



IMPROVING NURSING HOME  
ENFORCEMENT:  
FINDINGS FROM  
ENFORCEMENT CASE STUDIES

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## 1. BACKGROUND

Poor quality of care is a major concern in U.S. nursing homes. Extreme vulnerability of nursing home residents, low skill levels of staff, limited participation by physicians and other skilled medical professionals, and the large number of homes have all contributed to this problem. Various approaches can improve or assure the quality of nursing home care including internal quality improvement of practices by the nursing home industry, public reporting of consumer information of nursing home quality, federal regulatory oversight, and/or the institution of minimum staffing ratios. Since a majority (78%) of nursing home residents are reimbursed through the government funded Medicare and Medicaid programs and virtually all nursing homes are Medicare or Medicaid certified, federal regulation has a key role in assuring the quality of nursing home.<sup>(1)</sup>

Assuring that high quality care is provided by the nursing home industry is a formidable task. Commissioned by Congress, the Institute of Medicine (IOM) reported widespread quality of care problems in nursing homes in 1986 and outlined extensive reforms in the nursing home regulatory process.<sup>(2)</sup> Since the IOM report, strategies to improve the quality of nursing home care have largely taken the form of federal regulation and enforcement, including the institution of the Nursing Home Regulatory Act (NHRA).

State survey agencies (SA) are contracted by the federal government to survey nursing facilities annually to assure compliance with the federal guidelines for nursing home care. Non-compliance with a federal guideline for nursing homes results in a citation, which is assigned a level of severity and scope. For CMS to enforce standards, States are required to refer certain types of noncompliance (e.g., immediate jeopardy cases) to CMS for a potential sanction, such as a Civil Money Penalty or the Denial of Payment for New Admissions.

Based on the Nursing Home Reform Act (NHRA), the Centers for Medicare & Medicaid (CMS, formerly HCFA the Health Care Financing Administration) revised the annual nursing home survey and certification process to assess compliance with regulations.

Research has found significant problems with the survey and certification process including inadequate identification of quality of care concerns by the surveyors, reliability and validity concerns with the outcome measures of the state survey, and inconsistency in the implementation and administration of the survey and enforcement process.<sup>(3-5)</sup> In a HCFA-funded study conducted by the University of Colorado Health Sciences Center (UCHSC) under contract to Abt Associates, the sensitivity of survey activities to detect quality of care problems was found to be less than 50% for various quality measures.<sup>(3)</sup> This finding was supported in a report to Congress prepared by the Health Care Financing Administration, with Abt Associates and UCHSC, and echoed in a report of the General Accounting Office in the same year: 1998. The GAO concluded that the federal enforcement process cannot be effective in its mandate to correct quality of care problems if the process for identification of these problems is deficient.<sup>(4)</sup>

More recent oversight investigations by the Office of the Inspector General (OIG) have found that 8 percent of required nursing home enforcement cases were not referred to CMS.<sup>(6)</sup> Another OIG investigation<sup>(7)</sup> found that of 55 cases they examined requiring termination, CMS did not apply the mandatory remedy as required in 30 cases (55 percent). A comprehensive investigation by the US Government Accountability Office (GAO) found that despite increased oversight by CMS, “. . .inconsistency among state surveyors in conducting surveys and understatement by state surveyors of serious deficiencies.”<sup>(8)</sup>

In response to concerns about the consistency of the process used in state surveys, HCFA funded the UCHSC to adapt and pilot its research instrument to meet the requirements of the state survey.<sup>(9)</sup> Subsequently, this approach was refined and tested in several states and sites, and is now being tested in a five-state demonstration.<sup>(10;11)</sup> Some of these same quality assessment methodologies are used in the study reported herein. The results of these initial tests were promising, with state surveyors more frequently and consistently identifying resident outcome problems than in the standard survey.

Finally, research indicates that the type of deficiencies issued to nursing facilities varies greatly by state, suggesting inconsistency in the survey process and the process of issuing deficiencies.<sup>(5;12)</sup> In addition, Harrington & Carrillo<sup>(12)</sup> found a 100% increase in the number of facilities with no deficiencies for the period between 1991-1997 and a 44% decrease in the average number of citations. While some have argued that trends for this period may reflect an actual improvement in quality of care in nursing homes, GAO findings suggested this was not the case.<sup>(4)</sup>

More recent data indicates that high variability for the nation over time and between states has continued into the present: “From 2001 to 2005, the percentage of surveys resulting in a citation for deficiencies at the actual harm level or higher decreased from 21.9 percent to 16.5 percent. Similarly, the percentage of surveys resulting in the determination of substandard quality of care declined from 4.5 percent in 2001 to 3.3 percent in 2005.”<sup>(13)</sup> In 2004, the percentage of nursing home surveys resulting in zero health deficiency citations ranged between about 1 percent for West Virginia and North Dakota to over 25% percent for New Hampshire and Oregon (Nursing Home Data Compendium, Table 4.6).<sup>(13)</sup>

Evidence of meaningful improvement in the quality of care since inception of the NHRA is lacking. The survey and enforcement process has demonstrated modest decreases in inappropriate use of physical restraint, psychotropic drug use, and hospitalization, but the overall quality of care in nursing homes remains a matter of concern as evidenced by the large percentage of serious deficiencies and/or repeat deficiencies incurred by nursing homes.<sup>(4;14;15)</sup> In particular, the high rate of repeat deficiencies (40 %) brings the effectiveness of the regulatory process into question.<sup>(16)</sup>

## 1.1. The Effectiveness of Enforcement

Basically, the enforcement system relies on the deterrent effect of enforcement to correct identified problems in nursing homes that receive a deficiency, and to prevent their reoccurrence in these homes and others who might not provide adequate care in the absence of this enforcement system. Although many aspects of this system have been studied, there is little empirical evidence supporting the most fundamental assumptions.

