lower Than the Allegations Warranted

When it identifies a complaint that involves a threat of imminent danger of death or serious bodily harm to a resident of a skilled nursing facility (immediate-jeopardy level), statutes require Health Services to begin its on-site inspection or investigation within 24 hours of the receipt of the complaint. For other complaints that warrant investigating, the statute allows Health Services 10 working days. We chose to review 35 complaints that Health Services had prioritized just below the immediate-jeopardy level, thus requiring an on-site investigation within 10 working days. We questioned whether Health Services should instead have prioritized some cases as immediate jeopardy, requiring an on-site investigation within 24 hours, by comparing the complaint allegations as recorded in the complaint-tracking system to examples of immediate jeopardy shown in Health Services' policy and procedures manual and federal guidelines for determining immediate jeopardy. Although we discussed a number of cases with Health Services' officials, we ultimately questioned its prioritization of 12 of the 35 complaints in our sample. Appendix A presents the circumstances surrounding these 12 cases and Health Services' perspective on each.

In six of the 12 complaint prioritizations we questioned, Health Services agreed with our assessment that the cases should have been classified as immediate jeopardy and investigated within 24 hours.

In six of the 12 cases, Health Services agreed with our assessment, acknowledging that the cases should have been classified as immediate jeopardy and investigated within 24 hours. In one case, the complaint alleged that the skilled nursing facility failed to turn off the resident's feeding tube, causing the resident to vomit while on her back. Under federal guidance, this case should have been prioritized as an immediate-jeopardy case because of the skilled nursing facility's alleged failure to prevent neglect, as evidenced by improper feeding of an individual with known aspiration risk. Health Services indicated that it did not prioritize the complaint at a higher level because there was no alleged adverse outcome, such as the need for hospitalization. However, after reviewing the file, Health Services' management agreed that even though there was no adverse impact, the complaint should have been investigated within 24 hours given the seriousness of the event.

In two of the 12 cases we questioned, Health Services disagreed with our analysis because the residents who were the subject of the allegations had died before Health Services received the complaints. We question Health Services' rationale because the causes of the deaths might have been attributable to systemic conditions at the skilled nursing facilities, thus placing other residents at similar risk. In one case, the complaint alleged that the skilled nursing facility incorrectly administered the resident's medication, resulting in death by overdose. We would have expected Health Services to investigate this case within 24 hours because of the possibility that other residents were being similarly overmedicated. Explaining its decision, Health Services indicated that the complaint was received two months after the resident died, and so there was no longer an immediate-jeopardy condition to be addressed. This explanation does not alter our view that such an outcome could indicate that other residents might be at risk.

In four other cases, Health Services disagreed with our conclusions because the individuals involved in the complaints were no longer at the skilled nursing facilities, thus removing the potential for immediate jeopardy. In one case, the complaint alleged that the skilled nursing facility's contract therapist coaxed one of its residents to live with him at his apartment for less money and also sold him jars of medicine. After two weeks, the therapist drove the wheelchair-bound resident to a gas station and left him there to fend for himself. When we asked Health Services to explain why it did not investigate this case within 24 hours, it indicated that the resident and the alleged perpetrator were no longer at the skilled nursing facility and that the perpetrator was barred from returning. Regardless of whether or not the individuals related to these incidents were still at the facilities, we question whether similar conditions could still be occurring at these facilities and pose a similar risk to residents.

When it fails to cite deficiencies at sufficiently severe levels, the enforcement actions Health Services imposes on skilled nursing facilities may not be adequate.

In Its Reviews of Facilities for Compliance With Federal Requirements, Health Services Understated the Severity of Some Identified Deficiencies

During our audit we questioned Health Services' characterization of the deficiencies cited in nine of the 35 recertification surveys we reviewed. Overall, Health Services agreed that two of the nine cases we questioned should have been classified at higher scope and severity levels. When it fails to cite deficiencies at sufficiently severe levels, the enforcement actions Health Services imposes on





skilled nursing facilities may not be adequate, and concerned stakeholders may form misperceptions about the quality of care these facilities offer.

At the conclusion of a federal recertification survey, Health Services provides the skilled nursing facility with a statement of deficiencies listing the areas of noncompliance identified and their related scope and severity levels. The Centers for Medicare and Medicaid Services (CMS) requires Health Services to assess the scope of the deficiency as either isolated, pattern, or widespread, and the four severity levels range from no actual harm to immediate jeopardy. The various scope and severity levels, and their corresponding letter-based codes, are shown in Table 4.

TABLE 4
Assessment Factors Used to Determine the Severity and Scope of Deficiencies at Skilled Nursing Facilities

Level of Severity	Description of Severity	Level of Scope		
		Isolated	Pattern	Widespread
4	Immediate jeopardy to resident health or safety	J	K	L
3	Actual harm that is not immediate	G	H	I
2	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
1	No actual harm with potential for minimal harm	A	B	C

Required Federal Enforcement Actions

-  State may appoint a temporary management company to operate the facility, or may terminate its Medicare/Medicaid provider agreement. State may also impose civil monetary penalties of up to \$10,000 per day or per instance of noncompliance.
-  Facility may lose some or all Medicare/Medicaid payments, and/or be assessed civil monetary penalties of up to \$3,000 per day or \$10,000 per instance of noncompliance.
-  State may develop plan of corrective action for the facility, appoint a monitor to oversee corrective action taken, or require facility staff to attend training.
-  Skilled nursing facility is in substantial compliance with federal requirements.

Sources: Centers for Medicare and Medicaid Services’ State Operations Manual, Chapter 7—Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities.

Note: In addition to the required enforcement actions, each facility that has a deficiency labeled with the letters “B” through “L” must submit an acceptable plan of correction. For a deficiency labeled with a letter “A”, no plan of correction is required.

As shown in Table 4, the CMS makes a general distinction between actual harm (levels 3 and 4) and no actual harm (levels 1 and 2). The CMS definition of level 3 actual harm is noncompliance that results in a negative outcome compromising residents' abilities to maintain or reach their highest practical physical, mental, and psychosocial well-being. In a level 3 case, codes G through I are used to indicate deficiencies that require sanctions be imposed on the skilled nursing facility, such as a fine of up to \$3,000 per day and/or denial of Medicare or Medicaid payments for new residents. In contrast, the CMS defines a level 2 deficiency as noncompliance that results in no more than minimal physical, mental, and/or psychosocial discomfort to the resident. Health Services uses deficiency codes D through F to indicate these lower-level cases that may result in the facilities having to submit plans of correction, participate in directed in-service training, or face state monitoring unless the condition was widespread (code F). For code F deficiencies, the required remedies are the same as deficiencies at severity level 3.

We identified nine cases in which Health Services could have categorized the noncompliance at a higher severity level.

Our audit included a review of 35 surveys in which the most serious deficiencies cited were categorized at level 2. We reviewed the circumstances for the most severe deficiencies on each of the 35 surveys, based on the findings and conclusions in the statements of deficiencies Health Services sent to the facilities, to assess whether Health Services categorized instances of noncompliance at the appropriate severity level. Although we discussed a number of cases with Health Services' officials and agreed that it categorized most of the 35 deficiencies at an appropriate level, we identified nine cases in which Health Services could have categorized the noncompliance at a higher severity level, based on CMS criteria and the conditions cited as a result of the recertification survey.

In one example, we found a deficiency that Health Services might have assessed at a scope and severity level well below what was warranted, based on our review of the evidence within the recertification survey file. Our review entailed comparing the written findings of the survey team to the CMS' criteria for immediate jeopardy. Our reading of the survey team's report causes us to believe this deficiency, as written, could have been assessed as immediate jeopardy—the highest possible severity level—requiring Health Services to recommend that the CMS impose sanctions such as large monetary penalties, the appointment of a temporary management company, or the termination of their Medicare/Medicaid provider agreement.

According to the recertification survey report, the survey team concluded that the facility had failed to ensure that seven residents had the proper physician orders for the administration of oxygen and proper care of the oxygen equipment providing the therapy. One of these residents was admitted to the facility in September 2005 with diagnoses that included stroke and respiratory failure, along with a physician's order requiring the continuous administration of oxygen. During the recertification survey, the team of facility evaluators documented that the resident's oxygen concentrator was turned off, that its filter was caked with layers of dust, and that the resident had told them it had been turned off for weeks. Upon further review, the survey team documented that the facility's policy requires the medication nurse to monitor and document oxygen levels every shift. The survey team found that oxygen-monitoring data had not been logged for 20 shifts during November and the first week of December 2005. As a result of these findings, the survey team cited a letter E deficiency. As shown previously in Table 4, a letter E deficiency constitutes a "pattern" scope of noncompliance with a severity level of "no actual harm with potential for more than minimal harm that is not immediate jeopardy." Due to the number of residents affected by the deficiency, along with the survey team's written description of the conditions they observed, we believe that the potential for serious actual harm existed, and that the deficiency therefore could have warranted a letter K immediate-jeopardy assessment.

In its response about a deficiency involving a facility's failure to ensure the proper administration of oxygen, Health Services acknowledged that the survey team's report should have been written more clearly.

In its response to our inquiry on this deficiency, Health Services acknowledged that the survey team's report should have been written more clearly and indicated that it understood how we reached our conclusion; however, its clinical review of this case indicated that the affected residents were not at risk of serious harm. As a result, Health Services concurred with the scope and severity level cited by its survey team and stated that an "additional investigation should have been done to clearly draw out the deficient practice, and had that further investigation occurred it would have demonstrated that there was no immediate jeopardy situation." Furthermore, Health Services asserted "there was no evidence of harm or adverse symptoms for any of the residents related to the deficiency based on observation, interviews, and record review. The findings regarding dust on equipment, old filters, charting issues, and physician's orders need more clarity and indicate a pattern for the facility and are evidence of deficient practices but do not rise to the level of immediate jeopardy." While we are

not challenging the clinical findings of Health Services' survey team, this example highlights the need for Health Services to ensure that its conclusions are clearly supported with sufficient written documentation to ensure that program stakeholders do not form misperceptions about a skilled nursing facility's deficient practices.

For two deficiencies that we questioned, Health Services agreed that the nature of the deficiency and the evidence documented by the survey team warranted a higher severity level than the one that was assessed.

For two other deficiencies that we questioned, Health Services agreed that the nature of the deficiency and the evidence documented by the survey team warranted a higher severity level than the one that was assessed. For both of these cases, Health Services should have recommended a remedial action against the facility to the CMS. In one example, a resident suffered a fall in April 2005 that resulted in a cut to the left side of the forehead that was bleeding and measured 3 centimeters by 4 centimeters in size and 0.4 centimeters deep. Additional injuries to the resident included a bump protruding 1.5 centimeters from one eye, along with a skin tear on one knee and an abrasion on one elbow. According to the evaluator's description of this case, the skilled nursing facility had determined in February 2005 that the resident needed assistance for walking, and in March 2005 the facility assessed the resident as being at high risk for falling. Health Services cited the skilled nursing facility in May 2005 for failure to investigate the fall and to revise the resident's plan of care after the fall. Health Services assessed the severity of this noncompliance as level 2 in the statement of deficiencies for this facility. When we questioned it about this case, Health Services agreed that a deficiency code of G, or a severity level of 3, should have been assessed.

Health Services also agreed with us regarding a second case that we questioned. In July 2005 a skilled nursing facility admitted a resident who had two moderate pressure sores on her left and right buttocks, measuring 8 centimeters by 5 centimeters and 6 centimeters by 5 centimeters, respectively. An evaluation of the resident's condition in March 2006 indicated that the resident had one severe pressure sore. During a recertification survey in April 2006, the facility evaluator observed a large, deep pressure sore by the base of the resident's spinal column. At that time, the licensed nurse at the facility stated that the severe sore began as a pressure sore on her right buttock and became enlarged. The facility evaluator further documented that a change in treatment for the pressure sores was delayed by six days in July 2005 and 11 days in August 2006, after the nursing staff noted that the pressure sores had been worsening.

