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Report to Congressional Requesters

July 2003

NURSING HOME QUALITY

Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight

GAO-03-561

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Highlights

Highlights of GAO-03-561, a report to congressional requesters

Why GAO Did This Study

Since July 1998, GAO has reported numerous times on nursing home quality-of-care issues and identified significant weaknesses in federal and state oversight. GAO was asked to assess the extent of the progress made in improving the quality of care provided by nursing homes to vulnerable elderly and disabled individuals, including (1) trends in measured nursing home quality, (2) state responses to previously identified weaknesses in their survey, complaint, and enforcement activities, and (3) the status of oversight and quality improvement efforts by the Centers for Medicare & Medicaid Services (CMS).

What GAO Recommends

GAO is making several recommendations to the Administrator of CMS to (1) strengthen the nursing home survey process, (2) ensure that state survey and complaint activities adequately assess quality-of-care problems, and (3) improve CMS oversight of state survey activities. CMS concurred with the report's recommendations, but its comments on intended actions were not fully responsive to all of the recommendations. Eleven states provided comments that most often focused on the resource constraints states face in meeting federal standards for oversight of nursing homes.

www.gao.gov/cgi-bin/getrpt?GAO-03-561.

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

What GAO Found

The proportion of nursing homes with serious quality problems remains unacceptably high, despite a decline in the incidence of such reported problems. Actual harm or more serious deficiencies were cited for 20 percent or about 3,500 nursing homes during an 18-month period ending January 2002, compared to 29 percent for an earlier period. Fewer discrepancies between federal and state surveys of the same homes suggests that state surveyors are doing a better job of documenting serious deficiencies and that the decline in serious quality problems is potentially real. Despite these improvements, the continuing prevalence of and state surveyor understatement of actual harm deficiencies is disturbing. For example, 39 percent of 76 state surveys from homes with a history of quality-of-care problems—but whose current survey found no actual harm deficiencies—had documented problems that should have been classified as actual harm or higher, such as serious, avoidable pressure sores.

Weaknesses persist in state survey, complaint, and enforcement activities. According to CMS and states, several factors contribute to the understatement of serious quality problems, including poor investigation and documentation of deficiencies, limited quality assurance systems, and a large number of inexperienced surveyors in some states. In addition, GAO found that about one-third of the most recent state surveys nationwide remained predictable in their timing, allowing homes to conceal problems if they chose to do so. Considerable state variation remains regarding the ease of filing a complaint, the appropriateness of the investigation priorities, and the timeliness of investigations. Some states attributed timeliness problems to inadequate staff and an increase in the number of complaints. Although the agency strengthened enforcement policy by requiring states to refer for immediate sanction homes that had repeatedly harmed residents, GAO found that states failed to refer a substantial number of such homes, significantly undermining the policy's intended deterrent effect.

CMS oversight of state survey activities has improved but requires continued attention to help ensure compliance with federal requirements. While CMS strengthened oversight by initiating annual state performance reviews, officials acknowledged that the reviews' effectiveness could be improved. For the initial fiscal year 2001 review, officials said they lacked the capability to systematically distinguish between minor lapses and more serious problems that required intervention. CMS oversight is also hampered by continuing database limitations, the inability of some CMS regions to use available data to monitor state activities, and inadequate oversight in areas such as survey predictability and state referral of homes for enforcement. Three key CMS initiatives have been significantly delayed—strengthening the survey methodology, improving surveyor guidance for determining the scope and severity of deficiencies, and producing greater standardization in state complaint processes. These initiatives are critical to reducing the subjectivity evident in current state survey and complaint activities.

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Abbreviations

ACTS	ASPEN Complaint Tracking System
CMS	Centers for Medicare & Medicaid Services
CMP	civil money penalties
HCFA	Health Care Financing Administration
MDS	minimum data set
OSCAR	On-Line Survey, Certification, and Reporting system
RN	registered nurse

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

July 15, 2003

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Christopher S. Bond
United States Senate

A number of congressional hearings since July 1998 have focused considerable attention on the need to improve the quality of care for the nation's 1.7 million nursing home residents, a highly vulnerable population of elderly and disabled individuals. As we previously reported, poor quality of care at about 15 percent of the nation's approximately 17,000 nursing homes—an unacceptably high proportion—had repeatedly caused actual harm to residents, such as worsening pressure sores or untreated weight loss, or had placed them at risk of death or serious injury.[1] Significant weaknesses in federal and state nursing home oversight that we identified in a series of reports and testimonies since 1998 included (1) periodic state inspections, known as surveys, that understated the extent of serious care problems due to procedural weaknesses, (2) considerable state delays in investigating public complaints alleging harm to residents, (3) federal enforcement policies that did not ensure deficiencies were addressed and remained corrected, and (4) federal oversight of state survey activities that was limited in scope and effectiveness.[2]

In July 1998, the Health Care Financing Administration (HCFA)—the federal agency with responsibility for managing Medicare and Medicaid and overseeing compliance with federal nursing home quality standards—launched a series of actions intended to address many of the weaknesses we identified.[3] Since 1998, the agency has worked to strengthen surveyors'

[1]See U.S. General Accounting Office, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, GAO/HEHS-99-157 (Washington, D.C.: June 30, 1999).

[2]A list of related GAO products is at the end of this report.

[3]Effective July 1, 2001, HCFA's name changed to the Centers for Medicare & Medicaid Services (CMS). In this report we continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

ability to detect quality-of-care deficiencies; required states to investigate complaints alleging resident harm within 10 days; mandated immediate sanctions for nursing homes with a pattern of harming residents;[4] and begun measuring state compliance with federal survey requirements and reviewing data on the results of state surveys to help pinpoint shortcomings in state survey activities.

To evaluate the extent of the progress made in improving the quality of nursing home care since we last addressed this issue in September 2000, you asked us to assess:

- trends in measured nursing home quality;
- state responses to previously identified weaknesses in their survey, complaint, and enforcement activities; and
- the status of key federal efforts to oversee state survey agency performance and improve quality.

To assess recent trends in measured nursing home quality, we analyzed survey results for the period July 11, 2000, through January 31, 2002, and compared them to survey results for two earlier 18-month periods: (1) January 1, 1997, through June 30, 1998, and (2) January 1, 1999, through July 10, 2000. Our analysis relied on data from the Centers for Medicare & Medicaid Services' (CMS) On-Line Survey, Certification, and Reporting (OSCAR) system, which compiles the results of all state nursing home surveys nationwide. To better understand the trends identified through our OSCAR analysis, we analyzed the results of federal comparative surveys, conducted at recently surveyed nursing homes to assess the adequacy of the state surveys, for two time periods—October 1998 through May 2000 and June 2000 through February 2002. We also reviewed 76 survey reports from homes with a history of actual harm deficiencies but whose most recent survey found no such deficiencies in states where the percentage of homes cited for actual harm had declined to below the national average since mid-2000. Our review of deficiencies from these survey reports focused on the types of quality-of-care deficiencies most frequently cited nationwide.

[4]The term used in the law and regulations to describe a nursing home penalty for noncompliance is "remedy." Throughout this report, we use a more common term, "sanction," to refer to such penalties. Sanctions include actions such as fines, denial of payment for new admissions, and termination from the Medicare and Medicaid programs.

To assess state survey activities as well as federal oversight, we analyzed the conduct and results of fiscal year 2001 state survey agency performance reviews during which CMS regional offices determined state compliance with seven federal standards; we focused on the five standards related to statutory survey intervals, survey documentation, complaint activities, enforcement requirements, and OSCAR data entry. We conducted structured interviews with officials from CMS, CMS's 10 regional offices, and 16 state survey agencies to discuss trends in survey deficiencies, the underlying causes of problems identified during the performance reviews, and state and federal efforts to address these problems.[5] We also discussed these issues with officials from 10 additional states during a governing board meeting of the Association of Health Facility Survey Agencies. We selected the 16 states with the goal of including states that (1) were from diverse geographic areas, (2) had shown either increases or decreases in the percentage of homes cited for actual harm, (3) had been contacted in our prior work, and (4) represented a mixture of strong and weak performance based on the results of federal performance reviews of state survey activities. We also obtained data from most state survey agencies on staffing issues such as nursing home surveyor experience and vacancies. To assess enforcement actions, we analyzed data in CMS's enforcement database and compared homes identified in OSCAR as requiring immediate sanctions with those actually referred to CMS for sanctions by state survey agencies. See appendix I for a more detailed description of our scope and methodology. Our work was performed from January 2002 through June 2003 in accordance with generally accepted government auditing standards.

Results in Brief

State survey data indicate that the proportion of nursing homes with serious quality problems remains unacceptably high, despite a decline in such reported problems since mid-2000. Compared to the prior 18-month period, the percentage of nursing homes cited for actual harm or immediate jeopardy from July 2000 through January 2002 declined by about one-third—from 29 percent (about 5,000 homes) to 20 percent (about 3,500 homes). Consistent with this reported improvement in quality, federal comparative surveys completed during a recent 20-month period found actual harm or higher-level deficiencies in 22 percent of

[5]We contacted officials in Alabama, California, Colorado, Connecticut, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New York, Oklahoma, Pennsylvania, Tennessee, Washington, and Virginia.

homes where state surveyors found no such deficiencies, compared to 34 percent in an earlier period. Fewer discrepancies between federal and state surveys suggest that state surveyors' performance in documenting serious deficiencies has improved and that the decline in serious quality problems nationwide is potentially real. Despite this improvement, however, the magnitude of understatement of actual harm deficiencies remains a cause for concern. Federal surveyors found examples of actual harm deficiencies in about one-fifth of homes that states had judged to be deficiency free. Moreover, 39 percent of 76 surveys we reviewed from homes with a history of quality-of-care problems—but whose current survey indicated no actual harm deficiencies—had documented problems that should have been classified as actual harm: serious, avoidable pressure sores; severe weight loss; and multiple falls resulting in broken bones and other injuries.

Weaknesses persist in state survey, complaint investigation, and enforcement activities. Several factors at the state level contribute to the understatement of serious quality-of-care problems. Poor investigation and documentation of deficiencies identified during nursing home surveys preclude a determination of the seriousness of some deficiencies. According to some state officials, the large number of inexperienced surveyors due to high attrition and hiring limitations has also had a negative impact on the quality of surveys. While most of the 16 states we contacted had a quality assurance process in place to review deficiencies cited at the actual harm level and higher, half did not have such a process to help ensure that the scope and severity of less serious deficiencies were not understated. The continued predictability of the occurrence of standard surveys also likely contributes to the understatement of deficiencies. Our analysis of OSCAR data indicated that about one-third of the most recent state surveys nationwide occurred on a predictable schedule, allowing homes to conceal problems if they chose to do so. In addition, many states' complaint investigation policies and procedures were still inadequate to provide intended protections. For example, 15 states did not provide toll-free hotlines to facilitate the filing of complaints, the majority of states lacked adequate systems for managing complaints, and one or more states in most of CMS's 10 regions did not correctly determine the investigation priority for complaints. Moreover, most states did not investigate all complaints involving actual harm within 10 days, as required. Some states attributed the timeliness problem to insufficient staff and an increase in the number of complaints. Although HCFA strengthened its enforcement policy by requiring state survey agencies, beginning in January 2000, to refer for immediate sanction homes that had a pattern of harming residents, we found that states failed to refer a

substantial number of such homes, significantly undermining the intended deterrent effect of this policy.

While CMS has increased its oversight of state survey and complaint activities, continued attention is required to help ensure compliance with federal requirements. In October 2000, HCFA implemented new annual performance reviews to measure state performance in seven areas, including the timeliness of survey and complaint investigations and the proper documentation of survey findings. The first round of results, however, did not produce information enabling the agency to identify and initiate needed improvements. For example, some regional office summary reports provided too little information to determine if a state did not meet a particular standard by a wide or a narrow margin—information that could help CMS to judge the seriousness of problems identified. We also found inconsistencies in how CMS regions conducted their reviews, raising questions about the validity and fairness of the results. Rather than relying on its regional offices, CMS plans to more centrally manage future state performance reviews to improve consistency and to help ensure that the results of those reviews could be used to more readily identify serious problems. Implementation has been significantly delayed for three other federal initiatives that are critical to reducing the subjectivity evident in the state survey process for identifying deficiencies and investigating complaints. These delayed initiatives were intended to strengthen the methodology for conducting surveys, improve surveyor guidance for determining the scope and severity of deficiencies, and increase standardization in state complaint investigation processes.

We are recommending that the Administrator of CMS strengthen survey, complaint, enforcement, and oversight processes by (1) finishing the development of a more rigorous survey methodology, (2) requiring states to implement a quality assurance process to test the validity of cited deficiencies for surveys that include deficiencies below the actual harm level, (3) developing guidance for states that addresses key weaknesses in their complaint investigation processes, and (4) improving the ability of federal oversight of state survey activities to distinguish between systemic and less serious state survey performance problems. Although CMS concurred with our recommendations, its comments did not fully address our concerns about the status of the initiative intended to improve the effectiveness of the survey process or the recommendation regarding state quality assurance systems. Eleven states provided comments that most often focused on the resource constraints states face in meeting federal standards for oversight of nursing homes.

Background

Combined Medicare and Medicaid payments to nursing homes for care provided to vulnerable elderly and disabled beneficiaries were expected to total about $63 billion in 2002, with a federal share of approximately $42 billion. Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. A range of statutorily defined sanctions is available to help ensure that homes maintain compliance with federal quality requirements. CMS is also responsible for monitoring the adequacy of state survey activities.

Standard Surveys

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.[6] A standard survey entails a team of state surveyors, including registered nurses (RN), spending several days in the nursing home to assess compliance with federal long-term care facility requirements, particularly whether care and services provided meet the assessed needs of the residents and whether the home is providing adequate quality care, such as preventing avoidable pressure sores, weight loss, or accidents. Based on our earlier work indicating that facilities could mask certain deficiencies, such as routinely having too few staff to care for residents, if they could predict the survey timing, HCFA directed states in 1999 to (1) avoid scheduling a home's survey for the same month of the year as the home's previous standard survey and (2) begin at least 10 percent of standard surveys outside the normal workday (either on weekends, early in the morning, or late in the evening).

State surveyors' assessment of the quality of care provided to a sample of residents during the standard survey serves as the basis for evaluating nursing homes' compliance with federal requirements. CMS establishes specific investigative protocols for state surveyors to use in conducting these comprehensive surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states. In response to our earlier recommendations concerning the need to better ensure that surveyors do not miss significant care problems, HCFA

[6]CMS generally interprets these requirements to permit a statewide average interval of 12.9 months and a maximum interval of 15.9 months for each home.

planned a two-phase revision of the survey process. In phase one, HCFA instructed states in 1999 to (1) begin using a series of new investigative protocols covering pressure sores, weight loss, dehydration, and other key quality areas, (2) increase the sample of residents reviewed with conditions related to these areas, and (3) review "quality indicator" information on the care provided to a home's residents, before actually visiting the home, to help guide survey activities. Quality indicators are essentially numeric warning signs of the prevalence of care problems such as greater-than-expected instances of weight loss, dehydration, or pressures sores.[7] They are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in the state.[8] By using the quality indicators to select a preliminary sample of residents before the on-site review, surveyors are better prepared to identify potential care problems. Surveyors augment this preliminary sample with additional resident cases once they arrive in the home. To address remaining problems with sampling and the investigative protocols, CMS is planning a second set of revisions to its survey methodology. The focus of phase two is (1) improving the on-site augmentation of the preliminary sample selected off-site using the quality indicators and (2) strengthening the protocols used by surveyors to ensure more rigor in their on-site investigations.

Complaint Investigations

Complaint investigations provide an opportunity for state surveyors to intervene promptly if quality-of-care problems arise between standard surveys. Within certain federal guidelines and time frames, surveyors generally follow state procedures when investigating complaints filed against a home by a resident, the resident's family, or nursing home employees, and typically target a single area in response to the complaint.

[7]Quality indicators were the result of a HCFA-funded project at the University of Wisconsin. The developers based their work on nursing home resident assessment information, known as the minimum data set (MDS)—data on each resident that homes are required to report to CMS. See Center for Health Systems Research and Analysis, *Facility Guide for the Nursing Home Quality Indicators* (University of Wisconsin-Madison: Sept. 1999).

[8]Because resident assessment data are used by CMS and states to calculate quality indicators and to determine the level of nursing homes' payments for Medicare (and for Medicaid in some states), ensuring accuracy at the facility level is critical. We have made earlier recommendations to CMS on ways to improve the accuracy of these data. See U.S. General Accounting Office, *Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities*, GAO-02-279 (Washington, D.C.: Feb. 15, 2002).

Historically, HCFA had played a minimal role in providing states with guidance and oversight of complaint investigations. Until 1999, federal guidelines were limited to requiring the investigation of complaints alleging immediate jeopardy conditions within 2 workdays. In March 1999, HCFA acted to strengthen state complaint procedures by instructing states to investigate any complaint alleging harm to a nursing home resident within 10 workdays. Additional guidance provided to states in late 1999 specified that, as with immediate jeopardy complaints, investigations should generally be conducted on-site at the nursing home. This guidance also identified techniques to help states identify complaints having a higher level of actual harm. As part of a complaint improvement project, also initiated in late 1999, HCFA plans to issue more detailed guidance to states, such as identifying model programs or practices to increase the effectiveness of complaint investigations.

Deficiency Reporting

Quality-of-care deficiencies identified during either standard surveys or complaint investigations are classified in 1of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). States are required to enter information about surveys and complaint investigations, including the scope and severity of deficiencies identified, in CMS's OSCAR database.

Table 1: Scope and Severity of Deficiencies Identified During Nursing Home Surveys

	Scope		
Severity	**Isolated**	**Pattern**	**Widespread**
Immediate jeopardy[a]	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm[b]	A	B	C

Source: CMS.

[a]Actual or potential for death/serious injury.

[b]Nursing home is considered to be in "substantial compliance."

The importance of accurate and timely reporting of nursing home deficiency data has increased with the public reporting of survey deficiencies, which HCFA initiated in 1998 on its Nursing Home Compare Web site.[9] The public reporting of deficiency data is intended to assist individuals in differentiating among nursing homes. In November 2002, CMS augmented the deficiency data available on its Web site with 10 clinical indicators of quality, such as the percentage of residents with pressure sores, in nursing homes nationwide. While the intent of this new initiative is worthwhile, CMS had not resolved several important issues that we raised prior to moving from a six-state pilot to nationwide implementation.[10] These issues included: (1) the ability of the new information to accurately identify differences in nursing home quality, (2) the accuracy of the underlying data used to calculate the quality indicators, and (3) the potential for public confusion over the available data.

Enforcement Policy

Ensuring that documented deficiencies are corrected is a shared federal-state responsibility. CMS imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification on the basis of state referrals.[11] CMS normally accepts a state's recommendation for sanctions but can modify it. The scope and severity of a deficiency determine the applicable sanctions that can involve, among other things, requiring training for staff providing care to residents, imposing monetary fines, denying the home Medicare and Medicaid payments for new admissions, and terminating the home from participation in these programs. Before a sanction is imposed, federal policy generally gives nursing homes a grace period of 30 to 60 days to correct the deficiency. We earlier reported, however, that the threat of federal sanctions did not prevent nursing homes from cycling in and out of compliance because they were able to avoid sanctions by returning to compliance within the grace period, even when they had been

[9]http://www.medicare.gov/NHCompare/home.asp.

[10]U.S. General Accounting Office, *Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature*, GAO-03-187 (Washington, D.C.: Oct. 31, 2002).

[11]States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of homes. They may use the federal sanctions or rely on their own state licensure authority and nursing home sanctions. States are responsible for ensuring that homes that have a pattern of harming residents are immediately sanctioned.

cited for actual harm on successive surveys.[12] In 1998, HCFA began a two-stage phase-in of a new enforcement policy. In the first stage, effective September 1998, HCFA required states to refer for immediate sanction homes found to have a pattern of harming residents or exposing them to actual or potential death or serious injury (H-level deficiencies and above on CMS's scope and severity grid). Effective January 14, 2000, HCFA expanded this policy to also require referral of homes found to have harmed one or a small number of residents (G-level deficiencies) on successive standard surveys.[13]

CMS Oversight

CMS is responsible for overseeing each state survey agency's performance in ensuring quality of care in state nursing homes. Its primary oversight tools are statutorily required federal monitoring surveys conducted annually in 5 percent of the nation's certified Medicare and Medicaid nursing homes, on-site annual state performance reviews instituted during fiscal year 2001, and analysis of periodic oversight reports that have been produced since 2000. Federal monitoring surveys can be either comparative or observational. A comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing home to observe the team's performance. Roughly 85 percent of federal surveys are observational. State performance reviews, implemented in October 2000, measure state performance against seven standards, including statutory requirements regarding survey frequency, requirements for documenting deficiencies, timeliness of complaint investigations, and timely and accurate entry of deficiencies into OSCAR. These reviews replaced state self-reporting of their compliance with federal requirements. In October 2000, HCFA also began to produce 19 periodic reports to monitor both state and regional office performance. The reports are based on OSCAR and other CMS databases. Examples of reports that track state activities include pending nursing home terminations (weekly), data entry

[12]U. S. General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, GAO/HEHS-99-46 (Washington, D.C.: Mar.18, 1999).

[13]States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G-L on CMS's scope and severity grid) in each of two successive surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

timeliness (quarterly), tallies of state surveys that find homes deficiency free (semiannually), and analyses of the most frequently cited deficiencies by states (annually). These reports, in a standard format, enable comparisons within and across states and regions and are intended to help identify problems and the need for intervention. Certain reports—such as the timeliness of state survey activities—are used to monitor compliance with state performance standards.

