California State Auditor

BUREAU OF STATE AUDITS

Department of Health Services:

A Conflict of Interest Did Not Cause the Fresno District's Inadequate Oversight of Skilled Nursing Facilities

October 2000
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October 11, 2000 2000-122

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Fresno district office of the Department of Health Services' Licensing and Certification Program's oversight of skilled nursing facilities.

This report concludes that inadequate oversight of skilled nursing facilities by the Fresno district office was not caused by a perceived conflict of interest its administrator had with the facilities owned by Mission Medical Enterprises, Inc. However, the Fresno district office did not always adequately safeguard the welfare of residents at skilled nursing facilities it oversees. Specifically, the Fresno district office did not properly prioritize three complaints or initiate and complete investigations of complaints in a timely manner. In addition, in 4 of 19 citations we reviewed, the Fresno district office issued citations that were at a lower level than was appropriate given the seriousness of the violation. In one of these instances, a resident's death was involved, but the Fresno district office staff did not exercise prudence by seeking opinions from medical consultants or other experts who likely would have issued a higher-level citation.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the Department of Health Services' (department) Licensing and Certification Program's oversight of skilled nursing facilities by its Fresno district office disclosed:

- ☑ *The Fresno district administrator took prompt action to avoid the appearance of a potential conflict of interest.*
- ☑ *The department has been slow to follow advice from its legal counsel to expand its conflict-of-interest policies.*
- ☑ *The Fresno district office did not appropriately prioritize complaints or initiate and complete complaint investigations in a timely manner.*
- ☑ *The Fresno district office issued four citations that were too lenient given the severity of the violations.*

RESULTS IN BRIEF

Allegations that the district administrator (administrator) at the Fresno district office (FDO) of the Department of Health Services' (department) Licensing and Certification Program (program) gave preferential treatment to certain skilled nursing facilities because of a perceived conflict of interest prompted the Legislature's request for this audit. The program, designed to ensure that skilled nursing facilities are operating in ways that protect residents' health and safety, is responsible for periodically inspecting facilities and for investigating complaints. The administrator in question has parents who live in a skilled nursing facility owned by Mission Medical Enterprises, Inc., and some members of the public became concerned that she had been inappropriately lenient in her oversight of that facility and one of three other facilities owned by the same company in her district.

However, we found no evidence suggesting that the administrator had improperly affected decisions concerning these four skilled nursing facilities. In fact, the administrator took prompt action to ensure that she removed herself from any potential perceived conflict of interest by seeking legal advice and delegating responsibility for those facilities to a senior supervisor in the FDO. Although the administrator did at one point inappropriately review a proposed citation, we found no evidence that the FDO treated the skilled nursing facilities owned by Mission Medical Enterprises more leniently than the other facilities it monitors.

As a result of public concerns about the administrator's perceived conflict of interest, the department transferred responsibility for monitoring the four skilled nursing facilities to the program's San Bernardino district office in June 2000. However, the department has been slow to implement the recommendation of the department's legal counsel that it expand its conflict-of-interest policies by adopting an impairment policy (a specific type of conflict-of-interest policy aimed at preventing biased decisions) to identify and prevent other potential conflicts of interest among its managers and employees.

Although we concluded that the four skilled nursing facilities owned by Mission Medical Enterprises did not receive special treatment, we did find that overall the FDO did not always adequately safeguard the welfare of residents at the skilled nursing facilities it oversees. For example, two top program managers at the central office in Sacramento agreed that, in 4 of the 19 citations we reviewed, the FDO issued citations that were at a level lower than what was appropriate given the seriousness of the violations. In one instance, despite the fact that a resident's death was involved, the FDO staff did not exercise prudence by seeking opinions from medical consultants or other experts who likely would have recommended a higher-level citation. In addition, the FDO did not always assign the appropriate priority to complaints, nor did it always ensure that its staff investigated complaints promptly.

RECOMMENDATIONS

To ensure that no perception of a conflict of interest arises, the FDO's district administrator should not participate in or review any district office activities related to skilled nursing facilities owned by Mission Medical Enterprises, Inc.

The department should follow the advice of its legal counsel to expand its existing conflict-of-interest policies by adopting an impairment policy that will ensure that all employees and managers can readily identify and avoid the appearance of bias and impropriety in their assessments of health care facilities.

To ensure that complaints are prioritized consistently and accurately, investigations are initiated and completed timely, and citations are issued at the appropriate level, the department should provide more detailed guidance to its Licensing and Certification Program's staff, and ensure that they meet all program requirements.

Finally, to ensure that the program's performance is consistently high throughout the State, the department should review the complaint and citation practices at each of its program's district offices and provide additional training, if necessary.

AGENCY COMMENTS

The department concurs with some of our conclusions and recommendations and disagrees with others. In particular, it acknowledges the need for more detailed guidance on the complaint and citation processes and states that it is updating its policies and procedures in these areas and recently provided extensive training for all evaluators. Additionally, the department states that in December 1999 it established standards for prioritizing complaints, classifying citations, and timeliness of complaint investigations. However, the department disagrees with our recommendation that it follow the advice of its legal counsel to expand its conflict-of-interest policies. Finally, the department disagrees that by not issuing citations at the highest possible level, the Fresno district office does not adequately safeguard residents of skilled nursing facilities. Our comments follow the department's response. ■

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INTRODUCTION

BACKGROUND

The Legislature requested this audit in response to public concerns that, due to a perceived conflict of interest its administrator has with respect to one of the licensees under its jurisdiction, the Fresno district office (FDO) of the Department of Health Services' (department) Licensing and Certification Program (program) has failed to fulfill its obligations to ensure that certain nursing facilities it oversees provide the best care possible.

The program is responsible for ensuring and promoting a high standard of care in health care facilities. The California Health and Safety Code requires the department to ensure that health care facilities comply with laws and regulations establishing health care standards. To meet this responsibility, and to be consistent with federal guidelines, the department has established two main procedures:

- Perform periodic inspections of health care facilities. The program conducts licensing and certification surveys, through a network of 19 district offices statewide and through a contract with the County of Los Angeles. During surveys, the program evaluators inspect the facilities for both state licensing and federal certification for Medicare and Medicaid (Medi-Cal) under Titles 18 and 19 of the Social Security Act (the act). Specifically, program evaluators assess the quality of care that facilities provide, the adequacy and accuracy of facilities' assessments of residents and written plans for their care, and facilities' compliance with the act's provisions regarding resident rights.

- Investigate complaints about health care facilities. Complaints may be received via telephone, mail, or personal visit from anyone outside the department, or they may be received during a facility inspection. The process of receiving and investigating complaints allows the district offices to monitor the facilities between standard inspections. For example, if a district office receives multiple complaints about one facility, it may decide to monitor the facility more closely or perform an additional inspection.