As a result, Health Services assessed a level 2 deficiency and cited the facility for not ensuring that a resident exhibiting pressure sores on admission received necessary treatment and services to promote healing when the resident required altered treatment. When we questioned Health Services on the assessment of this deficiency, it agreed that the findings for this deficiency should have been assessed at level 3 because the facility failed to alter the treatment and promptly notify the wound consultant.

Health Services responded to our inquiry regarding six other deficiencies by asserting that the injuries caused limited consequence to the residents, or resulted in no more than minimal discomfort.

For six other deficiencies in our sample, we believe the evidence documented by the survey team could have warranted a higher-level scope and severity assessment based on federal guidelines. Specifically, federal guidelines dictate that a higher-level deficiency is warranted when the recertification survey reveals that a resident suffered actual harm. Health Services responded to our inquiry on these six cases by asserting that the injuries caused limited consequences to the residents or resulted in no more than minimal discomfort. For example, a resident suffered several skin tears and abrasions as a result of two falls in August 2005. In September 2005 the same resident suffered another fall that caused his nose to bleed, and he sustained a skin tear to his left knee measuring 1.5 centimeters by 1.5 centimeters. Health Services cited the facility for a level 2 deficiency based on the facility's failure to establish a system to adequately develop care plans, ensure adequate supervision, provide assistive devices, and monitor and provide adequate post-fall assessments and interventions. According to Health Services, these injuries were limited in nature and resulted in no more than minimal discomfort, in the professional opinion of the facility evaluator at the time of the survey. However, we believe that a higher level of severity could have been warranted since the injuries documented by the evaluator show actual harm suffered by the resident due to the facility's noncompliance.

By the nature of their conditions, residents of skilled nursing facilities are dependent on good policies and practices at facilities to ensure their safety and well-being. The level of enforcement used by Health Services is especially critical when any incident of actual harm to a resident or a widespread issue involving substandard care is revealed during a recertification survey. To the extent that Health Services understates the severity of deficiencies, the level of remedial action required is less severe and facilities may be less likely to modify deficient practices and behaviors. To provide some perspective on the types of deficiencies Health Services has identified during recertification surveys performed at skilled nursing facilities,

Table 5 quantifies the nature and severity levels of deficiencies cited by Health Services as a result of recertification surveys completed during fiscal years 2004–05 and 2005–06. Although these deficiencies represent a significant part of Health Services’ oversight function, they do not represent all of its enforcement activities. As shown in Table 5, 542 (457 level 3 plus 85 level 4) of the 28,016 deficiencies cited during federal recertification surveys were for instances of actual harm, level 3, or higher.

TABLE 5

Deficiencies Cited by Health Services During Recertification Surveys

Nature of Deficiency	Level 1 No Actual Harm With Potential for Minimal Harm	Level 2 No Actual Harm With Potential for More Than Minimal Harm That Is Not Immediate Jeopardy	Level 3 Actual Harm That Is Not Immediate	Level 4 Immediate Jeopardy to Resident’s Health or Safety	Totals	Percentage of Totals
Quality of care	448	5,797	319	33	6,597	23.6%
Resident assessment	851	3,027	17	0	3,895	13.9
Quality of life	1,190	2,072	19	2	3,283	11.7
Dietary services	1,196	1,684	4	13	2,897	10.3
Administration	1,057	1,428	18	9	2,512	9.0
Pharmacy services	443	1,607	5	9	2,064	7.4
Resident rights	773	1,074	4	0	1,851	6.6
Physical environment	982	651	1	2	1,636	5.8
Resident behavior and facility practices	237	1,178	56	11	1,482	5.3
Infection control	259	903	4	6	1,172	4.2
Physician services	52	146	0	0	198	0.7
Nursing services	27	157	8	0	192	0.7
Admission, transfer, and discharge rights	44	49	0	0	93	0.3
Dental services	4	73	2	0	79	0.3
Specialized rehabilitative services	6	57	0	0	63	0.2
Definitions	0	2	0	0	2	0.0%
Totals	7,569	19,905	457	85	28,016	
Percentage of Totals	27.0%	71.1%	1.6%	0.3%		

Source: Department of Health Services’ survey-tracking system (fiscal years 2004–05 and 2005–06).

HEALTH SERVICES HAS FAILED TO MEET STATE REQUIREMENTS FOR PROVIDING PUBLIC ACCESS TO INFORMATION ON SKILLED NURSING FACILITIES

To enhance the quality and public accessibility of information on long-term care facilities, including skilled nursing facilities, the Legislature passed Assembly Bill 893 (Chapter 430, Statutes of 1999), which required Health Services to provide the public with an on-line inquiry system accessible through a toll-free telephone number and the Internet. However, our audit found that Health Services has been unable to fully implement this system, nearly five years after the Legislature's deadline of July 1, 2002. Program statutes require the inquiry system to provide consumers with certain information regarding the skilled nursing facility of their choice, including its location and owner, the number of units or beds, and information on state citations assessed. According to the bill analyses at the time, the Legislature's intent was to provide consumers with accessible public information regarding skilled nursing facilities, helping consumers make informed decisions when choosing a facility.

Health Services' management asserted that budget shortfalls in fiscal years 2003–04 and 2004–05 have hampered its efforts to implement the Internet-based inquiry system.

Although Health Services was able to establish a toll-free number allowing consumers to have their questions answered by district offices, it has been unable to implement an Internet based inquiry system. Health Services' management asserted that budget shortfalls in fiscal years 2003–04 and 2004–05 have hampered its efforts to implement the Internet-based system. Health Services is currently working on a new feasibility study report for an Internet system, called the Health Facilities Consumer Information System, which it intends to use for Internet-based inquiries. Health Services hopes this new system will be available to consumers in February 2008.

Although Health Services is optimistic about its ability to launch the new Internet inquiry system by February, we question how effectively the new system will serve the public. Specifically, our audit questioned the reliability of some data in Health Services' complaint-tracking system. As described in Chapter 2, we noted significant weaknesses in controls over data integrity related to this system and found that some data may not be accurate. Consequently, the ability of the proposed system to provide accurate complaint information to the public is questionable.

RECOMMENDATIONS

To proactively manage its complaint workload following the conclusion of the court order, Health Services should periodically evaluate the timeliness with which district offices initiate and complete complaint investigations. Based on this information, Health Services should identify strategies, such as temporarily lending its staff to address workload imbalances occurring among district offices.

To ensure that it fully complies with state law regarding communication with complainants, Health Services should reassess its current practice of delaying notification to complainants about investigation results until after it receives acceptable plans of correction from cited skilled nursing facilities. If Health Services continues to support this practice, it should seek authorization from the Legislature to adjust the timing of communications with complainants accordingly.

To ensure that district offices consistently investigate complaints and include all relevant documentation in the complaint files, Health Services should clarify its policies and procedures, provide training as necessary, and periodically monitor district office performance to ensure compliance. At a minimum, Health Services should:

- Clarify its 45-working-day policy for closing complaints by establishing target time frames for facility evaluators, supervisors, and support staff to complete key stages in the complaint process.
- Ensure that each complaint file includes a workload report (timesheet), an investigation report, and copies of both letters sent to complainants.
- Clarify that investigation reports should be signed and approved prior to notifying skilled nursing facilities about the results of investigations.
- Attempt to obtain mailing addresses from all complainants that do not wish to remain anonymous.
- Ensure that staff correctly and consistently prioritize complaints and categorize the deficient practices of skilled nursing facilities.

To ensure that it can provide the public access to complete and accurate information regarding skilled nursing facilities as the Legislature intended, Health Services should continue in its efforts to implement an Internet-based inquiry system and take steps to ensure that the data it plans to provide through the system are accurate. ■

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CHAPTER 2

To Strengthen Its Oversight of Skilled Nursing Facilities, the Department of Health Services Needs to Improve Its Business Practices

CHAPTER SUMMARY

The problems the Department of Health Services (Health Services) has overseeing skilled nursing facilities might be alleviated if it enhanced certain business practices. For instance, improving controls and the quality of data in its complaint-tracking system would enable Health Services to better monitor its processing of complaints and ensure that data it provides to stakeholders are accurate. However, we found weaknesses in application controls over data integrity and identified some data that may not be accurate.

Additionally, Health Services could improve its oversight by making its federal recertification surveys less predictable. Although Health Services has complied with federal requirements regarding the timing of the surveys, we believe that varying the scheduling of recertification surveys would increase their effectiveness in identifying deficiencies at skilled nursing facilities.

Finally, we found that Health Services has weak internal controls over its disbursement of funds from the Health Facilities Citation Penalties Account (citation account). For example, between fiscal years 2001–02 and 2005–06, Health Services based its disbursement of more than \$14.7 million in funds from the citation account primarily on e-mails from vendors, with no subsequent assurance that the payments were necessary.

THE DATA IN THE COMPLAINT-TRACKING SYSTEM ARE GOVERNED BY WEAK APPLICATION CONTROLS

We obtained Health Services' data related to complaint investigations to assess whether it was initiating and completing complaint investigations for all its skilled nursing facilities within the required time frames. The

complaint-tracking system is one module in the Automated Survey Processing Environment (ASPEN), a database that the Centers for Medicare and Medicaid Services (CMS) developed and maintains. Health Services' district offices enter complaint investigation and federal recertification survey data into ASPEN for all facilities within California. We found that the complaint-tracking system has weak application controls that preclude Health Services from preventing erroneous data from being entered into the system or detecting data errors or omissions in its system. We further analyzed the system's data and identified a number of data fields that contained illogical data. Taking these weaknesses into consideration, we tried to find corroborating evidence to validate key fields used in our analysis. However, in some instances we were unsuccessful and therefore could not verify the accuracy and completeness of the data. For example, for the purpose of assessing the timeliness of initiating and completing complaint investigations, we determined the data to be of undetermined reliability.

Weak Application Controls May Affect Data Integrity

The system Health Services uses to track complaint investigations for skilled nursing facilities does not include strong controls that prevent erroneous data from being entered into the system, nor does Health Services have the ability to detect errors or omissions in its complaint-tracking system data. Specifically, we noted problems with Health Services' controls over changes to information that has already been entered into the system. Management has the ability to control access to the system by determining what parts of the system each employee can view. However, management has allowed data entry staff to make changes to records they or others created without management's review and approval. These changes can relate to key data fields, such as the dates when the complaint was received, investigated, and closed. Strong controls would ensure that data entry staff could not change critical fields without management's review and approval.

Health Services' management has allowed data entry staff to make changes to records they or others created without management's review and approval.

According to Health Services, data entry staff also have the ability to override system edit checks. The system merely requests confirmation from the data entry staff before overwriting the existing information. A system edit check is a control used to help ensure the integrity of the data. Because data entry staff can override this control mechanism without management review or approval, the control no longer serves

the purpose for which it was intended. These weaknesses may result in data entry staff making incorrect or inappropriate changes to complaint records, as we discuss later.

Health Services' Staff Do Not Record Complaint Data Consistently

Some data entry staff record the date that the on-site investigation ended, while others record the date when the facility evaluators have determined the type of enforcement action to take.

District office data entry staff are not consistently using the complaint-tracking system to record data regarding complaint investigations. For example, data entry staff record two different events in the field designed to capture the on-site investigation completion date. Some data entry staff record the date that the on-site investigation ended, while others record the date when the facility evaluators have determined the type of enforcement action to take. According to Health Services, staff should be using only the date that the on-site investigation was completed.

In addition, according to a district manager, data entry staff sometimes reenter complaint records after the investigation has been closed to update or add new information to the record. When this happens, some data entry staff change the complaint-closed date to reflect the date that changes were made, while others do not. This inconsistency hinders the ability of Health Services to accurately track and monitor the completion of complaint investigations.