Magnitude of Problems Remains Cause for Concern Even Though Fewer Serious Nursing Home Quality Problems Reported

The magnitude of the problems uncovered during standard nursing home surveys remains a cause for concern even though OSCAR deficiency data indicate that state surveyors are finding fewer serious quality problems. Compared to an earlier period, the percentage of homes nationwide cited since mid-2000 for actual harm or immediate jeopardy has decreased in over three-quarters of states—with seven states reporting a drop of 20 percentage points or more. State surveys conducted since about mid-2000 showed less variance from federal comparative surveys, suggesting that (1) state surveyors' performance in documenting serious deficiencies has improved and (2) the decline in serious nursing home quality problems is potentially real. However, federal comparative surveys, as well as our review of a sample of survey reports from homes with a history of quality-of-care problems, continued to find understatement of actual harm deficiencies.

Proportion of Nursing Homes with Documented Actual Harm or Immediate Jeopardy Care Problems Has Declined since 2000

Compared to the preceding 18-month period, the proportion of nursing homes cited for actual harm or immediate jeopardy has declined nationally from 29 percent to 20 percent since mid-2000.[14] In contrast, from early 1997 through mid-2000, the percentage of homes cited for such serious deficiencies was either relatively stable or increased in 31 states.[15] From July 2000 through January 2002, 40 states cited a smaller percentage of homes with such serious deficiencies, while only 9 states and the District of Columbia cited a larger proportion of homes with such deficiencies.[16] Despite these changes, there is still considerable variation in the proportion of homes cited for serious deficiencies, ranging from about 7 percent in Wisconsin to about 50 percent in Connecticut. Appendix II provides trend data on the percentage of nursing homes cited for serious deficiencies for all 50 states and the District of Columbia.

Table 2 shows the recent change in actual harm and immediate jeopardy deficiencies for states that surveyed at least 100 nursing homes.[17] Specifically:

- Twenty-five states had a 5 percentage point or greater decrease in the proportion of homes identified with actual harm or immediate jeopardy. For over two-thirds of these states, the decrease in serious deficiencies was greater than 10 percentage points. Seven states—Arizona, Alabama,

[14]We analyzed OSCAR data for surveys performed from January 1, 1999, through July 10, 2000, and from July 11, 2000, through January 31, 2002, and entered into OSCAR as of June 24, 2002. See app. I for our complete scope and methodology. Our analysis considered only standard surveys. In commenting on a draft of this report, Missouri stated that our findings would have shown that quality had remained "fairly stable" had we included actual harm and immediate jeopardy deficiencies identified during complaint investigations in our analysis in table 2. However, we found that both nationally and in Missouri, the proportion of homes cited for actual harm or immediate jeopardy showed a similar decline even when complaint surveys were considered.

[15]The two earlier time periods we analyzed are for surveys conducted from January 1, 1997, through June 30, 1998, and from January 1, 1999, through July 10, 2000. See U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: Sept. 28, 2000).

[16]The proportion of nursing homes in Utah cited with serious deficiencies remained the same between the two time periods.

[17]We excluded Alaska, Delaware, the District of Columbia, Hawaii, Idaho, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, Utah, Vermont, and Wyoming from this analysis because fewer than 100 homes were surveyed and even a small increase or decrease in the number of homes with serious deficiencies in such states produces a relatively large percentage point change.

California, Michigan, Indiana, Pennsylvania, and Washington—experienced declines of 15 percentage points or more.

- Two states, South Dakota and Colorado, experienced an increase of 5 percentage points or greater in the proportion of homes with actual harm or immediate jeopardy deficiencies (6.6 and 10.8, respectively).
- The remaining 11 states were relatively stable—experiencing approximately a 4 percentage point change or less.

Table 2: Change in the Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during State Standard Surveys between the periods January 1, 1999, through July 10, 2000, and July 11, 2000, through January 31, 2002, by State

State[a]	Number of homes surveyed (7/00-1/02)	Percentage of homes with actual harm or immediate jeopardy deficiencies		Percentage point difference[b]
		1/99-7/00	7/00-1/02	
Decrease of 5 percentage points or greater				
Arizona	147	33.8	8.8	-25.0
Alabama	228	42.2	18.4	-23.8
Pennsylvania	764	32.2	11.6	-20.6
California	1,348	29.1	9.3	-19.9
Indiana	573	45.3	26.2	-19.1
Michigan	441	42.1	24.7	-17.4
Washington	275	54.1	38.5	-15.6
Oregon	152	47.5	33.6	-13.9
Illinois	881	29.3	15.4	-13.9
Mississippi	219	33.2	19.6	-13.5
Minnesota	431	31.7	18.8	-12.9
Montana	103	37.5	25.2	-12.3
Missouri	569	22.3	10.2	-12.1
South Carolina	180	28.7	17.8	-10.9
North Carolina	419	40.8	30.1	-10.7
Arkansas	267	37.7	27.3	-10.4
Massachusetts	512	33.0	22.9	-10.2
Iowa	494	19.3	9.9	-9.4
Tennessee	377	26.0	16.7	-9.3
Nation	**17,149**	**29.3**	**20.5**	**-8.8**
Virginia	285	19.9	11.6	-8.3
Kansas	400	37.1	29.0	-8.1
Nebraska	243	26.0	18.9	-7.1
Wisconsin	421	14.0	7.1	-6.9
Maryland	248	25.6	20.2	-5.5
Ohio	1,029	29.0	23.7	-5.3
Change of less than 5 percentage points				
Kentucky	306	28.8	25.2	-3.7

State[a]	Number of homes surveyed (7/00-1/02)	Percentage of homes with actual harm or immediate jeopardy deficiencies		Percentage point difference[b]
		1/99-7/00	7/00-1/02	
New Jersey	366	24.5	22.4	-2.1
Georgia	370	22.6	20.5	-2.0
West Virginia	143	15.6	14.0	-1.7
Texas	1,275	26.9	25.5	-1.5
Florida	742	20.8	20.1	-0.8
Maine	124	10.3	9.7	-0.6
New York	671	32.2	32.3	0.2
Connecticut	259	48.5	49.4	0.9
Louisiana	367	19.9	23.4	3.5
Oklahoma	394	16.7	20.6	3.9
Increase of 5 percentage points or greater				
South Dakota	114	24.1	30.7	6.6
Colorado	225	15.4	26.2	10.8

Source: GAO analysis of OSCAR data as of June 24, 2002.

[a]Includes only those states in which 100 or more homes were surveyed since July 2000.

[b]Differences are based on numbers before rounding.

States offered several explanations for the declines in actual harm and immediate jeopardy deficiencies, including (1) changing guidance from CMS regional offices as to what constitutes actual harm, (2) hiring additional staff, and (3) surveyors failing to properly identify actual harm deficiencies.

Federal Comparative Surveys Show Decreased Variance with State Survey Findings, but Understatement of Actual Harm Deficiencies Continued

Our analysis of federal comparative surveys conducted nationwide prior to and since June 2000 showed a decreased variance between federal and state survey findings (see app. I for a description of our scope and methodology). For comparative surveys completed from October 1998 through May 2000, federal surveyors found actual harm or higher-level deficiencies in 34 percent of homes where state surveyors had found no such deficiencies, compared to 22 percent for comparative surveys completed from June 2000 through February 2002. In addition, while federal surveyors found more serious care problems than state surveyors on 70 percent of the earlier comparative surveys, this percentage declined to 60 percent for the more recent surveys.

Despite the decline in understatement of actual harm deficiencies from 34 percent to 22 percent, the magnitude of the state surveyors'

understatement of quality problems remains an issue. For example, from June 2000 through February 2002, federal surveyors found at least one actual harm or immediate jeopardy quality-of-care deficiency in 16 of the 85 homes (19 percent) that the states had found to be free of deficiencies. For example, federal surveyors found that 1 of the 16 homes failed to prevent pressure sores, failed to consistently monitor pressure sores when they did develop, and failed to notify the physician promptly so that proper treatment could be started. The federal surveyors who conducted the comparative survey of this nursing home noted in the file that a lack of consistent monitoring of pressure sores existed at the home during the time of the state's survey and that the state surveyors should have found the deficiency.

Several states that reviewed a draft of this report questioned the value of federal comparative surveys because of their timing. Arizona noted that comparative surveys do not have to begin until up to 2 months after the state's survey, and Iowa and Virginia officials said they might occur so long after the state's survey that conditions in the home may have significantly changed. Although legislation requires comparative surveys to begin within 2 months of the state's survey, CMS is continuing to make progress in reducing the timeframe between the state and the comparative survey. Based on our earlier recommendation that comparative surveys begin as soon after the state's survey as possible, CMS instructed the regions to begin these surveys no later than one month following the state's survey, and the average time between surveys nationally has decreased from 33 calendar days in 1999 to about 26 calendar days for surveys conducted from June 2000 through February 2002.[18]

Quality-of-Care Problems Were Understated in Homes with a History of Problems

Even with the reported decline in serious deficiencies, an unacceptably high number of nursing homes—one in five nationwide—still had actual harm or immediate jeopardy deficiencies. Moreover, we found widespread understatement of actual harm deficiencies in a sample of surveys we reviewed that were conducted since July 2000 at homes with a history of harming residents (see app. I for a description of our methodology in selecting this sample). In 39 percent of the 76 survey reports we reviewed, we found sufficient evidence to conclude that deficiencies cited at a lower level (generally, potential for more than minimal harm, D or E) should

[18]U.S. General Accounting Office, *Nursing Homes: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, GAO/HEHS-00-6 (Washington, D.C.: Nov. 4, 1999).

have been cited at the level of actual harm or higher (G level or higher on CMS's scope and severity grid). We were unable to assess whether the scope and severity of other deficiencies in our sample of surveys were also understated because of weaknesses in the investigations conducted by surveyors and in the adequacy with which they documented those deficiencies.

Of the surveys we reviewed, 30 (39 percent) contained sufficient evidence for us to conclude that deficiencies cited at the D and E level should have been cited as at least actual harm because a deficient practice was identified and linked to documented actual harm involving at least one resident (see table 3). These 30 survey reports depicted examples of actual harm, including serious, avoidable pressure sores; severe weight loss; and multiple falls resulting in broken bones and other injuries (see app. III for abstracts of these 30 survey reports). The following example illustrates understated actual harm involving the failure to provide necessary care and services. A nurse at one facility noted a large area of bruising and swelling on an 89-year-old resident's chest. Nothing further was done to explore this injury until 11 days later when the resident began to experience shortness of breath and diminished breath sounds. Then a chest x ray was taken, revealing that the resident had sustained two fractured ribs and fluid had accumulated in the resident's left lung. A facility investigation determined that the resident had been injured by a lift used to transfer the resident to and from the bed. It was clear from the surveyor's information that the facility failed to take appropriate action to assess and provide the necessary care until the resident developed serious symptoms of chest trauma. Nevertheless, the surveyor concluded that there was no actual harm and cited a D-level deficiency—potential for more than minimal harm.

Table 3: Incidence of Underreported Actual Harm Deficiencies in Surveys GAO Reviewed

State	Number of surveys from state	Number of surveys in which GAO identified G-level deficiencies	Number of G-level deficiencies GAO identified
Alabama	6	2	2
Arizona	3	1	2
California	22	13	17
Iowa	7	5	7
Maryland	3	1	1
Minnesota	5	0	0
Mississippi	1	0	0
Missouri	4	1	1
Nebraska	4	2	2
Pennsylvania	11	2	3
South Carolina	1	0	0
Virginia	7	3	4
West Virginia	1	0	0
Wisconsin	1	0	0
Total	**76**	**30**	**39**

Source: GAO analysis of state surveys.

Note: We reviewed surveys where state surveyors had cited deficiencies at the D or E level (potential for more than minimal harm) in one or more of four quality-of-care areas (see app. I, table 6). We reviewed all such deficiencies to determine if, in our judgment, the deficiencies should have been cited at the G level or higher (actual harm).

State survey agency officials in Alabama, California, Iowa, and Nebraska told us that surveyors had originally cited G-level deficiencies in 10 of the surveys we reviewed, but that the deficiencies had been reduced to the D level during the states' reviews because of inadequate surveyor documentation. We concluded that 5 of the 10 surveys did contain adequate documentation to support actual harm because there was a clear link between the deficient facility practice and the documented harm to a resident. For example, the survey managers in one state changed a G- to a D-level deficiency because the surveyor only cited one source of evidence to support the deficiency—nurses' notes in the residents' medical records.[19] According to the surveyor, a resident with dementia, experiencing long- and short-term memory problems, fell 11 times and

[19]Instructions from the state's CMS regional office suggest, but do not require, the use of more than one source of information to support a deficiency.

sustained a fractured wrist, three fractured ribs, and numerous bruises, abrasions, and skin tears. According to the notes of facility nurses, a personal alarm unit was in place as a safety device to prevent falls. The surveyor found that the facility had (1) failed to provide adequate interventions to prevent accidents and (2) continued to use the alarm unit even though it did not prevent any of the falls. The medical record documentation of these events was extensive and, in our judgment, was sufficient evidence of a deficiency that resulted in actual harm to the resident.

In many of the 76 surveys we reviewed, including surveys in which we found no D- or E-level deficiencies that would appear to meet the criteria for actual harm deficiencies, we identified serious investigation or documentation weaknesses that could further contribute to the understatement of serious deficiencies in nursing homes. In some cases, the survey did not clearly describe the elements of the deficient practice, such as whether the resident developed a pressure sore in the facility or what the facility did to prevent the development of a facility-acquired pressure sore. In other cases, the survey omitted critical facts, such as whether a pressure sore had worsened or the size of the pressure sore.

Weaknesses Persist in State Survey, Complaint, and Enforcement Activities

Widespread weaknesses persist in state survey, complaint investigation, and enforcement activities despite increased attention to these issues in recent years. Several factors at the state level contribute to the understatement of serious quality-of-care problems, including poor investigation and documentation of deficiencies, the absence of adequate quality assurance processes, and a large number of inexperienced surveyors in some states due to high attrition or hiring limitations. In addition, our analysis of OSCAR data indicated that the timing of a significant proportion of state surveys remained predictable, allowing homes to conceal problems if they choose to do so. Many states' complaint investigation policies and procedures were still inadequate to provide intended protections. For example, many states do not investigate all complaints identified as alleging actual harm in a timely manner, a problem some states attributed to insufficient staff and an increase in the number of complaints. Although HCFA strengthened its enforcement policy by requiring state survey agencies, beginning in January 2000, to refer for immediate sanction homes that had a pattern of harming residents, we found that many states did not fully comply with this new requirement. States failed to refer a substantial number of homes for sanction, significantly undermining the policy's intended deterrent effect.

Investigation Weaknesses and Other Factors Contribute to Underreporting of Care Problems

CMS and state officials identified several factors that they believe contribute to state surveys continuing to miss significant care problems. These weaknesses persist, in part, because many states lack adequate quality assurance processes to ensure that deficiencies identified by surveyors are appropriately classified. According to officials we interviewed, the large number of inexperienced surveyors in some states due to high attrition has also had a negative impact on the quality of state surveys and investigations. Our analysis of OSCAR data also indicated that nursing homes could conceal problems if they choose to do so because a significant proportion of current state surveys remain predictable.

Investigation and Documentation Weaknesses

Consistent with the investigation and documentation weaknesses we found in our review of a sample of survey reports from homes with a history of actual harm deficiencies, CMS officials told us that their own activities had identified similar problems that could contribute to an understatement of serious deficiencies at nursing homes.

- CMS reviews of state survey reports during fiscal year 2001 demonstrated weaknesses in a majority of states, including: (1) inadequate investigation and documentation of a poor outcome, such as reviewing available records to help identify when a pressure sore was first observed and how it changed over time, (2) failure to specifically identify the deficient practice that contributed to a poor outcome, or (3) understatement of the seriousness of a deficiency, such as citing a deficiency at the D level (potential for actual harm) when there was sufficient evidence in the survey report to cite the deficiency at the G level (actual harm).
- State survey agency officials expressed confusion about the definition of "actual harm" and "immediate jeopardy," suggesting that such confusion contributes to the variability in state deficiency trends. For example, officials in one state told us that, in their view, residents must experience functional impairment for state surveyors to cite an actual harm deficiency, an interpretation that CMS officials told us was incorrect. Under such a definition, repeated falls that resulted in bruises, cuts, and painful skin tears would not be cited as actual harm, even if the facility failed to assess the resident for measures to prevent falls.
- CMS officials also told us that, contrary to federal guidance, state surveyors in at least one state did not cite all identified deficiencies but rather brought them to the homes' attention with the expectation that the deficiencies would be corrected. CMS officials told us that they identified the problem by asking state officials about the unusually high number of homes with no deficiencies on their standard surveys.

Inadequate Quality Assurance Processes

Some state officials told us that considerable staff resources are devoted to scrutinizing the support for actual harm and higher-level deficiencies that could lead to the imposition of a sanction. While most of the 16 states we contacted had quality assurance processes to review deficiencies cited at the actual harm level and higher, half did not have such processes to help ensure that the scope and severity of less serious deficiencies were not understated.[20] State officials generally told us that they lacked the staff and time to review deficiencies that did not involve actual harm or immediate jeopardy, but some states have established such programs. For example, Maryland established a technical assistance unit in early 2001 to review a sample of survey reports; the review looks at all deficiencies—not just those involving actual harm or immediate jeopardy. A Maryland official told us that she had the resources to do so because the state legislature authorized a substantial increase in the number of surveyors in 1999. However, staff cutbacks in late 2002 due to the state's budget crisis have resulted in the reviews being less systematic than originally planned. In Colorado, two long-term-care supervisors reviewed all 1,351 deficiencies cited in fiscal year 2001. Maryland and Colorado officials told us that the reviews have identified shortcomings in the investigation and documentation of deficiencies, such as the failure to interview residents or the classification of deficiencies as process issues when they actually involved quality of care. The reviews, we were told, provide an opportunity for surveyor feedback or training that improves the quality and consistency of future surveys.

Inexperienced State Surveyors

State officials cited the limited experience level of state surveyors as a factor contributing to the variability in citing actual harm or higher-level deficiencies and the understatement of such deficiencies. Data we obtained from 42 state survey agencies in July 2002 revealed the magnitude of the problem: in 11 states, 50 percent or more of surveyors had 2-years' experience or less; in another 13 states, from 30 percent to 48 percent of surveyors had similarly limited experience (see app. IV). For example, Alabama's and Louisiana's recent annual attrition rates were 29 percent and 18 percent, respectively, and, as a result, almost half of the surveyors in both states had been on the job for 2 years or less. In California and Maryland—states that hired a significant number of new surveyors since 2000—52 percent and 70 percent of surveyors,

[20]Officials explained the focus on actual harm or higher-level deficiencies by noting that the potential for sanctions increased the likelihood that the deficiencies would be challenged by the nursing home and perhaps appealed in an administrative hearing.

respectively, had less than 2 years of on-the-job experience.[21] According to CMS regional office and state officials, the first year for a new surveyor is essentially a period of training and low productivity, and it takes as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well. High staff turnover was attributed, in part, to low salaries for RN surveyors—salaries that may not be competitive with other employment opportunities for nurses. Overall, 29 of the 42 states that responded to our inquiry indicated that they believed nurse surveyor salaries were not competitive (see app. IV). Officials in several states also told us that the combination of low starting salaries and a highly competitive market forced them to hire less qualified candidates with less breadth of experience.

Predictable Surveys

Even though HCFA directed states, beginning January 1, 1999, to avoid scheduling a nursing home's survey for the same month of the year as its previous survey, over one-third of state surveys remain predictable. Our analysis demonstrated little change in the proportion of predictable nursing home surveys. Predictable surveys can allow quality-of-care problems to go undetected because homes, if they choose to do so, may conceal problems.[22] We recommended in 1998 that HCFA segment the standard survey into more than one review throughout the year, simultaneously increasing state surveyor presence in nursing homes and decreasing survey predictability. Although HCFA disagreed with segmenting the survey, it did recognize the need to reduce predictability.

Our analysis of OSCAR data demonstrated that, on average, the timing of 34 percent of current surveys nationwide could have been predicted by nursing homes, a slight reduction from the prior surveys when about 38 percent of all surveys were predictable. The predictability of current surveys ranged from 83 percent in Alabama to 10 percent in Michigan (see app. V for data on all 50 states and the District of Columbia). In 34 states, 25 percent to 50 percent of current surveys were predictable, as shown in

[21]As of July 2002, both states had vacant surveyor positions and a surveyor hiring freeze.

[22]In commenting on a draft of this report, Arizona disagreed with the significance we attribute to survey predictability, questioning whether poor homes would, or even could, hide problems if they knew a survey was imminent. However, advocates and family members have told us that a home that operates with too few staff could temporarily augment its staff during the expected period of a survey in order to mask an otherwise serious deficiency—a common practice based on advocates' own observations.

table 4. In 9 states, more than 50 percent of current surveys were predictable.[23]

Table 4: Predictability of Nursing Home Surveys

Percentage of predictable surveys[a]	Number of states[b]
More than 50 percent	9
25 percent to 50 percent	34
Less than 25 percent	8

Source: GAO analysis of OSCAR data as of April 9, 2002.

[a]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys, or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys.

[b]Includes the District of Columbia.

Many State Complaint Investigation Systems Still Have Timeliness Problems and Other Weaknesses

Most state agencies did not investigate serious complaints filed against nursing homes within required time frames, and practices for investigating complaints in many states may not be as effective as they could be. A CMS review of states' timeliness in investigating complaints alleging harm to residents revealed that most states did not investigate all such complaints within 10 days, as CMS requires. Additionally, a CMS-sponsored study of complaint practices in 47 states raised concerns about state approaches to accepting and investigating complaints.

