

Mr. Chairman and Members of the Committee:

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

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

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

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

Policies or practices that may limit the number of complaints filed;

Serious complaints alleging harmful situations not being investigated promptly; and,

Incomplete reporting on nursing homes' compliance history and states' complaint investigation performance.

Further, regarding enforcement actions, HCFA has not yet realized its main goal -- to help ensure that homes maintain compliance with federal health care standards. We found that too often there is a yo-yo pattern where homes cycle in and out of compliance. More than one-fourth of the more than 17,000 nursing homes nationwide had serious deficiencies including inadequate prevention of pressure sores,

failure to prevent accidents, and failure to assess residents' needs and provide appropriate care -- that caused actual harm to residents or placed them at risk of death or serious injury. Although most homes corrected deficiencies identified in an initial survey, 40 percent of these homes with serious deficiencies were repeat violators. In most cases, sanctions initiated by HCFA never took effect. The threat of sanctions appeared to have little effect on deterring homes from falling out of compliance because homes could continue to avoid the sanctions' effect as long as they kept temporarily correcting their deficiencies.

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

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

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

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

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

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

Michigan's statute allows 30 days, but Michigan's operating practice in 1998 allowed 45 days;

Tennessee allows 60 days; and,

Kansas allows 180 days.

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

## **Some States Assign Low Priority Levels to Serious Complaints**

We found that some states classify few complaints in high-priority levels that would require a prompt investigation. For example, in the 1-year period from July 1997 to June 1998, Maryland did not classify any complaints as having the potential to immediately jeopardize residents and thereby requiring a visit within 2 workdays. Maryland most frequently classified complaints as not requiring a visit until the next on-site inspection which could be as long as a year or more away. Similarly, Michigan categorized nearly all of its complaints between July 1997 and June 1998 as not requiring a visit for 45 days or until the next annual survey. In contrast, Washington determined that 9 out of 10 complaints should be investigated within either 2 or 10 workdays.

Several states have explicit procedures or operating practices that do not place serious complaints in high priority categories for investigation. A Maryland official, for example, acknowledged reducing the priority of some complaints since the agency recognized that it could not meet shorter timeframes due to insufficient staff. Michigan gave some complaints low priority if the resident was no longer at the nursing home when the complaint is received -- even if the resident had died or been transferred to a hospital or another nursing home due to care problems. For example, in one such complaint in Michigan, it was alleged in July 1998 that a resident died because the home did not properly manage his insulin injections or perform blood sugar tests. The state had recently investigated the home and determined that previous problems with treatment of diabetic residents had been corrected. However, the state did not investigate the complaint until this month as part of the most recent annual survey nearly 8 months after the complaint was received -- and state investigators did not identify any problems with treatment of diabetic residents. We question why the state agency did not investigate this complaint sooner given that the resident died and the home had previous deficiencies related to diabetic care. Michigan also delayed investigating certain non-immediate jeopardy complaints against nursing homes undergoing a federal enforcement action. Officials told us that they adopted this practice to avoid potential confusion that may result from having two enforcement actions pending simultaneously. This practice, however, could unreasonably delay the investigation of serious complaints at nursing homes already identified as violating federal standards.

In reviewing complaints from the states visited, we identified several complaints that raise questions about why they were not considered as involving potential immediate jeopardy and thereby requiring a visit within 2 workdays. Examples of these allegations include:

A resident was found dead with her head trapped between the mattress and the siderail of the bed with her body lying on the floor. The state categorized this complaint as one needing to be investigated within 45 days. The state investigated this complaint within 13 days and determined that 11 of 24 sampled beds had similar siderail problems.

An alert resident who was placed in a nursing home for a 20-day rehabilitation stay to recover from hip surgery was transferred in less than 3 weeks to a hospital because of an "unprecedented rapid decline (in his condition)." A member of the ambulance crew transporting the resident to the hospital reported that the resident "had dried blood in his fingernails and on his hands sores all over his body smelled like feces and (was) unable to walk or take care of himself I personally feel he was not being properly cared for." The state eventually determined that the nursing home had harmed the resident, but only after categorizing this complaint as not needing an investigation until the next on-site inspection that was more than 4 months after receipt of the complaint.

## **Some States Not Conducting Complaint Investigations in Timely Manner**

Further, we found that states often did not conduct investigations within the timeframes they assigned complaints, even though some states frequently placed complaints in priority categories that would increase the time available to investigate them. Some of these complaints, despite alleging serious risk to resident health and safety, remained uninvestigated for several months after the deadline for investigation. For example, Maryland only met its timeframes for 21 percent of complaints assigned to the 10 workday category and for 69 percent of complaints assigned to the 45 workday category. Michigan met its timeframes in about one-fourth of cases. Washington, which assigned most complaints to the category requiring a visit within 10 workdays, met its timeframes in slightly more than half (55 percent) of all complaints.

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

Failure by states to investigate complaints promptly can delay the identification of serious problems in nursing homes and postpone needed corrective actions. As a result of delayed investigations, situations in which residents are harmed are permitted to continue for extended periods. For example, we found a complaint in Michigan alleging inadequate care for pressure sores and fractures due to falls that was not investigated for over 7 months. When the state did investigate, it found that the nursing home had a pattern of deficiencies of inadequate care that actually harmed residents.