We also noted problems with the way Health Services uses the complaint-tracking system to record and monitor communications with complainants and facilities. There are two fields in the system called "acknowledged date" and "date acknowledged." According to Health Services' staff, these fields can display a number of different kinds of acknowledgments, such as dates of letters sent to complainants or facilities, and do not consistently contain data for one specific type of acknowledgment, such as the acknowledgment sent to a complainant when the results of an investigation are known. Additionally, Health Services' staff does not always use the complaint-tracking system to record all the acknowledgments sent to complainants and facilities. According to Health Services, its staff are supposed to use the system's template to create these letters and record the communication within the system's notification table. Health Services' staff further indicated that many district offices have continued to use other methods for managing this information, such as maintaining a separate letter template and a list of the dates letters were sent. As a result of these inconsistencies, Health Services cannot use

the information in the complaint-tracking system to monitor whether it is complying with key time requirements related to its communications with complainants and facilities.

Health Services explained that for several years data entry personnel did not receive ongoing training.

Health Services staff attributed the data entry inconsistencies to a lack of training for data entry staff. Health Services explained that for several years data entry personnel did not receive ongoing training, and data entry policies and procedures were not consistently implemented across all district offices. As a result, staff did not know how to properly enter information into the system, which caused the data to have missing or inaccurate elements. Health Services began a new training program in November 2006 to eliminate some of these problems. According to Health Services' staff, they have coordinated with the CMS to identify areas where more training is needed and have worked with representatives from the district offices to determine the best ways to communicate the information to staff.

Some Complaint Records Contained Illogical Data That May or May Not Be Accurate

We found instances in which various dates in the complaint-tracking system conflicted with the normal sequence of events that occurs when Health Services investigates a complaint. For example, 677 of the 17,042 records in the system's population of complaints that were prioritized at either the immediate-jeopardy or non-immediate-jeopardy level and were received between July 1, 2004, and April 14, 2006, have entries indicating that some step in the investigation process occurred before the complaint was recorded as received. In certain situations, this may be accurate. For example, if a second complaint is received for an incident that is already under investigation based on a complaint received earlier, Health Services links the second complaint to the original investigation. As a result, the investigation start date for the second complaint would appropriately precede the date the second complaint was received.

In addition, 14 records had fields with dates beyond September 5, 2006, the date we acquired the data file. We would have expected the system to have sufficient edit checks

or error reports to identify these types of errors. According to Health Services, there is an edit check to verify that the on-site investigation exit date is later than the investigation start date, but the system does not run similar checks for all dates. Health Services further explained that the system was developed and is maintained by the CMS and that Health Services staff do not have the ability to modify it.

BY MAKING ITS VISITS LESS PREDICTABLE, HEALTH SERVICES COULD ENHANCE THE VALUE OF ITS RECERTIFICATION SURVEYS

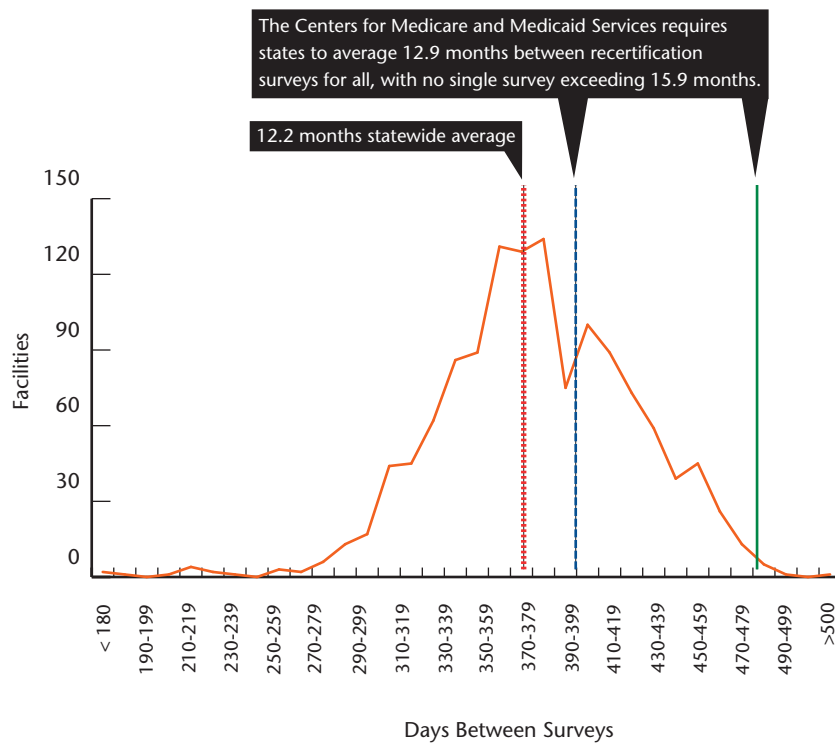
Federal regulations prescribe the frequency with which Health Services must conduct its recertification surveys of skilled nursing facilities, requiring a survey no later than 15 months after a facility's prior survey, with an average of 12 months between all its recertification surveys of skilled nursing facilities statewide. In interpreting these regulations, the CMS actually allows states more generous time frames of 15.9 months between recertification surveys and a statewide average survey interval of 12.9 months. Figure 2 on the following page identifies the federal guidelines and demonstrates that Health Services has generally met the requirements. As of June 2006 Health Services' survey interval averaged 12.2 months, and only one survey had occurred more than 15.9 months after the facility's last survey.

The CMS considers recertification surveys to be among Health Services' highest priorities and may impose financial penalties if Health Services does not complete its workload.

Health Services' focus on meeting recertification survey frequency requirements reflects the CMS designation of this oversight function as a tier 1 activity. In its annual mission-and-priority document, the CMS ranks Health Services' workload into various tiers. The CMS considers recertification surveys to be among Health Services' highest priorities under its contract and may impose financial penalties if Health Services does not complete its workload in this area. However, facing staffing shortages and higher workload expectations mandated by the Legislature, issues we discuss in Chapter 3, we question whether Health Services can continue to meet the federal frequency requirements.

FIGURE 2

Intervals Between Health Services’ Recertification Surveys of Skilled Nursing Facilities



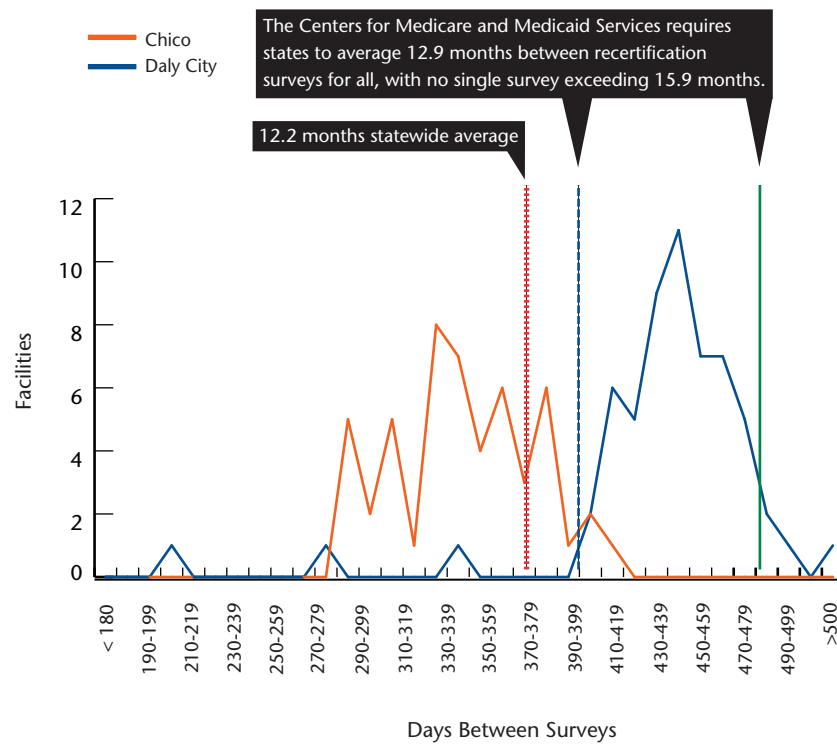
Sources: Department of Health Services’ survey-tracking system and the Centers for Medicare and Medicaid Services’ 2005–06 State Survey Agency Mission and Priority Document.

Note: “Days Between Surveys” represents the time interval between a skilled nursing facility’s prior two federal recertification surveys completed during fiscal years 2004–05 and 2005–06.

Although Health Services has been able to meet recertification survey frequency requirements statewide, it could improve the randomness with which it schedules the surveys. The CMS state operations manual recognizes the importance of unpredictable reviews: “The State has the responsibility for keeping surveys unannounced and their timing unpredictable. This gives the State agency doing the surveying greater ability to obtain valid information.” To promote this objective, the CMS requires that at least 10 percent of all surveys begin either on a weekend or during off-hours, such as before 8 a.m. or after 6 p.m. Although the CMS reviewed and approved Health Services’ scheduling of recertification surveys for federal fiscal year 2005, our own analysis indicates that some district offices may have performed better than others in managing their workloads and varying the timing of their recertification surveys. Figure 3 shows recertification statistics for two district offices—Chico and Daly City—measuring the intervals in days elapsed between current and prior survey exit dates.

FIGURE 3

Intervals Between Health Services' Recertification Surveys for Two District Offices



Sources: Department of Health Services' survey-tracking system and the Centers for Medicare and Medicaid Services' 2005-06 State Survey Agency Mission and Priority Document.

Note: "Days Between Surveys" represents the time interval between a skilled nursing facility's prior two federal recertification surveys completed during fiscal years 2004-05 and 2005-06.

As the figure illustrates, most recertification surveys conducted within the jurisdiction of the Daly City district office occurred nearly 14 months after each facility's prior recertification survey. If skilled nursing facilities within Daly City's service area had faced unpredictable survey scheduling, each facility would have known it had a reasonably equal chance of being selected before or after approximately 12.9 months, generating a flatter line in Figure 3. However, Daly City's surveys occurred primarily near the end of the 15.9-month federal deadline, allowing little room for variability. Survey statistics for Daly City are especially problematic because they suggest there was little margin for error as it attempted to process its workload to comply with federal requirements. In contrast, the Chico district office was less predictable in its scheduling of surveys because it did not concentrate its activity immediately before a known deadline.

Health Services explained Daly City's statistics by citing the high staff vacancy rates facing that district office, which reflects the overall staffing issues confronting Health Services, as reported in Chapter 3. According to Health Services, this district office has been difficult to staff with facility evaluators and, as of February 2007, has a vacancy rate for facility evaluators of 17.4 percent. We agree that the ability of Health Services' district offices to schedule their survey workload in an unpredictable manner depends in part on their resources. Because Health Services faces staffing challenges, it is possible that for skilled nursing facilities in some regions of the State, recertification surveys will be more predictable than for those in other regions.

Moreover, Health Services' recent changes in prioritizing its workload cause it to devote more resources to addressing complaints, which could affect its ability to meet the 15.9-month survey requirement. According to its own worst-case scenario, Health Services predicted in November 2006 that 138 facilities might not be inspected within 15.9 months for the current federal fiscal year. In January 2007 the division's assistant deputy director asserted that the district offices were reporting that Health Services would end up missing fewer recertification surveys than anticipated in November 2006. However, it is apparent that district offices with higher vacancy rates among facility evaluators—the only staff members qualified to perform federal recertification surveys—are at increased risk for incomplete federal certification surveys within the State. For example, as of February 2007, the Daly City district office had not finished eight recertification inspections within the required 15.9-month interval.