Until March 1999, states could set their own complaint investigation time frames, except that they were required to investigate within 2 workdays all complaints alleging immediate jeopardy conditions. In March 1999, we reported that inadequate complaint intake and investigation practices in states we reviewed had too often resulted in extensive delays in investigating serious complaints.[24] As a result of our findings, HCFA began requiring states to investigate complaints that allege actual harm, but do

[23]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys (13 percent of homes, nationally) or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys (21 percent of homes, nationally). Because homes know the maximum allowable interval between surveys, those whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

[24]U.S. General Accounting Office, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, GAO/HEHS-99-80 (Washington, D.C.: Mar. 22, 1999).

not rise to the level of immediate jeopardy, within 10 workdays.[25] CMS's 2001 review of a sample of complaints in all states demonstrated that many states were not complying with these requirements. Specifically, 12 states were not investigating all immediate jeopardy complaints within the required 2 workdays, and 42 states were not complying with the requirement to investigate actual harm complaints within 10 days.[26] The agency also found that the triaging of complaints to determine how quickly each complaint should be investigated was inadequate in many states.

The extent to which states did not meet the 2-day and 10-day investigation requirements varied considerably. Officials from 12 of the 16 states we contacted indicated that they were unable to investigate complaints on time because of staff shortages. Oklahoma investigated only 3 of the 21 immediate jeopardy complaints that CMS sampled within the required 2-day period and none of 14 sampled actual harm complaints in 10 days. Oklahoma officials attributed this timeliness problem to staff shortages and a surge in the number of complaints received in 2000, from about 5 per day to about 35. The rising volume of complaints is a particular problem for California, which receives about 10,000 complaints annually, and had a 20 percent increase in complaints from January 2001 through July 2002. State officials told us that California law requires all complaints alleging immediate jeopardy to a resident to be investigated within 24 hours and all others to be investigated within 10 days, and that the increase in the number of complaints requires an additional 32 surveyor positions.[27] CMS regional officials told us that the vast majority of California complaints were investigated within 10 days. However, the 2001 review also showed that about 9 percent of the state's standard surveys were conducted late.[28] Both CMS and California officials indicated that the priority the state attaches to investigating complaints affected survey timeliness. Officials

[25]In some states, the 10-day requirement significantly compressed the time frame in which complaints alleging potential actual harm must be investigated. For instance, prior to HCFA's change, such complaints were supposed to be investigated within 30 days in Michigan and 60 days in Tennessee.

[26]Staff from each of CMS's regional offices reviewed a 10 percent random sample of complaint files (maximum of 40 files) in each state.

[27]According to a state official, a hiring freeze precluded increasing the number of surveyors.

[28]Because CMS based its analysis of timeliness only on nursing homes that actually were surveyed during fiscal year 2001—and not on all homes in the state—the 9 percent figure is understated. Our analysis of all homes indicated that about 12 percent of the state's homes were not surveyed within the required time frame.

from Washington told us that their practice of investigating facility self-reported incidents led to their not meeting the 10-day requirement on all complaints that CMS reviewed. Washington investigated 18 of 20 sampled actual harm complaints on time—missing the 10-day requirement for the other two by 2 days and 4 days, respectively. Washington officials pointed out that the two complaints not investigated within 10 days were facility self-reported incidents and commented that many other states do not even require investigation of such incidents. Thus, in these other states, such incidents would not even have been included in CMS's review.

In its review of state complaint files, CMS also evaluated whether states had appropriately triaged complaints—that is, determined how quickly each complaint should be investigated. Most of the regions told us that one or more of their states had difficulty determining the investigation priority for complaints. In an extreme case, a regional office discovered that one of its states was prioritizing its complaints on the basis of staff availability rather than on the seriousness of the complaints. Several regions indicated that some states improperly assigned complaints to categories that permitted longer investigation time frames, and one region indicated that triaging difficulties involved state personnel not collecting enough information from the complainant to make a proper decision. Officials from some of the 16 state survey agencies we contacted indicated that HCFA's 1999 guidance to states on what constitutes an actual harm complaint was unclear and confusing.

In an effort to improve state responsiveness to complaints, HCFA hired a contractor in 1999 to assess and recommend improvements to state complaint practices. The study identified significant problems with states' complaint processes, including complaint intake activities, investigation procedures, and complaint substantiation practices.[29] For example, the report noted that 15 states did not have toll-free hotlines for the public to file complaints. In our earlier reports, we noted that the process of filing a complaint should not place an unnecessary burden on a complainant and that an easy-to-use complaint process should include a toll-free number that permits the complainant to leave a recorded message when state staff

[29]Center for Health Systems Research and Analysis at the University of Wisconsin, Madison, *Final Report: Complaint Improvement Project*, prepared for CMS, June 3, 2002. The report is based on a questionnaire sent to the 50 states, the District of Columbia, Puerto Rico, and CMS's 10 regional offices. Three states did not respond to the questionnaire. The report treated the District of Columbia and Puerto Rico as states.

are unavailable.[30] Table 5 summarizes major findings from the contractor's report to CMS.

Table 5: Key Findings of Report to CMS on State Complaint Investigation Processes

Finding	Description
States vary in the ease with which the public can file a complaint.	Thirty-four states indicated that they provide toll-free hotlines for the public to file complaints. Twenty-nine of the 34 states indicated that they operate their hotlines 24 hours a day, 7 days a week, and 5 said their hotlines were answered during business hours. Nineteen states had no provisions or plans to handle non-English speaking complainants.
States need to improve their complaint intake and triaging systems.	States need to better triage their complaints and decide which complaints should be referred to other agencies for investigation. They should also improve procedures for merging complaints with ongoing survey activities at a nursing home. More consistency is needed in handling facility self-reported incidents.
State survey staffs that conduct complaint intake and investigation often have additional duties.	States should use staff dedicated to investigating complaints to improve the quality of investigations. This might include assigning responsibility for a state's total complaint system to a single complaint supervisor or coordinator and also may require more careful hiring standards with specific job qualifications.
Investigation procedures vary across states.	States do not use all available data when preparing for a complaint investigation. There is little agreement among states regarding how many resident records should be sampled during a complaint investigation.[a]
Complaint investigation training is needed.	Specialized complaint training and periodic refresher training on complaint intake, triaging, and investigation techniques are needed to improve the quality of complaint investigations.
Resolution of complaints is inconsistent across states.	States have developed varying criteria for determining what constitutes a substantiated complaint and varying practices for communicating the results of investigations to complainants. Twenty-two states could not indicate how long it takes them to provide the results of an investigation to the complainant, and at least four states do not inform the complainant of the results.
Not all states have comprehensive complaint tracking systems, and CMS tracking systems are not up-to-date or user friendly.[b]	Twenty states indicated that they could track the status of complaints and produce summary reports.

Source: CMS.

[30]See GAO/HEHS-99-80 and U.S. General Accounting Office, *Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues*, GAO-02-382 (Washington, D.C.: July 19, 2002).

Note: GAO analysis of information from Center for Health Systems Research and Analysis at the University of Wisconsin, Madison, *Final Report: Complaint Improvement Project*, prepared for CMS, June 3, 2002.

[a]In 1999, we reported that HCFA had not provided states with guidance on when to expand a complaint review beyond the residents who were the subject of the original complaint. See GAO/HEHS-99-80.

[b]CMS is planning to implement a new complaint tracking system nationwide that should address this shortcoming.

States Did Not Refer a Substantial Number of Nursing Homes to CMS for Immediate Sanctions

State survey agencies did not refer 711 cases in which nursing homes were found to have a pattern of harming residents to CMS for immediate sanction as required by CMS policy.[31] Our earlier work found that nursing homes tended to "yo-yo" in and out of compliance, in part because HCFA rarely imposed sanctions on homes with a pattern of deficiencies that harmed residents.[32] In response, the agency required that homes found to have harmed residents on successive standard surveys be referred to it for immediate sanction.[33] Most states did not refer at least some cases that should have been referred under this policy.[34] Figure 1 shows the results of our analysis for the four states—Massachusetts, New York, Pennsylvania, and Texas—with the greatest numbers of cases that should have been

[31]Using CMS data, we identified 1,334 cases that appeared to meet the criteria for immediate sanctions but that did not appear to have been referred to CMS by states. (See app. I for a description of our methodology.) We use the term "cases" rather than "nursing homes" because some nursing homes had multiple referrals for immediate sanctions. At our request, CMS reviewed most of these cases and determined that 711 (62 percent of those CMS reviewed) should have been—but were not—referred for immediate sanction. CMS did not analyze 155 of the cases we asked it to examine and was unable to determine the status of an additional 30 cases.

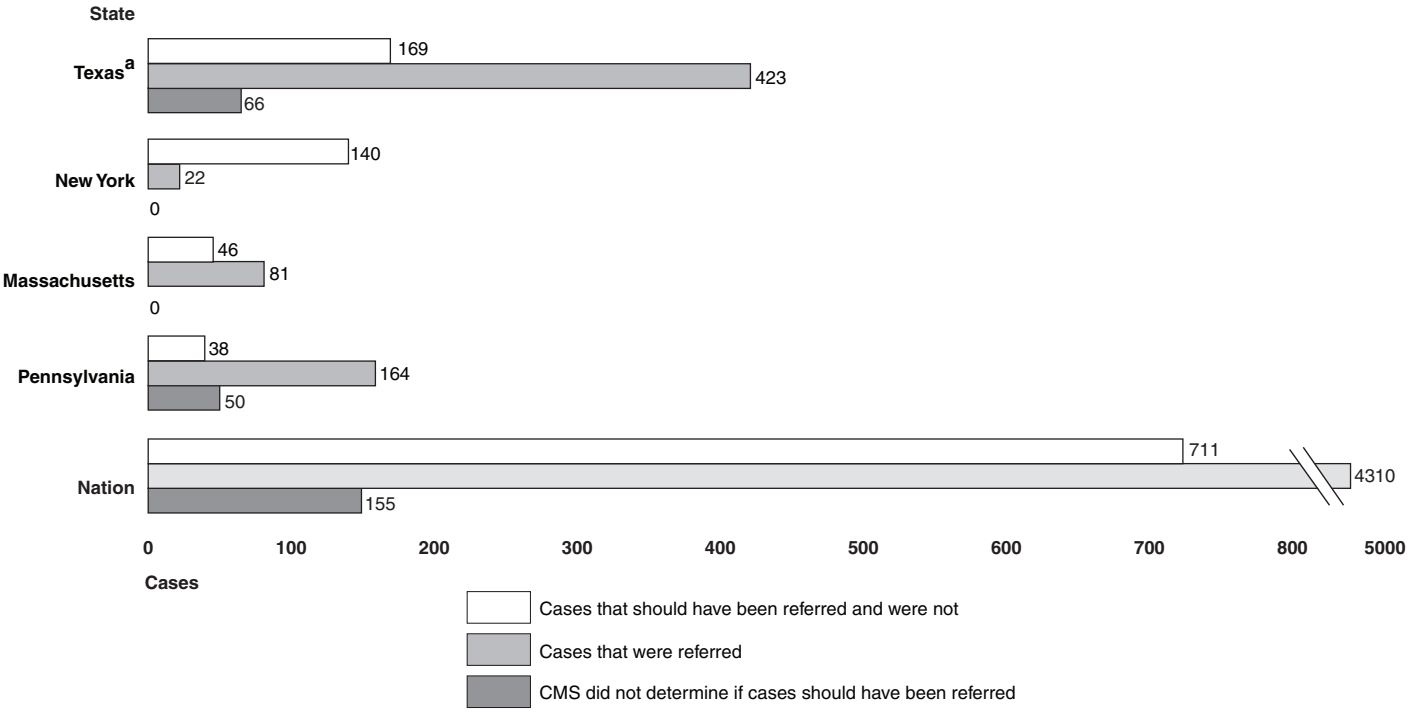
[32]See GAO/HEHS-99-46.

[33]This policy was implemented in two stages, and our analysis focused on implementation of the second stage in January 2000. Beginning in September 1998, HCFA required states to refer homes that had a pattern of harming a significant number of residents or placed residents at high risk of death or serious injury (H-level deficiencies and above on CMS's scope and severity grid). Effective January 14, 2000, HCFA expanded this policy by requiring state survey agencies to refer for immediate sanction homes that had harmed residents—G-level deficiencies on the agency's scope and severity grid—on successive surveys. States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G-L on CMS's scope and severity grid) in each of two surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

[34]We found that states did refer 4,310 cases over a 27-month period. See app. VI for a summary of all sanctions that were implemented, including the amount of civil money penalties (CMPs) by state.

referred and for the nation (see app. VII for information on all states). These four states accounted for 55 percent of the 711 cases.

Figure 1: Four States with the Greatest Number of Cases that Should Have Been Referred for Immediate Sanctions, January 14, 2000, through March 28, 2002



Source: GAO and CMS analysis of OSCAR and enforcement data.

Note: Analysis includes cases entered in CMS's enforcement database by March 28, 2002.

[a]According to a Dallas regional office official, Texas referred most of the 423 cases because the nursing homes had a "poor enforcement history," not because of repeat harm level deficiencies. However, based on other information, the region coded these cases as requiring immediate sanction.

State and CMS officials identified several reasons why state agencies failed to forward cases to CMS for immediate sanction, including (1) an initial misunderstanding of the policy on the part of some states and regions, (2) poor state systems for monitoring the survey history of homes to identify those meeting the criteria for referral for immediate sanction, and (3) actions, by two states, that were at variance with CMS policy. First, officials from some states—and some CMS regional officials as well—told

us that they did not initially fully understand the criteria for referring homes for immediate sanction.[35] For example, several states and CMS regional offices reported that they did not understand that CMS required states to look back before the January 2000 policy implementation date to determine if there was an earlier survey with an actual-harm-level deficiency. The look-back requirement was specifically addressed in a February 10, 2000, CMS policy clarification specifying that state agencies were to consider the home's survey history before the January 14, 2000, implementation date in determining if a home met the criteria for immediate referral for sanction. However, officials in one region told us that they had instructed three of four states not to look back before the January 2000 implementation date of the policy. Two other regional offices told us that CMS policy did not require the state to look back before January 2000 for earlier surveys. Officials at another regional office did not recall the look-back policy at the time we talked to them in mid-2002, and were not sure what advice they had given their states when the policy was first implemented.

Second, some state survey agencies told us that their managers responsible for enforcement did not have an adequate methodology for checking the survey history of homes to identify those meeting the criteria. Some states said that their managers relied on manual systems, which are less accurate and sometimes failed to identify cases that should have been referred. Officials in one state told us that its district offices had no consistent procedure for checking the survey history of homes. An official in another state told us that some cases were not referred because time lags in reporting some surveys meant that an earlier survey—such as a complaint survey—with an actual harm deficiency might not have been entered in the state's tracking system until after a later survey that also found harm-level deficiencies.

Third, two states did not implement CMS's expanded policy on immediate sanctions. New York was in direct conflict with CMS policy. Although CMS policy calls for state referrals to CMS regardless of the type of deficiency,

[35]Arizona's comments on a draft of this report indicated that eight of the nine cases not referred for immediate sanction were during the period January through October 2000 when the state was struggling with various interpretations of CMS's new requirement. Similarly, Missouri officials indicated in their comments that the majority of cases they did not refer occurred during the initial stages of the new policy, which Missouri believes was "complicated, at best." Missouri officials added that the number of missed cases significantly declined as the state gained a better understanding of the policy.

a state agency official told us that the state only referred a home to CMS for immediate sanction if both actual harm citations were for the exact same deficiency.[36] A CMS official indicated that New York began complying with the policy in September 2002.[37] Texas, the second state, did not implement the CMS policy statewide until July 2002, when it received our inquiry about the cases not referred for immediate sanction. In the interim from January 2000 through July 2002, three of Texas's 11 district offices specifically requested from state survey agency officials, and were granted, permission to implement the policy.

CMS Oversight of State Survey Activities Requires Further Strengthening

While CMS has increased its oversight of state survey and complaint activities and instituted a more systematic oversight process by initiating annual state performance reviews, CMS officials acknowledged that the effectiveness of the reviews could be improved. In particular, CMS officials told us that for the initial state performance review in fiscal year 2001, they lacked the capability to systematically distinguish between minor lapses identified during the reviews and more serious problems that require intervention. CMS oversight is also hampered by continuing limitations in OSCAR data, the inability or reluctance of some CMS regions to use such data to monitor state activities, and inadequate oversight of certain areas, such as survey predictability and state referral of homes for immediate enforcement actions. CMS has restructured regional office responsibilities to improve the consistency of federal oversight and plans to further strengthen oversight by increasing the number of federal comparative surveys. However, three federal initiatives critical to reducing the subjectivity evident in the current survey process and the investigation of complaints have been delayed.

[36]This New York state official told us that the state believed it was in compliance with CMS's policy because it imposed one of two minor federal sanctions and a state civil money penalty on all consecutive G-level cases. This state official also indicated that state fines were imposed in place of federal civil money penalties in all cases. (The maximum state fine is $2,000 per violation, lower than the federal maximum of $10,000 per instance or per day of noncompliance.) However, when we discussed this explanation with officials in the CMS central office, they disagreed that the state was in compliance.

[37]In commenting on a draft of our report, New York officials indicated that their initial failure to refer nursing homes for immediate sanctions was based on their misinterpretation of the new policy and not on a deliberate refusal to implement it. They also indicated that their procedures are now consistent with the federal policy.

CMS Reviews of State Performance Have Identified Areas for Improvement

In the first of what is planned as an annual process, CMS's 10 regional offices reviewed states' fiscal year 2001 performance for seven standards to determine how well states met their nursing home survey responsibilities (see app. VIII for a description of the seven standards).[38] This enhanced oversight of state survey agency performance responds to our prior recommendations. In 1999, we reported that HCFA's oversight of state efforts had limitations preventing it from developing accurate and reliable assessments of state performance.[39] HCFA regional office policies, practices, and oversight had been inconsistent, a reflection of coordination problems between HCFA's central office and its regional staffs. In important areas, such as the adequacy of surveyors' findings and complaint investigations, HCFA relied on states to evaluate their own performance and report their findings to HCFA. Although OSCAR data were available to HCFA for monitoring state performance, they were infrequently used, and neither the states nor HCFA's regional offices were held accountable for failing to meet or enforce established performance standards.

To promote consistent application of the standards across the 10 regions, the agency developed detailed guidance for measuring each standard, including the method of evaluation, the data sources to be used, and the criteria for determining whether a state met a standard. Only two states met each of the five standards we reviewed and many did not meet several standards. Appendix IX identifies the standards we analyzed and the results of CMS's review of these standards. During the 2001 review, CMS elected not to impose the most serious sanctions available for inadequate state performance, including reducing federal payments to the state or initiating action to terminate the state's agreement, but advised the states that annual reviews in subsequent years will serve as the basis for such actions. While imposing no sanctions during the 2001 review, CMS did require several states to prepare corrective action plans. Each year, CMS plans to update and improve the standards based on experience gained in prior years.

[38]The CMS regions assessed each state's performance by (1) reviewing a set of standardized reports drawn from information contained in CMS's databases and (2) visiting states to review procedures and to examine a sample of records, such as complaint investigation files. Some reviews, such as assessing state complaint investigation timeliness, were performed semiannually, enabling regional office staff to provide midpoint feedback intended to correct any deficiencies identified.

[39]GAO/HEHS-00-6.

CMS's State Performance Standards and Review Had Shortcomings

Characterizing its fiscal year 2001 state performance review as a "shakeout cruise," CMS is working to address several weaknesses identified during the reviews, including difficulty in determining if identified problems were isolated incidents or systemic problems, flawed criteria for evaluating a critical standard, and inconsistencies in how regional offices conducted the reviews. In our discussions of the results of the performance reviews with officials of CMS's regional offices, it was evident that some regions had a much better appreciation of the strengths and weaknesses of survey activities in their respective states than was reflected in the state performance reports. However, this information was not readily available to CMS's central office. In addition, CMS has not released a summary of the review to permit easy comparison of the results. For subsequent reviews, CMS plans to more centrally manage the process to improve consistency and help ensure that future reviews distinguish serious from minor problems.

Distinctions in State Performance Were Hard to Identify

CMS officials acknowledged that the first performance review did not provide adequate information regarding the seriousness of identified problems. The agency indicated that it had since revised the performance standards to enable it to determine the seriousness of the problems identified. Some regional office summary reports provided insufficient information to determine whether a state did not meet a particular standard by a wide or a narrow margin. For example, although California did not meet the standard to investigate all complaints alleging actual harm within 10 days, the regional office summary provided no details about the results. Regional officials told us that they found very few California complaints that were not investigated within the 10-day deadline and those that were not were generally investigated by the 13th day.[40] Conversely, although the report for Oregon shows that the state met the 10-day requirement, our discussions with regional officials revealed that serious shortcomings nevertheless existed in the state's complaint investigation practices. [41] Officials in the Seattle region told us that for many years Oregon had contracted out investigations of complaints to local government entities not under the control of the state agency and, as

[40]According to CMS regional officials, California state law requires that all complaints other than those alleging immediate jeopardy be investigated within 10 days, irrespective of the seriousness of the allegation.

[41]CMS's database showed that Oregon conducted only 14 on-site complaint investigations during fiscal year 2001. Because of this low number, the region reviewed the entire universe of complaints (instead of a sample), but did not identify the number reviewed in its report.

a result, exercised little control over the roughly 2,000 complaints the state receives against nursing homes each year. For instance, under this arrangement, information about complaint investigations, including deficiencies identified, was not entered into CMS's database. Regional officials told us that the Oregon state agency recently assumed responsibility for investigating complaints filed by the public, but that the local government entities continue to investigate facility self-reported incidents.