Put simply, we do not know the impact of enforcement on the quality of care. Up until recently it has not been possible to measure enforcement – the data have been widely scattered and there has not been any centralized database. Absent such a database, researchers have used deficiencies as a proxy for enforcement. But the receipt of a deficiency is only the beginning of an enforcement process, a process that may, but usually does not, result in the imposition of a significant sanction. Fortunately, a centralized database has become available that permits the generation of enforcement measures and for the first time, an analysis of the impact of enforcement on resident outcomes. This ongoing study complements the qualitative case studies reported here.

The above noted widespread variation in deficiency citation rates both between and within states and over time has been viewed by the industry as evidence of inconsistency and erroneous citations where the rates are high; it is assumed that nursing homes are generally providing good care in compliance with federal regulations. In contrast, nursing home advocates think that the general level of care is poor and that the low citation rates are evidence of an ineffective enforcement system and failure to enforce federal regulatory standards. There has been no **independent** assessment of whether citations are appropriate and consistent with federal regulations. This study will address that fundamental question and is unique in at least two aspects:

- There have been no studies that have examined the *process* of enforcement – an objective that inherently requires a longitudinal (and qualitative) design. As we will show below the process of enforcement begins with the identification of noncompliance by nursing home surveyors, the issuance of a deficiency, a Plan of Correction (POC) in response by the provider, revisit by the survey agency to determine if the POC has been implemented, potential appeals by the provider, and possibly the issuance of a sanction. This process takes place over time with meetings and discussions in the nursing home and survey agency. Essentially, this process is the black box of enforcement, a process that is difficult to observe. Reports by the GAO and OIG have often looked at one or another aspect of this process – e.g., whether high-level deficiencies are appropriately referred to the CMS' Regional Office for enforcement sanctions – but they have not looked at the entire process. This observational study constitutes a first time investigation look into the black box.

- This study will also employ investigatory protocols to independently determine for the study cases if the citations are inappropriately generated for nonexistent problems, as the industry often claims, or inappropriately not cited for regulatory violations, as often asserted by the nursing home advocates.

## 2. METHODS

While qualitative methods are often assigned a secondary or nominal role in health care and policy research, this need not be the case. As David Morgan notes,<sup>(17)</sup> qualitative methods are uniquely suited to exploratory and confirmatory work, and to inquiries that seek to answer how and why certain outcomes are produced. In the case of this study, process and outcome variables are somewhat confounded in the survey and enforcement process, making any inquiry complex. A qualitative approach is uniquely suited to this dilemma because of the ability to ‘unpack’ the relationship between process and outcome. It is also ideally suited to the assigned task because qualitative (naturalistic) inquiry is able to capture the meaning that informants assign to their decisions and actions in the survey and enforcement process, a domain that is absent in quantitative approaches and would be difficult to capture via quantitative means alone. Thus, a qualitative approach was employed in this study because of its strengths: the ability to address and uncover decision-making processes; explain patterns of reporting and enforcement (some of which had already been demonstrated quantitatively); and answer questions emerging from prior research and observation that could not be addressed effectively through quantitative means alone.

It should be noted that case studies, as a methodology, are inherently labor-intensive and the 26 reported here represent both theoretical saturation (the standard in qualitative methods that is comparable to the concept of “power”) and a relatively high number of cases. The results of the 26 case studies were remarkably consistent, even given the geographic diversity of the sample, and it is unlikely that a larger sample size would have yielded different results. With respect to the standard of rigor in qualitative research, it is important to recognize that the data collection protocol for this study required a very high level of skill and intensive training for the nurse data collectors to conduct. This presented a significant problem in data collector recruitment and indeed, one data collector was dismissed after data collection had begun because she was unable to fully grasp and enact what was required.

It should also be noted that the states and facilities volunteered their participation in this study. Although we make no claim that the sample is representative of the U.S., any bias that may have resulted from the volunteer sampling strategy is likely in the direction of producing results that are more favorable to the survey agencies and nursing homes. Apart from the 10 states that declined participation, two states withdrew after initially consenting, and six case studies were aborted. Among those that did participate, this independent study found many problems that were not identified by the survey agency, as well as instances of nursing home responses that did not effectively address identified deficiencies. Given the voluntary nature of

the sampling, it is unlikely that a more flattering portrait of the enforcement process would have emerged had more case studies been completed.

## 2.1. Overview of Data Collection and Analysis

The qualitative case studies followed the nursing home enforcement process longitudinally from the beginning of the annual re-certification survey until completion of the nursing home re-certification surveys. Case studies were conducted in 25 nursing facilities in four different states, with the results reported as 26 case studies.<sup>1</sup>

The study evaluated the survey's ability to identify deficient practices and the impact of enforcement activities on nursing home care. This evaluation occurred via observation of facility care practices during a series of visits; for each case study, three visits were made to the targeted nursing home facility and three visits/observations were made of the state agency/survey team. The purpose and content of these visits is described in detail in section 2.6.

Data collection consisted of direct observation, in-depth interviews, and detailed record review. Instruments and questionnaires were designed to encourage a systematic and comprehensive approach to data collection, while allowing flexibility and responsiveness to accommodate varying circumstances and emergent findings. Field notes were taken in real time, then notes were transcribed and prepared for electronic transmission to the study coordinator. An initial review of the data occurred in the field where RN data collectors used their professional expertise to interpret the data and provide summary evaluations. For each stage of the case study, data collectors completed a research summary sheet, by transposing their field notes in detail and composing a summary evaluation tailored to the research questions and study objectives. These summary evaluations and field notes were then reviewed by the study coordinator and prepared for further analysis.

Using the summary evaluations and field notes created by the nurse researchers, data were analyzed using a combination of inductive and deductive approaches. Data were coded deductively, using the study goals, steps of the enforcement process, and key terms (i.e. severity, impact, etc.) as markers for data abstraction. Data were simultaneously abstracted and coded inductively, using emergent themes identified by the data collectors and study coordinator. This method of axial and thematic coding was followed by a synthesis and summary of the observations *by case study* and *across case studies*. Case studies were reviewed, compared, and contrasted to discover trends and to assess the accuracy of analytic conclusions. Comparisons were made between states, facilities, the survey team, and the study team regarding quality of care. Explicit attention was given to negative cases in order to better understand the potential mechanisms driving differing results. This method was particularly useful with respect to exploration of issues such as differences in monetary penalties between states or the downgrading of citations.