Because the CMS uses the number and timeliness of recertification surveys as performance metrics to assess the amount of funding it will provide to state agencies annually, California may be at risk of losing some of its federal funding if it fails to complete recertification surveys within the prescribed time frames. Health Services made a presentation to the CMS on the status of its recertification survey workload in November 2006. Health Services' management expects that the CMS will limit any financial penalties it might impose on California for failing to meet workload metrics in a manner consistent with similar penalties it has imposed on other states in the past. According to the CMS's regional director (regional director), as

In November 2006 Health Services predicted in its own "worst-case scenario" that 138 facilities might not be inspected within the federally required 15.9-month time frame.

of March 2007 the CMS is uncertain as to the penalty amount it will withhold from California due to delinquent recertification survey workload. The regional director asserted that if California stays on track in meeting the legal and staffing requirements that are challenging it, the CMS is willing to consider a cap of 50 percent of the total penalty amount that could be assessed for delinquent recertification surveys.

HEALTH SERVICES HAS WEAK CONTROLS FOR DISBURSING CERTAIN FUNDS FROM THE CITATION ACCOUNT

The Health and Safety Code establishes the citation account within the Special Deposit Fund. When Health Services imposes fines on long-term health care facilities, including skilled nursing facilities, that have violated state laws relating to patient care, money collected from these fines is deposited in the citation account. Under Section 1417.2 of the Health and Safety Code, the following expenditures can be charged to the citation account:

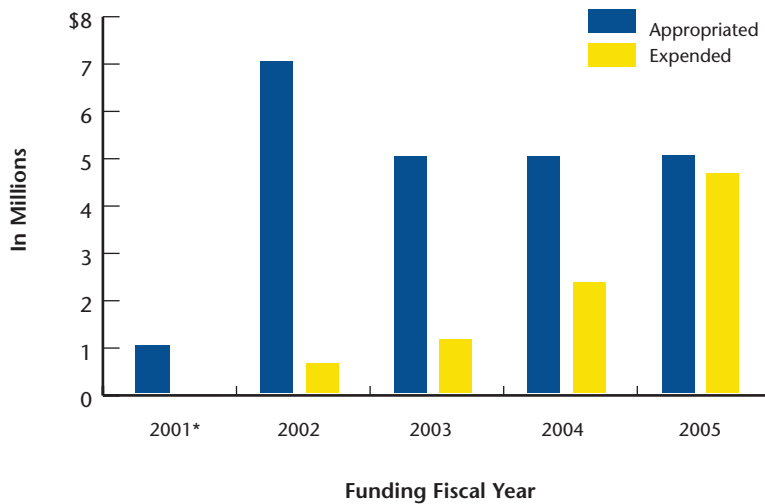
- Relocation expenses for displaced residents in the event of a skilled nursing facility's closure.
- Costs to ensure the continued operation of a skilled nursing facility pending its correction of cited deficiencies or closure, including the appointment of temporary management or receivership, in the event that revenues from the facility are insufficient.
- Reimbursements to residents for personal funds lost; if the loss of funds is the result of the actions of the facility or a member of the staff at the skilled nursing facility, facility funds must be used first.

Between fiscal years 2001–02 and 2005–06, the Legislature appropriated approximately \$23 million from the citation account, of which \$14.7 million has been expended.

Between fiscal years 2001–02 and 2005–06, the Legislature appropriated a total of approximately \$23 million to Health Services from the citation account. During that same period, Health Services spent approximately \$14.7 million from these appropriations. Figure 4 on the following page depicts the Legislature's annual appropriations and Health Services' expenditures through fiscal year 2005–06.

FIGURE 4

Health Services' Appropriations and Expenditures for the Health Facilities Citation Penalties Account



Sources: Department of Health Services' (Health Services) CALSTARS accounting records, annual budget acts, and other appropriations for fiscal years 2001–02 through 2005–06.

* Health Services expended \$1,556.70 from its fiscal year 2001–02 appropriation.

Table 6 provides a summary of the \$14.7 million spent from the citation account through fiscal year 2005–06. We generally found that the controls over the expenditure of these funds were weak. Most of the expenditures were for temporary management costs. Health Services has the statutory authority under the Health and Safety Code to appoint a temporary management company to take control of a skilled nursing facility that fails to comply with federal and/or state requirements. Health Services may use funds from the citation account to help the temporary management company operate the skilled nursing facility after all other facility revenues have been exhausted.

Health Services has provided more than \$10.5 million to one temporary management company, Sycamore Asset Management (Sycamore), representing more than 71 percent of the \$14.7 million disbursed between fiscal years 2001–02 and 2005–06. In explaining its heavy reliance on Sycamore, Health Services asserted that it has shown itself to be a reliable, agile, and responsive temporary management company with a proven ability to bring facilities with serious operational and financial problems back into compliance within a short period. Although we do not question Health Services' decision to use Sycamore for

TABLE 6**Purposes of Health Services' Expenditures From the Health Facilities Citation Penalties Account**

Purpose	Amount
Temporary manager	\$13,790,985
Computer upgrade	581,025
Financial assistance payments*	347,415
Miscellaneous charges†	19,470
Total	\$14,738,895

Source: Department of Health Services' CALSTARS accounting records (fiscal years 2001–02 through 2005–06).

* Financial assistance payments primarily include funding advanced to pay the workers' compensation premiums for eight skilled nursing facilities.

† Miscellaneous charges include expenses for legal and distributed administrative costs, among others.

most of its temporary management appointments, the practice could become problematic should Sycamore be unable to take on additional assignments as a result of scheduling conflicts or other factors. In addition, Health Services has indicated that it currently has only one other approved temporary management company. With such a small pool of qualified and available temporary management companies, Health Services may have less ability to employ such firms as a means of effecting change in underperforming skilled nursing facilities and has less assurance that it is getting a competitive price for these services.

We also found that Health Services' existing policies and procedures related to the process for selecting temporary management companies as of September 2003 incorporate requirements listed under federal regulations. However, these policies and procedures provide few specifics other than assigning responsibility for maintaining a list of eligible temporary management companies and specifying what documents must be included in a temporary management company's application packet. When we asked about these policies, Health Services indicated that, prior to 2005, it lacked sufficient experience related to all the situations that can occur when appointing temporary management companies and acknowledged that it is using the federal process as a starting point to further expand and refine its policies regarding the appointment and use of temporary management companies.

Our review of its draft procedures dated June 2006 revealed that Health Services has focused on defining its internal approval process for appointing temporary management companies but has not defined how it will select them. Recognizing that its draft procedures are a work in progress, we found that Health Services was considering adding procedures aimed at building its pool of qualified temporary management companies. Specifically, we found that Health Services was considering the best way to solicit potential temporary management companies, the number of companies to have in the pool, and the payment model.

In addition to our concerns about Health Services' process for selecting temporary management companies, we also questioned the level of scrutiny Health Services has given the payments it made to these companies. In its appointment document, Health Services requires a temporary management company to provide an initial assessment of the financial status of the skilled nursing facility it is managing. However, the document does not specify an invoicing process or require a full accounting of revenues and expenses at the end of the appointment term. In practice, the temporary management company provides high-level forecasts of the expected revenues and expenses for upcoming periods, using these as a basis to request funding. Our review noted that temporary management companies frequently provided these reports in e-mails to Health Services. Once received and approved, Health Services pays the temporary management companies any funds requested to cover expected expenses.

Temporary management companies frequently provided high-level forecasts of expected revenues and expenses in e-mails to Health Services, using these as a basis to request funding.

Given the magnitude of some of these payments—we noted one instance in which a single payment exceeded \$700,000—we would have expected Health Services to eventually request evidence beyond the e-mails to support the initial funding request and thus gain some assurance that the payments made were necessary. Although Health Services asserted that it had additional internal controls to ensure that the amounts disbursed were actually needed, these controls were aimed at ensuring that the temporary management company improved the operations of skilled nursing facilities, and not whether the requested funds were actually needed. By the end of fiscal year 2006–07, Health Services plans to require temporary management companies, operating under new agreements, to submit financial statements at the end of their appointment periods. These financial statements would be attested to by a

certified public accountant and would provide Health Services with detailed information on all revenues and expenses during the appointment period.

Health Services also used citation account funds to purchase 439 desktop computers and 70 laptop computers for the division, at a total cost of roughly \$581,000. We concluded that this purchase was appropriately charged to the citation account because the Legislature had appropriated funding from the citation account to be used for general support purposes. The amount charged to the citation account was part of a department-wide purchase of computer equipment totaling roughly \$2.4 million. We expected Health Services to prorate a portion of this total cost, based on the number of computers used by the Licensing and Certification Division, to arrive at the \$581,000 it ultimately charged to the citation account. However, Health Services was unable to explain its rationale for how it arrived at the \$581,000 amount. Our own proration of the computer costs suggests that the actual costs assessed to the citation account should have been \$574,000, about \$7,000 less than the amount Health Services actually charged. Even though the results of our proration were not significantly different from Health Services' method, within 2 percent of Health Services' proration, Health Services nevertheless should maintain documentation of its cost allocation methodology as part of its support for citation account expenditures.

RECOMMENDATIONS

To improve the accuracy of complaint data used to monitor its workload and staff performance, Health Services should develop strong application controls to ensure that its data are accurate, complete, and consistent. This process should include validating the data entered into key data fields, ensuring that key data fields are complete, and training staff to ensure consistent input into key data fields, such as the field designed to capture the date on which the investigation was completed.

To reduce the predictability of its federal recertification surveys, Health Services should institute a practice of conducting surveys throughout the survey cycle, ensuring that each facility has a greater probability of being selected at any given time.

To ensure that it can adequately justify the expenses it charges to the citation account, Health Services should take steps to gain assurance from temporary management

companies that the funds they received were necessary. This should include reviewing the support behind temporary management companies' e-mails requesting payments. In addition, Health Services should take steps to expand its pool of qualified temporary management companies to ensure that it has sufficient numbers of temporary management companies available and receives competitive prices. Finally, when Health Services charges general support items to the citation account, it should be able to document its rationale for determining the amounts charged. ■

CHAPTER 3

The Department of Health Services Faces Challenges in Fulfilling Its Oversight Responsibilities

CHAPTER SUMMARY

The Department of Health Services (Health Services) frequently cited staffing shortages as the primary cause for many of the performance problems discussed in Chapter 1. For example, Health Services cited limited staff resources as the source of the difficulties it has had in promptly initiating investigations of complaints about skilled nursing facilities. This perspective appears to have merit. Between fiscal years 2002–03 and 2005–06, Health Services had a vacancy rate averaging 16 percent annually among its facility evaluators that are registered nurses. While the Legislature’s decision to increase Health Services’ fiscal year 2006–07 budget for more staff could be a possible solution to its resource problem, Health Services might have difficulty in filling these positions, as it is challenged in its recruiting and training of facility evaluator staff. Furthermore, Health Services’ practice of allowing its district offices independence in allocating their survey and complaint workload to facility evaluators has created regional differences in how skilled nursing facility oversight functions are managed.

Recognizing Health Services’ resource limitations, the Legislature has historically allowed the department to exempt skilled nursing facilities from facing state licensing reviews if they meet federal recertification requirements. As a result, Health Services’ reviews of skilled nursing facilities did not always include ensuring compliance with state requirements, such as maintaining certain nurse-to-resident staffing ratios. The Legislature’s decision in fiscal year 2006–07 to remove this exemption, thus mandating that facilities be reviewed for compliance with both federal and state requirements, places an even greater strain on Health Services’ limited resources.

STAFFING SHORTAGES HAMPER HEALTH SERVICES' ENFORCEMENT EFFORTS, AND FILLING ITS VACANT POSITIONS REMAINS DIFFICULT

Facility evaluators at Health Services' 14 district offices, and by contract within Los Angeles County, conduct federal recertification surveys and complaint investigations at skilled nursing facilities. In acknowledging its inability to consistently initiate timely complaint investigations, Health Services has pointed to its past difficulties in securing adequate staff to perform the work. Our review of the staffing levels within the Field Operations Branch (branch) of Health Services' Licensing and Certification Division (division) indicated that securing adequate staffing has been a problem. In the fiscal year 2005–06 budget, the Legislature approved funding for 485 positions within the branch, of which 397 were facility evaluator positions. During the same year, the branch reported that it was able to fill 426 of these approved positions, of which 347 were facility evaluators. Most of these facility evaluators are registered nurses, accounting for 78 percent of the 397 health facility evaluator positions authorized in fiscal year 2005–06. Health Services has focused on hiring registered nurses because federal guidelines require that at least one member of every recertification survey team have that level of expertise.