CMS's Standard for Measuring States' Documentation of Deficiencies Was Flawed

CMS's standard for measuring how well states document deficiencies identified during standard surveys was flawed because it mixed major and minor issues, blurring the significance of findings. CMS's protocol required assessment of 33 items, ranging from the important issue of whether state surveyors cited deficiencies at the correct scope and severity level to the less significant issue of whether they used active voice when writing deficiencies. Because of the complexity of the criteria and concerns about the consistency of regional office reviews of states' documentation practices, CMS decided not to report the results for this standard for 2001. For the 2002 review, CMS reduced the number of criteria to be assessed from 33 to 7.[42] Based on the available evidence of the understatement of actual harm deficiencies, we believe that successful implementation of the documentation standard in 2002 and future years is critical to help ensure that deficiencies are cited at the appropriate scope and severity level.

CMS Regions' Reviews Were Inconsistent

CMS's regional offices were sometimes inconsistent in how they conducted their reviews, raising questions about the validity and fairness of the results. For example:

- Although the guidelines for the review indicated that the regional offices were to assess the timeliness of complaint investigations based on the state's prioritization of the complaint, officials from one region told us that they judged timeliness based on their opinion of how the complaint should have been prioritized.

[42]CMS's criteria for evaluating the documentation standard in 2002 are (1) the proper regulation is cited for each deficiency, (2) evidence supports the cited area of noncompliance, (3) several components required by the relevant regulation for each deficiency, such as identifying the citation number, are included, (4) the deficient practice is identified, (5) the cited severity of each deficiency is accurate, (6) the cited scope of each deficiency is accurate, and (7) the sources and identifiers in the deficient practice statement match the sources and identifiers in the findings.

- Two regional offices acknowledged that they did not use clinicians to review complaint triaging. Officials from two states questioned the credibility of reviews not conducted by clinicians.
- Although one objective of the reviews was to review some immediate jeopardy complaints in every state, the random samples selected in some states did not yield such complaints. In such cases, one region indicated that it specifically selected a few immediate jeopardy complaints outside the sample while another region did not. To eliminate this inconsistency in future years, CMS has instructed the regions to expand their sample to ensure that at least two immediate jeopardy complaints are reviewed in each state.
- While some regions examined more than the required number of complaints to assess overall timeliness, one region felt that additional reviews were unnecessary. For instance, surveyors reviewing California, which receives thousands of complaints per year, expanded the number of complaints reviewed beyond the minimum number required because they felt that the required random sample of 40 complaints did not provide sufficient information about overall timeliness in the state. To assess overall timeliness, they visited all but 1 of the state's 17 district offices to review complaints. However, surveyors from another CMS region reviewed only 3 or 4 of the roughly 18 complaints a state received and told us that additional reviews were unnecessary because the state had already failed the timeliness criterion based on the few complaints reviewed. Although the review of 3 or 4 complaints technically met CMS's sampling requirement, we believe examination of most or all of the relatively few remaining complaints would have provided a more complete picture of the state's overall timeliness.

Performance Standards Excluded Some Important Areas

While CMS has addressed some of the weaknesses in its 2001 state performance review by revising the standards and guidance for the 2002 review, including simplifying the criteria for assessing documentation and requiring regions to assess states' complaint prioritization efforts separately from the timeliness issue, the performance standards do not yet address certain issues that are important for assessing state performance and that would further strengthen CMS oversight of state survey activities. These issues include:

- **Assessing the predictability of state surveys**. Although CMS monitored compliance with its requirement for state survey agencies to initiate at least 10 percent of their standard surveys outside normal working hours to reduce predictability, it did not examine compliance with its 1999 instructions for states to avoid scheduling a home's survey during the same month each year. As shown in app. V, our analysis of CMS data found that from 10 percent to 31 percent of surveys in 31 states were

predictable because they were initiated within 15 days of the 1-year anniversary of the prior survey.

- **Evaluating states' compliance with the requirement to refer nursing homes that have a pattern of harming residents for immediate sanctions**. CMS officials confirmed that there was no consistent oversight of state agencies' implementation of this policy. Several CMS regional offices generally did not know, for example, how their states were monitoring homes' survey history to detect cases that should be referred for immediate sanction. CMS could have used the enforcement database to determine that New York was not adhering to the agency's immediate sanctions policy. During calendar years 2000 and 2001, New York cited actual harm at a relatively high proportion of its nursing homes but only referred 19 cases for immediate sanction. Over a comparable period, New Jersey, a state with far fewer homes and citations, referred almost three times as many cases.[43]
- **Developing better measures of the quality of state performance, in addition to process measures**. Several CMS regional officials believed that the scope of the state performance standards should address additional areas of performance, including assessing the adequacy of nursing homes' plans of correction submitted in response to deficiencies and the appropriateness of states' recommended enforcement remedies. In particular, several regions noted that rather than focusing only on the timeliness of complaint investigations, regions should also assess the adequacy of the investigation itself, including whether the complaint should have been substantiated. The introduction of a new CMS complaint tracking database, discussed below, should enable regions to automate the review of complaint timeliness, thereby allowing them to focus more attention on such issues.

Data Limitations and Inconsistent Use of Periodic Reports Hamper Oversight

CMS's oversight of state survey activities is further hampered by limitations in the data used to develop the 19 periodic reports intended to assist the regions in monitoring state performance and by the regions' inconsistent use of the reports.[44] For instance, CMS's current complaint database does not provide key information about the number of

[43]While cases referred by states were typically recorded in CMS's enforcement database, a New York regional official indicated that because of the departure of key staff members, the region had not entered all cases into the database.

[44]CMS's central office and the regions have jointly produced the reports since they were created in 2000. As CMS's systems become more user-friendly, the regions will be able to produce them independently.

complaints each state receives (including facility self-reported incidents) or the time frame in which each complaint is investigated.[45] In addition, officials from one region emphasized to us that information about complaints provided in the reports did not correspond with CMS's required complaint investigation time frames. The reports identify the number of state on-site complaint investigations that took place in three different time periods—3 days, from 4 to 14 days, and 15 days or more; however, required time frames for complaint investigations are 2 days for complaints alleging immediate jeopardy and 10 days for those alleging harm. Additionally, a regional official pointed out that investigations shown in one of the reports as taking place within 3 days do not necessarily represent complaints that the state prioritized as immediate jeopardy. Despite the problems with these data, however, several regional offices indicated that the reports could at least serve as a starting point for discussions with states about their complaint programs and often lead to a better understanding of state complaint activities. CMS indicated that the deficiencies in complaint data should be addressed by the new automated complaint tracking system that it is developing for use by all states as part of the redesign of OSCAR.[46]

Officials from several regions also told us that the value of some of the 19 periodic reports was unclear, and officials in three regions said they either lacked the staff expertise or the time to use the reports routinely to oversee state activities. For example, officials in one region told us that

[45]As we reported previously, although HCFA standards require states to report information about complaints, the process for collecting it results in inaccurate and incomplete information. For example, the form CMS requires states to use to record the results of complaint investigations was created to record information about a single complaint, but many states investigate multiple complaints at a nursing home during one on-site visit. As a result, the timeliness, prioritization, and other important tracking information related to multiple complaints is reported as though it applies to one complaint. See GAO/HEHS-99-80.

[46]CMS planned to implement the new system, known as the ASPEN Complaint Tracking System, or ACTS, nationwide in October 2002. However, implementation was delayed because of several issues that surfaced during pilot testing: (1) states have different policies regarding the treatment of self-reported facility incidents, (2) complaints filed with some states may be investigated by entities other than the state survey agency (for instance, the Board of Nursing), and (3) 8 to 10 states have indicated that their current state complaint tracking systems have superior capability to ACTS and they do not wish to discontinue using their own system or maintain separate systems. CMS plans to evaluate this last issue during the extended pilot test. As of July 2003, nationwide implementation had been further delayed by the need to obtain approval from the Office of Management and Budget for publication of a notice in the *Federal Register*, a procedure that applies to establishing a system of federal records.

they used one of the reports about complaints to ask states questions about their prioritization practices. But a different region appeared unaware that the reports showed that two of its states might be outliers in terms of the percentage of complaints they prioritized as actual harm or immediate jeopardy. Additionally, because the periodic reports do not include trend data, many regional offices were unaware of the trends in the percentage of homes cited in their states for actual harm or immediate jeopardy. We believe that such data could be useful to CMS's regions in identifying significant trends in their states.

CMS indicated that it is continuing to make progress in redesigning the OSCAR reporting system. In 1999, we recommended that the agency develop an improved management information system that would help it track the status and history of deficiencies, integrate the results of complaint investigations, and monitor enforcement actions.[47] Another objective of the OSCAR redesign is to make it easier to analyze the data it contains, addressing the problem that generating analytical reports from OSCAR was difficult and most regions lacked the expertise to do so. The redesigned system, called the Quality Improvement and Evaluation System, would also eliminate the need for duplicate data entry, which should reduce the potential for data entry errors to which OSCAR is susceptible.[48] CMS has faced some problems in the implementation of the new system, such as inadvertent modifications of survey data results when data are transferred from the old OSCAR database into the new system, but the agency indicated that its target date for completing the redesign is 2005.

CMS Is Making Progress but Also Encountering Delays in Several Key Efforts

CMS has taken, or is undertaking, several other efforts to improve federal oversight and survey procedures, including making structural changes to the regional offices to improve coordination, expanding the number of comparative surveys conducted each year, improving the survey methodology, developing clearer guidance for surveyors, and developing additional guidance to states for investigating complaints. As of April 2003, only the effort to restructure the regional offices had been completed. The

[47]GAO/HEHS-99-46.

[48]Until recently, states had to manually enter data into a computerized system that generated survey reports and then manually reenter much of the same data into OSCAR. This duplicative data entry process increased the chances for errors in OSCAR.

other efforts critical to reducing the subjectivity evident in the current survey process and the investigation of complaints have been delayed.

CMS Is Taking Additional Steps to Address Inconsistencies in Regional Office Performance and Improve Federal Oversight

In December 2002, CMS reduced the number of regional managers in charge of survey activities from 10 (1 per region) to 5, a change intended to provide more management attention to survey matters and to improve accountability, direction, and leadership. Our prior and current work found that regional offices' policies, practices, and oversight were often inconsistent. For example, in 1999 we reported that regional offices used different criteria for selecting and conducting comparative surveys. The 5 regional managers will be responsible only for survey and certification activities, while in the past many of the 10 were also responsible for managing their regions' Medicaid programs.

In response to our prior recommendations, CMS plans to more than double the number of federal comparative surveys in which federal surveyors resurvey a nursing home within 2 months of the state survey to assess state performance. We noted in 1999 that, although insufficient in number, comparative surveys were the most effective technique for assessing state agencies' abilities to identify serious deficiencies in nursing homes because they constitute an independent evaluation of the state survey. CMS plans to hire a contractor to perform approximately 170 additional comparative surveys per year, bringing the annual total of comparative surveys performed by both CMS surveyors and the contractor to about 330. Although CMS had intended to award a contract and begin surveys by spring 2003, as of July 2003, it was still in the process of identifying qualified contractors. CMS officials stated that using a contractor would provide CMS flexibility because if it suspects that a state or region is having problems with surveys, it can quickly have the contractor conduct several comparative surveys there. Being able to direct the contractor to quickly focus on states or regions where state surveys may be problematic could represent a significant improvement in CMS's oversight of state survey agencies.

Key Initiatives to Improve Survey Consistency and Complaint Investigations Have Been Delayed

CMS's implementation schedules have slipped for three critical initiatives intended to enhance the consistency and accuracy of state surveys and complaint investigations, delaying the introduction of improved methodologies or guidance until 2003 or 2004. Because surveyors often missed significant care problems due to weaknesses in the survey process, HCFA took some initial steps to strengthen the survey methodology, with the goal of introducing an improved survey process in 2000. In July 1999, the agency introduced quality indicators to help surveyors do a better job of selecting a resident sample, instructed states to increase the sample size

in areas of particular concern, and required the use of investigative protocols in certain areas, such as pressures sores and nutrition, to help make the survey process more systematic.[49] However, HCFA recognized that additional steps were required to ensure that surveyors thoroughly and systematically identify and assess care problems.

To address remaining problems with sampling and the investigative protocols, CMS contracted for the development of a revised survey methodology. The contractor has proposed a two-phase survey process.[50] In the first phase, surveyors would initially identify potential care problems using quality indicators generated off-site prior to the start of the survey and additional, standardized information collected on-site, from a sample of as many as 70 residents. During the second phase, surveyors would conduct an investigation to confirm and document the care deficiencies initially identified.[51] According to CMS officials, this process differs from the current methodology because it would more systematically target potential problems at a home and give surveyors new tools to more adequately document care outcomes and conduct on-site investigations. Use of the new methodology could result in survey findings that more accurately identify the quality of care provided by a nursing home to all of its residents.[52] Initial testing to evaluate the proposed methodology focused primarily on the first phase and was completed in

[49]Quality indicators are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in a state. By using the quality indicators to select a preliminary sample of residents before the on-site review, surveyors are better prepared to identify potential care problems.

[50]The agency is committed to implementing only those portions of the new methodology that are proven to be significantly more effective than the current survey methodology. CMS officials said the new process must be manageable and easy to use, add no additional time to surveys, and require limited additional training resources. Given the high turnover among surveyors and state budget constraints, the agency is particularly concerned about imposing new training requirements that would interfere with the conduct of mandatory surveys.

[51]A minimum of three residents would be included in the sample for each of the care problems identified in phase one, which covers as many as 33-35 resident-care areas.

[52]The goals of the new survey methodology are to (1) ensure that all areas of care are addressed, (2) make the survey process more data-driven and less reliant on surveyor judgment, thus reducing variability in the citation of serious deficiencies, (3) focus surveyors' attention more on nursing homes with poor quality and less on better performing homes, (4) more reliably determine the scope of deficiencies at nursing homes, that is, the number of residents potentially or actually affected, and (5) produce better documented and defensible survey deficiencies.

three states during 2002. As of April 2003, a CMS official told us that the agency lacked adequate funding to conduct further testing that more fully incorporates phase two. As a result, it is not clear when changes to survey methodology will be implemented. We continue to believe that redesign of the survey methodology, under way since 1998, is necessary for CMS to fully respond to our past recommendation to improve the ability of surveys to effectively identify the existence and extent of deficiencies. While CMS's goal of not adding additional time to surveys is an important consideration, it should not take priority over the goal of ensuring that surveys are as effective as possible in identifying the quality of care provided to residents.

Recognizing inconsistencies in how the scope and severity of deficiencies are cited across states, in October 2000, HCFA began developing more structured guidance for surveyors, including survey investigative protocols for assessing specific deficiencies. The intent of this initiative is to enable surveyors to better (1) identify specific deficiencies, (2) investigate whether a deficiency is the result of poor care, and (3) document the level of harm resulting from a home's identified deficient care practices. The areas originally targeted for this initiative included deficiencies related to pressure sores, urinary catheters and incontinence, activities programming, safe food handling, and nutrition. Delays have occurred because CMS is committed to incorporating the work of multiple expert panels and two rounds of public comments for each deficiency. The project has been further delayed because the approach used to identify resident harm shifted during the course of work. The process should proceed more quickly, however, now that CMS has developed its approach. CMS expected to release the first new guidance, addressing pressure sores, in early 2003, but officials were unable to tell us how many of the 190 federal nursing home requirements will ultimately receive new guidance or a specific time line for when this initiative will be completed.[53] As discussed earlier, CMS's state performance reviews include an assessment of state surveyors' documentation of the scope and severity of a sample of deficiencies cited, which should provide CMS with an opportunity to assess the effectiveness of the new guidance.

Finally, despite initiation of a complaint improvement project in 1999, CMS has not yet developed detailed guidance for states to help improve their complaint systems. Effective complaint procedures are critical

[53]As of July 2003, the guidance had not yet been released.

because complaints offer an opportunity to assess nursing home care between standard surveys, which can be as long as 15 months apart. In 1999, HCFA commissioned a contractor to assess and recommend improvements to state complaint practices. CMS received the contractor's final report in June 2002, and indicated agreement with the contractor that reforming the complaint system is urgently needed to achieve a more standardized, consistent, and effective process. The study identified serious weaknesses in state complaint processes (see table 5) and made numerous recommendations to CMS for strengthening them. Key recommendations were that CMS increase direction and oversight of states' complaint processes and establish mechanisms to monitor states' performance. CMS indicated that it has already taken steps to address these recommendations by initiating annual performance reviews that include evaluating the timeliness of state complaint investigations and the accuracy of states' complaint triaging decisions, and by developing the new ASPEN complaint tracking system, which should provide more complete data about complaint activities than the current system. The contractor also recommended that CMS (1) expand outreach for the initiation of complaints, such as use of billboards or media advertising, (2) enhance complaint intake processes by using professional intake staff, (3) improve investigation and resolution processes by using available data about the home being investigated and establishing uniform definitions and criteria for substantiating complaints, (4) make the process more responsive by conducting timely investigations and allowing the complainant to track the progress of the investigation, and (5) establish a higher priority for complaint investigations in the state survey agency. CMS noted that some of these recommendations are beyond the agency's purview and will require the support of all stakeholders to accomplish. CMS told us that it plans to issue new guidance to the states in late fiscal year 2003—about 4 years after the complaint improvement project initiative was launched.

Conclusions

As we reported in September 2000, continued federal and state attention is required to ensure necessary improvements in the quality of care provided to the nation's vulnerable nursing home residents. The reported decline in the percentage of homes cited for serious deficiencies that harm residents is consistent with the concerted congressional, federal, and state attention focused on addressing quality-of-care problems. More active and data-driven oversight is increasing CMS's understanding of the nature and extent of weaknesses in state survey activities. Despite these efforts, however, the proportion of homes reported to have harmed residents is still unacceptably high. It is therefore essential that CMS fully implement

key initiatives to improve the rigor and consistency of state survey, complaint investigation, and enforcement processes.

The seriousness of the challenge confronting CMS in ensuring consistency in state survey activities is also becoming more apparent. Our work, as well as that of CMS, demonstrates the persistence of several long-standing problems and also provides insights on factors that may be contributing to these shortcomings:

- state surveyors continue to understate serious deficiencies that caused actual harm or placed residents in immediate jeopardy;
- deficiencies are often poorly investigated and documented, making it difficult to determine the appropriate severity category;
- states focus considerable effort on reviewing proposed actual harm deficiencies, but many have no quality assurance processes in place to determine if less serious deficiencies are understated or have investigation and documentation problems;
- the timing of too many surveys remains predictable, allowing problems to go undetected if a home chooses to conceal deficiencies;
- numerous weaknesses persist in many states' complaint processes, including the lack of consumer toll-free hotlines in many states, confusion over prioritization of complaints, inconsistent complaint investigation procedures, and the failure of most states to investigate all complaints alleging actual harm within 10 days, as required; and
- states did not refer a substantial number of homes that had a pattern of harming residents to CMS for immediate sanctions.

Over the past several years, CMS has taken numerous steps to improve its oversight of state survey agencies, but needs to continue its efforts to help better ensure consistent compliance with federal requirements. Several areas that require CMS's ongoing attention include (1) the newly established standard performance reviews to ensure that critical elements of the review, such as assessing states' ability to properly document deficiencies, are successfully implemented, (2) the successful modernization of CMS's data system by 2005 to support the survey process and provide key information for monitoring state survey activities, (3) the planned expansion of comparative surveys to improve federal oversight of the state survey process, (4) the survey methodology redesign intended to make the survey process more systematic, (5) the development of more structured guidance for surveyors to address inconsistencies in how the scope and severity of deficiencies are cited across states, and (6) the provision of detailed guidance to states to ensure thorough and consistent complaint investigations. Some of these efforts have been under way for

several years, and CMS has consistently extended their estimated completion and implementation dates. We believe that effective implementation of planned improvements in each of these six areas is critical to ensuring better quality care for the nation's 1.7 million nursing home residents.

Recommendations for Executive Action

To strengthen the ability of the nursing home survey process to identify and address problems that affect the quality of care, we recommend that the Administrator of CMS

- finalize the development, testing, and implementation of a more rigorous survey methodology, including guidance for surveyors in documenting deficiencies at the appropriate level of scope and severity.

To better ensure that state survey and complaint activities adequately address quality-of-care problems, we recommend that the Administrator

- require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.
- finalize the development of guidance to states for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to residents; the handling of facility self-reported incidents; and the use of appropriate complaint investigation practices.

To better ensure that states comply with statutory, regulatory, and other CMS nursing home requirements designed to protect resident health and safety, we recommend that the Administrator

- further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.

Agency and State Comments and Our Evaluation

We provided a draft of this report to CMS and the 22 states we contacted during the course of our review. (CMS's comments are reproduced in app. X.) CMS concurred with our findings and recommendations, stating that it already had initiatives under way to improve the effectiveness of the survey process, address the understatement of serious deficiencies, provide better data on state complaint activities, and improve the annual federal performance reviews of state survey activities. Although CMS concurred with our recommendations, its comments on intended actions did not fully address our concerns about the status of the initiative to improve the effectiveness of the survey process or the recommendation regarding state quality assurance systems. Eleven of the 22 states also commented on our draft report.[54] CMS and state comments generally covered five areas: survey methodology, state quality assurance systems, definition of actual harm, survey predictability, and resource constraints.