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<sup>1</sup> In one survey, two case studies were conducted: one on a standard survey and one on a complaint.

## **2.2. RN Data Collectors**

Registered nurses (RNs) were recruited to conduct on-site data collection; one for each of the four participating states. The study team placed great emphasis on recruiting nurses familiar with the nursing home survey, and who had substantial professional experience in a nursing home setting. In addition, since case studies relied heavily on observation and interviews, it was imperative that the nurses be able to skillfully employ these data collection techniques. When the desired combination of traits proved unattainable, we sought nurses with professional experience in the nursing home setting who had interpersonal skills amenable to qualitative research. Specifically, we sought evidence of the ability to establish easy rapport with people, good observation skills, and the ability to persistently elicit information from informants without alienating them. All data collectors were RNs recruited in the study state of their residence, all had extensive professional experience in nursing home care, each had experience with the nursing home enforcement process either in a consulting capacity to the nursing home industry or in a managerial position in a nursing facility.

Each data collector received one week of training at the University of Colorado Health Sciences Center Facilities, in Denver. The training consisted of instruction in the study protocols and an introduction to qualitative research techniques, including: classroom instruction, role-play, and experiential application of the observation and interview techniques at a local health care facility. Immediately following the training, a member of the research team accompanied each data collector to a study facility in her state to practice the new skills the data collection protocols on-site.

## **2.3. State, Facility and Care Area Selection Process**

The study protocol for selection of states, facilities, and care areas is described in this section of the report and is illustrated in Figure 1.

### **2.3.1. State Selection Process**

Four states were recruited from the ten federal enforcement regions. Regional representation was ensured by inclusion of states from four of the CMS geographic regions: west, mid-west, mid-Atlantic and south. A purposive sample was chosen based on state enforcement and citation records provided by CMS. State selection relied upon two criteria that favored states with higher citation rates in targeted care areas and sought to create a sample that reflected variation in enforcement procedures. States exhibiting deficiency rates above the national average were selected for inclusion in the study because adequate deficiency activity was necessary to assure the team would encounter surveys in which citations were given. Once this initial deficiency criterion was met, states were selected on the basis of variation in enforcement procedures to assure that the study included a range of programmatic approaches. A CMS introductory note was emailed to each selected SA office, followed by a faxed letter explaining

the study. In addition, every effort was made to contact each SA by telephone. Ultimately the selection of states was also influenced by the willingness of the states to participate in the study. Ten states declined participation, claiming lack of resources and manpower. Two states withdrew after initially consenting, and in one state no qualified data collector could be recruited.

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**Figure 1: State, Facility, and Care Area Selection Process**

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\* If more than 1 targeted care area was identified, the study care area was selected based on prevalence (lower prevalence areas were chosen first to provide an adequate sample in all of the targeted care areas) and scope/severity (preference for higher scope/severity).

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2.3.2. Facility Selection

Within the four participating states, the study sample was selected from all nursing facilities receiving a Medicare/Medicaid standard survey for re-certification during the time of the field data collection. Facilities undergoing extended partial surveys or abbreviated standard surveys were not eligible, due to significant differences in the scope of the survey tasks performed in these types of evaluations.

Facilities were selected when the annual re-certification survey revealed preliminary findings that indicated a potential citation for one of the targeted F tags in the first two days of the survey. The study team also selected facilities purposively in order to achieve a relatively representative distribution of those F tags that were targeted in the study. Overall, selected nursing facilities evidenced a high level of willingness to participate.

Case studies were initiated in thirty-one nursing facilities during the annual re-certification survey. Six case studies were aborted, for two reasons: 1) refusal of the participants (refusal of the state or the facility staff); or, 2) failure to issue a citation in one of the study’s targeted care areas (despite preliminary survey findings indicating a potential citation). Thus, with the removal of the 6 aborted cases, case studies were completed in 25 facilities.

One facility was subjected to a complaint investigation during the compliance cycle, which was followed as a separate case study. With the addition of this case, the 25 facilities yielded 26 completed case studies.

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**Table 1: Number & Distribution of Facilities and Case Studies**

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<u>State</u>	<u># Facilities with Completed Case Studies</u>	<u># Completed Case Studies</u>
1	7	7

2	4	4
3	8	8
4	6	7*
<b>Total</b>	<b>25</b>	<b>26</b>

\*Includes complaint investigation.

### 2.3.3. Study Care Area and F Tag Selection

To investigate the impact of the enforcement process on the quality of care in nursing facilities, the study team identified five care areas of interest: pressure ulcers, weight loss, abuse/neglect, physical restraints and pain management. Study care areas were linked to federal regulatory tags, or F tags, outlining standard practice guidelines (Table 2).

To study survey accuracy and the impact of enforcement on nursing staff behavior, each case study was required to have at least one F tag for which the preliminary survey findings showed facility practices sufficiently deficient to result in a citation. Additionally, to evaluate the surveyors' ability to detect problems, an additional study care area was selected at each site. The requirement for this second care area was that the preliminary survey findings indicated no deficient facility practices.

**Table 2: Study Care Area Related to F Tag**

<u>Care Area</u>	<u>Definition</u>	<u>F Tag</u>	<u>Regulation</u>
Pressure Ulcer	At risk for pressure ulcers Current pressure ulcer stage 2, 3, 4	F314	Prevention and /or treatment of pressure ulcers
Weight Loss	At risk for weight loss 5% weight loss in last 30 days 10% weight loss in last 180 days	F325	Nutritional status
Abuse/Neglect	At risk for abuse/neglect	F223	Free from abuse
	Incident of abuse/neglect in past year	F224	Staff treatment of residents
		F225	Investigation/reporting of abuse
Physical Restraint	Current use of devices restricting free movement	F221	Physical restraints
		F324	Prevention of accidents
Pain Management	Routine pain medication and daily pain	F309	Care and services

In each case study, the study team selected at least two study care areas: one for which the survey team had indicated a potential citation (F tag) and one for which no such indication existed (alternate F tag). F tag selection was determined by the survey team's findings. The study team aimed to achieve equal distribution of F tags for the overall study; this objective, however, was dependent on duration of data collection and availability of F tags. The selection of the second (alternate) F tag was based on each facility's deficiency history; care areas were targeted for which the facility had incurred one or more citations in the past 3 compliance cycles. If no such citation existed the data collector determined on-site which care area was the most suitable, because the surveyors had indicated that: 1) no problems were found; 2) facility records revealed a high prevalence/incidence rate for specific conditions; or 3) study observation indicated concerns for one particular care area. The selection of study care areas was limited to two per case study in order to allow the data collectors adequate time for thorough investigation while minimizing undue burden on the investigated nursing facility and SA.

