Joint Legislative Audit Committee Hearing
March 8, 2006

Request to Audit the California Department of Health Services Licensing and Certification Division

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Madame Chair and Members, California Advocates for Nursing Home Reform strongly supports the Licensing and Certification audit sought by Senators Alquist, Cox and Ortiz. Our organization has been monitoring the problems with California's nursing homes and addressing consumer concerns for over 23 years.

An independent investigation by the State Auditor is urgently needed at this time because California nursing home residents are endangered by Licensing and Certification's continuing neglect of its duties. It is failing its most basic responsibility to protect nursing home residents from abuse and neglect and is ignoring numerous California nursing home reform laws. Nursing home residents are being denied the hard fought rights and protections under state law enacted by California legislators over the past twenty years.

In addition to the human toll, lax enforcement puts California's enormous financial investment in nursing home care at risk. Medi-Cal spends billions of dollars each year on nursing home care and is increasing average rates by more than 25 percent during the next three years through its new rate system. Our licensing system must help ensure those funds are properly spent to improve staffing and resident care.

Some of Licensing and Certification's key failures are unrelated to its reported lack of resources. It has adopted misguided policies and priorities that often appear to be dictated by the nursing home industry, at the expense of the consumers it is supposed to serve. An examination of these policies and practices is long overdue.

Sharp Cuts in Inspections and Enforcement

In recent years, Licensing and Certification has drastically cut the number of nurse evaluators assigned to nursing home inspections, resulting in cursory, ineffective inspections. The Senate Office on Research reported in July 2005 that the hours of inspection for skilled nursing facilities dropped from 357,893 hours in 2001-02 to 252,688 hours in 2003-04, a decrease of 30 percent.

A recent investigation by the Government Accountability Office (*Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety*) found that California inspectors issue far fewer serious deficiencies than most other states. From July 2003 through January 2005, California issued serious deficiencies to just 6 percent of its nursing homes, compared to 54 percent in Connecticut. According to the report, California inspectors often missed serious deficiencies or understated their severity.

Furthermore, GAO found that predictable scheduling of inspections in California allows nursing homes to conceal violations.

On February 23, 2006, the Legislative Analyst's Office (LAO) published a report (*Analysis of the 2006-07 Budget Bill*) that analyzed Licensing and Certification's nursing home monitoring system. According to LAO, the system "suffers from serious weaknesses" and lagging productivity demonstrated by:

A reduction in the amount of citations issued by Licensing and Certification, dropping from 705 citations issued in 2003 to 461 citations issued in 2004.
A drop in the amount of penalties, dropping from $3.5 million is 2003 to $2.3 million in 2004.

The Los Angeles Times, Sacramento Bee and other newspapers chronicled Licensing and Certification's nursing home inspection system failures in 2005 and 2006. For example, the Los Angeles Times published a lengthy article on July 31, 2005 that described sharp cuts in nursing home enforcement, citing a 36 percent cut in citations during the same period complaints rose by 23 percent.

On November 3, 2005, the SEIU Nurse Alliance published results of a survey it conducted of nurse evaluators employed by Licensing and Certification to conduct inspections. It reports that managers often delete recommendations for enforcement actions against nursing homes or downgrade those actions.

Licensing and Certification is ignoring egregious, widespread patterns of neglect. For instance, although California nursing home data shows that at least one-third of 1,358 skilled nursing facilities violate California's minimum staffing requirement on an annual basis, DHS reported on July 20, 2005 (*Joint Informational Hearing, Senate Health Committee and Subcommittee on Aging and Long-Term Care*) that it issued only 5 California "B" citations for this violation in 2003-04 and only 19 citations in 2004-05. As another example, California nursing homes physically restrain nursing home residents at more than twice the national average, but relatively few deficiencies are issued for this harmful practice.

Inadequate Complaint Investigations

DHS reports show that complaints against long-term care facilities skyrocketed from 11,599 in 2001-02 to 15,008 in 2003-04, an increase of almost 30 percent. Instead of devoting more resources to complaints, Licensing and Certification has defied California law by delaying investigations by months or years. California law requires nursing home complaints be investigated within 24 hours when they involve imminent danger to a resident; all other complaints must be investigated onsite within 10 working days of the complaint.

According to the February 23, 2006 LAO report, Licensing and Certification only investigated about one-half of all complaints within the ten-day timeframe in 2004-05, compared with nearly 72 percent in 2001-02. The Los Angeles Times reported instances where nursing home residents actually died before DHS investigated complaints submitted by their family members.

The California HealthCare Foundation and other sources report that the substantiation rate for complaints has dropped due to untimely investigations. Licensing and Certification only substantiates about 25 percent of nursing home complaints, and many of them only partially so. By the time it investigates, evidence is missing, staff is gone, witnesses are unavailable and the resident may not be alive.

In recent months, Licensing and Certification has begun distinguishing between "public" complaints and facility reported incidents, questionably claiming that public complaints are declining while facility reports are growing rapidly. Nursing homes are required to notify Licensing and Certification about suspected instances of abuse and neglect and other unusual conditions that might endanger residents. CANHR is greatly concerned that Licensing and Certification is ignoring its responsibility to conduct timely onsite investigations of suspected abuse and neglect reports filed by long term care facilities.