Survey Methodology Redesign

In response to our recommendation that the agency finalize the development, testing, and implementation of a more rigorous nursing home survey methodology, under way since 1998, CMS commented that it had already taken steps to improve the effectiveness of the survey process, such as the development of surveyor guidance on a series of clinical issues.[55] However, the agency did not specifically comment on any actions it would take to finalize and implement its new survey methodology, which is broader than the actions CMS described. Our draft report noted that, earlier this year, CMS said it lacked adequate funding for the additional field testing needed to implement the new survey methodology. Through September 2003, CMS will have committed $4.7 million to this effort. While CMS did not address the lack of adequate funding in its comments on our draft report, a CMS official subsequently told us that about $508,000 has now been slated for additional field testing. This amount, however, has not yet been approved. Not funding additional field testing could jeopardize the entire initiative, in which a substantial investment has already been made. We continue to believe that CMS should implement a revised survey methodology to address our 1998

[54]States that commented included Alabama, Arizona, California, Connecticut, Iowa, Missouri, Nebraska, New York, Pennsylvania, Tennessee, and Virginia.

[55]Our draft report discussed the problems CMS encountered in developing this guidance and pointed out that the guidance on the first clinical issue to be addressed, pressure sores, was expected in early 2003. As of July 2003, the guidance had not yet been released.

finding that state surveyors often missed significant care problems due to weaknesses in the survey process.

State Quality Assurance Systems

We recommended that CMS require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm to help reduce instances of understated quality-of-care problems. CMS commented on the importance of this concept and noted it had already incorporated such reviews into CMS regional offices' reviews of the state performance standards. However, the agency did not indicate whether it would require states to initiate an ongoing process that would evaluate the appropriateness of the scope and severity of documented deficiencies, as we recommended. While federal oversight is critical, the annual performance reviews conducted by federal surveyors examine only a small, random sample of state survey reports and should not be considered a substitute for appropriate and ongoing state quality assurance mechanisms. In its comments, New York stated that, in April 2003, it had implemented a process consistent with our recommendation and it had already realized positive results. New York is using the results of these reviews to provide surveyor feedback and expects that instances where deficiencies may be understated will decrease. California also commented that it fully supports this recommendation but indicated that a new requirement could not be implemented without additional resources.

State Resource Constraints

Officials from five states indicated that resource shortages are a challenge in meeting federal standards for oversight of nursing homes. Alabama commented that there is a relationship among (1) the scheduling of nursing home standard surveys, (2) the number and timing of complaint surveys, (3) the tasks that must be accomplished during each survey, and (4) the resources that are available to state agencies. According to Alabama, the funding provided by CMS is insufficient to meet all of the CMS workload demands, and many of the serious problems identified in our draft report were attributable to insufficient funding for state agencies to hire and retain the staff necessary to do the required surveys. For example, Alabama indicated that the inability of some states to meet survey time frames—maintaining a 12-month average between standard surveys and investigating complaints alleging actual harm within 10 days—is almost always the result of states not having enough surveyors to accomplish the required workload.

Comments from other states echoed Alabama's concerns about the adequacy of funding provided by CMS. Arizona said that, in order to hire and retain qualified surveyors, it increased surveyor salaries in 2001. Because CMS did not increase the state's survey and certification budget to accommodate these increases, the state left surveyor positions unfilled and curtailed training to make up for the funding shortfall. Arizona also observed that CMS's priorities sometimes conflict, further complicating effective resource use. CMS's performance standards require states to investigate all complaints alleging immediate jeopardy or actual harm in 2 and 10 days, respectively. For budgeting purposes, however, CMS ranks complaint investigations as a lower priority than annual surveys and instructs states to ensure that annual surveys will be completed before beginning work on complaints. California and Connecticut officials said that the growing volume of complaints in their states, combined with limited resources, is a concern. California officials observed that the growth in the number of complaints, coupled with the lack of significant funding increase from CMS, has made it impossible to meet all federal and state standards. They added that they received a 3-percent increase in survey funding from fiscal years 2000 through 2003, but documented the need for a 24-percent increase over this period. As noted in our draft report, the higher priority California attaches to investigating complaints affected survey timeliness—about 12 percent of the state's homes were not surveyed within the required 15 months. Connecticut indicated that 90 percent of the complaints it receives allege actual harm and require investigation within 10 days, but that with fairly stagnant budget allocations from CMS, its ability to initiate investigations of so many complaints within 10 days was limited. CMS's fiscal year 2001 state performance review found that Connecticut did not investigate about 30 percent of the sampled actual harm complaints in a timely manner. Although not specifically mentioning resources, New York noted that the increasing volume of complaints was a concern and indicated that any assistance CMS could provide would be welcome.

Definition of Actual Harm

Comments from four states on our analysis of a sample of survey deficiencies from homes with a history of harming residents revealed state confusion about CMS's definition of actual harm and immediate jeopardy, a situation that contributes to the variability in state deficiency trends shown in table 2. CMS's written comments did not address our review of these deficiencies; however, during an interview to follow up on state comments, CMS officials told us that they agreed with our determinations of actual harm as detailed in appendix III.

Arizona and California agreed that some of the deficiencies we reviewed for nursing homes in their states should have been cited at the level of actual harm. However, their disagreement regarding others stemmed from differing interpretations of CMS guidance, particularly the language on the extent of the consequences to a resident resulting from a deficiency.[56] For example, Arizona stated that one of the two deficiencies we reviewed could not be supported at the actual harm level because the injuries from multiple falls—including skin tears and lacerations of the extremities and head requiring suturing—did not compromise the residents' ability to function at their highest optimal level (table 8, Arizona 3). In these cases, it was documented that nursing home staff had failed to implement plans of care intended to prevent such falls. In contrast, California agreed with us that state surveyors should have cited actual harm for similar injuries resulting from falls—head lacerations and a minimal impaction fracture of the hip—due to the inappropriate use of bed side rails (table 8, California 9). CMS officials noted that the definition of actual harm uses the term "well-being" rather than function because harm can be psychological as well as physical. Moreover, they indicated that whether the consequence was small or large was irrelevant to determining harm. CMS central office officials acknowledged that the language linking actual harm to practices that have "limited consequences" for a resident has created confusion for state surveyors and that this reference will be eliminated in an upcoming revision of the guidance.

Regarding preventable stage II pressure sores, California stated that guidance received from CMS's San Francisco regional office in November 2000 precluded citing actual harm unless the pressure sores had an impact on residents' ability to function.[57] According to a California official, this and similar guidance on weight loss was the CMS regional office's reaction to the growing volume of appeals by nursing homes of actual harm

[56]CMS guidance to states in the *Medicare State Operations Manual* defines actual harm as "noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident."

[57]Stages of pressure sore formation are I—skin of involved area is reddened; II—upper layer of skin is involved and blistered or abraded; III—skin has an open sore and involves all layers of skin down to underlying connective tissue; and IV—tissue surrounding the sore has died and may extend to muscle and bone and involve infection.

citations as well as a reaction to administrative law hearing decisions.[58] Prior to this written guidance, which California received in late 2000, it routinely cited preventable stage II pressure sores as actual harm. The guidance noted that small stage II pressure sores seldom cause actual harm because they have the potential to heal relatively quickly and are usually of limited consequence to the resident's ability to function. We discussed the San Francisco regional office guidance with another regional office as well as with CMS central office officials, who agreed that the San Francisco region's pressure sore guidance was inconsistent with CMS's definition of harm, which judges the impact of a deficiency on a resident's "well-being" rather than functioning. Moreover, central office officials indicated that the regional office's guidance should have been submitted to CMS's Policy Clearinghouse for approval. This entity was created in June 2000 to ensure that regional directives to states are consistent with national policy. San Francisco regional office officials indicated that the individual responsible for the guidance provided to California had since left the agency.

California also disagreed with our assessment that state surveyors should have cited immediate jeopardy for a resident who repeatedly wandered (eloped) outside the facility near a busy intersection. According to state officials, California's policy on immediate jeopardy requires the surveyor to witness the incident. A San Francisco regional office official told us that surveyors did not have to witness an elopement to cite immediate jeopardy. An official from a different regional office agreed and noted that repeated elopements suggested the existence of a systemic problem that warranted citation of immediate jeopardy.

Although Iowa and Nebraska did not comment specifically on the deficiencies in their surveys that we determined to be actual harm, they did address the definition of harm and the role of surveyor judgment in classifying deficiencies. Iowa officials indicated that a more precise definition of harm is needed because of varying emphasis over the last several years on the degree of harm—harm that has a small consequence for the resident or serious harm. Nebraska commented that we may have based our conclusion that two deficiencies in its surveys should have been cited at the actual harm level on insufficient information because citing

[58]Nursing homes can appeal civil money penalties imposed by CMS when they are found to have serious deficiencies. The appeals are decided by the Department of Health and Human Service's Departmental Appeals Board.

actual harm is a judgment call that varies among state and federal surveyors based on experience and expertise. As noted in our draft report, we found sufficient evidence in the surveys we reviewed to conclude that some deficiencies should have been cited as actual harm because a deficient practice was identified and linked to documented actual harm.

Survey Predictability

CMS, Arizona, and Iowa commented that nursing home surveys, as currently structured, are inherently predictable because of the statutory requirement to survey nursing homes on average every 12 months with a maximum interval of 15 months between each home's survey. We agree but believe that survey predictability could be further mitigated by segmenting the surveys into more than one visit, a recommendation we made in 1998 but that CMS has not implemented.[59] Currently, surveys are comprehensive reviews that can last several days and entail examining not only a home's compliance with resident care standards but also with administrative and housekeeping standards. Dividing the survey into segments performed over several visits, particularly for those homes with a history of serious deficiencies, would increase the presence of surveyors in these homes and provide an opportunity for surveyors to initiate broader reviews when warranted. With a segmented set of inspections, homes would be less able to predict their next scheduled visit and adjust the care they provide in anticipation of such visits.

CMS also commented that our report captures only the number of days since the prior survey and does not take into account other predictors, for example the time of day or day of the week. Rather than segmenting standard surveys as we earlier recommended, the agency instructed states to reduce survey predictability by starting at least 10 percent of surveys outside the normal workday—either on weekends, in the early morning, or in the evening. It also instructed states to avoid, if possible, scheduling a home's survey for the same month as its previous standard survey. Though varying the starting time of surveys may be beneficial, this initiative is too limited in reducing survey predictability, as evidenced by our finding that 34 percent of current surveys were predictable. Arizona commented that it was unaware of any CMS guidance to avoid scheduling a home's survey for the same month of the year as the home's previous standard survey

[59]U.S. General Accounting Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, GAO/HEHS-98-202 (Washington, D.C.: July 27, 1998).

and indicated the state will now incorporate the requirement into its scheduling process.

Comments from CMS and Arizona stated that the window of time for a survey to be unpredictable was limited and, as a result, little could be done to reduce predictability. CMS's technical comments noted that many states have annual state licensing inspection requirements that would limit the window available to conduct surveys to 9 to 12 months after the prior survey, particularly since most inspections are done in conjunction with the federal survey to maximize available resources. CMS, however, was unable to provide a list of such states. None of the 10 states we subsequently contacted had state licensure inspection requirements that would explain their high levels of survey predictability.[60] Arizona commented that the state's licensing inspections are triggered by facilities applying to renew their licenses 60-120 days before their annual license expires. Due to budgetary constraints, Arizona conducts both this state and the federal survey at the same time. While not a requirement, the state strives to complete surveys during this 60-120 day period of time. Thus, nursing homes in Arizona may have some level of control over when federal surveys are conducted, particularly when the state begins complying with CMS guidance to avoid scheduling a home's survey for the same month as its previous survey. As we reported in September 2000, Tennessee also had an annual licensing inspection requirement that contributed to survey predictability, but the state modified its law to permit homes to be surveyed at a maximum interval of 15 months.[61] Since then, the proportion of predictable surveys in Tennessee decreased from about 56 percent to 29 percent. Arizona also stated that surveys had to be conducted within a 45-day window after the 1-year anniversary of the prior survey to be considered unpredictable.[62] Arizona's comments erroneously assume that a survey cannot take place before the 1-year anniversary of the prior survey. There is no prohibition on resurveying a home prior to the 1-year anniversary of its last survey, and many states do so. In fact,

[60]We contacted 10 states that were included in our review and that had a significant percentage of predictable surveys—Alabama, California, Connecticut, Maryland, Nebraska, New York, Oklahoma, Tennessee, Virginia, and Washington. As shown in table 10 (see app. V), the proportion of predictable surveys in these states ranged from 29 percent to 83 percent.

[61]See GAO/HEHS-00-197.

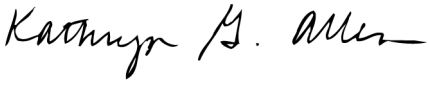
[62]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys.

from October 1, 2000 through September 30, 2001, Arizona conducted 23 percent of its surveys before the 1-year anniversary.

CMS provided several technical comments that we incorporated as appropriate.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services and appropriate congressional committees. We also will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please contact me at (202) 512-7118 or Walter Ochinko, Assistant Director at (202) 512-7157 if you or your staffs have any questions. GAO staff acknowledgments are listed in appendix XI.



Kathryn G. Allen
Director, Health Care—Medicaid
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Appendix I: Scope and Methodology

This appendix describes our scope and methodology following the order that findings appear in the report.

Nursing home deficiency trends. To identify trends in the proportion of nursing homes cited for actual harm or immediate jeopardy, we analyzed data from CMS's OSCAR system. We compared standard survey results for three approximately 18-month periods: (1) January 1, 1997, through June 30, 1998, (2) January 1, 1999, through July 10, 2000, and (3) July 11, 2000, through January 31, 2002. Because surveys are to be conducted at least once every 15 months (with a required 12-month state average), it is possible that a facility was surveyed more than once in a time period. To avoid double counting of facilities, we included only the most recent survey of a facility from each of the time periods. The data from the two earliest time periods were included in our September 2000 report.[1] We updated our earlier analysis of surveys conducted from January 1, 1999, through July 10, 2000, because it excluded approximately 300 surveys that had been conducted but not entered into OSCAR at the time we conducted our analysis in July 2000.

Sample of state survey reports. To assess the trends in actual harm and immediate jeopardy deficiencies discussed above, we (1) identified 14 states in which the percentage of homes cited for actual harm had declined to below the national average since mid-2000 or was consistently below that average and (2) reviewed 76 survey reports from homes that had G-level or higher quality-of-care deficiencies on prior surveys but whose current survey had quality-of-care deficiencies at the D or E level, suggesting that the homes had improved.[2] All the surveys we reviewed were conducted from July 2000 through April 2002. Our review focused on four quality-of-care requirements that are the most frequently cited nursing home deficiencies nationwide (see table 6). According to OSCAR data, 99 surveys in the 14 states conducted on or after July 2000 documented a D- or E-level deficiency in at least one of these four quality-of-care requirements. We reviewed all such deficiencies in surveys from 13 states but randomly selected 22 surveys from California, which cited the majority (45) of these deficiencies. In reviewing the surveys, we looked for a description of the resident's diagnoses, any assessment of special problems, and a description of the care plan and physician orders

[1]GAO/HEHS-00-197.

[2]The 14 states are Alabama, Arizona, California, Iowa, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, Virginia, West Virginia, and Wisconsin.

connected with the deficiency identified. We also looked for a clear statement of the home's deficient practice and the relationship between the deficiency and the care outcome.

Table 6: Quality of Care Requirements Reviewed in a Sample of State Survey Reports

Nursing home quality of care requirements	Description
Necessary care and services	Facility must provide the necessary care and services for each resident to attain or maintain the highest practicable well-being.
Pressure sores	Facility must ensure residents entering facility without pressure sores do not develop sores, unless the individual's clinical condition indicates the pressure sores were unavoidable, and that residents with sores receive necessary treatment to promote healing, prevent infection, and prevent new sores.
Prevention of accidents	Facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents.
Maintenance of nutrition	Facility must ensure each resident maintains acceptable parameters of nutritional status, such as body weight.

Source: CMS's *Medicare State Operations Manual.*

Federal comparative surveys. In September 2000, we reported on the results of 157 comparative surveys completed from October 1998 through May 2000.[3] To update our analysis, we asked each CMS region to provide the results of more recent comparative surveys, including data on the corresponding state survey. The regions identified and provided information on the deficiencies identified in 277 comparative surveys that were completed from June 2000 through February 2002.[4]

Survey predictability. In order to determine the predictability of nursing home surveys, we analyzed data from CMS's OSCAR database. We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior survey or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys. Consistent with CMS's interpretation, we used 15.9 months as the maximum allowable interval between surveys. Because homes know the maximum allowable interval between surveys, those

[3]See GAO/HEHS-00-197.

[4]One of the comparative surveys in our updated analysis was completed in May 2000.

whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

Complaints. We analyzed the results of CMS's state performance review for fiscal year 2001 to determine states' success in investigating both immediate jeopardy complaints and actual harm complaints within time frames required either by statute or by CMS instructions. To better understand the results of state performance as determined by CMS's review, we interviewed officials from CMS's 10 regional offices and 16 state survey agencies (see state performance standards below for a description of how these states were chosen).[5] We also reviewed the report submitted to CMS by its contractor, which was intended to assess and recommend ways to strengthen state complaint practices.[6] Finally, to assess the implementation of CMS's new automated system for tracking information about complaints, we reviewed CMS guidance materials and interviewed CMS officials and state survey agency officials from our 16 sample states.

Enforcement. To determine if states had consistently applied the expanded immediate sanction policy, we analyzed state surveys in OSCAR that were conducted before April 9, 2002, and identified homes that met the criteria for referral for immediate sanction. We included surveys conducted prior to the implementation of the expanded immediate sanction policy because actual harm deficiencies identified in such surveys were to be considered by states in recommending a home for immediate sanction beginning in January 2000. To be affected by CMS's expanded policy, a home with actual harm on two surveys must have an intervening period of compliance between the two surveys. Because OSCAR is not structured to consistently record the date a home with deficiencies returned to compliance, we had to estimate compliance dates using revisit dates as a proxy. We compared the results of our analysis to CMS's enforcement database to determine if CMS had opened enforcement cases for the homes we identified. Our analysis compared the survey date in OSCAR to the survey date in CMS's enforcement database. We considered any survey date in the enforcement database within 30 days of the OSCAR survey date to be a match. CMS officials reviewed and

[5]We contacted officials in Alabama, California, Colorado, Connecticut, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New York, Oklahoma, Pennsylvania, Tennessee, Washington, and Virginia.

[6]Center for Health Systems Research and Analysis at the University of Wisconsin, Madison.

concurred with our methodology. We then asked CMS to analyze the resulting 1,334 unmatched cases to determine if a referral should have been made.[7]

State performance standards. To assess state survey activities as well as federal oversight of state performance, we analyzed the conduct and results of fiscal year 2001 state survey agency performance reviews during which the CMS regional offices determined compliance with seven federal standards; we focused on the five standards related to statutory survey intervals, deficiency documentation, complaint activities, enforcement requirements, and OSCAR data entry. Because some regional office summary reports on the results of their reviews for each state did not provide detailed information about the results, we also obtained and reviewed regions' worksheets on which the summary reports were based. In addition, we conducted structured interviews with officials from CMS, CMS's 10 regional offices, and 16 state survey agencies to discuss nursing home deficiency trends, the underlying causes of problems identified during the performance reviews, and state and federal efforts to address these problems. We also discussed these issues with officials from 10 additional states during a governing board meeting of the Association of Health Facility Survey Agencies. We selected the 16 states with the goal of including states that (1) were from diverse geographic areas, (2) had shown either an increase or a decrease in the percentage of homes cited for actual harm, (3) had been contacted in our prior work, and (4) represented a mixture of results from federal performance reviews of state survey activities. We also obtained data from 42 state survey agencies on surveyor experience, vacancies, and related staffing issues.

[7]CMS determined that for 438 of the 1,334 cases we asked it to examine, the state had indeed made a referral to CMS. In some of these 438 instances, there was no corresponding case in the enforcement database because OSCAR had a different survey date. The "survey date" variable in OSCAR is the latter of the health survey date and the life-safety code survey, while the corresponding date in the enforcement database is usually the health survey date. For others, an enforcement case was already open for the home at the time of the referral, and CMS officials did not open an additional case. There was also a small number of cases where the state agency referred the home for immediate sanction, and CMS chose not to accept the state's recommendation. States failed to refer 711 cases that met CMS criteria for immediate referral. In addition, CMS did not analyze 155 other cases and was unable to determine the status of 30 cases.

Appendix II: Trends in The Proportion of Nursing Homes Cited for Actual Harm or Immediate Jeopardy Deficiencies, 1997-2002

Nationwide, the proportion of nursing homes cited for actual harm or immediate jeopardy during state standard surveys declined from 29 percent in mid-2000 to 20 percent in January 2002. From July 2000 through January 2002, 40 states cited a smaller percentage of homes with such serious deficiencies while only 9 states and the District of Columbia cited a larger proportion of homes with such deficiencies.[1] In contrast, from early 1997 through mid-2000, the percentage of homes cited for such serious deficiencies was either relatively stable or increased in 31 states.

To identify these trends, we analyzed data from CMS's OSCAR system. We compared results for three approximately 18-month periods: (1) January 1, 1997, through June 30, 1998, (2) January 1, 1999, through July 10, 2000, and (3) July 11, 2000, through January 31, 2002 (see table 7). Because surveys are to be conducted at least once every 15 months (with a required 12-month state average), it is possible that a facility was surveyed more than once in a time period. To avoid double counting of facilities, we included only the most recent survey from each of the time periods. Some of the data in table 7 were included in our September 2000 report.[2] However, we updated our analysis of surveys conducted from January 1, 1999, through July 10, 2000, because it excluded approximately 300 surveys that had been conducted but not entered into OSCAR at the time we conducted our analysis in July 2000.

[1]The proportion of nursing homes in Utah cited with serious deficiencies remained the same between the two time periods.

[2]GAO/HEHS-00-197.