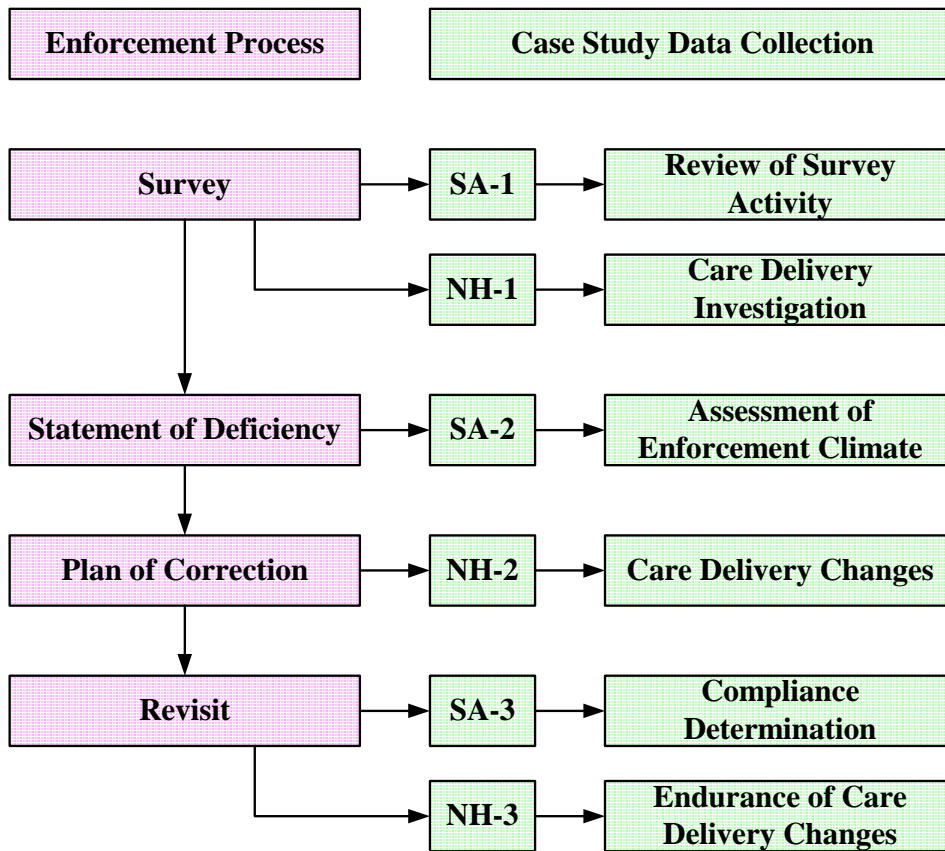
In each facility, the data collectors targeted 2-4 residents for an in-depth investigation. Residents were selected because their records indicated at-risk status for a condition relevant to one or both of the selected study care areas.

#### **2.4. Data Collection**

Each SA committed to share the preliminary survey findings with staff at the Division of Health Care Policy and Research (DH CPR) by the second or third day of the agency's survey visit. DH CPR staff determined whether the facility met the eligibility criteria for a case study. If the agency's preliminary findings demonstrated significant concerns in one or more study care areas, the nursing facility was chosen for inclusion in the study project. Deficiency history and facility observations determined the alternate study care area.

Once a facility was chosen, a total of six visits were conducted per case study to either the SA or the nursing home. These visits alternated between the SA and nursing facility for the duration of one enforcement cycle (from initial re-certification survey to re-certification). Visits coincided with distinct steps in the enforcement cycle: a) the survey; b) release of the Statement of Deficiency; c) last implementation date of the corrective actions outlined in the Plan of Correction; d) revisit; and, e) one month following implementation of the corrective actions. The study site visit protocol is depicted in Figure 2.

**FIGURE 2: Overview of Data Collection Process**



Each visit had a specific objective:

**SA1 Visit:** Visit to the nursing facility during the last day of the survey. The purpose of the SA1 visit was to observe the surveyors' decision-making process. Specifically, the study evaluated the survey team's ability to identify deficient practices through an independent observation of facility care practices. Observation of surveyors' investigative actions, F tag designation meeting, and exit conference with the facility. Data collectors were always present on the last day of the survey from the team's arrival until the team's departure from the facility following the exit conference. Data collection during this visit consisted of direct observation; questions were kept to a minimum and then only for clarification purposes. Even though the visit focused on decision-making and the F tag designation meeting, the data collectors also observed some of the investigative actions of the team and the interactions between facility- and state agency staff.

**NH1 Visit:** a 2-3 day visit at the nursing facility immediately following SA1 to independently study the facility's care practices. The focus was on the study care area relevant to survey citation and one alternate study care area not implicated in a survey citation. Data collection involved record review, observation of facility practices, and review of organizational

structures. The NH1 visit provided a baseline assessment to evaluate any changes resulting from enforcement process. During the NH1 visit, care delivery was observed for at least four sampled residents, who were either at risk or treated for a specified condition relevant to one specific nursing care area for which the survey had found no preliminary findings. The resident-centered assessment involved structured resident record reviews; facility record reviews; observation of specific care practices; and interviews with direct care and management staff. Structured assessments were conducted using protocols and tools derived from the Quality Indicator Survey (QIS).<sup>(18)</sup> The data collectors then determined for each resident review whether deficient practices had occurred and if so, whether the deficiency warranted a citation.