Health Services has focused on hiring registered nurses because federal guidelines require that at least one member of every recertification survey team have that level of expertise.

Table 7 shows the number of facility evaluator positions the Legislature has authorized within the branch and the number Health Services has filled—limited to the single classification in the facility evaluator series that requires the employee to be a registered nurse—from fiscal year 2002–03 through 2005–06. Annual vacancy rates for these positions have averaged around 16 percent over the period but have declined slightly each year since fiscal year 2003–04.

Health Services has made efforts to inform the Legislature and program stakeholders of its low staffing levels. In November 2005 Health Services' management provided testimony to the Senate Subcommittee on Health, Aging, and Long-Term Care, explaining that it did not have enough staff to do everything it is mandated to do. Health Services provided additional perspective on its staffing shortages in the July 2006 court filing discussed in Chapter 1. In this filing, Health Services made the following statement:

Since 2001, continuing through the present time, there has been a confluence of events that have led to severe understaffing of the [division] at [Health Services]. Due to hiring freezes beginning in the Fall of 2001, [the division] accumulated many vacancies that it was unable to fill. [The division] lost a significant number of staff because of attrition and was unable to hire behind them . . . In fiscal year 2002–03, a state General Fund unallocated budget reduction led to the elimination of all vacant positions.

TABLE 7

Number of Authorized, Filled, and Vacant Facility Evaluator Positions Requiring Registered Nurses Fiscal Years 2002–03 Through 2005–06

	2002–03	2003–04	2004–05	2005–06
Authorized * †	344	327	308	308
Filled ‡	284	264	259	266
Vacant	60	63	49	42
Vacancy Rate	17%	19%	16%	14%

Sources: Governor’s salary and wage information and State Controller’s Office payroll records.

* Positions to be filled by registered nurses.

† Authorized positions are based on the governor’s salary and wage information for the Department of Health Services’ Licensing and Certification Division, Field Operations Branch. The data only includes the health facility evaluator nurse classification.

‡ Filled positions are based on the State Controller’s Office payroll records. These figures are slightly less than those reported in the governor’s salary and wage information. We identified the number of months in which an employee received more than \$1,000 in pay and divided that number by 12 to get an estimate of the number of filled positions.

Responding to its request for more staffing in fiscal year 2006–07, the Legislature authorized Health Services to add 141 positions, of which 115 were facility evaluator positions. To further insulate the division from future budget reductions, the Legislature approved a restructuring of how the division is funded, using fees collected from medical facilities, including skilled nursing facilities, to pay for the division’s oversight functions. Although Health Services deserves credit for both seeking the authority to obtain more staff and suggesting a way to insulate itself from future budget reductions, its inability to fill the positions that the Legislature has authorized remains problematic.

Health Services' attempts to fill its facility evaluator positions with registered nurses is exacerbated by a nursing shortage.

Given the historic vacancy rates shown previously in Table 7, simply authorizing Health Services to hire more staff seems insufficient to ensure that these positions will in fact be filled. As of late February 2007 Health Services' internal staffing reports indicated that the division had 73 vacancies out of the 443 facility evaluator positions it was trying to fill with registered nurses. This equates to a vacancy rate of 16.5 percent, which remains similar to the vacancy rates in previous years. Health Services has historically faced several impediments that have made filling its authorized positions difficult. For example, Health Services' attempts to fill its facility evaluator positions primarily with registered nurses is exacerbated by a nursing shortage that has existed within California for some time. For example, in April 2005, the governor announced a \$90 million five-year nursing initiative aimed at reducing California's shortage of approximately 14,000 nurses. As the nursing shortage and demand for nurses increase, registered nurses are able to command higher salary levels within the labor market.

In this environment of declining resources, increasing demand, and higher salary requirements for registered nurses comes a second impediment affecting Health Services' recruiting efforts: its salary rates for nurses entering its facility evaluator classifications are not competitive with other state jobs, such as medical staff at the Department of Corrections and Rehabilitation (Corrections). According to information provided in a May 2006 hearing before the Assembly Budget Subcommittee on Health and Human Services, the federal district court ordered the State to implement recruitment and retention incentives for medical staff at the State's 33 prisons to address high vacancy rates. This placed other state agencies, including Health Services, at a comparative disadvantage because they are unable to pay the same salaries as the correctional facilities. For example, Health Services is able to offer only a maximum of \$6,263 per month, or approximately \$75,156 per year, to registered nurses in its facility evaluator positions. By comparison, Corrections can offer between \$84,540 and \$107,880 annually for a registered nurse with no experience. Health Services asserted that although Chapter 209, Statutes of 2006, increased compensation for registered nurses with a 3.5 percent general salary increase and a cost-of-living adjustment of between 2 percent and 4 percent, its salaries remain uncompetitive.

Health Services recently reported that it has been proactive in recruiting to fill its authorized positions. Specifically, Health Services informed the Legislature that it has mailed informational postcards to approximately 190,000 registered nurses statewide. These postcards describe the benefits package for registered nurses and the potential job locations. Other recruiting efforts it described include advertising in nursing publications such as *Nurse Week*, *Working Nurse*, and the *California Job Journal*. Health Services also asserted that district offices have placed advertisements in local newspapers. Finally, the division plans to offer an on-line testing process for facility evaluators that are registered nurses, allowing prospective candidates to take the exam at their own convenience instead of waiting for scheduled examination dates. Health Services expects that this new process will reduce the time from testing to start date for new staff by one to two months.

We estimated that 72, or 27 percent of facility evaluators in the branch had less than one year of experience as of June 2006.

In addition to its difficulties in filling vacancies, Health Services faces challenges in training the facility evaluators it currently employs as well as the new staff it is trying to hire. We estimated the number of facility evaluators who are registered nurses and had less than one year of experience working at Health Services' district offices based on payroll data from the State Controller's Office. As shown in Table 8 on the following page, we estimated that 72, or 27 percent, of these facility evaluators had less than one year of experience as of June 2006. Although each district had some of these less-experienced facility evaluators, San Jose and Bakersfield each had only two, and Redwood Coast had 13, the largest number among the 14 districts.

Until facility evaluators are certified to perform federal recertification surveys, federal regulations require that a certified evaluator accompany a new evaluator while performing surveys. This requirement reduces the amount of work that existing staff can accomplish. In addition, Health Services asserted that it takes more than a year for newly hired facility evaluators to be able to perform survey tasks independently. Further, in a November 2006 presentation to the Centers for Medicare and Medicaid Services (CMS), Health Services indicated that facility evaluators hired in January 2007 would need to complete various training experiences in the first 12 months of employment, including a 13-week combination of classroom and on-line courses and 24 weeks of inspection experience. This required amount of classroom time and on-the-job experience

that a facility evaluator must go through in the first year of employment directly affects the amount of work Health Services can accomplish.

TABLE 8
Number of Facility Evaluators Who Are Registered Nurses and Have Less Than One Year of Experience as of June 2006

District Offices	On Payroll as of June 2006	On Payroll in June 2006 and 2005	Estimated Number With Less Than 1 Year Experience*
Santa Rosa/Redwood Coast	21	8	13
Sacramento	37	28	9
San Diego North	23	17	6
San Bernardino	23	17	6
Chico	14	9	5
East Bay	24	19	5
Fresno	19	14	5
Riverside	18	13	5
San Diego South	18	13	5
Orange County	16	12	4
Ventura	15	11	4
Bakersfield	10	8	2
San Jose	16	14	2
Daly City	13	12	1
Totals	267	195	72

Source: State Controller’s Office payroll data (fiscal years 2004–05 and 2005–06).

* Some staff could have been promoted or worked at another district but the Department of Health Services indicated that payroll units do not change when staff temporarily move.

In light of these challenges and the potential for federal monetary sanctions as described in Chapter 2, Health Services must maximize the productivity of its existing facility evaluator staff. During our discussions with Health Services’ staff, we learned that to meet its workload requirements, the division’s headquarters establishes basic workload priorities for all the district offices. In executing these prioritized workloads, Health Services allocates facility evaluators to district offices and delegates responsibility for assigning work to facility evaluators to its district managers.

While performing our fieldwork at district offices, we found that district managers used various approaches for assigning work to their staff.

While performing our fieldwork at district offices, we found that district managers used various approaches for assigning work to their staff. For example, the Sacramento district manager explained that he uses a team approach, designating groups of facility evaluators who are responsible for performing all recertification surveys and investigating all complaints for the specific facilities assigned to the group. He indicated that the benefits of this approach include team cohesiveness, the ability to manage staff and office schedules, and a reduction in job-related stress because his staff maintain some control over their work assignments, which may include overnight travel. The Sacramento district manager explained that another benefit of the team approach is an increased familiarity with each provider's operational practices and an enhanced response by the district office to enforcement actions due to the in-depth historical knowledge of each facility's performance.

Managers at the two Los Angeles districts we visited said they used an approach similar to the Sacramento district office in the past or prefer using such a practice; however, limited resources have required them to reassess the makeup of recertification survey teams on a monthly basis. Similarly, managers at the Chico, Daly City, and San Jose district offices told us that they meet with their supervisors monthly to develop a work schedule and assign teams.

In contrast, the San Diego North district manager explained that she meets with her supervisory staff on a daily basis to discuss current workload priorities and to assign staff according to the present workload demands. Facility evaluators operating under this management structure do not have a specific group of facilities for which they are responsible and are considered part of a resource pool for the entire district office that can be flexibly assigned to accomplish the current workload. According to the San Diego North district manager, this approach has been successful because it allows for complete utilization of all staff available on a daily basis. Staff can be redirected as workload priorities change without canceling assigned recertification surveys. If a facility evaluator has additional workload tasks to complete, such as citation writing, preparing for depositions, or completing a complex complaint investigation, that facility evaluator is taken out of the available resource pool until those assignments are completed.

Within an environment of changing workload priorities, it seems that a resource-pooling approach, such as the one used by the San Diego North district office, provides greater flexibility and effectiveness in meeting workload requirements. Assigning teams to cover all the work at a specific group of facilities may be suitable for a district office with ample staff and a low vacancy rate, but using a resource-pooling approach that provides greater flexibility may be a better solution for district offices during times of scarce personnel resources.

Moreover, Health Services indicated that it has not been a common practice for it to temporarily reallocate staff from one district office to another to meet workload. Although it described no formal impediments to this practice, such as provisions of labor agreements, Health Services indicated that staff would be reluctant to travel even more than their jobs routinely require. However, we believe Health Services needs to consider all options at its disposal so that it can complete all required work to ensure the safety and well-being of residents of skilled nursing facilities.

STATUTORY CHANGES INCREASE THE STRAIN ON HEALTH SERVICES' LIMITED RESOURCES

Since 1993 Health Services has been focusing its priorities on meeting the requirements of its federal recertification survey workload, one of its largest tasks in overseeing the State's skilled nursing facilities. Section 1279 of the Health and Safety Code, which resulted from an urgency bill, became effective in September 1992 and allows Health Services to focus its resources on meeting federal recertification requirements by not requiring skilled nursing facilities that are certified under the Medicare and Medicaid programs to be subject to state licensing inspections. Based on this state law, Health Services has not been routinely inspecting for compliance with several state-specific requirements during periodic inspections of skilled nursing facilities. However, Senate Bill 1312 (SB 1312) (Chapter 895, Statutes of 2006) amended the law to require Health Services to incorporate state licensing requirements into its recertification surveys starting in July 2007. This requirement will further strain Health Services' staff resources, as described in the previous section.