Table 7: Trends in the Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during State Standard Surveys, by State

	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference[a]	
State	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98 and 1/99-7/00	1/99-7/00 and 7/00-1/02
Alabama	227	225	228	51.1	42.2	18.4	-8.9	-23.8
Alaska	16	15	15	37.5	20.0	33.3	-17.5	13.3
Arizona	163	142	147	17.2	33.8	8.8	16.6	-25.0
Arkansas	285	273	267	14.7	37.7	27.3	23.0	-10.4
California	1,435	1,400	1,348	28.2	29.1	9.3	0.9	-19.9
Colorado	234	227	225	11.1	15.4	26.2	4.3	10.8
Connecticut	263	262	259	52.9	48.5	49.4	-4.4	0.9
Delaware	44	42	42	45.5	52.4	14.3	6.9	-38.1
District of Columbia	24	20	21	12.5	10.0	33.3	-2.5	23.3
Florida	730	753	742	36.3	20.8	20.1	-15.5	-0.8
Georgia	371	368	370	17.8	22.6	20.5	4.8	-2.0
Hawaii	45	47	46	24.4	25.5	15.2	1.1	-10.3
Idaho	86	83	84	55.8	54.2	31.0	-1.6	-23.3
Illinois	899	900	881	29.8	29.3	15.4	-0.5	-13.9
Indiana	602	590	573	40.5	45.3	26.2	4.8	-19.1
Iowa	525	492	494	39.2	19.3	9.9	-19.9	-9.4
Kansas	445	410	400	47.0	37.1	29.0	-9.9	-8.1
Kentucky	318	312	306	28.6	28.8	25.2	0.2	-3.7
Louisiana	433	387	367	12.7	19.9	23.4	7.2	3.5
Maine	135	126	124	7.4	10.3	9.7	2.9	-0.6
Maryland	258	242	248	19.0	25.6	20.2	6.6	-5.5
Massachusetts	576	542	512	24.0	33.0	22.9	9.0	-10.2
Michigan	451	449	441	43.7	42.1	24.7	-1.6	-17.4
Minnesota	446	439	431	29.6	31.7	18.8	2.1	-12.9
Mississippi	218	202	219	24.8	33.2	19.6	8.4	-13.5
Missouri	595	584	569	21.0	22.3	10.2	1.3	-12.1
Montana	106	104	103	38.7	37.5	25.2	-1.2	-12.3
Nebraska	263	242	243	32.3	26.0	18.9	-6.3	-7.1
Nevada	49	52	51	40.8	32.7	9.8	-8.1	-22.9
New Hampshire	86	83	79	30.2	37.3	21.5	7.1	-15.8
New Jersey	377	359	366	13.0	24.5	22.4	11.5	-2.1
New Mexico	88	82	82	11.4	31.7	17.1	20.3	-14.6
New York	662	668	671	13.3	32.2	32.3	18.9	0.2
North Carolina	407	414	419	31.0	40.8	30.1	9.8	-10.7
North Dakota	88	89	88	55.7	21.3	28.4	-34.4	7.1
Ohio	1,043	1,047	1,029	31.2	29.0	23.7	-2.2	-5.3
Oklahoma	463	432	394	8.4	16.7	20.6	8.3	3.9
Oregon	171	158	152	43.9	47.5	33.6	3.6	-13.9

	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference[a]	
State	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98 and 1/99-7/00	1/99-7/00 and 7/00-1/02
Pennsylvania	811	788	764	29.3	32.2	11.6	2.9	-20.6
Rhode Island	102	99	99	11.8	12.1	10.1	0.3	-2.0
South Carolina	175	178	180	28.6	28.7	17.8	0.1	-10.9
South Dakota	124	112	114	40.3	24.1	30.7	-16.2	6.6
Tennessee	361	354	377	11.1	26.0	16.7	14.9	-9.3
Texas	1,381	1,336	1,275	22.2	26.9	25.5	4.7	-1.5
Utah	98	95	95	15.3	15.8	15.8	0.5	0.0
Vermont	45	46	45	20.0	15.2	17.8	-4.8	2.6
Virginia	279	287	285	24.7	19.9	11.6	-4.8	-8.3
Washington	288	279	275	63.2	54.1	38.5	-9.1	-15.6
West Virginia	130	147	143	12.3	15.6	14.0	3.3	-1.7
Wisconsin	438	428	421	17.1	14.0	7.1	-3.1	-6.9
Wyoming	38	41	40	28.9	43.9	22.5	15.0	-21.4
Nation	**17,897**	**17,452**	**17,149**	**27.7**	**29.3**	**20.5**	**1.6**	**-8.8**

Source: GAO analysis of OSCAR data as of June 24, 2002.

[a]Differences are based on numbers before rounding.

Appendix III: Abstracts of Nursing Home Survey Reports That Understated Quality-of-Care Problems

Our analysis of a sample of 76 nursing home survey reports demonstrated a substantial understatement of quality-of-care problems. Our sample was selected from 14 states in which the percentage of homes cited for actual harm had declined to below the national average since mid-2000 or was consistently below that average. We identified survey reports in these states from homes that had G-level or higher quality-of-care deficiencies (see table 1) on prior surveys but whose current survey had quality-of-care deficiencies at the D or E level, suggesting that the homes had improved. All the surveys we reviewed were conducted from July 2000 through April 2002. Our review focused on four quality-of-care requirements that are the most frequently cited nursing home deficiencies nationwide (see table 6).[1]

In our judgment, 30 of the 76 surveys (39 percent) from 9 of the 14 states had one or more deficiencies that documented actual harm to residents—G-level deficiencies—and 1 survey contained a deficiency that could have been cited at the immediate jeopardy level. While state surveyors classified these deficiencies as less severe, we believe that the survey reports document that poor care provided to and injuries sustained by these residents constituted at least actual harm. Table 8 provides abstracts of the 39 deficiencies that understated quality problems.

[1]According to OSCAR data, 99 surveys in the 14 states conducted on or after July 2000 documented a D- or E-level deficiency in at least one of the quality-of-care requirements we selected. We reviewed all such deficiencies in surveys from 13 states but randomly selected 22 of the 45 California surveys. The 14 states are Alabama, Arizona, California, Iowa, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, Virginia, West Virginia, and Wisconsin.

Table 8: Abstracts of the 39 Nursing Home Deficiencies that Understated Actual Harm from a Sample of 76 Nursing Home Survey Reports

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Alabama-1 November 2001	Provide necessary care and services: D	Resident admitted to facility 5/15/01with a fractured hip; a gastrostomy tube was inserted through the abdomen into the stomach to maintain feeding. On 10/9/01, resident was hospitalized for abdominal pain and signs of infection related to the gastrostomy tube. On return to facility, physician orders state, "clean G tube site with soap and water, apply a drain sponge."	Site of gastrostomy tube insertion became reddened with thick yellow-green drainage, and had an odor, indicating signs of infection, on 11/7/01.	Facility failed to provide proper care and services: daily cleaning and application of a drain sponge around the gastrostomy tube. Family indicated no one changed the dressing. There is no documentation to show resident's gastrostomy tube site was cleansed as ordered 12 out of 16 opportunities.
Alabama-5 March 2001	Provide supervision and devices to prevent accidents: D	Resident 1 admitted to facility 11/6/00 with diagnoses of stroke, pressure sores, and kidney failure. On 11/16/00, resident was noted to have abrasions and bruises.	Resident 1 sustained four skin tears on right arm and leg and multiple bruises to both legs from 1/16/01 to 3/21/01.	The facility failed to consistently reassess for preventive measures to address the problem of skin tears and bruises for both residents. Staff were unable to provide documentation of preventive interventions.
		Resident 2 was admitted to the facility 11/23/98 with anemia, depression, urinary incontinence, and a history of falls. She was identified as having a problem with skin tears and bruising.[c]	Resident 2 sustained seven skin tears and bruises to legs from 12/29/99 to 10/9/00.	

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Arizona-3 July 2000	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 08/24/99 with heart failure, high blood pressure, paraplegia, and a stage II pressure sore on lower back.[d] Pressure sore remained a stage II until May 2000, when wound was documented to be a stage III.	On 7/5/00, it was noted that the resident had developed a stage IV pressure sore.	The necessary services and care to promote healing and prevent worsening of existing pressure sore were not provided. Even after the pressure sore progressed to stage IV and a physician ordered that the resident be turned every hour, the staff failed to turn the resident as directed. Surveyor observed resident lying on her back for 2 or more hours. Resident stated that frequently she was turned only twice in 8 hours. Charge nurse did not know physician had ordered resident to be turned every hour.
Arizona-3 July 2000	Ensure adequate supervision to prevent accidents: D	Resident 1 admitted to the facility 4/7/00 with diabetes, partial paralysis of left side, and inability to speak. Resident also had a history of spinal fractures, and a fall prevention plan was developed on 4/15/00.	Resident 1 fell four times and sustained skin tears, abrasions, and lacerations.	Facility staff failed to implement a plan of care that called for identifying resident as a fall risk by placing a star on his door by his name. No other preventive measures were identified, and surveyor observed no star next to resident's name outside his door.
		Resident 2 admitted to the facility 12/10/97 with dementia, painful joints, and visual problems. A 7/13/00 assessment indicated resident was cognitively impaired and had a mental function that varied throughout the day. She was also identified as a wanderer.	Resident sustained 12 falls from 2/18 to 7/8/00 with lacerations of extremities and head requiring suturing and with other cuts and bruises.	Although resident was identified as at risk for falls in a care plan of 4/22/00, the facility staff failed to develop approaches to prevent falls even though the resident continued to fall and injure herself.
California-2 September 2000	Ensure prevention and healing of pressure sores: D	Resident 1 with leg contractures (permanent tightening of muscle, tendons, ligaments, or skin that prevents normal movement) was noted to have a small reddened area on left lower back on 9/20/00.	Resident 1 developed a reddened open area .3 cm. in diameter, (stage II pressure sore) on left lower back by 9/23/00.	The surveyor found that the facility did not identify, document, or provide intervention to prevent this facility-acquired pressure sore. The reddened area noted was not documented in the medical record 9/20-9/22/00.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
		Resident 2 was admitted to facility on 2/2/00. Family identified resident as having a "skin problem" on 9/17/00.	Resident 2 developed a stage II pressure sore.	The facility developed a nursing care plan for prevention of pressure sores and turning the resident every 2 hours on 9/8/00. The family identified a stage II pressure sore on 9/17/00. The surveyor found no evidence that the care plan was implemented at time of survey.
		Resident 3 admitted to facility 9/20/00 with diagnoses of multiple sclerosis, bilateral fractures of the femur, and obesity. Resident was unable to turn herself in bed; physician documented resident had no areas of skin breakdown and ordered resident to be up in a wheel chair two to three times a day.	Seven days after admission, resident 3 was noted to have four stage II pressure sores on right and left shoulder blades and right buttock and three stage I pressure sores on the left buttock.	The facility failed to prevent a rapid decline in resident's condition and occurrence of facility-acquired pressure sores. Staff said they were unable to turn resident (a larger bed and mattress were not provided, which would have facilitated turning). No pressure-relieving devices and staff assistance in getting out of bed were provided. In the 7 days after admission, the resident was out of bed only once, at which time the pressure sores were discovered.
California-2 September 2000	Maintain nutritional status: D	Resident admitted to facility 7/7/00 with a diagnosis of failure to thrive and a recorded weight of 89 pounds.	Resident's weight was recorded as 77 pounds 1 month after admission. Resident sustained a severe loss of 12 pounds (13 percent) between July and August.	Facility failed to provide a comprehensive nutritional assessment to meet resident's nutritional needs in order to maintain body weight.
California-5 February 2001	Provide supervision and devices to prevent accidents: D	Resident was identified as at high risk for falls in 5/00.	Resident fell while walking unassisted on 6/21/00 and again on 2/22/01, fracturing his right hip each time.	Facility failed to develop and implement a fall prevention plan when resident was identified as being a high risk for falls and after the first hip fracture.

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California-6 May 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility on 2/12/01with dizziness, fainting, poor vision, and cognitive impairment. Care plan of 2/20/01 identified resident as a wanderer and at risk for falls. Interventions suggested were visual checks every 2 hours and involvement of resident in facility activities. On 2/20/01 at 9:30 pm resident was found wandering outside on the patio and had fallen and sustained abrasions.	Resident wandered to an area 100 yards from facility near two busy intersections on 3/26/01 and again on 5/19/01. According to CMS, the failure of a facility to provide supervision of a cognitively impaired individual with known risk for wandering is considered failure to prevent neglect and places the resident in immediate jeopardy for death or serious injury during such an incident.	Facility failed to provide supervision and devices to prevent accidents even after resident was found wandering outside the facility on 2/20/01. The facility did not immediately implement procedures cited in the care plan to supervise the resident and prevent accidents and wandering, nor did the facility implement existing facility policies to prevent wandering and injury.
California-8 June 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility in 1996 with stroke, paralysis of lower right side, and senile dementia. Physician orders of 4/5/01 called for an air mattress. Assessment of 4/24/01 noted resident had a stage IV pressure sore on the right outer ankle. On 5/17/01, physician ordered cleansing of the wound with saline and an anti-infective solution, dressing it with soft protective gauze.	Resident sustained a facility-acquired stage IV pressure sore of the right ankle measuring 7 cm. by 5 cm.	Facility failed to ensure necessary treatment and service to promote healing and prevent infection of the pressure sore. Surveyor observed on 6/20 and 6/21/01 that there was no air mattress on resident's bed and on 6/20/01 that inappropriate technique was used in changing the dressing on the resident's ankle.
California-8 June 2001	Ensure maintenance of nutritional status: D	Resident admitted to facility in 1990 with a diagnosis of stroke and inability to speak. A 3/7/01 assessment noted erosive gastritis, anemia, and weight of 111 lbs. The county was the conservator and requested maximum treatment. Resident was placed on an enriched pureed diet with supplemental feedings three times daily.	Resident weighed 98.4 lbs and experienced a severe weight loss of 13 pounds (12 percent) in 3 months.	Facility failed to ensure that the resident maintained adequate nutrition. It did not monitor the amount of nutritional supplements consumed by the resident and inconsistently recorded weights, often without associated dates. It did not notify the physician of the resident's weight loss.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-9 December 2000	Provide supervision and devices to prevent accidents: B[e,f]	Resident 1, 48 years old, admitted to facility after a stroke with incontinence, inability to speak, right-side paralysis, and functional use of his left side. Resident communicated by signs and sounds.	Resident fell when trying to climb over side rails, sustaining a laceration to his head.	The facility failed to supervise the resident and prevent accidents from occurring: staff failed to accurately assess resident's safety needs and inappropriately assumed resident needed full side rails on the bed.
		Resident 2 had a history of a right hip fracture, chronic weakness in both legs, and dementia. Resident had a physician's order (9/16/99) for soft belt restraints when in wheelchair to prevent resident from getting up from wheelchair without assistance.	On 3/29/00, resident climbed over the bed side rails and was found on the floor at the foot of his bed with both side rails in the up position. Seven hours later, an x ray was taken and found that resident had a "minimal impaction fracture" of the left hip. Because restraints, including side rails, can pose a serious health and safety risk to nursing home residents if used improperly, CMS requires that restraints should only be used when other, less severe alternatives fail to address a resident's medical needs, and the benefits outweigh the potential risks. In such cases, the nursing home must ensure that any restraints are used safely and properly.	The facility failed to provide supervision and appropriate interventions to prevent this resident's fall. According to the surveyor, there were no orders for restraints in bed and no indication that all reasonable efforts had been made to safeguard the resident from additional injuries.

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California-9 December 2000	Ensure maintenance of nutritional status: D	Resident was readmitted (6/11/00) to facility following the removal of a hip prosthesis and a surgical incision that became infected with a fungus, resulting in a large gaping wound. Resident was unable to swallow following a stroke and was fed via a nasogastric tube.	A stage IV pressure sore on right heel was noted on 7/27/00.	Facility was slow to implement the dietician's recommendations of 6/15/00 for caloric, protein, and water intake necessary for wound healing. Diet ordered on 6/20/00. On 6/24/00 resident was admitted to the hospital for care of gastrointestinal bleeding and found to need nutritional supplements to address gastrointestinal bleeding and promote wound healing. Resident was readmitted to facility on 6/29/00. Following readmission, the facility also failed to implement both the hospital's and its own dietician's recommendations for increased protein, calories, and water to encourage wound healing.
California-10 May 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility with diagnoses of dementia and Alzheimer's disease and a history of falls, confusion, and unsteady gait. Resident identified as high risk for falls and had a physician's order for a restraining belt when in bed.	Resident fell while attempting to get out of bed and lacerated left elbow.	Facility failed to provide supervision and devices to prevent accidents. Specifically, resident was put to bed without a restraining belt.
California-11 May 2001	Provide necessary care and services: D	Resident admitted to the facility in 1999 with dementia and neurological disorders. Resident was receiving an antipsychotic medication that has a side effect of constipation. Care plan of 1/04/01 called for (1) providing liquids, roughage, and exercise, (2) monitoring for abdominal distention, pain, cramps, nausea, and vomiting, and (3) checking for impaction every 3 days.	Resident admitted to hospital for "several days" to relieve a fecal impaction.	Staff failed to implement the care plan. On 5/23/01 the surveyor noted the resident crying out, moaning, grimacing, and moving her arms and legs about. Last bowel movement recorded was on 5/19/01. The charge nurse administered Tylenol with codeine for what she believed was an earache at 10 a.m. Resident continued to cry out and the charge nurse called the physician who had the resident transferred to a hospital emergency room.

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California-11	Provide supervision and devices to prevent accidents: E	Resident was admitted 4/25/01 with acute kidney failure and emphysema and was one of five residents identified as being at risk for skin tears; all five developed skin tears. A care plan for potential for skin breakdown and treatment of the skin tears was developed.	Resident sustained a 9 cm. skin tear to the lower left leg on 4/28/01 and two 3 cm. skin tears below the left knee on 5/3/01. Four other residents also sustained multiple skin tears to their extremities and hip.	Facility failed to develop skin tear prevention plans. Staff did not fully investigate causes of the tears and did not know how to prevent skin tears. The staff development director stated that she had never provided instruction for the certified nurse aides on prevention of skin tears.
California-14 March 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 1/26/01 following a stroke, with inability to swallow, a gastric tube in place for feedings, and a stage I pressure sore on right hip.	Resident's pressure sore progressed to a stage II by 2/28/01 and a stage III on 3/7/01.	Facility staff failed to promote healing or prevent worsening of pressure sore by failing to employ the appropriate sheets that are used in conjunction with the low-air-loss, pressure sore mattress, thereby negating the pressure-relieving benefits of the mattress.
California-16 April 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 11/16/98 with dementia, anemia, irregular heartbeat, diabetes, high blood pressure, and difficulty in swallowing.	Resident developed a new stage II pressure sore on 4/26/01.	Facility staff did not prevent the development of a facility-acquired pressure sore. Specifically, the surveyor observed on 4/24/01 that the staff did not turn resident every 2 hours as directed by the care plan, and left her in the same position for as long as 8 hours.
California-18 April 2001	Provide necessary care and services: E	Resident admitted to the facility with a steel plate implanted in her back following a fracture. Nursing care plan called for comfort measures for back pain, such as heat/cold application, therapeutic touch, and staying with resident when she was in distress. Resident also had an order for Methadone 20 mg. that had been reduced to 2.5 mg.	Resident was observed screaming and writhing in unrelieved pain for greater than an hour.	Facility staff failed to assess the resident's pain levels after decreasing her Methadone. They did not do an in-depth pain assessment at any time after admission. The surveyor observed the staff ignoring the resident's cries for help and relief, which continued until the surveyor intervened.

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California-19 June 2001	Provide necessary care and services: D	Resident admitted to facility on 3/97 with stroke, one-sided paralysis, and moderate contractures of upper and lower extremities. Resident took Tylenol four times a day since 2/98 for pain. As his pain worsened, he began to refuse the splinting of his contracted extremities because it was too painful.	As a result of the facility's failure to address the resident's pain, the resident refused the splints used to control the contractures and the contractures worsened, leading to greater pain.	Facility staff did not reassess this resident's pain level and need for stronger pain relief.
California-20 January 2001	Provide supervision and devices to prevent accidents: D	Resident was admitted to facility on 3/6/00 and identified as a high risk for falls on 12/6/00 because of resident's failure to remember warnings about personal safety and poor safety awareness.	Resident fell and sustained abrasions to her right flank and hip on 12/24/00 and again on 1/7/01, sustaining a scalp laceration on the back of her head.	Facility failed to implement care plan of 12/19/00 that called for safety assessment and rehabilitation screening related to falls. In addition, facility failed to reassess resident's safety needs and alternative preventive measures after the two falls, as called for by facility policy and the care plan. Physical therapy staff did not assess resident for safety needs either. There was no documented evidence that a plan was implemented to prevent future falls.
California-22 October 2000	Provide supervision and devices to prevent accidents: D	Resident had diagnoses of diabetes, bipolar disease, and high blood pressure. Resident was assessed as at risk for falls.	Resident fell 17 documented times from 4/21 to 10/14/00, when she sustained a bruising of the right eye, and a bruise and an abrasion to her forehead.	Facility failed to provide supervision and prevent accidents. Specifically, facility staff did not provide a self-releasing seat belt or pressure sensitive alarm on resident's wheelchair as recommended by the facility's fall/risk committee. Although the MDS assessment of 9/4/00 indicated that the resident had no falls for 180 days, the resident's medical record indicated that the resident fell at least six times in this period.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Iowa-1 June 2001	Ensure prevention and healing of pressure sores: D	Resident 1 had diagnoses that included renal failure, diabetes, and dementia. Resident's record noted the presence of two pressure sores, one on 1/9/01 and the second on 4/1/01, between the buttocks and on the lower right back, respectively.	Resident's stage II pressure sores healed and then reopened repeatedly from 1/9/01 to 6/20/01.	Facility staff failed to provide appropriate treatment to prevent reoccurrence of pressure sores, resulting in the reappearance of pressure sores after they had resolved. Specifically, the facility did not reassess the current plan of treatment and did not modify the care plan to meet the needs of the resident.
		Resident 2 had a history of stroke and dementia. A 4/20/01 assessment note indicated that the resident had no ulcers, skin problems, or lesions. On 4/22/01, the resident fell, was admitted to the hospital for treatment of a fracture of the right wrist, and was readmitted to nursing home on 4/27/01 with a cast on the right arm, including the lower half of the hand and thumb.	Resident developed an infected stage II pressure ulcer at the base of the right thumb.	Facility staff failed to prevent an avoidable pressure sore. After the resident was readmitted with the cast on his arm, the staff did not assess whether the skin around the cast was intact for 18 days (4/27-5/14/01), at which time the nurse noted a foul odor and a reddened thumb.
Iowa-2 March 2002	(1) Ensure prevention and healing of pressure sores: D	On 2/25/02, surveyor observed resident being transferred using a mechanical lift and noted an open stage II pressure sore on the lower back. A record review revealed a history of healing and reoccurrence of a lower-back pressure sore on several occasions from 7/8/01 through 2/26/02.	Resident developed a stage II pressure sore that persisted and reopened after resolving.	Facility staff failed to ensure that a resident with a pressure sore received necessary treatment to promote healing and to prevent new sores from developing. Specifically, the record lacked evidence of assessment of potential causal factors and interventions to prevent the reoccurring pressure sore.