SA2 Visit: Visit to the SA following release of the Statement of Deficiency (SOD). The focus was on exploration of SA decisions and perceptions with respect to citations and designation of scope and severity through semi-structured interviews with surveyors, licensing/enforcement officers and supervisory staff.

NH2 Visit: 1-2 day visit at nursing facility to verify implementation of corrective actions. The focus was on care delivery modification involving residents implicated in the original F tag and, additionally all residents selected for review at NH1. Data collection consisted of record review; observation of care delivery, interviews with management, QA staff, and direct care staff.

SA3 Visit: Visit to SA following surveyors' re-assessment of facility compliance. The focus was on exploration of determination of compliance and SA staff perceptions of enforcement process effectiveness through interviews with re-visit officer(s) and supervisory staff.

NH3 Visit: 1-day visit to nursing facility one month following NH2. Focus on endurance of compliance. Focus on staff retention of knowledge related to in-services involving survey citations, continuation of corrected care practices according to regulation. Data collection consisted of record review, observation of care delivery practices and interviews with management staff and new hires.

In summary, the following qualitative methods were used to examine the accuracy and efficacy of the enforcement process, including: 1) direct observation of care practices relative to the investigated care areas; 2) interviews with nursing home direct care staff, management staff and residents regarding care delivery, management and organizational practices; 3) interviews with SA staff regarding their perceptions of care delivery in specific nursing facilities; 4) review of facility protocols and guidelines pertaining to the care areas under investigation; and, 5) review of selected individual resident records

Data collection tools were designed to encourage a systematic approach to the study subject while providing the nurse researcher maximum flexibility in order to allow on-going responsiveness to specific situations observed in the visited nursing facilities.

The nurse researcher recorded the data on provided data collection instruments at the time of observation and interview. The nurse researcher synthesized some of the information while in the field. Further analysis and selection of material for case studies was performed by DHCPR staff.

### **3. CASE STUDY FINDINGS**

The federal regulatory system for nursing homes is complex, consisting of various components that depend on and/or support each other. The case studies conducted an in-depth study of this system by observing several distinct steps in the process, which are used to organize the findings. This chapter follows the enforcement process sequentially, as if following one nursing facility's experience through one enforcement cycle. The sections include: 3.1 Survey to detect and identify deficient practices; 3.2 Statement of Deficiencies, reflecting the formal survey outcome; 3.3 Enforcement, to encourage the correction of deficient practices; and, 3.4 Revisit, to evaluate adequacy and implementation of facility corrections. Each of these four sections is divided into three subsections. In the first subsection, a brief summary of the guidelines for that aspect of the survey is provided. In the second subsection, summary statistics across all case studies are provided. In the final subsection, the qualitative case study findings are highlighted on survey and enforcement practices.

#### **3.1 Survey to Detect and Identify Deficient Practices**

##### **3.1.1. CMS' Annual Re-certification Survey**

All facilities participating in the Medicare/Medicaid programs are subjected to regular surveys to determine compliance with the federal regulations. The survey initiates the enforcement process through detection and identification of deficient practices; those practices that do not meet the federal standards as outlined in the regulation. Surveys are conducted at least annually to re-certify a nursing facility into the Medicare/Medicaid programs. A survey determines a facility's compliance status either as compliant or non-compliant for each of the federal regulatory requirements or F tags. Non-compliance is established when a facility does not meet federal requirements for a specific F tag and results in a citation. If, during the survey, no deficient practices are identified, the facility is considered in compliance with the federal regulations and no enforcement is needed. In 2004, the percentage of surveys that were deficiency-free was 10.2%.

##### **3.1.2. Survey Findings: Detection and Omissions**

The case study surveys detected many deficient practices and many resulted in citations. These are discussed in the section on citation decisions. In this section the focus is on deficient practices that the survey did not detect, and hence did not cite; and, alternatively on those deficient practices that were identified by the surveyors but did not result in a citation during the survey.

### 3.1.2.1. Detection Problem

Twenty-five case studies (*complaint investigation excluded*) were evaluated for identification of deficient practices. The study detected deficient practices in 24 facilities; in 18 of these the survey found no deficiency related to the relevant F tag (Table 3). The deficiencies identified by the study involved many F tags including: dehydration (F227); weight loss (F225); inappropriate restraint use (F221); inadequate supervision and or monitoring to prevent accidents (F323); abuse and neglect (F223); inadequate pain management ((F309); and inadequate prevention or treatment of pressure ulcers (F314). Additionally the study often cited inadequate nursing assessment (F272) and/or care planning (F279).

For the six facilities where both the study and survey found deficient facility practices resulting in a citation, in some cases the study selected different but related F tags than the survey. Nonetheless, both the study and the survey determined that facility deficiencies had occurred. This highlights the issue that often different F tags are justifiable for the same care problem. In only one case study did the study not find deficient practice that warranted a citation and as such agreed with the survey that no deficiencies relative to the study area had been observed.

The study citations also assessed the Scope/Severity level and in most cases these ranged between D and G, with emphasis on the higher Scope/Severity levels E, F and G.

**Table 3: Identification of Deficient Practices for Selected F tags Based on Survey and Study**

	SURVEY		
	Deficient Practice Detected	No Deficient Practice Detected	Total
Study Evaluation			
Deficient Practice Detected	6	18	24
No Deficient Practice Detected	0	1	1
Total	6	19	25

### 3.1.2.2. Omitted Citations

At times the surveyors detected deficient facility practices, but these deficient practices did not result in a citation. These omissions occurred either through a deliberate process of decision-making on the part of the surveyors or the identified deficient practices never reached the decision-making stages. Omitted citations were in general not officially registered; hence, they disappeared from the federal enforcement process and escaped enforcement actions and regulatory scrutiny.