In addition to performing inspections and investigating complaints, the program has enforcement powers, which include the ability to issue citations and deficiency notices and to assess monetary penalties. When a program evaluator determines that a long-term health care facility violates state or federal laws or regulations relating to facility operation or maintenance, the California Health and Safety Code (HSC) requires the evaluator to issue a notice requiring the licensee to correct the violation and stating the program's intent to issue a citation to the licensee.

Before the evaluator completes the investigation and decides whether to issue a citation, the HSC also requires him or her to discuss violations with the licensee and allow the licensee to present additional information related to the violation. The district office must consider this information when determining whether to issue a citation or whether some other action is appropriate.

Allegations of inadequate enforcement of legal requirements and substandard care at two facilities monitored by the FDO—the Hanford and the Kings nursing and rehabilitation hospitals—originated in part because the district administrator's parents reside at a facility owned by the same company, Mission Medical Enterprises, Inc. Some members of the public have suggested that the FDO has been lenient in its oversight of these two facilities, and in response to these allegations of impropriety, the program recently transferred oversight responsibilities for the facilities in question to the San Bernardino district office.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee asked us to review how the department's program and district office ensure that they identify potential conflicts of interest on the part of their employees and whether they adequately prevent any conflicts of interest from resulting in inadequate monitoring of skilled nursing facilities under their jurisdiction. Specifically, the committee asked us to review the FDO's policies and practices.

Skilled Nursing Facilities Owned by Mission Medical Enterprises, Inc.

- Delta Nursing and Rehabilitation Hospital
- Hanford Nursing and Rehabilitation Hospital
- Kings Nursing and Rehabilitation Hospital
- Tulare Nursing and Rehabilitation Hospital

In conducting this audit, we analyzed and verified information related to the FDO's evaluation, monitoring, and enforcement activities. In addition, we reviewed laws, regulations, and policies related to conflict of interest and to monitoring and enforcement activities. We also reviewed a letter

from the department's legal counsel regarding the district administrator's possible conflict of interest.[1] Additionally, we reviewed the program's policies regarding conflict of interest and incompatible activities. We reviewed complaint and citation files to compare the FDO's oversight of facilities owned by Mission Medical Enterprises to that of other facilities within its jurisdiction.

We reviewed complaint and survey files for fiscal years 1997-98 through 1999-2000 to determine whether the FDO properly monitored and evaluated health care facilities. Specifically, except for three complaints that were not in the FDO's files, we reviewed all 41 complaints that the FDO received for fiscal years 1997-98 through 1999-2000 for the facilities owned by Mission Medical. The three missing complaints were received in July 1997, when a different administrator managed the FDO. To determine whether the FDO treated complaints differently for skilled nursing facilities owned by other companies, we selected 21 different facilities and examined one complaint that the FDO received for each of these facilities from fiscal years 1997-98 through 1999-2000. We also examined all available certification survey files for Mission Medical facilities from fiscal years 1996-97 through 1999-2000 to assess whether the FDO properly monitored health care facilities by performing required inspections within the time requirements.

Further, we examined a sample of files for citations issued from fiscal years 1997-98 through 1999-2000 to determine whether the FDO processed citations properly and enforced penalties and corrective action as required. We also reviewed the citation files to assess the reasonableness of the FDO's conclusions for the citations that it issued. Additionally, we reviewed the citation files to evaluate whether appropriate monetary penalties were imposed and corrective action was enforced.

To identify specific instances of potential lenient oversight or preferential treatment caused by the perceived conflict of interest, we spoke with program staff, including the program's deputy director, the chief of its standards and quality section, the acting

[1] The department has asked us to include the following information as a footnote to our report: "The Bureau of State Audits has requested and received from the Department of Health Services a waiver of the attorney-client privilege, which is limited in scope to the communications in the advice given regarding any potential conflict of interest arising from the district administrator's parents residing in a Fresno-area nursing facility."

chief of field operations for the central region, the department's senior legal counsel, and the FDO's administrator, supervisors, and some evaluators.

We also interviewed members of the public and requested information from the ombudsman for the Kings/Tulare region. The Office of the State Long-Term Care Ombudsman Program (OSLTCO) is under the direction of the Department of Aging and is responsible for receiving, investigating, and seeking to resolve complaints made by or on behalf of residents in long-term care facilities. Ombudsman services are provided by community-based organizations, for which the OSLTCO provides policy direction, technical assistance, training, and oversight. The ombudsman for the Kings/Tulare region told us that she was not aware of family members or residents that were reluctant to file complaints because of a perceived conflict of interest and she did not know why family members had not raised their concerns to the department's central office. She also stated that the FDO had been responsive to complaints filed by her office, even though she may not always have agreed with their conclusions. As a result, we did not expand the scope of our audit work beyond that described above. ■

CHAPTER 1

An Administrator's Potential Conflict of Interest Did Not Cause Inadequate Monitoring of Skilled Nursing Facilities in the Fresno District

CHAPTER SUMMARY

We found no evidence that the administrator of the Fresno district office (FDO) had improperly affected decisions concerning skilled nursing facilities owned by the company that provides services to her family members. In fact, the administrator acted promptly to ensure that she removed herself from any potential perceived conflict of interest by seeking legal advice and delegating responsibility for those facilities to another district employee. She reviewed one proposed enforcement action against a facility owned by the company, but it does not appear that she influenced the final decision. However, she created the appearance of a conflict of interest by reviewing the document.

Although the Department of Health Services (department) addressed public concerns about the district administrator's perceived conflict of interest by transferring responsibility for the facilities in question to another district, we found that it has not yet adequately addressed the larger issue of avoiding potential conflicts of interests within the Licensing and Certification Program (program). Despite the fact that a need for an expanded conflict-of-interest policy to identify and prevent a certain type of potential conflict of interest was brought to the program's attention in October 1998, it still has not developed such a policy. As a result, the program cannot ensure that employees and managers who are responsible for evaluating health care facilities can readily identify and avoid the appearance of bias or impropriety.

THE FRESNO DISTRICT ADMINISTRATOR ACTED TO AVOID A CONFLICT OF INTEREST

Because the public, including patients and their families, must rely on the program's integrity, the department has a responsibility to ensure that program employees are free of any impairments

that could bias their monitoring and enforcement activities. Moreover, to earn and maintain the public's trust, the employees must ensure that they avoid even the appearance of a conflict of interest. An employee should not participate in any situation that could result in that employee giving or being perceived as giving special treatment to a skilled nursing facility. In accordance with this policy, the FDO administrator acted appropriately to avoid a conflict of interest that might have affected her ability to oversee several skilled nursing facilities.

Because existing policies did not specifically address her situation, the district administrator sought guidance from the department.