Based on this state law, Health Services has not been routinely inspecting for compliance with several state-specific requirements during periodic inspections of skilled nursing facilities.

Until Recently, State Law Exempted Health Services From Conducting State Licensing Inspections

In 1992 the Legislature amended the Health and Safety Code, Section 1279, to suspend the requirement that Health Services inspect for compliance with state licensing requirements at skilled nursing facilities in response to a fiscal crisis. The revised state law dropped the requirement that Health Services perform both federal recertification surveys and state licensing inspections of skilled nursing facilities receiving Medicare and Medicaid payments. Certified status is maintained through passing annual recertification surveys performed by the division on behalf of the CMS. Therefore, skilled nursing facilities found to be in compliance with federal standards during a recertification survey also maintained their state license. According to a former division manager, at the same time the statute was amended in 1992, the Legislature took nearly \$2 million out of Health Services' budget and reduced the number of authorized positions to coincide with the funding reduction.

Assembly Bill 1731 (AB 1731) (Chapter 451, Statutes of 2000), which became effective January 1, 2001, revised the law to require Health Services to inspect skilled nursing facilities for compliance with state licensing requirements at least once every two years. This statutory change had no effect on certified skilled nursing facilities because Section 1279 of the Health and Safety Code remained in effect. In its analysis of the 2006–07 Governor's Budget, the Legislative Analyst's Office pointed out that the requirement imposed by AB 1731 that state licensing inspections occur every two years conflicted with Health and Safety Code, Section 1279. The Legislative Analyst's Office recommended that the Legislature enact legislation to reconcile the two sections of the law and require Health Services to incorporate both state and federal requirements into its recertification survey tools. As a result, SB 1312 amended Section 1279 of the Health and Safety Code, and starting July 1, 2007, Health Services will be required to incorporate both state and federal requirements into the periodic certification survey process that it performs at skilled nursing facilities.

Starting July 1, 2007, Health Services will be required to incorporate both state and federal requirements into the periodic recertification survey process that it performs at skilled nursing facilities.

According to Health Services, current legal requirements and its workloads have impaired its ability to adequately prepare for the change. Because of this, Health Services plans to propose trailer bill language that will clarify how the state licensing

requirements will be incorporated into recertification surveys, giving it greater flexibility in implementing the recent statutory change.

Federal Recertification Surveys Do Not Address, and May Conflict With, Some State Requirements

During recertification surveys, Health Services follows the CMS’ guidance and is responsible for citing facility deficiencies when it finds that federal requirements are not being met. Because the recertification survey is specifically performed to assess a skilled nursing facility’s ability to meet federal requirements, state-specific licensing requirements may not be addressed and may, in fact, differ from the federal requirements being assessed. The division has identified key differences between state and federal requirements, some of which appear in Table 9.

TABLE 9

Differences Between State and Federal Requirements for Skilled Nursing Facilities

Requirement Focus	State Requirement	Federal Requirement
Facility staffing	The facility must provide at least 3.2 hours of direct nursing care to each resident each day.	Facilities must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
Residents’ rights	Consumer information must be posted prominently and conspicuously in a prominent location accessible to the public. The facility must have written admission and discharge policies available for residents to review. The most recent licensing report, plan of correction, names and addresses of previous owners, a list of all other skilled nursing facilities owned by the facility, and a local district office contact must be posted.	No comparable federal requirement on this specific issue.
Quality of life	Each facility shall provide equipment, supplies, and designated space for both independent and group activities.	No comparable federal requirement on this specific issue.
Quality of care	For residents who have been diagnosed as being incontinent, a licensed nurse must make a written assessment to determine the patient’s ability to participate in a bowel and/or bladder management program within two weeks of admission to the facility. Fluid intake and output shall be recorded, and evaluated at least weekly, for each resident if ordered by a physician or for each catheterized resident.	No comparable federal requirement on this specific issue.

Sources: Department of Health Services’ crosswalk document of federal and state requirements; California Health and Safety Code; Title 42, Code of Federal Regulations; and Title 22, Code of California Regulations.

For example, as reflected in the table, federal requirements related to adequate staffing stipulate that a facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable well-being of each resident. However, state law requires that facilities provide at least 3.2 hours of direct nursing care to each resident each day. Because Health Services has been following the federal guidance in assessing skilled nursing facility compliance, it does not regularly assess compliance with the 3.2-hour requirement during recertification surveys at skilled nursing facilities. This was confirmed during our review of 35 current recertification surveys, when we found that only seven contained a nursing staff analysis specific enough to determine compliance with the state requirement.

Because of the statutory changes enacted by SB 1312, Health Services needs to modify and enhance its recertification survey process to address these and other state requirements. However, ensuring compliance with state regulations in addition to ensuring compliance with federal regulations as part of its recertification surveys of skilled nursing facilities will increase Health Services' workload and further tax its staffing resources.

RECOMMENDATIONS

To fill its authorized positions and manage its federal and state workloads, Health Services should consider working with the Department of Personnel Administration to adjust the salaries of its staff to make them more competitive with those of other state agencies seeking similarly qualified candidates. In addition, Health Services may want to consider hiring qualified candidates who are not registered nurses, in accordance with CMS guidelines. Finally, if these options prove unsuccessful, Health Services should develop additional strategies, such as temporarily reallocating its staff from district offices that are less burdened by their workloads to those facing the highest workloads.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,



ELAINE M. HOWLE
State Auditor

Date: April 12, 2007

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APPENDIX A

The Department of Health Services May Have Understated the Priority Levels of Complaints It Received

As discussed in Chapter 1, the Health and Safety Code requires the Department of Health Services (Health Services) to investigate complaints within 24 hours when the allegations suggest the likelihood that actual harm to a resident of a skilled nursing facility is imminent. Our review of 35 complaint cases revealed 12 cases for which we believe Health Services should have initiated an investigation within 24 hours. Table A summarizes these 12 cases and presents Health Services' perspective. In six of the 12 cases, Health Services agreed with our analyses. In the other cases, Health Services provided its rationale for the complaint prioritization decisions it made.

TABLE A

Abstracts of the 12 Complaint Cases That Health Services Had Questionably Prioritized as Non-Immediate Jeopardy

Date Complaint Received	Description of Allegation	Actual Harm or Potential Harm	Response From Health Services
December 27, 2005	Resident was admitted to the hospital with pneumonia and pressure sores. The resident's breathing tube had not been changed for 10 months. The resident had begged the facility for 2 weeks to send her to the hospital, which was refused.	Failure to adequately monitor and intervene for serious medical conditions.	<p>The prioritization is appropriate. The resident was in an acute care hospital, and not in immediate jeopardy, when the Licensing and Certification Division (division) received the complaint on December 27, 2005. The resident was admitted to an acute care hospital on December 13, 2005, and discharged on January 30, 2006. We received the complaint from an ombudsman and she included in her information to our office that the resident was in an acute hospital at the time of her complaint.</p> <p><i>Auditor's Note: Although the resident related to this incident was no longer at the facility, we question whether the actual or potential harm indicated could pose a similar risk to other residents at the facility.</i></p>

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Date Complaint Received	Description of Allegation	Actual Harm or Potential Harm	Response From Health Services
October 4, 2005	The facility illegally attempted to discharge or transfer 36 of its residents. The residents were told that long-term custodial care would no longer be provided. One resident being forced out was 90 years old and suffered from dementia. She had lived at the facility for over 10 years.	Failure of the facility to provide for the health and safety of residents due to illegal transfer or discharge.	The district office contacted the facility on October 5, 2005,* to stop discharges in accordance with legal consultation. Staff were not available to send on-site until October 7, 2005, two days later. This should have been assigned as a Priority A complaint.
September 16, 2005	Resident was transferred to the facility and after one week the resident's foot had worsened since dressing or wound care were not done. After the resident had been at the facility for two weeks, he was sent to an emergency room and was given intravenous fluids and was severely dehydrated and had a low blood level. He was admitted and given a blood transfusion.	Failure to protect adequate nutrition and hydration resulting in malnutrition.	This complaint was received at the office on September 16, 2005. The resident had already been discharged to the acute care hospital the day before, September 15, 2005. However, in retrospect, this complaint could have indicated a "systems" problem and the complaint should have been a Priority A.
September 6, 2005	A physical therapist approached a resident and offered to rent him a room for \$200 to \$300 a month. The resident left against medical advice. While living with the physical therapist, the resident was induced to purchase jars of "medicine" for \$100 per jar. The resident paid the physical therapist a total of \$400. A week later, the physical therapist ended the relationship by driving the resident to a gas station and leaving him to fend for himself.	Failure to protect resident from psychological and potential physical harm from inappropriate behavior by staff.	Nonimmediate jeopardy. Based on review of the complaint intake information, both the resident and the alleged perpetrator were no longer at the facility. The alleged perpetrator was also restricted from returning to the facility. <i>Auditor's Note: Although the resident related to this incident was no longer at the facility, we question whether the actual or potential harm indicated could pose a similar risk to other residents at the facility.</i>
September 2, 2005	A certified nursing assistant did not transfer a resident appropriately with an electric lift to stand her up, which resulted in the resident's ankle fracture.	Failure to protect from serious injuries, such as an ankle fracture.	The facility reported the incident on September 1, 2005.* The certified nursing assistant who was involved in the incident was terminated immediately, thus removing an unsafe individual who was providing care. However, this complaint could have signaled a "systems" problem and should have been a Priority A complaint.
June 7, 2005	A resident was admitted to the facility to recover from brain surgery after a stroke. When admitted, the family had told the facility she needed to be restrained due to confusion. The resident fell a total of five times because the resident was not properly restrained. On the last two occasions, the facility called the family member to report that the resident was taken to the emergency room after falling.	Failure to prevent neglect: repeated occurrences of falls, which ultimately placed the individual at risk of harm from falls.	The complainant informed the supervisor that the resident was discharged from the facility to a hospital emergency room and was not readmitted. The complaint investigation would be a closed record review which, at the time, justified a prioritization of nonimmediate jeopardy. However, in retrospect, even though the resident was no longer in the facility, the problems that were alleged in the initial complaint indicated a "systems" problem that should have been investigated as a Priority A complaint.

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Date Complaint Received	Description of Allegation	Actual Harm or Potential Harm	Response From Health Services
April 22, 2005	The resident passed away after having vomited and aspirated. Prior to the incident, she had been getting better from her pressure sores. Police had been called to investigate foul play.	Failure to prevent neglect: either due to improper feeding/positioning, which is a known cause for aspiration or inadequate supervision to prevent such incidents.	<p>The resident had expired on April 20, 2005, but the complaint was received on April 22. The investigation would be a closed record review, which would justify prioritizing this complaint as non-immediate jeopardy.</p> <p><i>Auditor's Note: Although the resident related to this incident had expired, we question whether the actual or potential harm indicated could be indicative of a systemic problem that could put other residents at risk.</i></p>
December 17, 2004	One certified nursing assistant witnessed another certified nursing assistant hitting a resident with an open hand to the left side of the neck.	Failure of the facility to protect the resident from abuse, more specifically a staff striking a resident.	<p>The facility self-reported this abuse incident on December 14, 2004. A health facility evaluator supervisor called and spoke to the administrator on December 15, 2004. The administrator informed her that the certified nursing assistant had been suspended on December 10, 2004, and was terminated after their investigation. Health Services' investigation was initiated on December 16, 2004. Therefore, there was no immediate jeopardy [for the December 14, 2004, complaint] and with the investigation already in progress there would be no immediate jeopardy when the ombudsmen sent in their complaint on December 17, 2004.</p> <p><i>Auditor's Note: Although the facility asserted that the employee no longer works at the facility, we question whether this case is indicative of systemic problems, such as poor hiring practices, which might place other residents at similar risk.</i></p>
December 8, 2004	<ul style="list-style-type: none"> • Facility operating without an administrator for the last 5 months. • No heat, residents complaining about it being too cold, and no blankets available. • Not enough diapers to make sufficient changes per day. • Patients trust money is being spent for payroll. • The owner pays her personal bills before the needs of the facility are met. • Takes a week before residents can get their pensions and investments money. • Not enough supplies for resident care. • Facility is infested with roaches and rats. • No maintenance person on duty, he is working at the owners house doing work for her. • No money provided for activities. • No pest control. 	Failure to provide safety from environment hazards such as lack of functioning ventilation and heating or cooling systems, placing individuals at risk. In addition, there is a failure to provide safety from environment hazards such as the lack of preventing infestations by insects/rodents.	In retrospect, this complaint should have been prioritized as a Priority A complaint.