Omitted citations were a common occurrence for the twenty-three case studies for which the study had adequate data; all but one survey revealed at least one such omission. In addition, the omitted citations occurred with relative frequency, ranging from 1-5 F tags per survey. The omitted citations can be categorized as follows: 1) *missed*, for those that were identified as deficient practices, but never reached the F tag stage; 2) *comments*, for those identified deficient practices that were relayed to facility staff, but not cited; and, 3) *state citations*, for those deficient practices that were said to be issued as a state citation, and never occurred under a federal regulatory tag.

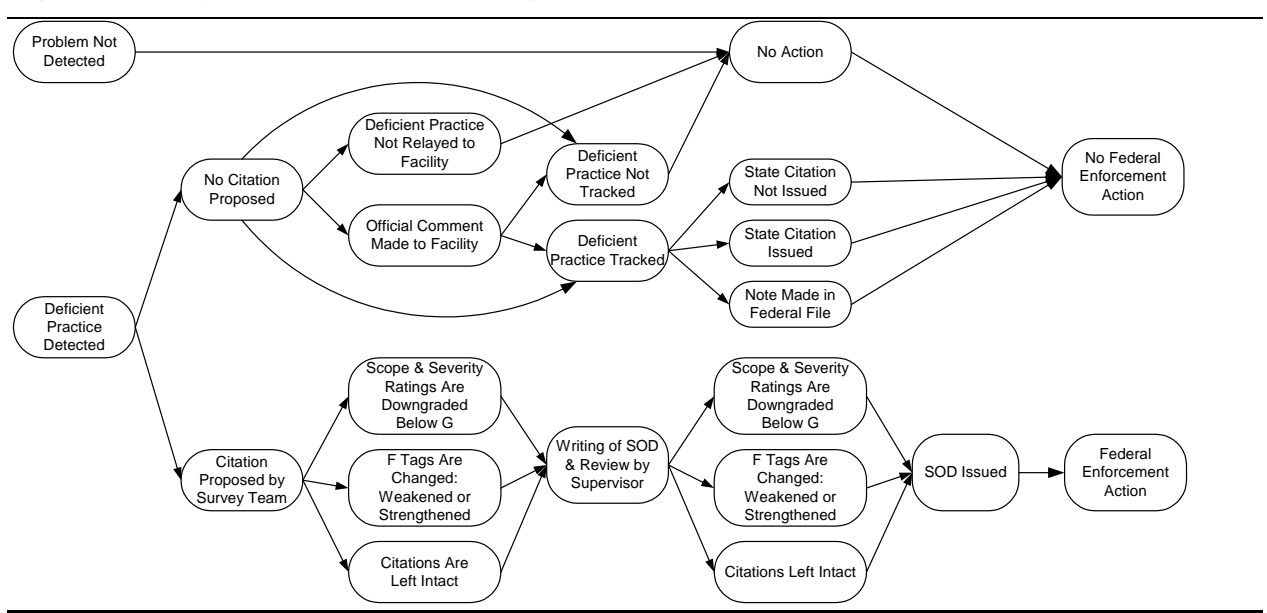
**Table 4: Frequency of Omitted F Tag Citations per Facility**

	<u># Of Facilities where this occurred</u>	<u># of F tags per facility</u>
Missed F tags	15	1 – 3 F tags
Comment for Deficient Practice	12	1 – 5 F tags
State Citation	3	1 F tag

3.1.2.3. Survey Practices

Observations of the surveyors in action during the survey offered a great opportunity to understand what happened behind closed doors, how decisions were made, and what factors affected the outcome of this decision process of the survey level. The citation decision-making process, as observed by the study team, is presented in Figure 3.

**Figure 3: Survey Citation Decision-Making Process**



#### 3.1.2.4. Summary of Detection Issues

The case studies revealed common failures to detect deficient facility practice. It is difficult to ascertain exactly why the survey teams often failed to detect deficient practice. Surveyors were invariably diligent in their adherence to the complex and exacting procedural protocols. Nevertheless, very basic and openly practiced deficient care and documentation irregularities were often missed by a survey team. These omissions included insufficient repositioning of residents at risk for pressure ulcers; improper documentation; use of comfortable reclining chairs preventing rising etc. Standardized care plans instructing meaningless and/or ineffective interventions or failures to implement care plan interventions as instructed were often entirely missed or overlooked. These practices were not incidental or isolated occurrences; rather, they were common and affected many residents. At times more serious isolated incidents were also overlooked, as illustrated by the following passage:

*Young male resident, recently re-admitted to the facility from the hospital where the resident had been treated for dehydration, was found restrained in bed, water pitcher out of reach. The resident had dry, furrowed tongue and was complaining of thirst. IO records required per facility policy had **not** been documented, since re-admission. CNAs, when questioned, were not aware of this resident's need for fluids and had not been assisting the resident with fluid intake. During the F tag meeting the survey team had discussed dehydration and found no problems.'* FAC24SA1+NH1

The data collector who observed this team on the last day of survey found the two surveyors primarily in the office completing record reviews. It is possible that this team had observed this resident at an earlier time during the survey, but the fact that no I&O records were available for this recently re-admitted bedfast resident should have reached the surveyors' attention and invoked an investigation. This survey team complained of insufficient time to investigate due to staffing shortages; however, not detecting this apparent and very basic deficient nursing practice implies problems with the investigative process.

Another factor potentially contributing to the surveyors' inability to detect deficient facility practices is the casual, often hurried and perfunctory manner in which some survey teams treat the *closed record review*. When questioned, subjects' responses revealed that many surveyors considered a closed record review to be meaningless, reasoning that a citation could no longer be of service to the resident once a resident had been discharged. Although these responses indicated a 'resident advocacy' attitude on the part of the surveyors, this is a rather limited view, since closed records could reveal care problems that may potentially affect a large group of current and future residents. Since the aim of the regulatory process is to create lasting and enduring compliance with minimum requirements *for all residents*, this narrow interpretation ignores the broader purpose of the closed record review and ultimately may fail to protect current residents.