As stated earlier, the administrator's parents reside in a skilled nursing facility owned by Mission Medical Enterprises, Inc. In addition to this facility, Mission Medical Enterprises, Inc. owns three other facilities in the Fresno district. As the administrator was aware, department policy prohibits program evaluators and supervisors from participating in evaluations of facilities in which their family members live.

However, even though district administrators are responsible for overseeing evaluations of nursing facilities in their districts, department policy does not specifically address district administrators who may have family members living in those facilities. The FDO administrator was concerned that her impartiality might be questioned, so she discussed her situation with her immediate supervisor shortly after she assumed her position in February 1998, and her supervisor brought the issue to the attention of the department's legal counsel. In a written response dated October 8, 1998, the legal counsel advised the program to separate the administrator from all decisions involving skilled nursing facilities owned by Mission Medical Enterprises, Inc. by assigning another supervisor to act as district administrator in all matters regarding those facilities.

For the most part, the administrator followed the legal counsel's advice and removed herself from decisions involving the four facilities by delegating oversight of monitoring activities to a senior supervisor in the FDO. Still, after she had announced that she delegated this responsibility, the administrator involved herself in an enforcement action against a Mission Medical facility by reviewing a draft report of a citation issued in April 2000 to the Hanford Nursing and Rehabilitation Hospital. During our audit, we found that the level of the citation issued to the Hanford facility was inappropriately low, which we discuss in Chapter 2. However, the responsible supervisor already had approved the level of the citation before the administrator reviewed the draft, and it did not appear that the administrator

inappropriately influenced either the evaluator's or the supervisor's decision to issue a low-level citation. According to the administrator, she reviewed this citation as well as citations that were issued to other facilities because supervisor workloads were high. We did not find evidence to indicate that she influenced or participated in any other decisions concerning skilled nursing facilities owned by Mission Medical Enterprises, Inc.

THE FRESNO DISTRICT OFFICE'S OVERSIGHT OF MISSION MEDICAL FACILITIES WAS COMPARABLE TO ITS OVERSIGHT OF OTHER FACILITIES

For the 62 complaints we reviewed, the decision as to whether a complaint was substantiated was reasonable based on the evidence found during the FDO's investigation.

In our examination of investigations of complaints and annual certification evaluations, we found no evidence that oversight of Mission Medical facilities had been less strict than that of other facilities. We reviewed 41 complaints filed against Mission Medical facilities and 21 complaints against other facilities from July 15, 1997, through June 5, 2000. In each case, the evaluator's decision as to whether a complaint was substantiated was approved by a supervisor and was reasonable based on the evidence found during the FDO's investigation. However, we do not believe the FDO took sufficiently vigorous action to penalize the facility for a few substantiated complaints. We discuss these complaints in more detail in Chapter 2. Overall, we did not find that the FDO's treatment of Mission Medical facilities was less rigorous than its treatment of other facilities.

We also reviewed annual certification surveys conducted from fiscal years 1996-97 through 1999-2000 for the four facilities owned by Mission Medical, including those for the three years in which the district administrator was in charge of the FDO. The Social Security Act requires the program to conduct periodic certification surveys or inspections of nursing homes to ensure that they remain in compliance with Medicare and Medicaid program requirements. As part of these surveys, program staff determines whether facilities are providing services required by federal regulations and whether facilities are operating according to federal standards, to ensure that nursing home residents receive the care and services they need to meet their highest practicable level of functioning. Using federal guidelines, program staff conducts facility inspections to identify deficiencies, assess their severity, and determine the types of remedies available.

We found that, in each of the three years, the FDO identified and reported deficiencies in various areas of Mission Medical facilities and followed up to ensure that the facilities took corrective action. These violations included minor issues involving resident satisfaction, such as not having enough recreational activities, but they also included serious quality-of-care deficiencies that resulted in harm to residents. For example, the survey for fiscal year 1999-2000 for the Hanford Nursing and Rehabilitation Hospital found that, because the facility did not provide adequate supervision, one resident fell and seriously injured his leg and another fell on numerous occasions and injured his knees and elbows. Although the FDO identified numerous violations at Mission Medical facilities over the four years, we did not identify a pattern where the same types of violations recurred over the period. Therefore, it appears that Mission Medical took action to address the violations that the FDO cited. The Appendix summarizes the deficiencies found at facilities owned by Mission Medical Enterprises during the surveys we reviewed.

Although the district office identified numerous violations at Mission Medical facilities, it appears that Mission Medical took corrective action.

Federal guidelines require the program to follow up on serious deficiencies, such as those resulting in physical harm, by revisiting the facility to determine whether it has corrected the problem. For the last three certification surveys of Mission Medical facilities, the FDO identified and reported deficiencies and conducted follow-up visits as required by law to ensure that the facilities had implemented appropriate corrective action for all violations cited.

THE DEPARTMENT HAS BEEN SLOW TO IMPLEMENT A COMPREHENSIVE CONFLICT-OF-INTEREST POLICY AS RECOMMENDED BY ITS LEGAL COUNSEL

The program's integrity depends on its staff's ability to avoid actual or potential conflicts of interest while performing their duties. By requiring that information related to the source of such conflicts be disclosed to management, the department can take appropriate action to ensure that employees are not participating in decisions that can result in the appearance of bias. It is the department's responsibility to assist program staff in recognizing and avoiding these conflicts.

Because department policies and procedures applicable to the program do not specifically address the potential for conflict of interest among district administrators, the department's legal

counsel recommended that the program adopt an impairment policy that would better enable its management staff to avoid this type of conflict. In her October 1998 letter advising the program to ensure that the FDO administrator separate herself from decisions involving the Mission Medical Enterprises facilities, the department's legal counsel emphasized the importance of program staff remaining independent from facilities they oversee and of their avoiding even the appearance of improprieties. The legal counsel recognized that similar situations might arise frequently and recommended that the department request an advisory opinion on the issue from the Fair Political Practices Commission (FPPC). Although the FPPC is responsible for enforcing provisions of the Political Reform Act, which prohibits various types of conflicts of interest, it does not address all types of conflicts. The Office of the Attorney General also has compiled information regarding conflicts covered by the Political Reform Act as well as other types of conflicts of interest. The advice of the FPPC and the attorney general would enable the department to adopt a more comprehensive conflict-of-interest policy by incorporating such advice into department procedures and then communicating this to employees, which would allow all employees and managers—within the program as well as within the department as a whole—to readily recognize and avoid actual and potential conflicts of interest.

To eliminate the appearance of bias at the FDO, the department had transferred responsibility for oversight of Mission Medical facilities to the program's San Bernardino district office by June 2000. However, the department has not acted promptly to follow the advice its legal counsel issued in October 1998, advising the program to adopt an impairment policy that would better enable its management staff to avoid conflicts of interest. Although it has taken some steps toward developing an impairment policy, and expects to incorporate such a policy into its existing conflict-of-interest policies by the end of this year, it has not yet done so. By not taking timely action to develop an impairment policy, the department runs the risk that other situations similar to the one in the FDO will arise, potentially causing problems for the program and the department if residents in nursing homes and their families believe they cannot trust those responsible for ensuring that these facilities provide quality care.