## **APPLICATION OF SANCTIONS DOES NOT ENSURE NURSING HOMES MAINTAIN COMPLIANCE**

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

### **Many Nursing Homes Incur Repeated Serious Deficiencies**

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

problems in their first survey during the period we examined (July 1995 to October 1998) had them again in their last survey during the period.

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

Our work in four states and four HCFA regions showed that HCFA-initiated sanctions against non-compliant nursing homes did not take effect in a majority of cases and generally did not ensure that the homes maintained compliance with standards.<sup>(4)</sup> Our review of 74 homes that states had referred to HCFA for federal enforcement action, as a result of serious or uncorrected deficiencies, showed that the threat of sanctions often helped bring the homes back into temporary compliance but provided little incentive to keep them from slipping back out of compliance. Based on state recommendations, the most common sanctions HCFA initiated for these homes were denial of payments for new admissions, civil monetary penalties, and termination.<sup>(5)</sup> States had referred these homes to HCFA for possible sanctions an average of about 3 times each. Because many homes corrected their deficiencies before the effective date of the sanction, HCFA often rescinded the sanction before it took effect. For example, sanctions did not take effect in 55 percent of cases where denial of payments were recommended; in 68 percent of cases for civil monetary penalties; and 72 percent of cases for recommended termination.<sup>(6)</sup>

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

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

### **FURTHER HCFA OVERSIGHT AND ENFORCEMENT NEEDED**

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

among some homes, it has not used them effectively.

### **HCFA Oversight of Complaints is Limited**

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

A HCFA initiative to strengthen federal requirements for complaint investigations was discontinued in 1995, and resulting guidance developed for states' optional use had not been widely adopted.

Federal monitoring reviews of state nursing home inspections primarily focus on the annual standard survey of nursing homes, with very few conducted of complaint investigations.

Since 1998, HCFA has required state agencies to develop their own performance measures and quality improvement plans for their complaint investigations, but for several states we reviewed complaint processes were addressed superficially or not at all.

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

### **HCFA Policy Limits Enforcement Sanctions' Effectiveness**

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

Since July 1998, HCFA has taken or proposed several initiatives to improve nursing home oversight. These initiatives include staggering annual survey schedules to reduce the predictability of surveyors' visits, revising the definition of a poorly performing facility to broaden the criteria for taking immediate enforcement action, and prosecuting egregious violations of care standards. While these are important steps, it is too early to gauge their effect in resolving earlier identified problems. HCFA's initiatives do

not, however, address some weaknesses identified in our most recent work. For example:

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

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

### **HCFA's Management Information Systems are Inadequate**

Finally, our work points to weaknesses in HCFA's management information systems that have limited its effectiveness in addressing both nursing home complaints and enforcement. HCFA reporting systems for nursing homes' compliance history and complaint investigations do not collect timely, consistent, and complete information. Having full and accurate information on a nursing home's compliance and enforcement history, including the results of complaint investigations, would improve HCFA's ability to identify nursing homes in need of further enforcement sanctions. Further information system weaknesses pertain to the inability to centrally track enforcement actions or to identify nursing homes under common ownership.

### **CONCLUSIONS AND RECOMMENDATIONS**

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

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

Develop additional standards for the prompt investigation of serious complaints and strengthen its oversight of state complaint investigations;

Improve the effectiveness of enforcement actions, including reducing the backlog of appeals of civil monetary penalties, and strengthen policies regarding terminated homes such as requiring reasonable assurance periods of sufficient duration and maintaining the home's pre-termination history.

Develop better management information systems to integrate the results of complaint investigations, track the status and history of deficiencies, and monitor enforcement actions.

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

1. <sup>1</sup>See California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations (GAO/T-HEHS-98-219, July 28, 1998) and California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).
2. <sup>2</sup>See Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, March 22, 1999). We examined Maryland, Michigan, and Washington as well as 11 other states reviewed by state auditors -- Iowa, Kansas, Kentucky, Louisiana, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Wisconsin.
3. <sup>3</sup>See Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, March 18, 1999). The scope of this review included analysis of HCFA's nationwide database of periodic inspections and detailed work in four states -- California, Michigan, Pennsylvania, and Texas.
4. <sup>4</sup>The four states were California, Michigan, Pennsylvania, and Texas that combined account for 23 percent of nursing homes nationwide. The HCFA regions we reviewed included San Francisco, Chicago, Philadelphia, and Dallas that are responsible for overseeing states with 55 percent of nursing homes nationwide. Within these 4 states, we chose a judgmental sample of 74 nursing homes that had deficiencies of sufficient severity that states had referred the homes to HCFA for 241 separate federal enforcement actions.
5. <sup>5</sup>Other sanctions, including increased state monitoring, appointment of a temporary manager to oversee the home while it corrects its deficiencies, and state-directed plans of correction, have been infrequently used.
6. <sup>6</sup>The relatively small number of civil monetary penalties that have taken effect is a reflection of the large number of fines under appeal. As appeals are settled, a higher proportion of the fines imposed may take effect.
7. <sup>7</sup>When a home is terminated, it loses any income from Medicare and Medicaid payments, which for many homes represents a substantial part of operating revenues. Residents who receive support from Medicare or Medicaid must be moved to other facilities.