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	(2) Provide supervision and devices to prevent accidents: D	During the above cited observation of the same resident on the mechanical lift, the surveyor also noted bilateral purple bruises on the resident's lower legs and later checked the resident more fully and noted a total of five bruises and a scrape to the legs. A review of the resident's record revealed multiple bruises, abrasions, and skin tears going back 1 year. The surveyor observed that there was no padding on the mechanical lift.	Resident sustained multiple bruises, skin tears, and scrapes.	Facility failed to prevent bruises and skin tear injuries. The staff did not assess the cause of the injuries or implement protective devices, such as padding of the lift and wheelchair. On 2/26/02, a staff member stated that the probable cause of the bruises was the resident's hitting the mechanical Hoyer lift during transfers and that the lift should be padded.
Iowa-4 February 2001	Provide necessary care and services: E	Resident with a diagnosis of multiple sclerosis required extensive assistance with transfers, walking, and other activities of daily living. Care plan of 1/19/01 directed staff to monitor and record all skin changes. Surveyor noted multiple bruises on resident's legs.	Surveyor noted bruises on resident's legs and saw how resident's legs and feet were twisted between the wheelchair pedals and dragged and bumped against the wheelchair on 1/30 and 1/31/01. Resident sustained multiple bruises on both lower legs.	Facility staff failed to provide the necessary care and services in accordance with the plan of care. Staff failed to assess for risk of skin injury from wheelchair transfers and to protect resident from harm during transfers. Staff also failed to document resident's bruises.
Iowa-5 March 2001	Provide necessary care and services: D	Resident admitted to facility on 7/6/99 with Alzheimer's disease, high blood pressure, and anemia. Resident was receiving a diuretic to reduce blood pressure and an antihistamine for itching. Both drugs can reduce blood pressure below normal levels, causing dizziness or a drop in blood pressure when rising to stand (orthostatic hypotension). Resident's plan of care called for staff to monitor blood pressure on a weekly basis.	Resident fell five documented times, sustaining abrasions to the forehead, a bloody nose and mouth, a bump to the forehead, a broken tooth, a carpet burn of the knees, and a broken nose.	Facility failed to properly assess and monitor after the resident fell, striking her head on all five occasions. There was no documentation of weekly monitoring of blood pressure or for neurological status after resident struck her head.

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Iowa-7 August 2001	Provide necessary care and services: D	Resident 1 admitted to facility on 3/2/01 with history of stroke, heart failure, and poor circulation, with related rash of the legs and feet. Assessment revealed a small scab on the left ankle that healed by 5/01. Resident developed a scabbed area on right foot. The physician ordered skin and heel protectors to be worn at night on 5/29/01.	Resident developed two stage II ulcers of the foot and ankle, one on 6/18/01 and the other on 6/26/01, which were still present, unhealed, on 8/7/01.	Facility staff did not consistently follow the orders and provide the necessary care for the resident. According to the surveyor, the skin and heel protectors were left off and the wheelchair was not padded and was causing additional erosion of the ankle lesions.
		Resident 2 was admitted with lung cancer, degenerative arthritis, osteoporosis, and anxiety. Physician's note of 5/16/01 indicated that resident was dying and would need to be assessed for pain relief as the disease progressed and that stronger, more effective pain relievers would be considered. As the resident began to experience increasing pain, he was given Tylenol even when pain appeared severe and unrelieved.	Resident 2 experienced severe unrelieved pain.	Facility staff failed to provide the necessary care for this resident to maintain comfort measures and avoid pain. The care plan of 5/21 and 6/13/01 did not include pain management. The staff did not assess the resident's complaints of pain and need for effective pain relief.
Iowa-7 August 2001	Provide supervision and devices to prevent accidents: D	Resident 1 has diagnoses of dementia and depression with long- and short-term memory deficits. Surveyor noted resident had fallen frequently from 2/23/01 through 7/23/01 and sustained serious injuries. Personal safety alarms selected for resident were ineffective in preventing falls.	Resident 1 fell 11 times and sustained a fractured wrist, three fractured ribs, bruises, abrasions, and a skin tear, plus pain associated with all these falls and injuries.	The facility failed to provide adequate interventions to prevent accidents. The personal alarm system was the only safety device employed, and there is no evidence that the staff evaluated its effectiveness and selected other measures.

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		Resident 2 was admitted to facility on 8/8/00 with renal failure and impaired mobility. On 4/3/01, he was assessed as being mentally confused at times. Surveyor noted the resident's record stated that resident fell frequently. The care plan and monthly summary for April identify the personal alarm unit as the safety device in use during this time (initiated 3/25/01). The resident frequently removed the unit or put it in his pocket.	Resident 2 fell 21 times from 1/6/01 to 6/26/01 and sustained multiple skin tears, two lacerations to the head and elbow requiring emergency room or clinic visits for sutures, multiple bruises and abrasions, and head injuries.	The facility failed to provide adequate interventions to prevent accidents. The personal alarm unit in use for this resident did not prevent his falls from occurring and there is no indication that other safety options were considered.
Maryland-1 August 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility with multiple diagnoses including congestive heart failure, high blood pressure, and obesity. Resident suffered from shortness of breath and required oxygen at 3 liters per minute. She also had a history of falls and was considered a high risk for falls. Resident had a physician order for a quick-release belt while in wheelchair for safety.	Resident fell out of the wheelchair, was bleeding from nose and mouth, and was in acute respiratory distress. Staff did not intervene to address respiratory distress until resident stopped breathing and her pulse stopped. At this time the staff began to administer cardiopulmonary resuscitation (CPR).	The facility failed to provide supervision and devices to prevent accidents by not placing safety belt around resident while she was in the wheelchair. Staff also did not provide the resident with oxygen as ordered while she was in the wheelchair. Staff did not respond in a timely and appropriate manner to resident's onset of respiratory distress following the fall from the wheelchair. Staff did not initiate CPR until resident was no longer breathing and her pulse stopped.
Missouri-3 May 2001	Ensure adequate nutritional status: D	Resident had diagnoses of peptic ulcer disease, aspiration pneumonia, and a penicillin-resistant infection requiring long-term antibiotic treatment. From 11/00 through 2/01, resident sustained a severe weight loss of 10 to 12 percent.	Resident experienced another severe weight loss, dropping from 126 lbs in 3/01 to 116.9 lbs in 4/01, a loss of 7.2 percent in 1 month.	The facility failed to ensure adequate nutritional status. After noting resident's weight loss in 2/01, no care plan was developed to address the weight loss. In March, the dietician recommended a dietary supplement, which did not begin for a month.

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Nebraska-1 September 2000	Provide necessary care and services: D	Resident 1 readmitted to facility from hospital with a diagnosis of insulin-dependent diabetes. Physician orders stated that the physician was to be called when resident's blood sugar fell below 40 or rose above 350 (normal range is 70 to 110). Resident received insulin on a sliding scale (insulin dose based on most recent blood sugar), and a variety of dietary interventions.	Over a period of 9 months, resident's blood sugar fluctuated, including frequent episodes of symptomatic hypoglycemia (low blood sugar between 48 and 60) and loss of consciousness.	Facility failed to provide the necessary care and services required to manage resident's diabetes. Specifically, (1) the staff infrequently called the physician about blood sugars below 40, the frequent blood sugar fluctuations, or the resident's episodes of symptomatic hypoglycemia, (2) fluctuating blood sugars were not identified as a problem in the care plan, and (3) there was no assessment of the resident's diabetes, appropriate diet, treatment effectiveness of hypoglycemic episodes, and administration of insulin on a sliding scale.
		Resident 2 with diagnoses of emphysema, Parkinson's disease, and osteoarthritis was receiving hospice services. Resident experienced increasing pain on a daily basis, unrelieved by regular Tylenol, a tranquilizer, and an antipsychotic drug specific for schizophrenia and mania. Resident obtained short-term (2.5 hours) relief from Tylox (Tylenol and oxycodone for pain relief and sedation).	This terminally ill resident suffered with unrelieved pain for at least 4 months.	Facility staff did not provide the necessary care and services to this resident. The staff did not assess or respond to the resident's continuing complaints of pain and noted in the record that the resident was demanding and manipulative. Nor did they monitor the effectiveness of the medications administered, resulting (according to the surveyor) in the resident's voicing thoughts of suicide.

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Nebraska-3 September 2001	Ensure prevention and healing of pressure sores: D	Resident was readmitted to facility 5/24/01 with diagnoses of stroke, diabetes, and one stage II pressure sore of the lower back and one stage I pressure sore between the buttocks. Resident was totally dependent on staff for bed mobility because of a right-sided paralysis and developed pressure sores of both heels that were noted on 6/3/01 and identified as stage II on 7/24/01. A pressure-reducing mattress was added to the care plan on 9/4/01.	Resident developed a stage III pressure sore on the right heel with thick green drainage and foul odor.	Facility failed to ensure that a resident did not develop a pressure sore in the facility. Specifically, the facility staff failed to recognize the challenge the resident had in moving in bed because of the right-sided paralysis. In addition, they were slow to use a pressure-reducing mattress. When the mattress was placed on the bed the staff did not discontinue use of the fleece-lined protection booties and continued use for 3 weeks, which negated the pressure-reducing effects of the mattress.
Pennsylvania-3 May 2001	Ensure prevention and healing of pressure sores: D	Resident had a left hip fracture and was identified as high risk for skin breakdown on 12/18/00. A stage I pressure sore of the left heel was noted on 3/7/01 and by 3/14/01 it had progressed to stage II. A special boot to keep left heel elevated was not applied until 3/21/01 and was then left on continuously. A second stage II pressure sore was noted on the left outer foot 4/10/01. The boot was discontinued on 4/11/01. A nutrition assessment on 3/27/01 indicated resident's skin was intact and recommended no increase in protein in the diet.	In addition to the stage II pressure sore of the foot, resident developed a second stage II facility-acquired pressure sore on 4/10/01.	Facility failed to prevent the development of pressure sores. Specifically, the boot, which was left on continuously, contributed to the development of the pressure sore identified on 4/10/01. In addition, the dietician did not note the existing original pressure sore and wrongly assumed the resident had no extra need for protein. The need for additional protein in the diet was confirmed by laboratory tests indicating the resident's protein levels were below the normal range.

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Pennsylvania-3 May 2001	Provide supervision and devices to prevent accidents: E	Resident had piriformis syndrome (compression of the sciatic nerve by the piriformis muscle) with a physician's order for physical therapy using stretching exercises and heat application. Physical therapy used a hydrocollator pack to provide moist heat treatments.[9]	Resident developed a second-degree burn of the right buttock, which blistered and was still healing after a month.	Facility staff failed to provide supervision and prevent injury. During a routine check on 1/9/01, the facility found that the temperature on the hydrocollator pack was 11 degrees above the manufacturer's recommended temperature. On 4/16/01 the hydrocollator pack was applied to the resident's right buttock. Resident said that he told the therapy staff that the pack was getting too hot and the pack was removed. Facility staff did not check the water temperature after the incident.
		Resident 2 had diagnoses that included dementia, poor vision, and Parkinson's disease and was assessed as a moderate risk for falls on 12/29/00. The MDS significant change assessment of 1/24/01 and the 4/9/01 quarterly review noted a history of falls, impaired decision making, and the need for assistance for transferring and walking. The records noted interventions found to be ineffective continued to be used.	Resident 2 fell nine documented times and, as a result of these falls, sustained a skin tear, a laceration requiring transfer to the hospital for treatment, and a dislocated hip requiring another hospital visit.	The facility failed to ensure adequate supervision and assistance devices to prevent accidents. According to the surveyor, there was no evidence that the facility had implemented effective interventions to avoid the risk of such accidents for the resident. The surveyor noted that this at-risk resident's room was too far from the nurses' station, making observation difficult.
Pennsylvania-9 May 2001	Provide supervision and devices to prevent accidents: D	A dependent resident with cognitive impairment was assessed as at risk for falls and skin tears. Interventions to prevent falls listed in the care plan included use of personal alarms, protective sleeves, and padded side rails.	Resident sustained eight skin tears on 6/27/00, 7/24/00, 7/31/00, 8/16/00, 9/20/00, 10/24/00, 1/8/01, and 1/27/01.	Surveyor stated that the facility failed to ensure that the necessary safety measures and/or devices were implemented and failed to adequately assess the ongoing use of these devices given their ineffectiveness in preventing falls and skin tears.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-1 August 2000	Provide necessary care and services: D	Resident admitted to facility for pain management associated with spread of cancer to the spine. Resident had physician orders for Oxycontin every 12 hours for long-term pain relief, as needed, and Percocet every 4 hours for any additional pain, as needed. Staff noted resident lay very still in bed and seldom asked for pain medication but that it was obvious he was in a lot of pain whenever he was turned or touched. Resident's daughter said her father was in constant pain and was depressed.	This resident suffered with severe pain that was incompletely relieved by the use of Percocet. The longer acting Oxycontin was never used.	The facility did not provide necessary care and services to manage this resident's pain. Resident did not receive any of the longer-acting Oxycontin and received only 10 doses of the Percocet during the 6 days he was in the facility. He was not offered pain relief in the morning when he was being turned and bathed. Monitoring of medication effectiveness was incomplete. Percocet was given, on average, once a day.
Virginia-2 March 2001	Provide necessary care and services: D	Resident was admitted to facility 11/4/97, with diagnoses of stroke, depression, and delusions. An MDS of 11/9/00 indicated the resident was cognitively impaired and required lift transfer. On 12/27/00 the nurse noted a large area of bruising on the left chest and left underarm with swelling around the rib cage. On 1/6/01 resident began to experience shallow breathing. Physician ordered a chest x ray if resident's breathing difficulties continued.	Resident sustained fractures of the eighth and ninth ribs with fluid in the left lower lobe of the lung demonstrated by x ray.	The facility failed to provide the necessary care and services to provide prompt treatment of the resident's chest injury. Specifically, the facility failed to take appropriate action to assess and provide the necessary care for this resident's injury for 11 days. The results of an investigation implicated the lift used to transfer the resident to and from the bed.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-2 March 2001	Ensure prevention and healing of pressure sores: D	Resident 1 admitted to the facility with diagnoses of Alzheimer's disease, anemia, depression, and joint pain. No pressure sores were noted on the admission assessment form. The care plan on 2/22/00 noted the resident was incontinent of bowel and bladder and at risk for pressure sores. Resident's blood protein was low. The most recent MDS (2/23/01) indicated no pressure sores but noted the resident was losing weight, 5 percent or more in the past 30 days (1/24/01- 2/23/01).	Resident developed three open pressure sores of the buttocks, evident 2 days after the MDS assessment. One of the pressure sores was a stage III.	The facility failed to prevent the development of facility-acquired pressure sores. The staff did not obtain timely alternative treatments and interventions to promote healing of early pressure sores.
		Resident 2 admitted to facility on 12/24/00 with diabetes, stroke, prostate cancer, requiring limited assistance for activities of daily living, and incontinent of bowel and bladder. As of 12/31/00 resident had an unhealed surgical wound of the back, two stage IV pressure sores of the right and left heels, and an excoriated (stage I) buttock. After a brief hospitalization, resident was readmitted to facility and the clinical record on 2/26/00 described the buttock sore as a stage II pressure sore. Treatment with a sealed dressing continued.	Resident developed an open stage III pressure sore with yellow drainage.	Staff failed to obtain timely alternative treatments and interventions to promote healing upon worsening of these sores from1/18/01 through 3/1/01. Specifically, the staff continued to treat the pressure sores without evaluating the effectiveness of the treatment.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-4 March 2001	Provide necessary care and services: D	Resident was an 81-year-old admitted to the facility on 8/17/90 with psychoses and hypothyroidism. Recent assessment (1/22/01) indicated long- and short-term memory loss and moderate dependency for activities of daily living. Care plan identified resident as at risk for falls. A list of preventive measures was provided. On 9/14/00 at 7:30 p.m., resident fell and complained of pain all over.	Resident sustained a nondisplaced fracture of the left wrist and suffered unnecessary pain.	Facility failed to provide necessary care and services. The facility failed to assess and investigate the source of the resident's pain. Nurses' notes indicate no apparent injury after fall. On 9/15/00 at 6:30 p.m., resident complained of pain in left arm. There was bruising on wrist and thumb, and the arm was swollen and tender to touch. According to the surveyor, there was a delay in seeking more aggressive treatment or service, as evidenced by the fact that an x-ray was not obtained until 37 hours after the resident's fall.

Source: State nursing home survey reports.

[a]To more easily distinguish among multiple surveys from the same state, we assigned consecutive numbers to each state's surveys.

[b]The resident description and relevant diagnoses are limited to the information provided by the surveyor. In some of the surveys, no background or diagnostic information was provided.

[c]Skin tears and multiple bruises are serious and painful injuries for older individuals and should not be considered in the same context as cuts and bruises sustained by healthy and younger adults. A skin tear is a traumatic wound occurring principally on the extremities of older adults as a result of friction alone or shearing and friction forces that separate the top layer of skin from the underlying layer or both layers from the underlying structures. A skin tear is a painful but preventable injury. Individuals most at risk for skin tears are those with (1) fragile skin, (2) advanced age, (3) assistance devices (wheelchairs, lifts, walkers), (4) cognitive and sensory impairment, (5) history of skin tears, and (6) total dependence for care. In addition, treatment of bruises and skin tears for elderly residents of a nursing home is frequently complicated by diabetes, poor circulation, poor nutrition, and medications with blood thinning effects. See Sharon Baranoski, "Skin Tears: Staying on Guard Against the Enemy of Frail Skin," *Nursing 2000*, vol. 30, no. 9, 2000.

[d]Stages of pressure sore formation are I—skin of involved area is reddened, II—upper layer of skin is involved and blistered or abraded, III—skin has an open sore and involves all layers of skin down to underlying connective tissue, and IV—tissue surrounding the sore has died and may extend to muscle and bone and involve infection.

[e]The following two resident incidents were cited at the B level for scope and severity, which means the surveyor found that both injuries were unavoidable and that the nursing home was in substantial compliance with the requirements.

[f]These two citations involve two residents, one cognitively competent and the other with dementia, who were injured because side rails were in place on their beds. Numerous reports have cited the danger of side rails. Residents trying to get out of bed over the rails have injured themselves by falling. Other individuals have been caught between the bed rails and the mattress or have caught their heads in the rails. Some of these injuries resulted in death.

[9]A hydrocollator pack is a canvas bag containing a silicone gel paste that absorbs an amount of water 10 times its weight. The pack is placed in a heated water container, set at a temperature above 150° F. When ready, it is placed in a protective dry terrycloth wrap and applied on top of the area where the individual is experiencing pain. Lying or sitting on the pack negates the insulating effect of the terrycloth and the individual may be burned.

Appendix IV: Information on State Nursing Home Surveyor Staffing

Table 9 summarizes state survey agencies' responses to our July 2002 questions about nursing home surveyor experience, vacancies, hiring freezes, competitiveness of salaries, and minimum required experience.