By not acting promptly to adopt an impairment policy, the department cannot ensure that management staff in district offices avoid conflicts of interest.

RECOMMENDATIONS

- To ensure that no perception of a conflict of interest arises, the Fresno district administrator should not participate in or review any district office activities related to skilled nursing facilities owned by Mission Medical Enterprises, Inc.

- The department should follow its legal counsel's advice to obtain an opinion from the FPPC for adopting an impairment policy that will ensure that all employees and managers can readily identify and avoid the appearance of bias and impropriety in their assessments of health care facilities. Further, to ensure that its impairment policy covers financial as well as other types of conflicts of interest that can arise, the department also should obtain information from the Office of the Attorney General regarding conflicts of interest, incorporate it into its impairment policy, and communicate the new policy to its employees. ■

CHAPTER 2

The Fresno District Office's Oversight of Skilled Nursing Facilities Is Inadequate

CHAPTER SUMMARY

The Legislature requested this audit to determine whether an administrator's perceived conflict of interest had resulted in inadequate oversight by the Department of Health Services' (department) Licensing and Certification Program (program) of several Fresno district skilled nursing facilities. In reviewing this concern, we found no evidence that the district administrator had inappropriately influenced decisions regarding the facilities in question. However, overall we found that the oversight of these and other facilities in the Fresno district has been insufficient and that the Fresno district office (FDO) sometimes has failed to uphold program policies as well as the responsibilities assigned to it under state law. As a result, the FDO has not adequately safeguarded the health and safety of residents of skilled nursing facilities.

Specifically, the FDO did not always accurately assess the severity of complaints, nor did it promptly begin and complete investigations of complaints. Additionally, the FDO sometimes did not impose sufficiently vigorous penalties on skilled nursing facilities, even in instances involving a resident's death. For example, one facility received a lower-level citation for a case in which a resident's physician prescribed an extremely high dosage of thyroid medication. The resident's condition worsened as a result of the high dosage. The facility's nursing staff failed to recognize her response and consequently failed to notify her physician. According to the resident's death certificate, the high dosage of the thyroid medication contributed to the resident's cause of death.

Our audit focused on the FDO's treatment of facilities owned by Mission Medical Enterprises, so most complaints and citations we reviewed were related to these facilities. However, we do not believe the problems we found are limited to Mission Medical facilities; rather, they seem to be the result of the manner in which the FDO handles complaints and citations for all skilled

nursing facilities under its jurisdiction. By not monitoring these facilities appropriately, the FDO cannot ensure that it addresses violations as quickly as possible.

THE FRESNO DISTRICT OFFICE DID NOT RESPOND TO ALL COMPLAINTS PROMPTLY AND APPROPRIATELY

Program procedures require that supervisors assign a priority level to all complaints they receive, allowing district offices to investigate complaints that require immediate attention sooner than they would otherwise. Program policy establishes priority level 1 for a complaint that alleges an immediate and serious threat to the residents' life and safety. An example of a priority level 1 complaint that we reviewed involved alleged patient abuse. An evaluator must initiate the investigation for a priority level 1 complaint within two working days. All other complaints are assigned a priority level 2, which requires an investigation to begin within 10 working days. For example, a priority level 2 complaint we reviewed alleged that nursing staff would not answer a resident's call light.

In our review, we found that the FDO misidentified three complaints as priority 2 rather than priority 1. In addition, the FDO failed to initiate two of these and other investigations within the required 10-day period. For example, the FDO was 60 days late in beginning an investigation of an instance in which a resident's death may have been caused by staff error and 43 days late in beginning an investigation of a situation in which a resident may have been abused by staff. Inexperienced evaluators may have been partly responsible for this tardiness.

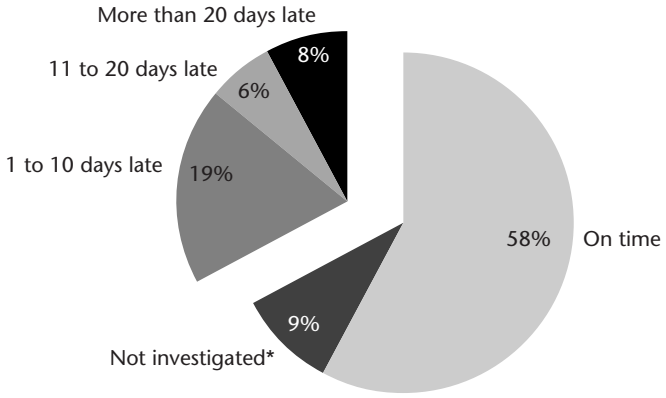
The FDO Did Not Appropriately Prioritize Several Complaints and Failed to Initiate Investigations in a Timely Manner

Based on the nature of the allegations, 3 of 52 complaints should have been assigned a higher priority and investigated sooner.

Although the FDO began investigating the six priority 1 complaints we reviewed within the required two days, we found that it did not begin investigating 21 of 52 priority 2 complaints we reviewed within the required 10-day time frame. In addition, we believe that 3 of these 52 complaints should have been classified as priority 1 rather than priority 2. The following figure shows that most investigations were initiated within the required time frame, and the majority of late investigations were not more than 10 days late.

FIGURE

Time Frame for Initiation of Investigations for All Complaints Reviewed



Source: FDO skilled nursing facility files.

* Six complaints did not warrant investigation. For example, a supervisor determined that an investigation was not warranted for one complaint after she discussed the situation with the complainant.

When asked to review the three complaints that we believe were prioritized incorrectly, two top managers at the program's central office in Sacramento agreed that, based on the nature of the allegations, all three complaints should have been assigned a priority level 1. For example, one complaint alleged that a resident's blood infection was diagnosed incorrectly as a urinary tract infection. In addition, the complaint alleged that the facility's staff continued to administer medication for high blood pressure when the resident's blood pressure was low. The complaint also alleged that the facility staff had not monitored the resident adequately and had not notified the physician when the resident's condition changed. In addition, the complainant stated that the resident had died recently. Based on the nature of the allegations, the two program managers agreed that the FDO should have assigned it a priority level 1 and responded within two days. However, the FDO assigned this complaint a priority level 2 and did not begin its investigation until 62 days after it received the complaint.

In another complaint, a member of the facility's staff alleged that the facility did not have a sufficient number of staff on the evening and night shifts for a week. The complainant also reported that a resident had a broken knee and a black eye, but that no one could explain how this happened. Because the complaint alleged possible patient abuse and inadequate staffing

at the facility, the FDO should have assigned it a priority level 1. However, the FDO assigned this complaint a priority level 2 and did not start its investigation until 45 days after it received the complaint.

