

DEPARTMENT OF HEALTH SERVICES

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

REPORT NUMBER 2000-122, OCTOBER 2000

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 (FDO) disclosed the following:

- The department has been slow to follow advice from its legal counsel to expand its conflict-of-interest policies.*
 - The FDO did not appropriately prioritize complaints or initiate and complete complaint investigations in a timely manner.*
 - The FDO issued four citations that were too lenient given the severity of the violations.*
-

We evaluated how the Department of Health Services (department) and its Licensing and Certification Programs' (program) Fresno district office (FDO) ensure that they identify potential conflicts of interest on the part of their employees. We also evaluated whether they prevent any conflicts of interest from resulting in inadequate monitoring of skilled nursing facilities under their jurisdiction.

Finding #1: 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 monitoring and enforcement duties. It is the department's responsibility to assist program staff in ensuring that employees are not participating in decisions that can result in the appearance of bias. Because department policies applicable to the program do not specifically address the potential for certain types of conflicts 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 these types of conflicts. The department had taken some steps toward developing such a policy and expected to incorporate it into its existing conflict-of-interest policies by the end of 2000. However, as of October 2000, it had not yet done so.

We recommended that the department follow its legal counsel's advice to obtain an opinion from the Fair Political Practices Commission 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, we recommended that the department also obtain

information from the attorney general regarding conflicts of interest, incorporate it into its impairment policy, and communicate the new policy to its employees.

Department Action: Pending.

The department is continuing work to finalize a Code of Conduct Policy that will provide a complete listing of rules governing conflicts of interest, incompatible activities, and potential for bias. The department will distribute the policy to all program staff when it is finalized.

Finding #2: The FDO administrator was part of an enforcement action against a skilled nursing facility that is owned by a company that also owns the facility in which her parents reside.

In October 1998 the department's legal counsel advised the program to separate the administrator from all decisions involving four skilled nursing facilities owned by the company. This was done 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 FDO supervisor. Still, after she had announced that she delegated this responsibility, the administrator reviewed a draft of a citation issued in April 2000 to one of the company's facilities.

We recommended that to ensure that no perception of a conflict of interest arises, the FDO administrator should not participate in or review any district office activities related to skilled nursing facilities owned by the company.

Department Action: Corrective action taken.

The department transferred the review and decision responsibility for the skilled nursing facilities owned by the company to the manager of the San Bernardino District Office on June 6, 2000.

Finding #3: The FDO did not appropriately prioritize several complaints and failed to initiate investigations promptly.

In our review, we found that the FDO misidentified 3 complaints as priority 2 rather than priority 1 and failed to initiate investigations for 2 of these within the required 2-day time period. In addition, the FDO failed to initiate investigations for 21 of

52 priority 2 complaints within the required 10-day time 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 facility staff.

The program's lack of guidance may contribute to the FDO's misidentifying priority 1 complaints. The program's procedures manual includes a chart with the required response time frame for the two complaint priorities. The manual additionally defines the priority levels and 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 definitions is limited; 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 assigning of priority levels.

We recommended that the department provide more guidance, such as examples of complaints, in its complaints procedures and require program staff to initiate investigations within the required time frames.

Department Action: Corrective action taken.

The department has updated its complaint investigation and citation policies and procedures and has hired additional program staff to decrease response times to complaints regarding resident care. In addition, the department has provided these staff extensive complaint and investigation training to ensure rapid response to complaints.

Finding #4: The FDO did not complete all 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 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.

We recommended that the department require program staff to complete complaint investigations within the required time frames.



Department Action: Partial corrective action taken.

The department has now fully staffed the FDO. However, it did not report whether the FDO is now completing its complaint investigations within the required time frames.

Finding #5: In four instances, the FDO issued inappropriately low citations.

The Health and Safety Code define three levels of citations—class AA, class A, and class B—with class AA issued for the most severe violations. However, the FDO did not issue an appropriately severe citation for 4 of the 19 citations we reviewed. Two top managers at the program’s central office in Sacramento reviewed the citations and agreed with our conclusions. For example, the FDO issued a class B citation when it found that 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 reactions. The severity of the violation called for a class A citation; however, neither the evaluator who investigated this complaint nor the supervisor who reviewed the citation consulted a medical expert for another opinion. Although the department’s program does not require its district offices to consult medical experts for class B citations, 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.

We recommended that the department 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.

We also recommended that 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.

Department Action: Corrective action taken.

The department provided extensive training on citations to all of its program's surveyors in June 2000. The department has also clarified various issues pertaining to citations in a memo to all district managers and administrators. The memo included examples of appropriate documentation of the reasons for determining penalty amounts. To ensure accurate assessment of citation levels and penalty amounts, the department now requires all class A and class AA citations to be reviewed by its regional field operations branch chiefs, its office of legal services, and its medical or other consultants as appropriate. In addition, the department will require its programs' branch chiefs to review some of the class B citations.