Finally, deficient care practices were sometimes lost in the *investigative process* itself. Even though this happened infrequently, sometimes a line of inquiry was dropped before an informed decision was reached; a surveyor became distracted by other demands and/or

responsibilities, a surveyor/team leader was disorganized, incompetent and/or the investigative process was chaotic. Although most surveyors were professional and very competent, occasionally a surveyor was clearly lost and did not receive direction from either team members or the team leader to complete all investigations relevant to the decision at hand.

At times the surveyors were aware of the fact that they did not follow a line of inquiry or were unable to investigate all they would have desired. Three reasons were provided for these failures: 1) cumbersome paperwork; 2) shortened survey (often a full day less than the usual allotted time); and 3) manpower shortage. This last complaint was heard frequently and unsolicited in one state where a 'hiring freeze' clearly had placed a dent in the numbers of surveyors per survey.

### 3.1.3. Citation Decisions: to Cite or Not to Cite?

Survey teams at times made the decision not to cite a detected deficient practice. This decision not to cite occurred with relative frequency (13/26). Reasons for doing so varied but in general insufficient time, inadequate substantiation, and/or relative unimportance of the transgressions were quoted.

Identified but not cited deficient facility practices were often, but not always, communicated directly to the facility's management staff and at times were mentioned during the exit conference. Three states had semi-formal ways to deal with these non-cited deficiencies; in two states these communicated non-cited deficient practices were referred to as '*comments*' and ended up in the facility compliance file, while the other state referred to these practices as '*mentionable*'. Comments and mentionables were discussed as such during the F tag designation meeting, revealing that this is an accepted survey practice. In one particular instance, the surveyors reviewed a facility's compliance file during the F tag meeting, concluded that a specific deficient facility practice had not been commented on in the previous year; therefore, this year the facility could receive a comment instead of a citation. Surveyors when questioned indicated that these non-cited deficiencies were '*not significant enough to warrant a deficiency*'. Other reasons provided for not citing a detected deficiency were: a) 'there was no resident outcome'; b) 'the universe is not big enough'; c) 'the care needs of the residents are met'; and, d) 'the facility has identified the problem and is working on it'.

In one state this practice to '*comment*' occurred in a completely informal way, no records were kept and no tracking mechanism existed, still comments appeared in the form of advice and /or recommendations to the facility. When asked, the respondents stated that these deficient practices would have been A-level citations that required no Plan of Correction, therefore, they were not worth the paperwork and effort.

Surveyors expressed the belief that these comments and mentionable would encourage the facility to look at the issue and make the necessary corrections, a belief for which the case studies found no support.

One state cited some of the more serious deficient facility practices under State statutes, choosing not to cite the deficiency under a federal F tag. This alternate system of citing was believed to be less restrictive than the federal regulatory system, which they argued allowed citations to be issued with less paperwork, and, resulted in more stringent and effective enforcement. Investigating the States' regulatory practices were beyond the scope of this project; therefore no details were obtained. It should be noted that this alternate citing system decreased the number of higher-level federal citations even in cases where deficiencies were identified that were out of compliance with federal standards. In addition, the observed instances of this alternate citing practice had not resulted in any formally presented state citation two months after the survey.

### **3.2. Statement of Deficiency, Reflecting the Formal Survey Outcome**

#### **3.2.1. Citing: Regulatory Decision-Making Process**

All deficient practices resulting in a citation are presented by F tag and S/S level on a Statement of Deficiencies (SOD) or 2567. The SOD represents the formal survey outcome and indicates the facility's compliance status according to the F tag at the highest scope and severity level. The citations on the SOD are the result of an extensive decision-making process that starts during the survey and is finalized at the SA.

The decision to cite is initially made during the survey activities. A citation decision is discussed with the survey team members during a general group session, the *F tag Designation Meeting*. During this session deficient facility practices are reviewed, and decisions are made with respect to issuing a citation.

Citations are specified by a federal regulatory tag, e.g., F 314 indicates that a facility did not meet all the federal requirements pertaining to the development and/or treatment of pressure ulcers. In addition, citations are assessed for scope and severity. A severity rating is assigned based on the extent of harm, whereas scope is determined based on the prevalence of the problem (how many residents were affected). Scope and severity designations range from A through J, with J indicating a more severe problem. For example, on this continuum a G-level citation indicates that an observed deficient practice was *isolated* (scope), but resulted in *actual harm* to one or more residents (severity). If, during the survey, the survey team decides to make a citation, decisions must then be made regarding the F tag, its scope and its severity. The resulting citation decisions are considered *preliminary survey findings*. These preliminary findings are presented to the nursing facility staff during the *exit conference*, a final open meeting with facility staff.

Following the survey, surveyors provide written substantiation for an F tag and the scope and severity level (S/S). This work is subsequently reviewed and scrutinized by supervisory SA staff and decisions are made about the appropriateness of an F tag and/or scope and severity level. Lastly a formal written document results, the Statement of Deficiency. The preliminary

survey findings may be revised and the survey citations on the SOD may look considerably different from the preliminary survey findings.

### 3.2.2. Statement of Deficiency Findings

Despite the survey flaws in detection and accuracy, many deficient facility practices become citations on the SOD. The Statements of Deficiency for the 26 case studies revealed considerable variation in frequency of citations (Table 5). The total number of citations per case study was as low as one citation (in *two case studies*) and as high as 21 citations (*in one case study*). However, most facilities averaged between 4-10 citations.

**Table 5: Citation Frequency per Case study by State**

	State 1 (N = 7 Case Studies)	State 2 (N = 4 Case Studies)	State 3 (N = 8 Case Studies)	State 4 (N = 7* Case Studies)	All States
#of citations					
1 – 3	1	1	0	1	3
4 – 6	1	1	4	1	7
7 – 9	1	1	3	1	6
10 – 12	1	1	1	2	5
13 – 15	3	0	0	0	3
16 – 18	0	0	0	0	0
19 – 21	0	0	0	2	2
Total	7	4	8	7	26

\* includes complaint investigation

Scope and severity designations ranged from B to IJ (*Immediate Jeopardy*) (Table 6). In all states the majority of citations were issued at B, D, and E levels. No A-level citations were given for any case study facility in any state. A-level citations do not require any enforcement actions, therefore, it was considered '*not worth the effort*' to write up these citations. The majority of S/S designations were at the D-level; very few citations were issued at or above the F level. This is likely related to the fact that higher-level citations (beginning with F) may change a facility's compliance status. In the case of issuance of an F tag at or above the F-level, the facility's compliance status may change from *substantial* to *substandard* compliance. G-level citations carry even more severe enforcement consequences and as such are an undesirable outcome for most facilities. Ten G-level citations were issued for seven case studies. The majority of Gs occurred in state 4 (5 Gs) and none were issued in state 2. Two of the case studies with G-level citations received multiple Gs on the SOD, respectively, three and two each. Immediate Jeopardy citations, which put a facility on a fast track to closure unless immediately corrected, were issued in three facilities in three different states.