The program's lack of guidance for prioritizing complaints may contribute to the FDO's misidentifying priority 1 complaints. To assist supervisors in assessing priority levels of complaints, the program's complaint procedures manual includes a chart that provides the required response time frame for the two complaint priorities. The manual defines a priority 1 complaint as one that involves an immediate and serious threat and priority 2 as everything else. It further defines an immediate and serious threat as a situation that has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. In addition, the manual provides a list of issues, such as physical and verbal abuse, inadequate staffing levels, food poisoning, and gross medication errors, that constitute an immediate and serious threat. However, the usefulness of the chart and the definitions is limited. For example, a complainant's description of problems at a facility does not always clearly match the issues enumerated by the department as constituting an immediate and serious threat. Moreover, a combination of problems may collectively constitute an immediate and serious threat, whereas the existence of only one of the problems does not. Those individuals assigning priorities to complaints often must rely on their own experiences with other complaints. Including a collection of actual case scenarios in the complaint procedures manual would enable the supervisors to put into context the complaint being reviewed, which could facilitate the more appropriate assignment of priority levels. In addition, providing this information to all district offices would help improve consistency in the assignment of priorities throughout the State.

Rather than relying on their own experience, having a collection of actual case scenarios as a reference could help supervisors appropriately prioritize complaints.

The FDO is not adequately reacting to patient-care issues when it incorrectly prioritizes complaints and initiates investigations late. Further, when the FDO does not accurately assess a complaint that should be at priority level 1, it cannot ensure that important evidence, such as visible bruises or fresh memories, is available when the investigation finally begins.

According to the district administrator, late initiation of investigations is due primarily to inexperienced evaluator staff. Of the 15 evaluators assigned to investigate complaints and conduct surveys at skilled nursing facilities, 11 had been in their positions one year or less as of June 30, 2000. Three of the 11 evaluators

were hired in June 2000. Further, according to the district administrator, after new evaluators attend three weeks of training at the program's headquarters in Sacramento, they require close supervision for their first year as an evaluator and another year of experience on the job before they can perform more efficiently with less supervision from more experienced staff. As a result, the workloads of experienced evaluators may be higher to compensate for those who have less experience.

The FDO Did Not Complete Nine Investigations in a Timely Manner

The department's program requires district office staff to complete an investigation within 40 working days from the receipt of a complaint. We found that for 6 of the 64 complaints we reviewed, the FDO took considerably longer than the permitted 40 days. For example, it took the FDO 89 days to complete an investigation involving patient abuse at Hanford Nursing and Rehabilitation Hospital, and it took 116 days to investigate a case at Wish-I-Ah Care Center.

Investigations That Exceeded 40 Days

- Fowler Convalescent Hospital – 47 days
- Hanford Nursing and Rehabilitation Hospital – 89 days
- Hanford Nursing and Rehabilitation Hospital – 82 days
- Hanford Nursing and Rehabilitation Hospital – 61 days
- Hanford Nursing and Rehabilitation Hospital – 45 days
- Merced Manor – 61 days
- Paris-Lamb Health Center – 69 days
- Twilight Haven – 41 days
- Wish-I-Ah Care Center – 116 days

Inexperienced evaluators are again the reason given for late completion of investigations, according to the district administrator. When the FDO does not complete investigations in a timely manner, it cannot ensure that it identifies and addresses violations and deficiencies as soon as possible so that residents receive quality care and are adequately protected. For example, in one complaint against the Hanford facility, the FDO's failure to complete its investigation within the required time span unnecessarily exposed residents to potential physical abuse or substandard care resulting from an inadequate staffing level.

THE FRESNO DISTRICT OFFICE DID NOT ALWAYS ISSUE CITATIONS AT THE APPROPRIATE LEVEL

Under the California Health and Safety Code (HSC), the program's primary tool for enforcement is the ability to issue citations, often accompanied by monetary penalties. Depending on the severity of a violation, district offices can issue a class AA,

class A, or class B citation. By issuing appropriate citations against facilities providing inadequate care, the district offices encourage facilities to address problems in a timely and effective manner.

However, in our review of the FDO's handling of citations, we found that the citations were not severe enough in 4 of 19 instances. The HSC does not require district offices to seek concurrence from a medical consultant for a class B citation. In one of these cases, however, the FDO should have exercised prudence and sought an opinion from a medical consultant because a resident's death was involved. In this case, a medical consultant may have recommended that the district office issue a higher-level citation to the facility. The FDO failed to hold the facilities fully accountable by not adhering more closely to the HSC requirements. If penalties against facilities are not assessed at the highest possible levels, facilities are less likely to take them seriously and take prompt action to ensure their residents' welfare.

The district office failed to hold the facilities fully accountable by not adhering more closely to the Health & Safety Code requirements.

In Four Instances, the FDO Issued Inappropriately Low Citations

The HSC defines three levels of citations:

- Class B citation: The code defines class B violations as those that have a direct or immediate relationship to the health, safety, or security of residents of long-term health care facilities, including skilled nursing facilities, but do not meet the definition of class A or class AA violations, which are more serious. For example, the FDO issued a class B citation to a facility that the FDO concluded had failed to protect a resident from physical abuse by the staff. Specifically, a member of the facility's nursing staff pinched a resident and pulled her hair. Class B citations carry a penalty of $100 to $1,000.

- Class A citation: The code defines class A violations as those that present an imminent danger of death or serious harm or a substantial probability that death or serious physical harm will occur to residents of long-term health care facilities, including skilled nursing facilities. For example, one facility received a class A citation because the FDO concluded that the facility's nursing staff improperly administered more than the prescribed dosage of insulin to four patients, causing hypoglycemia, or dangerously low blood sugar. Class A citations carry a penalty of $1,000 to $10,000.

- Class AA citation: The code defines class AA violations as those that meet the same criteria as a class A citation but are also a direct, proximate cause of a resident's death. For example, in one class AA citation we reviewed, the FDO concluded that the facility's failure to assess a resident's medical condition, identify and treat dehydration in a timely manner, and implement the care plan that a physician prescribed for the resident resulted in the resident's death. Class AA citations carry a penalty of $5,000 to $25,000.

The program's policy requires district offices to obtain the concurrence of a medical consultant before issuing a class A or class AA citation, except for cases involving resident abuse or burns caused by excessively hot water. Although medical consultants do not usually participate in class B citations, they occasionally provide testimony and advice.

Of the 19 citations we reviewed, we concluded that 4 warranted a higher-level citation with higher monetary penalties. Two top managers at the program's central office in Sacramento reviewed the citations and agreed with our conclusions.