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Date Complaint Received	Description of Allegation	Actual Harm or Potential Harm	Response From Health Services
October 1, 2004	The resident's feeding tube was not turned off, which caused the resident to vomit while on her back.	Failure to prevent neglect: improper feeding and positioning of individual with known aspiration risk.	The complaint was received on October 1, 2004, alleging the resident vomited on September 27, 2004, due to the feeding tube not being turned off. There was no alleged adverse outcome to the resident such as aspiration of the feeding tube or the need for hospitalization. Based on this information, the complaint received a lower prioritization. Even though there was no adverse impact, the complaint still should have been a Priority A given the seriousness of the event.
September 20, 2004	Patient arrived at a hospital emergency room with multiple areas of preventable skin breakdown. Family member was not allowed to examine the skin breakdown. The registered nurse at the facility was "unaware" of the severity of the problem.	Failure to prevent neglect due to the lack of timely assessment of individuals for injury.	<p>The prioritization was appropriate. The complaint came in on Thursday, September 23, 2004.* The complaint from the ombudsman alleged that the patient was admitted to a general acute care hospital from the skilled nursing facility with multiple pressure sore wounds and then identifies them as Stage 2. Since the patient was no longer at the facility there was non-immediate-jeopardy risk to the patient's health. He was being evaluated and treated at the general acute care hospital. The supervisor correctly prioritized the complaint as nonimmediate jeopardy and a nurse evaluator initiated the complaint investigation the next week on Wednesday, September 29, 2004.</p> <p><i>Auditor's Note: Although the resident related to this incident was no longer at the facility, we question whether the actual or potential harm indicated could pose a similar risk to other residents at the facility.</i></p>
August 13, 2004	Questionable handling of the resident's medication by the facility, which was the alleged cause of a resident's death due to medication overdose.	Failure to protect from adverse medication consequences that result in death.	<p>The complaint was received August 13, 2004. The resident died June 13, 2004. There was no immediate jeopardy to this resident.</p> <p><i>Auditor's Note: Although the resident related to this incident had expired, we question whether the actual or potential harm indicated could be indicative of a systemic problem, which might place other residents at similar risk.</i></p>

Sources: Department of Health Services' (Health Services) complaint investigation files.

* Complaint received dates in the responses from Health Services differed slightly from the dates in the first column of the table because dates in the complaint-tracking system differed from evidence, such as faxes and letters, we found in the complaint files.

APPENDIX B

Federal and State Criteria for the Timely Processing of Complaint Investigations and Recertification Surveys

In Chapter 1 of the audit report, we indicated that the Department of Health Services (Health Services) was unable to promptly initiate and complete complaint investigations. We also reported that Health Services had difficulty communicating with complainants in accordance with the time frames specified in statute. Table B provides a listing of the critical time requirements related to complaint investigations. The table also provides key time frame requirements pertaining to federal recertification surveys, an issue we discuss in Chapter 2 of the report.

TABLE B

Required Time Frames for Complaint Investigations and Recertification Surveys

Activity	Required Time Frame	From Date	Criteria Cited	Federal or State Requirement
<i>Complaint Investigations</i>				
Health Services notifies complainant with the name of the assigned inspector	Within two working days	From date complaint is received	Health and Safety Code (HSC) 1420(a)(1)	State
Health Services initiates on-site inspection or investigation for complaints that do involve imminent danger of death or serious bodily harm	Within 24 hours	From date complaint is received	HSC 1420(a)(1)	State
Health Services initiates on-site investigation for complaints that do not involve imminent danger of death or serious bodily harm	Within 10 working days	From date complaint is received	HSC 1420(a)(1)	State
Health Services informs complainant and skilled nursing facility of its determination as a result of the investigation in writing	Within 10 working days	From completion of the complaint investigation	HSC 1420(a)(3)	State
Skilled nursing facilities submit their plans to correct deficiencies identified	Within 10–15 calendar days*	From date the skilled nursing facility is informed of investigation results	See note* below	State
Complete the investigation, including data entry	Within 45 working days	From date complaint is received	Health Services' Policy and Procedures Manual, Chapter 4, Section 405	State

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Activity	Required Time Frame	From Date	Criteria Cited	Federal or State Requirement
<i>Recertification Surveys</i>				
Health Services completes a standard federal survey	Not later than 15 months [†]	After the last day of the previous standard survey	Title 42 of the Code of Federal Regulations, Section 488.308	Federal
Skilled nursing facilities submit their plans to correct cited deficiencies	Within 10 calendar days	From the date the skilled nursing facility received a statement of deficiencies from Health Services	Federal State Operations Manual, Chapter 7, Section 7304 D	Federal

Sources: Health and Safety Code, Department of Health Services' (Health Services) Policies and Procedures Manual, Federal Department of Health and Human Services—Centers for Medicare and Medicaid Services guidance, CMS State Operations Manual, and Federal Code of Regulations.

* Federal guidance allows Health Services to determine the timing of when skilled nursing facilities must submit their plans of corrective action resulting from complaint investigations. Further, Health Services allows its district office managers to determine the number of calendar days it will allow skilled nursing facilities to submit their plans. In practice, we noted that Health Services provides skilled nursing facilities between 10 and 15 calendar days to submit a plan of correction, which parallels federal guidance on recertification surveys.

[†] Federal guidance for federal fiscal year 2005 indicated that "no more than 15.9 months [should elapse] between surveys for any particular nursing home."

Agency Comments provided as text only.

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Dear Ms. Howle:

The California Department of Health Services (CDHS) has prepared its response to the draft report entitled *Department of Health Services: Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities*, dated March 22, 2007. The CDHS appreciates the work performed by the BSA and the opportunity to respond to the draft report.

Please contact Kathleen Billingsley, Deputy Director, Licensing and Certification, at (916) 440-7360 if you have any questions.

Sincerely,

(Signed by: Dr. Mark Horton for:)

Sandra Shewry
Director

* California State Auditor's comments appear on page 81.

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Bureau of State Audits' Draft Report Entitled *Department of Health Services: Its
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Chapter 1 Recommendations

Recommendation

To proactively manage its complaint workload following the conclusion of the court order, Health Services should periodically evaluate the timeliness with which district offices initiate and complete complaint investigations. Based on this information, Health Services should identify strategies, such as temporarily lending its staff to address workload imbalances occurring among district offices.

Response

The California Department of Health Services (CDHS) concurs that it did not meet the statutory timeframe for initiating complaints in long-term care facilities. The data collected and analyzed for this report reflected prior year's activities. CDHS acknowledged its inability to meet these timeframes due to insufficient staffing in testimony before the Senate Subcommittee on Health, Aging and Long Term Care in November 2005 and again during legal proceeding brought against CDHS by the California Association of Nursing Home Reform (CANHR).

On July 1, 2006, the Budget Act authorized CDHS to hire an additional 96 surveyors. CDHS has aggressively campaigned to recruit and fill these positions. As of March 14, 2007, CDHS has hired 55 new surveyors and an additional 10 new hires are pending final approval. These positions will substantially augment our ability to meet the statutory timeframes for complaint initiation and resolution.

In response to the court's decision in the CANHR lawsuit, CDHS instituted a number of changes. Effective October 1, 2006, the Licensing and Certification (L&C) Division established new workload priorities for its field offices. L&C elevated timely initiation of all long-term care (LTC) complaints **and** completion of those complaints to the first priority for every district office. CDHS directed district offices with a backlog of uninitiated complaints to initiate those complaints by January 31, 2007. At the time of the court decision, CDHS had a backlog of 1,299 uninitiated LTC complaints. In March 2007, CDHS submitted its second report to the court in response to the CANHR lawsuit. In that report, CDHS documented that the backlog of uninitiated complaints has been eliminated and at least 96 percent of all new complaints have been initiated within the statutory timeframes. CDHS is under court order to maintain 100 percent compliance with the statutory timeframes for 18 months and expects to meet that objective.

To track district office progress, L&C management runs weekly reports monitoring initiation dates for every LTC complaint since October 1, 2006. If a backlog occurs, CDHS will consider options such as temporarily lending staff from one office to another to meet its complaint initiation obligation.

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Recommendation

To ensure it fully complies with state law regarding communication with complainants, Health Services should reassess its current practice of delaying notification to complainants about investigation results until after it receives acceptable corrective action plans from cited skilled nursing facilities. If Health Services continues to support this practice, it should seek authorization from the Legislature to adjust the timing of communications with complainants accordingly.

Response

CDHS concurs with this recommendation and will revise its notification of complainants for complaints investigated under the state complaint process to conform to state statute. When the facility receives the results of our investigation, CDHS will notify the complainant in writing of the survey findings.

However, L&C has three district offices that are piloting the federal complaint investigation process. For those three offices, federal regulations consider the federal survey to be a public document only after L&C has received an acceptable plan of correction (POC) from the facility. For complaint investigations that use the federal process, CDHS will not notify complainants until the POC has been received.

Recommendation

To ensure that district offices consistently investigate complaints and include all relevant documentation in the complaint files, Health Services should clarify its policies and procedures, provide training as necessary, and periodically monitor district office performance to ensure compliance.

Response

L&C has established new monitoring reports verifying the timely initiation of complaints, and has implemented new quality assurance programs (see below) to ensure consistent prioritization, investigation, and filing of complaints. In addition, L&C now has greater capability to create ad hoc reports to identify and analyze outlier data from federal data collection systems. Finally, L&C is continuing its effort to identify standard reports, train field staff on the required frequency of these reports, and monitor the accuracy of data entered into tracking systems.

Recommendation

At a minimum Health Services should:

- Clarify its 45 working-day policy for closing complaints by establishing target timeframes for facility evaluators, supervisors, and support staff to complete key stages in the complaint process;

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Response

CDHS concurs that its policy and procedures manual for closing complaints needs to be clarified. In researching this recommendation, L&C realized that it may have shortened its self-imposed due date for closing complaints by as much as 10 days. Under current statute, L&C has up to 10 days to initiate certain complaint investigations. If a district office takes the full time allowed to begin an investigation, L&C would have only 30 days to complete the complaint per our current procedure.

Target timeframes for completing activities that are within our control are not clearly delineated. L&C will revise the policy and procedure manual to include clearly established timeframes and expectations for work products to be completed, reviewed, and processed.

Recommendation

- Ensure that each complaint file includes a workload report [timesheet], an investigation report and copies of both letters sent to complainants;

Response

CDHS concurs that these documents should be included in the complaint files. L&C will train each district office to ensure that staff understands the importance of filing all necessary paperwork in complaint and facility files.

Recommendation

- Clarify that investigation reports should be signed and approved prior to notifying skilled nursing facilities about the results of investigations;

Response

CDHS concurs with this recommendation. The investigation report is a fairly new process to surveyors and supervisors. L&C will use its preceptors in the field to continue to train district office staff on this procedure. The District Offices will conduct random audits on a quarterly basis to check for accuracy.

Recommendation

- Attempt to obtain mailing addresses from all complainants that do not wish to remain anonymous;

Response

CDHS concurs that complaint intake must obtain mailing addresses from all complainants and will include this recommendation in the complaint paperwork.

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Recommendation

- Ensure that staff correctly and consistently prioritizes complaints and categorize the deficient practices of skilled nursing facilities.