On October 17, 2005, CANHR and family members of deceased nursing home residents filed suit in San Francisco Superior Court against the Department of Health Services seeking enforcement of California's statute requiring timely complaint investigations.

Reform Laws Abandoned

During the last 20 years, the California legislature has enacted numerous nursing home reform laws designed to improve resident care and expand residents' rights. For example, the Legislature has set minimum staffing standards, required training of nursing assistants, established abuse and neglect reporting requirements, forbid evictions of residents who are seeking Medi-Cal, and established due process rights for residents seeking readmission from a hospital. These California reforms and many others exceed federal nursing home standards.

During 2005, Licensing and Certification revealed that it is not affirmatively enforcing any of the California reform laws. During annual inspections, it only evaluates compliance with federal standards.

In an effort to defend this indefensible practice, Licensing and Certification is claiming that an obscure 1992 law justifies its inaction, despite more recent law obligating it to conduct state licensing inspections. Making matters worse, Licensing and Certification test piloted projects in three district offices (San Jose, Alameda and Los Angeles) during 2005 where it expanded its practice of ignoring California law in favor of less rigorous federal standards.

On September 27, 2005, CANHR sent Brenda Klutz, Deputy Director of Licensing and Certification, a detailed five-page letter seeking action on this issue. See attached letter. Her office has not replied to the letter.

Statutory Obligations Neglected

DHS is also ignoring vital California laws that establish its responsibilities. For example:

DHS has failed to develop regulations, required to take effect by August 1, 2003, prescribing

staff to patient ratios for direct caregivers in skilled nursing facilities. Health & Safety Code §176.65
DHS has failed to establish an on-line consumer information system that provides consumers with performance histories of nursing homes. Health and Safety Code §1422.5
DHS central office has no current system to hear consumer appeals of complaint investigation findings, as required by Health and Safety Code §1420(c).
On January 2, 2006, DHS implemented a standard admission agreement for nursing homes six years after it was required to do so. Health and Safety Code §1599.61.

In addition to its lawsuit seeking DHS compliance with complaint investigation requirements, CANHR and consumers have sued DHS for failing to collect facility ownership information and make it available to the public as required by Health and Safety Code Section 1267.5.

Misguided Policies and Priorities

Some Licensing and Certification policies protect negligent providers. Recently, for example, Licensing and Certification established a procedure to verify compliance with California's minimum staffing requirements (*L&C Policy and Procedure: Computation of Nursing Hours per Patient Day in Skilled Nursing Facilities*). Its policy directs staff to evaluate skilled nursing facility compliance with staffing requirements in 2001-02 through 2003-04, but does not require review of staffing compliance this year or last. By policy, DHS is evaluating compliance with minimum staffing requirements only when it is too late to do anything about detected violations. See attached CANHR letter to DHS, November 18, 2005.

As another example, Licensing and Certification agreed to lower the staffing requirements in nursing facilities by eliminating "bed-holds" in the nurse staffing calculations. This action was taken after private meetings with the California Association of Health Facilities (CAHF), and with no public input. See All Facility Letter #05-33.

The misguided policies and procedures reveal a radical shift in Licensing and Certification's mission. Its priority is no longer to protect consumers and enforce their rights. It now views health facility operators as its "customers" and strives to improve relationships with them. This realignment of mission is most evident in the administration's current Licensing Reform Project, which focuses on improving "customer service" to providers and lacks measures to improve care for consumers.

Data System a Fiasco

Licensing and Certification's data system is dysfunctional. Since 2004, it has been converting from its own data system, ACLAIMS, to a federal data system designed by the Centers for Medicare and Medicaid Services (CMS). By all accounts, the chaotic transition is significantly impairing its ability to manage its responsibilities. Use of the federal data system is also making it harder to track enforcement of California nursing home standards.

Examination of Resource Requirements is Needed

Licensing and Certification is seeking a 16 percent funding increase for 2006-07 that would add 141 positions. LAO's budget analysis questions this request, pointing out that the productive hours for surveyors is declining. The audit can provide valuable information on this concern that will help legislators make informed budget decisions.

LAO is opposing Licensing and Certification's plan to begin adding new positions this fiscal year because it has more than 80 nurse evaluator vacancies, a 24 percent vacancy rate. The audit should evaluate why these positions are going unfilled. Nurse evaluators are complaining that dedicated employees are leaving out of sheer disgust at how their hands are tied while doing their jobs.

The Human Impact

When complaints are not investigated, when inspections are predictable, when laws are not enforced, more than 100,000 California nursing home residents are put at risk. These residents are not anonymous people; they are our parents, our grandparents, our brothers and sisters and friends. Due to abuse and neglect, they too often suffer from discomfort, disease, infections, dehydration, malnutrition, bedsores, fractured bones and preventable death. Their neglect is our shame.

Consumers from throughout California contact CANHR daily expressing heartache at the mistreatment of loved family members and friends. Many of them are angry that when they turned to Licensing and Certification for help, it looked the other way. A very recent letter from one consumer is attached to illustrate how people are affected by our broken monitoring system.

Licensing and Certification has lost sight of its mission and the people it is supposed to protect. Its business must be more than making excuses for not doing its job. It should help raise expectations about the quality of care, not lower them.

We urge you to vote for this audit request because it can provide the Legislature with objective information about Licensing and Certification's performance and give needed recommendations for establishing an enforcement system that Californians can be proud of.