In the first case, the FDO issued a class B citation because a facility allowed a resident to develop pressure sores and failed to provide the treatment necessary to promote healing and prevent new sores. According to the complaint investigation report, the facility had no documented evidence that it was adhering to the resident's care plan, which included examining his skin every shift and as needed for pressure sores. In addition, there was no documentation that the facility's staff used pressure-relieving devices to prevent sores. In fact, the resident developed numerous pressure sores. The FDO should have issued a class A citation because the facility failed to prevent serious physical harm to this resident.

Even though improper care contributed to the resident's death, the district office failed to assess the highest penalty.

In a second case at the same facility, the nursing staff failed to recognize a resident's response to an extremely high dosage of a thyroid medication and consequently failed to notify the resident's physician when her condition changed. Specifically, the citation stated that although the nursing staff notified the resident's physician that the pharmacy questioned the high dosage he had prescribed, the physician insisted the dosage was correct. As a result, the nursing staff continued to administer the high dosage even though the resident exhibited some of the serious side effects of the medication, including increasing body temperature and insomnia. In addition, the results of the

resident's laboratory tests indicated that she had symptoms of thyroid toxicity. Ultimately, just over one month after having been admitted to the facility, the resident died. According to the death certificate, the high dosage of the thyroid medication was a contributing factor. However, the FDO, which was then managed by a different administrator, issued a class A citation. The two program managers agreed with us that the FDO should have issued a class AA citation. The resident's family subsequently sued the facility and physician. The jury in the case found that both defendants were negligent in their care of the resident and that their negligence contributed to her death.

In a third case, the FDO issued a class B citation because a facility's nursing staff continually failed to recognize that a resident was dehydrated. Even though the facility's assessment of the resident noted that he showed signs of possible dehydration, including dry mouth and tongue and a lack of skin elasticity when he was admitted, dehydration was not addressed in the resident's care plan. Further, less than 24 hours after the facility admitted the resident, he became increasingly agitated, refusing meals and care, and swinging his arms and yelling. Some symptoms of dehydration are dry mouth and tongue, lack of skin elasticity and firmness, and restless or irritable behavior. However, the nursing staff did not recognize that the resident's symptoms were related to his dehydration. The staff called his physician, who prescribed Haldol, used to treat psychotic disturbances. The resident continued to be agitated even after he received the Haldol, but the nursing staff did not assess him to find the cause. Instead, the nursing staff contacted the physician, who then increased the dosage of Haldol, even though Haldol may have contributed to the resident's behavior. According to a medical publication referred to in the citation, the side effects of Haldol include inability to sit still, no pattern to movements, and confusion. The resident remained agitated and subsequently became delusional and combative, but the facility's staff never addressed his dehydration. Finally, a member of the resident's family insisted the facility send the resident to the hospital for evaluation, where the resident was found to be grossly dehydrated. We and two managers at the program's central office believe the FDO should have issued a class A citation to the facility because it failed to prevent serious physical harm to this resident.

In the fourth case, the nursing staff at a facility administered five medications that reduce blood pressure to a resident without properly monitoring her vital signs and without notifying the attending physician when the resident showed signs of adverse

An evaluator told us he issued a lower-level citation because the facility would be less likely to appeal it.

reactions. Specifically, the resident became pale, cold, and short of breath, and her blood pressure level dropped below a safe range as determined by her physician in her care plan. The resident later died, and the FDO issued a class B citation, which has a $1,000 maximum penalty, to the facility. The severity of the violation called for a class A citation, which has a $10,000 maximum penalty. According to the evaluator who investigated this complaint, rather than seek the opinion of a medical expert, he issued the lower-level citation because the facility would be less likely to appeal it. The supervisor who approved the citation also agreed that a class B citation was appropriate without consulting a medical expert for another opinion.[2]

Penalties such as those just listed should not turn on the possibility that a facility might appeal a class A or class AA citation. Instead, these decisions require the attention of medical experts. Although the department's program does not require its district offices to consult medical experts for class B citations, when the appropriate penalty is unclear or borderline, evaluators and supervisors should seek an expert's opinion before making a decision. The FDO is not using its maximum enforcement authority when it fails to seek the opinions of program experts if a decision regarding the suitability of a citation level is unclear. This allows long-term care facilities to receive penalties that are mild compared to the violation that occurred. As a result, the health, safety, and security of residents are less likely to be promptly and continuously addressed and ensured.

RECOMMENDATIONS

To ensure that complaints are prioritized consistently and accurately, investigations are initiated and completed in a timely manner, and citations are issued at the appropriate level, the department should:

- Provide more guidance, such as examples of complaints, in its complaint procedures.

- Require program staff to initiate and complete complaint investigations within the required time frames.

[2] As we discussed in Chapter 1, the district administrator also approved of this penalty, but only after another supervisor already had approved it.

- Require program staff to seek opinions from medical consultants, legal consultants, or other experts from its field operations branch when in doubt about the level of citation.

To ensure that the program's performance is consistently high throughout the State, the department should review the complaint and citation practices at each of its program's district offices and provide additional training, if necessary.

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

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: October 11, 2000

Staff: Ann K. Campbell, CFE
Debra L. Maus, CPA
Juan R. Perez
John J. Romero

APPENDIX

Certification Surveys for Mission Medical Facilities for Fiscal Years 1996-97 Through 1999-2000: Summary of Findings

As discussed in the body of the report, we reviewed the certification surveys that the Fresno district office (FDO) conducted for each of the four Mission Medical facilities from fiscal years 1996-97 to 1999-2000. We concluded that for these surveys, the FDO reported deficiencies and appropriately conducted follow-up visits as required by law to ensure that the facilities had implemented appropriate corrective action for all violations cited. In addition, it appears that Mission Medical facilities took action to address the violations cited by the FDO as a result of these surveys because we did not identify a pattern where the same types of violations occurred repeatedly over the period. For example, although the FDO's survey of the Hanford Nursing and Rehabilitation Hospital in fiscal year 1996-97 found that the facility failed to make a comprehensive assessment of each resident's needs, the FDO did not identify the same type of finding at this facility during the two surveys that followed.