Table 9: State Survey Agency Responses to Questions about Surveyor Experience, Vacancies, Hiring Freezes, Competitiveness of Salaries, and Minimum Required Experience

State[a]	Surveyors with 2 years or less experience (percent)	Surveyor positions vacant (percent)	Surveyor hiring freeze in effect as of mid-2002	RN surveyor salaries are competitive	Minimum required experience for RN surveyors (years)
Maryland	70	9	Yes	Yes	0 to 2
Oklahoma	67	4	Yes	Yes	0 to1
New Hampshire	60	12	Yes	No	2
Florida	55	8	No	No	0
Idaho	54	0	Yes	No	1
Washington	54	0	No	No	2
California	52	6	Yes	Yes	1
Georgia	51	14	No	No	3
Kentucky	51	17	No	Yes	4
District of Columbia	50	9	Yes	Yes	3
Utah	50	8	No	No	2
Louisiana	48	6	Yes	No	2 to 3
Alabama	48	10	No	No	0
Tennessee	45	18	No	No	3
Maine	42	9	Yes	No	5
Hawaii	40	17	No	No	2-½
New York	40	4	Yes	No	1 to 2
Missouri	36	11	No	No	2
Oregon	34	12	Yes	No	5
Arkansas	33	20	No	No	2
North Carolina	33	18	No	No	4
Texas	32	20[b]	No[b]	No	1
New Mexico	30	34	No	No	3
New Jersey	30	23	Yes	No	3
Nebraska	29	6	No	No	1 to 2
Connecticut	29	1	Yes	Yes	4
Alaska	29	22	No	No	2
Wisconsin	25	15	No	No	0
Colorado	24	17	No	No	1
Virginia	21	5	No	No	0
Indiana	20	18	No	No	1
Arizona	20	24	Yes	No	2
South Dakota	18	0	No	Yes	2
Ohio	17	5	No	Yes	0

State[a]	Surveyors with 2 years or less experience (percent)	Surveyor positions vacant (percent)	Surveyor hiring freeze in effect as of mid-2002	RN surveyor salaries are competitive	Minimum required experience for RN surveyors (years)
Michigan	17	5	Yes	No	0
Kansas	17	4	No	No	[c]
Massachusetts	16	14	Yes	Yes	1 to 3
Pennsylvania	15	7	No	Yes	1
Rhode Island	9	13	No	Yes	1
Illinois	5	5	Yes	Yes	2 to 3
Iowa	4	0	Yes	No	5
Minnesota	0	17	Yes	No	3

Source: State survey agency responses to July 2002 GAO questions.

[a]Nine states did not respond to our inquiry—Delaware, Mississippi, Montana, Nevada, North Dakota, South Carolina, Vermont, West Virginia, and Wyoming.

[b]Texas indicated that although there was no hiring freeze or layoffs, the survey staff was reduced by 107 positions through attrition from September 1, 2001, through June 1, 2002, in light of state funding changes and agency cuts. As of mid-2002, Texas was authorized 215 nurse surveyors and had 42 positions vacant.

[c]Kansas requires independent experience in professional health care, but does not specify a time period for that experience.

Appendix V: Predictability of Standard Nursing Home Surveys

Our analysis found that 34 percent of current nursing home surveys were predictable, allowing nursing homes to conceal deficiencies if they choose to do so. In order to determine the predictability of nursing home surveys, we analyzed data from CMS's OSCAR database (see table 10). We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior survey or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys. Consistent with CMS's interpretation, we used 15.9 months as the maximum allowable interval between surveys. Because homes know the maximum allowable interval between surveys, those whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

Table 10: Predictability of Current Nursing Home Surveys, by State

State	Number of active homes with a current and prior survey	Predictable surveys (percent)	Homes surveyed within 15 days of 1-year anniversary of prior survey (percent)	Homes surveyed within 1 month of 15-month maximum interval of prior survey (percent)
Alabama	225	82.7	5.8	76.9
Oklahoma	354	71.5	0.6	70.9
South Carolina	174	67.8	6.9	60.9
Nebraska	226	59.7	3.1	56.6
Utah	91	52.7	1.1	51.6
Montana	103	52.4	8.7	43.7
Georgia	357	52.4	0.6	51.8
Hawaii	44	52.3	13.6	38.6
New York	663	52.0	14.8	37.3
Idaho	84	50.0	4.8	45.2
New Mexico	80	43.8	13.8	30.0
Delaware	42	42.9	31.0	11.9
California	1,324	41.2	9.5	31.7
Nevada	45	40.0	24.4	15.6
Arizona	138	39.9	21.0	18.8
New Jersey	359	39.0	18.7	20.3
Oregon	142	38.0	14.1	23.9
Maryland	246	37.0	20.7	16.3
Massachusetts	497	36.2	17.3	18.9
Arkansas	239	35.6	27.6	7.9
Virginia	275	35.3	30.5	4.7
Iowa	457	34.6	31.1	3.5
Nation	**16,332**	**34.0**	**13.0**	**21.0**
Kentucky	303	33.7	10.6	23.1
Ohio	973	33.6	3.0	30.6
North Dakota	85	32.9	28.2	4.7
Vermont	43	32.6	11.6	20.9
New Hampshire	83	32.5	12.0	20.5
South Dakota	111	32.4	18.9	13.5
Wisconsin	404	32.4	19.6	12.9
Washington	268	32.1	22.4	9.7
Florida	718	32.0	9.3	22.7
Mississippi	187	31.6	2.1	29.4
Rhode Island	96	31.3	12.5	18.8
Connecticut	253	30.8	15.8	15.0
Wyoming	39	30.8	10.3	20.5
Indiana	550	30.7	14.4	16.4
Tennessee	324	29.0	6.2	22.8
Louisiana	315	28.6	19.0	9.5
Texas	1,122	27.2	15.7	11.5

State	Number of active homes with a current and prior survey	Predictable surveys (percent)	Homes surveyed within 15 days of 1-year anniversary of prior survey (percent)	Homes surveyed within 1 month of 15-month maximum interval of prior survey (percent)
Colorado	222	26.1	9.0	17.1
Pennsylvania	757	26.0	24.0	2.0
Kansas	369	25.2	13.6	11.7
Missouri	531	25.0	11.9	13.2
Maine	121	24.8	8.3	16.5
Minnesota	427	20.4	4.4	15.9
Alaska	15	20.0	6.7	13.3
District of Columbia	20	20.0	15.0	5.0
North Carolina	411	17.3	13.9	3.4
Illinois	849	15.2	9.7	5.5
West Virginia	138	10.9	8.7	2.2
Michigan	433	10.2	8.8	1.4

Source: GAO analysis of OSCAR data as of April 9, 2002.

Appendix VI: Immediate Sanctions Implemented Under CMS's Expanded Immediate Sanctions Policy

From January 2000 through March 2002, states referred 4,310 cases to CMS under its expanded immediate sanctions policy when nursing homes were found to have a pattern of harming residents.[1] Because some homes had more than one sanction or may have had multiple referrals for sanctions, 4,860 sanctions were implemented (see table 11). Table 12 summarizes the amounts of federal civil money penalties (CMP) implemented against nursing homes referred for immediate sanction. Although these monetary sanctions were implemented, CMS's enforcement database does not track collections. In addition, states may have imposed other sanctions under their own licensure authority, such as state monetary sanctions, in addition to or in lieu of federal sanctions. Such state sanctions are not recorded in CMS's enforcement database.

Table 11: Federal Sanctions Implemented against Nursing Homes Referred for Immediate Sanction, January 14, 2000, through March 28, 2002

Type of sanction[a]	Number implemented
CMP	2,933
Denial of payment for new admissions	1,232
Directed in-service training	345
State monitoring	192
Directed plan of correction	77
CMS approved alternative or additional state sanction	48
Termination from the Medicare and Medicaid programs	26
Temporary management	4
Denial of payment for all residents	2
Transfer of residents and closure of facility	1
Total	**4,860**

Source: CMS enforcement database as of March 28, 2002.

[a]We excluded sanctions that were not implemented either because they were pending as of March 28, 2002, the date of our extract of CMS's enforcement database, or because CMS withdrew them after imposition.

[1]We use the term "cases" because some homes had multiple referrals for immediate sanctions.

Table 12: Federal CMPs Implemented under CMS's Immediate Sanctions Policy, January 2000 through March 2002

State	CMP amount
Alabama	$375,627.50
Alaska	0.00
Arizona	350,652.50
Arkansas	1,571,654.04
California	1,681,813.50
Colorado	1,489,100.00
Connecticut	696,350.00
Delaware	214,342.50
District of Columbia	20,000.00
Florida	1,975,375.00
Georgia	487,050.00
Hawaii	20,000.00
Idaho	37,350.00
Illinois	2,801,656.50
Indiana	1,977,685.50
Iowa	175,945.00
Kansas	415,400.00
Kentucky	1,195,177.50
Louisiana	20,000.00
Maine	184,920.00
Maryland	290,270.00
Massachusetts	1,031,445.00
Michigan	1,035,815.00
Minnesota	66,307.50
Mississippi	186,977.50
Missouri	467,157.50
Montana	0.00
Nebraska	11,207.50
Nevada	429,500.00
New Hampshire	93,350.00
New Jersey	1,543,007.50
New Mexico	222,430.00
New York	0.00
North Carolina	2,171,013.75
North Dakota	15,730.00
Ohio	3,104,870.00
Oklahoma	1,075,036.50
Oregon	15,225.00
Pennsylvania	1,250,417.00
Rhode Island	9,425.00
South Carolina	29,250.00

State	CMP amount
South Dakota	0.00
Tennessee	381,432.50
Texas	7,677,219.58
Utah	37,157.00
Vermont	11,550.00
Virginia	934,425.00
Washington	0.00
West Virginia	112,160.00
Wisconsin	901,960.50
Wyoming	0.00
Total	**$38,794,439.37**

Source: CMS enforcement database.

Appendix VII: Cases States Did Not Refer to CMS for Immediate Sanction

State survey agencies did not refer to CMS for immediate sanction a substantial number of nursing homes found to have a pattern of harming residents. Most states failed to refer at least some cases and a few states did not refer a significant number of cases.[1] While seven states appropriately referred all cases, the number of cases that should have been but were not referred ranged from 1 to 169. Four states accounted for about 55 percent of cases that should have been referred. Table 13 shows the number of cases that states should have but did not refer for immediate sanction (711) as well as the number of cases that states appropriately referred (4,310) from January 2000 through March 2002.

Table 13: Number of Cases States Did Not Refer for Sanction, as Required, and the Number States Appropriately Referred, January 2000 through March 2002

State	Number of cases not referred as required	Number of cases referred[a]
Nation	**711**	**4,310**
Texas	169	423
New York	140	22
Massachusetts	46	81
Pennsylvania	38	164
Connecticut	26	244
Washington	26	227
Illinois	24	241
Florida	21	150
New Jersey	20	56
Tennessee	20	46
Minnesota	19	68
Missouri	18	108
South Carolina	18	3
North Carolina	10	242
Arizona	9	24
Maryland	9	34
Wyoming	9	11
California	7	96
Michigan	7	284
Arkansas	6	115
Montana	6	14
Ohio	6	323
Idaho	5	31

[1]We use the term "cases" because some homes had multiple referrals for immediate sanctions.

State	Number of cases not referred as required	Number of cases referred[a]
Indiana	5	270
Louisiana	5	82
Oklahoma	4	53
West Virginia	4	11
Delaware	3	14
Georgia	3	81
Hawaii	3	1
Iowa	3	44
New Hampshire	3	20
Colorado	2	116
District of Columbia	2	1
Oregon	2	51
Rhode Island	2	3
South Dakota	2	18
Virginia	2	41
Wisconsin	2	61
Alabama	1	50
Kansas	1	175
Maine	1	18
New Mexico	1	19
Nevada	1	12
Alaska	0	0
Kentucky	0	75
Mississippi	0	23
Nebraska	0	30
North Dakota	0	20
Utah	0	11
Vermont	0	3

Source: CMS regional office review of cases identified through GAO's analysis of OSCAR data and the CMS Enforcement Database.

[a]Reflects cases entered in CMS's enforcement database by March 28, 2002.

Appendix VIII: HCFA State Performance Standards for Fiscal Year 2001

Table 14 summarizes HCFA's state performance standards for fiscal year 2001, describes the source of the information CMS used to assess compliance with each standard, and identifies the criteria the agency used to determine whether states met or did not meet each standard.

Table 14: Overview of HCFA's Seven State Performance Standards for Nursing Home Survey Activities for Fiscal Year 2001

Description	Source of information	Criteria for determining compliance with standard
1. Surveys are planned, scheduled, and conducted in a timely manner		
At least 10 percent of standard surveys begin on weekends or "off-hours"	OSCAR and state survey schedules	At least 10 percent of standard surveys begin on weekends or off-hours
Standard surveys are conducted within prescribed time limits	OSCAR	100 percent of nursing homes are surveyed within statutory time limits
2. Survey findings (deficiencies) are supportable		
State surveyors explain and properly document all deficiencies in survey reports following HCFA guidance known as the "principles of documentation"	A random sample of 10 percent (maximum of 40, minimum of 5) of the state's survey results in which certain deficiencies were cited at "D" or higher levels of scope and severity	At least 85 percent of the deficiencies reviewed meet the principles of documentation
3. Surveys are fully documented and consistent with applicable laws, regulations, and general instructions		
Surveys are adequately conducted by state agencies using the standards, protocols, forms, methods, procedures, policies, and systems specified by HCFA instructions	Reports generated from HCFA's database on federal monitoring surveys	100 percent of standard surveys are adequately conducted by state agencies using the standards, protocols, forms, methods, procedures, policies, and systems specified by HCFA instructions
4. When states certify that nursing homes are not in compliance, they follow adverse action procedures set forth in regulations and general instructions		
"Immediate and Serious Threat" cases are processed in a timely manner	OSCAR, Enforcement Tracking System reports, and state agency provider certification files	In 95 percent of cases in which there is immediate jeopardy or a serious threat to resident health and safety, the state agency adheres to the 23-day termination process
Payments are not made to nursing homes that have not achieved substantial compliance within 6 months of their last surveys	OSCAR, Enforcement Tracking System reports, and state agency provider certification files	The state provides timely notice to HCFA (i.e., 20 days prior to the home's termination date) on 100 percent of the cases in which the nursing home has not achieved timely compliance
5. All expenditures and charges to the program are substantiated to the Secretary's satisfaction		
The state agency employs an acceptable process for charging federal programs	HCFA budget expenditure and workload reports	More than 20 different items on the two reports submitted by the states are reviewed for accuracy, completeness, and timeliness and are scored as either on time or late, or met or not met for a reporting period
The state agency has an acceptable method for monitoring its current rate of expenditures	OSCAR reports	Numerous items submitted by the states, such as quarterly expenditure reports and supplemental budget requests, are reviewed to determine if state requirements for monitoring expenditures are met, not met, or not applicable

Description	Source of information	Criteria for determining compliance with standard
6. Conduct and reporting of complaint investigations are timely and accurate, and comply with general instructions for handling complaints		
Investigate immediate jeopardy complaints within 2 workdays	Semiannual review of a 10 percent sample of a state's complaint files	100 percent of immediate jeopardy complaints are investigated within 2 days
Investigate actual harm complaints within 10 workdays	(maximum of 20 cases)	100 percent of actual harm complaints are investigated within 10 days
Maintain and follow guidelines for the prioritization of all other complaints		The state agency has and follows its own written criteria governing the prioritization of complaints that do not allege immediate jeopardy or actual harm
State enters complaint data into OSCAR appropriately and in a timely manner	Semiannual on-site reviews of 20 state complaint survey reports	100 percent of deficiencies cited in the sampled complaints are cited under the correct federal citation
	OSCAR data are reviewed quarterly for timely entry	Average time to enter results of complaint investigations does not exceed 20 calendar days from completion of the case
7. Accurate data on survey results are entered into OSCAR in a timely manner		
Results of standard surveys are entered into OSCAR in a timely manner	Semiannual review of all standard surveys based on OSCAR data	The statewide average time between state agency sign-off of the certification and transmittal form and entry of the survey results into OSCAR does not exceed 20 calendar days
Results of surveys are entered into OSCAR accurately	Semiannual review of a random sample of nursing home survey results	No less than 85 percent of cases reviewed demonstrate that data were entered into OSCAR accurately

Source: HCFA's *State Performance Review Protocol Guidance* for fiscal year 2001.

Note: HCFA did not finalize and issue the fiscal 2001 performance standards and guidance until April 2001.

Appendix IX: Highlights of State Compliance with CMS Performance Standards

Table 15 summarizes the results of CMS's fiscal year 2001 state performance review for each of the five standards we analyzed. We focused on five of CMS's seven performance standards: statutory survey intervals, the supportability of survey findings, enforcement requirements, the adequacy of complaint activities, and OSCAR data entry. Because several standards included multiple requirements, the table shows the results of each of these specific requirements separately.

Table 15: State Compliance with Selected CMS Performance Standards, Fiscal Year 2001

CMS standard and requirements	Number of states not meeting standard
Survey timeliness	
The state begins no less than 10 percent of its standard surveys during weekends or "off-hours." (Standard 1, criterion 1)	2
The state conducts standard surveys in prescribed times. (Standard 1, criterion 2)	
• The average statewide interval between consecutive standard surveys is not greater than 12 months.	9
• Each home is surveyed within 15 months of its prior survey.	17
Supportability of survey findings	
The state explains and properly documents deficiencies. (Standard 2)	Due to complications with the review protocol, this standard was not reported.
Enforcement	
The state properly follows termination procedures. (Standard 4, criterion 1)	3
The state notifies CMS when a nursing home has not achieved substantial compliance in a timely manner. (Standard 4, criterion 2)	4
Complaints	
The state investigates all complaints alleging immediate jeopardy to a resident within 2 workdays. (Standard 6, criterion 1)	12
The state investigates all complaints alleging actual harm to a resident within 10 workdays. (Standard 6, criterion 2)	42
The state has and follows guidelines for prioritizing complaints not alleging immediate jeopardy or actual harm. (Standard 6, criterion 3)	15
The state enters citations resulting from complaint investigations into CMS's complaint database. (Standard 6, criterion 4)	13
OSCAR	
The state enters survey results into CMS's database in a timely manner. (Standard 7, criterion 1)	9
The state enters survey results into CMS's database accurately. (Standard 7, criterion 2)	24

Source: GAO analysis of results of CMS Fiscal Year 2001 State Performance Standard Reviews.

Note: We reviewed five of the seven CMS performance standards. See app. VIII, table 14, for a description of standards three and five, which we did not review.

Appendix X: Comments from the Centers for Medicare & Medcaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 20 2003

TO: Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

FROM: Thomas A. Scully
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, *NURSING HOME QUALITY: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, (GAO-03-561)

Thank you for the opportunity to review your draft report to Congress concerning enforcement and oversight of Federal nursing home standards. We agree with the report's findings that the Centers for Medicare & Medicaid Services should continue to strengthen its ability to make sure that nursing homes comply with Medicare and Medicaid quality-of-care standards.

Attached are our specific comments to the report. We look forward to working with GAO on this and other issues in the future.

Attachment

The Centers for Medicare & Medicaid Comments to GAO's
Draft Report, *NURSING HOME QUALITY: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*,
(GAO-03-561)

GAO Recommendation

Finalize the development, testing, and implementation of a more rigorous survey methodology including guidance for surveyors in documenting deficiencies at the appropriate level of scope and severity.

CMS Response

We agree and have already taken steps to assist states in improving the effectiveness of the survey process. For example, we led a contract to develop a series of surveyor guidance on a series of clinical issues. Some of the clinical areas that have been identified include pressure sores, hydration and nutrition, accidents, unnecessary medications, and psychosocial harm. Additionally, we're continuing to refine data used by surveyors to help focus resources more effectively during a survey. Lastly, we are communicating to states through the Budget Call Letter more specific priorities of survey workload to assure that statutorily mandated surveys be completed.

GAO Recommendation

Require States to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G-level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality of care problems.

CMS Response

We believe this to be an important concept and have already incorporated this concept into Standard 2 of the State Performance Standards. This standard requires regions to take a sample of statement of deficiencies to evaluate a state's ability to document deficiencies. We will continue to refine this standard to better evaluate the sufficiency of documentation of varying harm levels. In addition to reviewing the appropriateness of the scope and severity of deficiencies, we have completed a number of data analyses to look nationally, and by state, at the number of deficiency free facilities and those with high and low numbers of deficiencies. We are working on a data system (Aspen Enforcement Module) so that we can more easily assess these trends in deficiencies.

GAO Recommendation

Finalize the development of guidance to States for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to resident; the handling of facility self-reported incidents; and, the use of appropriate complaint investigation practices.

CMS Response

We concur and are developing and implementing the Aspen Complaints/Incident Tracking System (ACTS). The ACTS will be a national complaint system that will standardize state complaints and incidents so that analysis across states can be accomplished. Over time, we expect to advance complaint improvement efforts that will not only address complaint investigation practices toward improvement, but also the prioritization of complaints.

GAO Recommendation

Further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze the trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.

CMS Response

We have already modified our FY'03 state performance standards to take into account assessing state compliance in a manner that differentiates between statutory and non-statutory performance standards. We have built in the ability to distinguish between systemic problems and less serious issues. We will continue to look at homes with varying levels of harm though the work we have done with our Nursing Home Data Compendium that is widely available to regions, states, Congress and other stakeholders. We are working on a data program to ascertain when individual nursing homes have deficiencies that would cause an immediate sanction for repeated instances of actual harm.

Regarding predictability of nursing home surveys, the report shows that two thirds of nursing home surveys are not predictable using the definition established by GAO. There is "predictability" that the law requires in that surveys be conducted other than on average of every twelve months, not to exceed 15 months. Within the bounds of those legal constraints, we have instituted a policy of "off-hour" surveys where survey teams conduct surveys either before or after the regular starting time, on weekends, evenings, and holidays. We have encouraged surveyors to start at a different time of the week, i.e., Wednesday instead of Monday. States have changed the way they are doing business. The findings in the report only capture the

number of days from the previous survey and don't take into account other predictors of when a survey occurs, for example the time of day or day of the week.

In addition to the CMS initiatives mentioned in the report, CMS is also working on other initiatives to help in the implementation, evaluation and monitoring of the nursing home program.

- Compiling a nursing home data compendium with information on nursing home characteristics, resident demographics and quality of care data,
- Evaluating the accuracy of the MDS through the Data Verification and Evaluation (DAVE) contract,
- Publishing a proposed rule on Feeding Assistants in nursing homes, and
- Enhancing centralized data monitoring capabilities for use by CMS staff, such as the ability to determine where states should refer cases for immediate sanctions to states.

Appendix XI: GAO Contact and Staff Acknowledgements

GAO Contact

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