Response

CDHS concurs that some complaints should have received a higher prioritization. Beginning January 2007, L&C implemented a complaint quality assurance program to address several issues raised in this report. L&C's Central Training Unit has designed a protocol to randomly pull a statistically valid sample of complaints from every district office. The quality assurance team comprises seasoned, registered nurse (RN) surveyors and supervisors.

L&C will conduct the quality assurance program in two phases: 1) quality assurance assessment, and 2) peer review. The quality assurance assessment will verify the process used to prioritize and investigate complaints, determine the appropriateness of complaint disposition, and verify that data in the automated complaint tracking system match the complaint file documentation. Beginning in February 2007, L&C management conduct peer review of review complaint reports to assess the appropriateness of decisions to conduct (or forgo) an onsite investigation.

CDHS will apply the quality assurance process quarterly, unless a significant number of results indicate that: 1) the complaint process is not being followed by surveyors in a specific district office; 2) the disposition of the complaints is not supported by the findings of the quality assurance process; or 3) the file information does not support data in the automated tracking system. If any of these situations occurs, the quality assurance process will be conducted. Additionally, CDHS will conduct training assessments to ensure that surveyors are following complaint investigations policies and procedures in each district office.

Based upon the assessment, CDHS will provide additional training, such as principles of documentation, principles of investigation, and/or automated complaint tracking system data, if necessary.

Recommendation

To ensure that it can provide the public access to complete and accurate information regarding skilled nursing facilities as intended by the Legislature, Health Services should continue in its efforts to implement an Internet-based inquiry system and take steps to ensure the data it plans to provide through the system is accurate.

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Response

CDHS concurs with this recommendation. L&C's management and staff are committed to implementing the Health Facilities Consumer Information System to provide health care consumers and the public with access to timely and accurate long-term care facility information. The feasibility study report (FSR) required for this project, "Health Facilities Consumer Information System Project," (HFCIS) is pending approval. Once approved, L&C will begin developing and implementing the web site upon enactment of the FY 2007-08 Budget Act.

To ensure the accuracy of the data to be displayed on the web site, in December 2006 L&C instituted its updated Complaint Policy and Procedure. These detailed instructions on processing and required data ensure timeliness and accuracy of the data at its entry point. All L&C district offices management and support staff must attend a two-and-a-half day systems training session on processing and data entry, provided jointly by the Program Application Support Section of L&C and Centers for Medicare and Medicaid (CMS) Region IX staff.

In addition, as part of the HFCIS automation project, L&C will provide long-term care facilities the opportunity to verify their profile and performance information in L&C's existing automation systems prior to the initial release of the information to the web site. If a facility disagrees with the information to be posted to the web site, the facility must follow the current processes to request changes.

Chapter 2 Recommendations

Recommendation

To improve the accuracy of complaint data used to monitor its workload and staff performance, Health Services should develop strong application controls to ensure its data are accurate, complete, and consistent. This process should include validating the data entered into key data fields, ensuring key data fields are complete, and training staff to ensure consistent input into key data fields such as the field designed to capture the investigation complete date.

Response

CDHS concurs with the need to ensure data integrity. The ASPEN Complaint Tracking System (ACTS) is a powerful automation tool that L&C uses to capture complaint data and survey results. However, ACTS is a federal proprietary software application that is designed and owned by CMS and states are neither allowed nor able to enhance or change this software. L&C participates in numerous national federal data systems workgroups and has brought systems issues to their attention. We are required to use the federal system and will work aggressively with CMS to enhance the system to ensure validation of all data input into the system.

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L&C has taken steps to improve data quality by developing its own ACTS user guides and manuals that mirror our complaint policy and procedure. L&C conducts ongoing training of district office staff that enter and review data entered into ACTS. Six such training sessions have taken place and an additional six are scheduled through May 2007. As we become aware of problems or misconceptions on entering and capturing data in the system, we revise the training materials to reflect these issues and further clarify the processes. Also, to ensure data accuracy, these training sessions provide clear criteria for maintaining high quality data. This includes business processes and standards that ensure that data is entered in accordance with state and federal guidelines.

L&C will implement oversight and monitoring measures to ensure the validity of the data and develop validation and point-of-time monitoring reports that will identify outliers such as illogical and missing data elements. Based on these reports, we will work with the district offices to correct errors while continuing to monitor data accuracy.

In addition, L&C will develop and provide a management tool with query capability that will be used at the district office, branch chief, and program level to look at the status and validity of survey and complaint data. This tool will be accessible to all levels of management to improve the performance of integrity checks. We will also implement procedures for identifying anomalies in data and correcting any inaccuracies. These procedures will provide data management tools for controlling, validating, and maintaining consistent, accurate, and reliable data.

Recommendation

To reduce the predictability of its federal recertification surveys, Health Services should institute a practice of conducting surveys throughout the survey cycle, ensuring that each facility has an equal probability of being selected at any given time.

Response

CDHS concurs that recertification survey predictability should be reduced. L&C is committed to ensuring the initiation of LTC complaints within statutory timeframes and to providing greater presence in LTC facilities. However, as with any system with a mandated deadline (i.e., recertification survey completed before 15.9 months), the predictability of an event increases as the deadline approaches. Although some surveys will fall close to the deadline, L&C tries to vary the survey cycle for any one facility from consistently falling in a predictable manner.

In those cases where the predictability increases, L&C may conduct off-hour surveys (on weekends, holidays, or before 6:00 a.m. or after 4:00 p.m.). L&C may also include one of its professional consultants (medical, pharmaceutical, or dietary) on the routine survey to provide an element of greater focus to the survey.

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To improve tracking of survey scheduling, L&C will begin using Aspen Scheduling and Tracking (AST) at the end of FY 2007, a module of the federal data collection system. AST will provide better reports to field managers to help track previous surveys and assist in scheduling future surveys with less predictability.

Depending of the severity of findings during a complaint investigation, a surveyor, with concurrence from his or her supervisor, may initiate an abbreviated recertification survey. Additionally, if a surveyor on a complaint investigation identifies a serious problem unrelated to the complaint, the surveyor will expand the investigation to include the new problem.

Finally, with the advent of biennial licensing surveys, as required by Chapter 895, Statutes of 2006, L&C will have more unexpected appearances in LTC facilities.

Recommendation

To ensure that it can adequately justify the expenses it charges to the citation account, Health Services should take steps to gain assurance from temporary management companies that the funds they received were necessary. This should include reviewing the support behind temporary management companies' e-mails requesting payments. In addition, Health Services should take steps to expand its pool of qualified temporary management companies to ensure that it has sufficient numbers of temporary management companies available and receives competitive prices. Finally, when Health Services charges general support items to the citation account, it should be able to document its rationale for determining the amounts charged.

Response

CDHS concurs with this recommendation. CDHS has convened a workgroup to address issues related to fiscal accountability and the selection process for temporary management (TM) appointments. The workgroup will develop a standardized screening process to solicit and select a pool of qualified TM companies. The process will include providing potential TM candidates with written policies for a TM appointment and include program requirements and requirements for requesting funding advances, monthly submission of invoices, quarterly status reports, and close-out reports. The fiscal requirements will include instructions and forms and will address submission of expenditure data, retention of source documents, and audit provisions. The application package submitted by the TM candidate will include their qualifications for meeting the requirements as well as their ability to provide reliable, agile, and responsive services.

The screening process will ensure a TM appointment knows and can meet the requirements to disburse, monitor, track and control expenditures in order to maintain the fiscal integrity of the citation account.

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For future general support procurements, L&C staff will work directly with CDHS accounting staff to ensure that expenditures are recorded accurately and fully supported by source documentation. These efforts have already begun through the monthly Expenditure Forecasting Report process that requires L&C to review monthly expenditures against the budget and project annual expenditure levels.

L&C will work with its provider associations and LTC advocacy groups to solicit names of organizations and individuals to expand the pool for future TM appointments.

Chapter 3 Recommendations

Recommendation

To fill its authorized positions and complete its federal and state workloads, Health Services should consider working with the Department of Personnel Administration to adjust the salaries of its staff to make them more competitive with other state agencies seeking similarly qualified candidates. In addition, Health Services may want to consider hiring qualified candidates who are not registered nurses, in accordance with CMS guidelines. Finally, if these options prove unsuccessful, Health Services should develop additional strategies, such as temporarily reallocating its staff from district offices that are less burdened by their workloads to those facing the highest workloads.

Response

In recognition of the challenges facing CDHS in competing with other state agencies for RNs, L&C has begun crafting a scope of work to perform a classification study, including job audits and analyses, of the Health Facilities Evaluator series. The goal of this study will be to present a plan to the Department of Personnel Administration that proposes the appropriate structure, levels, and pay needed to successfully hire and retain qualified individuals to perform surveys and complaint investigations. The study will assess workload, identify the appropriate classifications to perform the work, determine minimum qualifications and required certificates/licenses, and address pay and salary compaction issues.

There is no law or other prohibition that prevents L&C from using non-RNs (e.g., pharmacists, psychiatric technicians, dieticians, social workers, etc.) to address its workload. L&C currently has four units of medical physicians, pharmacists, medical records consultants, and dieticians that augment our surveyor workforce and bring their expertise to our survey and complaint investigations. In addition, L&C previously recruited psychiatric technicians, social workers, and other health-related professionals to conduct health facilities inspections and complaint investigations. A small number of staff in the non-RN classifications remain in the workforce.

However, the vast majority of our routine surveyor workforce is now composed of RNs. In FY 2006–07, the Administration proposed 23 additional surveyor positions using non-RNs. However, the Legislature chose to establish all of the requested positions as RNs. The Legislature clearly indicated their preference for RNs over other health professionals for purposes of surveying health facilities.

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Pharmacists, physicians, dieticians, and medical records consultants will continue to be instrumental in addressing L&C's surveying and complaint investigation workload. As new legislation or programs are adopted, L&C will recruit RNs for our standard surveyor workforce but will also request pharmacists, physicians, dieticians and medical records staff depending on the workload justification.

L&C has temporarily reallocated staff from a district office to help another office that is having difficulty meeting survey obligations in the past and will continue to do so as needed in the future. Last year, three district offices assembled survey teams to assist another office that was in danger of missing several home health agency recertification survey deadlines. This year, survey teams from the Central Valley and Southern California are being deployed to Northern California offices to assist in meeting federal workload requirements. In addition, L&C has deployed volunteer support staff to another district office to help reduce paperwork backlog. Finally, staff at L&C Headquarters who are qualified to conduct surveys have been deployed to assist district offices in conducting initial and recertification surveys.

COMMENTS

California State Auditor's Comments on the Response From the Department of Health Services

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Health Services (Health Services). The numbers below correspond with the numbers we have placed in the margins of Health Services' response.

- We are concerned that Health Services' proposed course of action for the three district offices will preclude it from complying with state law regarding communication with complainants. Regardless of how long it takes for Health Services to receive acceptable plans of correction from facilities, it could still notify complainants that their concerns had been substantiated at the same time it notifies the facilities. Later, once the plans of correction are deemed to be public documents, Health Services could provide them to complainants as well.
- Although Health Services does not have control over the federal system, we believe it has an obligation to ensure the integrity of its data related to complaints. To the extent that the federal system does not meet its needs for ensuring data integrity, Health Services needs to develop other solutions to ensure its complaint data are accurate, complete, and consistent.
- Health Services' response is unclear regarding its plans to increase fiscal accountability over citation account disbursements. Although Health Services mentions its intention to develop fiscal requirements including audit provisions in its agreements with temporary management companies, it has not specified who will review the expenditure data and whether this will occur for each agreement. While we appreciate that Health Services may need to advance citation account funds to temporary management companies, allowing them to maintain the operations of skilled nursing facilities under their control, we believe Health Services has an obligation to eventually take steps to ensure that the funds it advanced to these firms were actually necessary.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press