Fiscal Year 1996-97 Findings	Fiscal Year 1997-98 Findings	Fiscal Year 1999-2000 Findings
Delta		
Did not sufficiently protect residents against accidents/hazards	Did not provide for sufficient personal privacy (family meetings)	Did not provide for sufficient personal privacy (personal care/medical care)
Did not adequately assist residents to maintain good oral hygiene	Did not provide for prompt resolution of grievances	Failed to screen new staff and failed to report allegations of abuse
	Did not ensure that residents receive mail promptly	Failed to maintain resident dignity by not answering call lights in a timely manner
	Did not follow safe practice for self-administered drugs	Did not provide reasonable accommodation of resident preferences
	Failed to maintain resident dignity by not answering call lights in a timely manner	Did not provide medically related social services
	Did not offer ongoing activities to meet the interests of residents during weekends	Did not maintain a clean environment

Fiscal Year 1996-97 Findings	Fiscal Year 1997-98 Findings	Fiscal Year 1999-2000 Findings
	Did not maintain a safe and clean environment Did not adequately protect resident funds Size of bedrooms did not meet legal requirements (waiver granted because bedroom size variation was not significant and did not prevent facility from meeting the needs of residents)	Did not adequately prevent the development of pressure sores on residents Failed to ensure that drug regimens of residents are free from unnecessary drugs Failed to act on pharmacy reports of resident drug regimen irregularities
Hanford		
Failed to make a comprehensive assessment of each resident's needs Failed to provide services to resident with limited range of motion to prevent further decrease and maintain the resident's range of motion Failed to maintain evidence of prompt resolution of grievances Did not provide reasonable accommodation of individual needs to resident with severely limited vision Did not sufficiently protect residents against accidents/hazards Failed to gradually reduce dosage of antipsychotic drugs it administers to residents Failed to serve food at the proper temperature	Did not maintain a safe and clean environment Did not provide adequate treatment or services to prevent complications in residents fed through gastrostomy tubes Failed to ensure that drug regimens of residents are free from unnecessary drugs Did not properly train staff in emergency procedures Did not make survey results available in a place readily accessible to residents Did not maintain adequate medical records for each resident	Did not promote resident dignity by allowing staff to engage in verbal confrontations with residents Did not provide reasonable accommodation of resident preferences Did not maintain a clean environment Failed to conduct assessment promptly after significant changes in resident's physical or mental condition Failed to provide services to resident with limited range of motion to prevent further decrease and maintain the resident's range of motion Did not sufficiently protect residents against accidents/hazards Inadequate sanitation (staff failed to wash their hands after direct contact with each resident for which hand washing is indicated) Failed to maintain essential patient care equipment in safe operating condition
Tulare		
Did not make survey results available in a place readily accessible to residents Did not follow safe practice for self-administered drugs Failed to determine resident preference for labeling of clothing to ensure that resident dignity is maintained	Failed to maintain resident dignity by not answering call lights in a timely manner Did not offer ongoing activities to meet the interests of residents (selection of movies)	Failed to promote resident dignity by not promptly tending to residents who need assistance in using the rest room Failed to ensure that assessments accurately reflect residents' status Failed to carry out physician orders Failed to demonstrate that catheterization of a patient was clinically necessary

Fiscal Year 1996-97 Findings	Fiscal Year 1997-98 Findings	Fiscal Year 1999-2000 Findings
Did not provide reasonable accommodation of resident preferences Did not offer ongoing activities to meet the interests of residents (shopping) Did not provide medically related social services Failed to make a comprehensive assessment of each resident's needs Failed to develop a comprehensive care plan for each resident Did not provide necessary treatment and services to promote healing and prevent infection of residents' pressure sores Did not sufficiently protect residents against accidents/hazards Did not provide adequate supervision of residents to prevent accidents Failed to ensure timely physician visits for some residents		Did not sufficiently protect residents against accidents/hazards Failed to ensure that drug regimens of residents are free from unnecessary drugs Failed to act on pharmacy reports of resident drug regimen irregularities
Kings		
Not applicable (not a Mission Medical facility)*	Not applicable (not a Mission Medical facility)*	Did not provide medically related social services Did not provide adequate lighting in all areas Failed to conduct assessment promptly after significant changes in resident's physical or mental condition Did not provide adequate treatment or services to prevent infections Failed to maintain acceptable nutritional status in residents Did not provide sufficient nursing staff

Note: None of the certification surveys of Mission Medical facilities was completed during fiscal year 1998-99.

* The Kings Nursing and Rehabilitation Hospital was acquired by Mission Medical Enterprises, Inc. on July 21, 1999.

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Agency's comments provided as text only.

September 26, 2000

Health and Human Services Agency
Grantland Johnson, Secretary
1600 Ninth Street, Room 460
Sacramento, CA 95814

Elaine M. Howle*
State Auditor
555 Capitol Mall, Suite 300
Sacramento California 95814

Dear Ms. Howle:

Attached, please find a letter from my Director of Health Services, Diana Bontá, responding to your report relating to oversight of skilled nursing facilities by the Department of Health Services' Fresno District Office.

Ensuring quality of care for California residents in skilled nursing facilities is a top priority for this Administration. I am pleased that your report found no evidence of improper decision making in our Fresno District Office. The Governor's Aging with Dignity Initiative has further enhanced the Department's oversight abilities. We have augmented our Licensing and Certification Program to improve the timeliness and quality of complaint investigations. (1)

Please include the Director's comments with the release of your report.

Sincerely,

(Signed by: Grantland Johnson)

GRANTLAND JOHNSON
Secretary

*California State Auditor's comments begin on page 35.

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-1425

September 26, 2000

Ms. Elaine M. Howle
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

This is in response to your office's draft report. We are pleased that you "found no evidence suggesting that the administrator had improperly affected decisions concerning these four skilled nursing facilities." Moreover, you found that "the administrator took prompt action to ensure that she removed herself from any potential perceived conflict of interest by seeking legal advice and delegating responsibility for those facilities to a senior supervisor in the Fresno District Office (FDO)."

Before responding to the specific recommendations of the audit report, we believe it is necessary to address the report title. The title is extremely misleading. The title states that Fresno District (2) Office (FDO) oversight of skilled nursing facilities was "inadequate." What the auditors actually found was stated in the report as follows:

> "We found that, in each of the three years, the FDO identified and reported deficiencies in various areas of Mission Medical Enterprises facilities and followed up to ensure that the facilities took corrective action." (page 16, lines 12-14)*
>
> "Federal guidelines require the program to follow up on serious deficiencies, such as those resulting in physical harm, by revisiting the facility to determine whether it has corrected the problem. For the last three certification surveys of Mission Medical facilities, the FDO identified and reported deficiencies and appropriately conducted follow-up visits as required by law to ensure that the facilities had implemented appropriate corrective action for all violations cited." (page 17, lines 4-9)*

While the audit report identifies areas for improvement, it did not identify some of the steps that the program has already taken to make improvements. The program will continue to strive for perfection because the public deserves no less.

* These page numbers refer to an earlier draft of the report.

Our responses will correspond to the report recommendations.

The Fresno District Administrator should not participate in or review any decisions related to MME facilities.

We concur.

DHS should expand its conflict of interest policies to include an "impairment" policy addressing the appearance of bias and impropriety.

The department disagrees with this recommendation. The audit findings clearly demonstrate that L&C staff understand the concept of potential for bias and take appropriate action. (3)

L&C staff is already covered by the provisions of Section 7202 of the Health Care Financing Administration's State Operations Manual (SOM) which addresses Conflict of Interest for Federal and State employees. This section includes a list of four circumstances which disqualify a surveyor from surveying a particular skilled nursing facility (SNF) or a nursing facility (NF), including past or present employment relationships, personal or family financial interests, or having an immediate family member who is a resident in the facility. Further this section discusses HCFA's more general concerns about potential conflicts of interests. This subsection states that federal and state employees must consider all relevant circumstances that may exist to ensure the integrity of the survey process. This section applies to all state staff. (4)

The Licensing and Certification Program also has its own "Code of Conduct" requirements applicable to all its employees and expresses the expectation that performance of the employee's job be conducted with an ethical and independent viewpoint (free of biases), lack of external impairments (interfering with independent inspection), organizational independence (freedom from political pressure) and due professional care (good judgment and abstention from any appearance of impropriety). The policy discusses conduct and discipline, and states that "staff should be free from personal and external impairments to independence". Also, the policy discusses appearance of impropriety and states that "in all matters, the organization and the individual should (1) maintain independent attitude; (2) maintain impartial judgments: (3) avoid situations where others would question an employee's independence; or (4) avoid business conflicts or appearance of conflicts with duties."

In view of the fact that there exist requirements governing conflicts of interest involving employees' economic interests, and state/federal policies and guidelines setting forth "best practices" for ethical conflicts and bias, any additional requirements are unnecessary.

While we disagree with the need for an expanded policy, the Department believes that it would be helpful to employees and to the public to have a single document providing a complete listing of the rules governing conflicts of interest, incompatible activities and potential for bias, and we are continuing development of that resource. We also believe that we can enhance the training provided to employees on this subject, to ensure that they will recognize potential issues and seek appropriate direction, as did the Fresno District Administrator in this matter.

DHS should provide more detailed guidance to L&C staff on complaint and citation processes.

We concur. This recommendation is consistent with ongoing, recently completed and planned initiatives. These include updating the complaint investigation and citation policies and procedures, extensive training on citations for all surveyors in May, 2000, and extensive citation and complaint investigation training at the New Surveyor Orientation Academy.

DHS should review the complaint and citation processes at each of its district offices and provide additional training, if necessary.

We concur. In December 1999 a new Standards and Quality Section was established for the specific purpose of district office quality assurance. These standards include appropriate prioritization of complaints, classification of citations, timeliness of complaint investigations and other essential responsibilities.

Other Audit Statements

The audit commented on the timeliness and prioritization of completing complaint investigations. The issue of timeliness in completion of complaint investigations has been a long-standing concern of L&C Program management and staff alike. The current Administration has addressed this in the Governor's Aging with Dignity Initiative by allocating many new positions to the L&C Program, 33 of which are specifically designated to improving both the timeliness and quality of L&C's complaint investigations.

With the hiring and training of these new staff we expect timely initiation and completion of all complaints. The audit found that 3 out of 52 complaints reviewed should have been classified as a Priority 1 and an investigation initiated within 2 working days. We agree with that conclusion and will consider the inclusion of specific examples of prioritization in our policy and procedure.

The audit also comments on the classification of citations. Although we concur that four of the 19 citations reviewed were not assessed at the highest possible level, we strongly disagree with the findings that this affected the health, safety, and security of residents. When the Department determines that a violation has occurred, a notice to correct the violation and intent to issue a citation is issued to the facility. This notice requires the facility to begin immediate correction, irrespective of the level of the citation. In fact the notice of intent requiring correction is usually issued during the investigation and before the level of the citation has been determined or the penalty assessed. Classification of the citation affects the amount of the fine assessed and the type of appeal process that is provided, but it has no bearing on the requirement that the violation be promptly corrected. (5)

Conclusion

In conclusion, we appreciate the opportunity to respond to the draft report and the recommendations therein.

We wish to reassure you and all who read this report that the Licensing and Certification Program will continue to carry out its mandate with integrity and a firm commitment to protecting the health, safety, and welfare of all Californians using services over which the Program has oversight.

Sincerely,

(Signed by: Diana M. Bontá, R.N., Dr. P.H.)

Diana M. Bontá, R.N., Dr. P.H.
Director

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COMMENTS

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

To provide clarity and perspective, we are commenting on the Health and Human Services Agency's (agency) and the Department of Health Services' (department) responses to our audit report. The number corresponds to the number we placed in the response.

(1) The agency is overstating our overall conclusion. As we discuss on page 9, we found no evidence that the administrator of the Fresno district office (FDO) improperly affected decisions concerning Mission Medical facilities. However, on page 15 we point out that the problems we discuss in Chapter 2 resulted from a more pervasive problem with the FDO's decision making with respect to all skilled nursing facilities under its jurisdiction. In fact, on pages 16 and 20, respectively, we discuss the FDO's incorrect decisions regarding prioritizing complaints and issuing citations that are sufficiently severe.

(2) The report title is accurate. It encompasses the content of both chapters of our report. The second chapter is entitled, "The Fresno District Office's Oversight of Skilled Nursing Facilities Is Inadequate," and it discusses the fact that the FDO did not appropriately prioritize some complaints and did not take sufficiently vigorous action to penalize facilities because it issued citations that were inappropriately low. In light of these findings, we believe that the FDO's oversight was inadequate.

(3) Although the department now disagrees with our recommendation, it fails to mention that its own legal counsel recommended that the department adopt a comprehensive policy to better enable its staff to recognize and avoid actual and potential conflicts of interest. In addition, during our fieldwork, the department assured us that it was working on developing a new

policy and planned to seek guidance from the Fair Political Practices Commission and from the Office of the Attorney General. As we state on page 13, the department told us it expects to incorporate the new policy into its existing conflict-of-interest policies by the end of the year.

The department is also overstating our finding. Our report states that one person, the district administrator, sought guidance regarding her situation. Because the scope of our audit was limited to the department and the FDO, we do not know whether all other Licensing and Certification Program staff understand the concept of potential for bias and would know when to seek guidance or what action would be necessary to avoid potential conflicts of interest. Also, as we discuss on page 13, the department's legal counsel recognized that situations similar to that of the administrator may arise frequently and it recommended that the department adopt a policy that would better enable its staff to avoid the potential for a conflict of interest. Accordingly, it appears that the legal counsel believed that additional guidance in this area was needed.

(4) The department does not clearly explain that all of the provisions in Section 7202 relate only to surveyors (referred to as evaluators in our report) and other state employees who participate in the certification survey process. This section does not provide specific guidance to cover all of a district administrator's responsibilities, such as reviewing complaint investigations and citations, which are not related to the certification survey process. Again, since the department's own legal counsel recommended that the department adopt a comprehensive policy that would cover its employees at all levels, it appears that the counsel believed that additional guidance in this area was needed.

(5) The department misses our point. As we discuss on pages 20 and 23, when the department does not assess penalties against facilities at the highest possible levels, facilities are less likely to take them seriously. Severe monetary penalties are an incentive for nursing home owners to ensure that problems do not occur in the future, thus avoiding future severe monetary penalties.

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