**Table 6: Number of Citations by Severity and Scope Levels in each state.**

<u>S/S level</u>	<u>State 1</u>	<u>State 2</u>	<u>State 3</u>	<u>State 4</u>
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B	23	1	1	8
C	4	1	1	0
D	25	9	26	39
E	7	6	12	16
F	0	1	3	4
G	1	0	4	5
H	0	0	0	0
I/J	0	1	1	1
K	0	0	0	0
L	0	0	0	0

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\* Includes complaint investigation

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### 3.2.2.1. Discrepancy between Preliminary Survey Findings and Statement of Deficiency

Of the 25 case studies, 7 showed no change from exit conference to SOD. However, ‘downgrading’ of the scope and severity level occurred in 14 cases (12 of which involved complete removal of an F tag) and upgrading occurred in 5 cases. Thus, discrepancies between the preliminary survey findings presented during the exit-conference and the SOD occurred in a total of 18/25 case studies. (Note: both an upgrade and a downgrade occurred in one case study; resulting in 19 changes per 18 case studies).

It was apparent from the case studies that the revisions on the SOD were not random; rather a clear trend emerged toward minimizing the preliminary survey outcomes by lowering the scope and severity level and/or removing certain F tags altogether. Moreover, the frequency of downgrades per case study was considerably greater than the frequency of upgrades, again revealing a tendency to minimize the preliminary survey findings. Additionally, the downgrades were in general away from G. It must be emphasized that in almost all cases of change on the SOD the data collectors agreed with the surveyors’ original preliminary survey findings.

If one arrays the proportion of nursing homes receiving a G or higher level deficiency by quarter, there was a sharp downward trend beginning in January 2000, almost coincident with the introduction of the Double-G policy in January 2000. This policy required that all homes receiving two successive G or higher deficiencies had no opportunity to correct the deficiency and had to be referred to the regional office for a sanction. Since it is improbable that the quality of care in the nursing homes precipitously improved or declined, this change is likely due to survey agency behavior and not to any real change in the quality of care. It is likely that Survey Agencies were trying to avoid the referral process, an inference which is supported by these case studies. Thus, there may be inherent (albeit unintentional) incentives to downgrade and this is one such example of an incentive.

### 3.2.3. Citing Practices

### 3.2.3.1. Weakening- Strengthening of F tags

This is a relatively infrequent occurrence (5/25) happening mostly at the survey level although occasionally this occurred at the SA level. Weakening or strengthening involved the selection of an F tag that carries less/more weight either based on the facility's deficiency history, or in relative weight in the federal regulatory system. Additionally, one other way to strengthen a particular citation is by tagging it under a variety of F tags, each bearing some relevance to the deficient practice. The decision to weaken or strengthen an F tag was often, although not always, deliberate; however, the study could not discern a particular direction. In other words, weakening of an F tag occurred as frequently as strengthening. The following case illustrates an example of a chaotic survey by an independent survey team unwilling to assist one of its team members in reaching a conclusive citation with respect to pressure ulcers:

*'76-bed facility surveyed for its annual re-certification survey revealed a high incidence rate of facility acquired pressure ulcers, which the team investigated. During observation one resident had been found soaking wet. A medical record review revealed that this resident was treated for a 'diaper rash'; in addition, the records recorded repeated skin breakdown, which were documented as excoriations. The investigating surveyor was disturbed by these findings and had wanted to cite the incident under f 314 for failure to prevent pressure ulcer, but could not figure out how. The team did not offer assistance to reach a conclusion. The surveyor decided to cite under F316, failure to provide bladder training. Subsequent observations by the data collector revealed that the facility failed to provide its residents with the most basic preventive pressure ulcer care; keeping incontinent residents clean and dry and repositioning of mobility impaired residents. Study observations indicated that residents were left unchanged and without repositioning for stretches of six hours at a time.'* FAC13 SA1 and NH1

A rationale for strengthening an F tag was sought in the following example where the nursing home did not seem to understand the severity of their transgression, nor could the severity be elucidated through the S/S level. The team sought ways to signal to the facility their deep concern regarding the facility's practice by reviewing all regulations, federal and state, relative to the transgression in an attempt to issue more than one citation, 'double dipping'.

*'Mid-size facility (>100 beds) visited for annual re-certification survey by a team of 5 surveyors, including 3 RNs. The Team in obtaining a list of discharged residents noticed that one resident had no indication as to discharge location, and in questioning that omission, facility staff had replied, "He is missing, but he left his jacket here so we think he may be back." This remark sent the survey in a tailspin, the incident had taken place one month prior and facility staff did not know of the resident's whereabouts. An Immediate Jeopardy (IJ) citation was considered and the survey was extended. As the details of the incident emerged, the team's opinion shifted. The resident had been alert and oriented, had signed his own admission agreement with the facility and was deemed capable of making his own medical decisions. Nonetheless, the facility had failed to report this incident to the appropriate governing agencies, had failed to conduct an investigation into the matter and therefore had failed to protect the resident from the potential for harm. The Team remained in constant communication with the SA and it became apparent that SA supervisory staff would not support an IJ citation; some team members experienced this as a total lack of support. When the Team finally sat down to make citation decisions, the discussions often circled back to abuse and neglect. The team members*

*had reviewed the State Operations Manual extensively and tried to fit this incident under many F tags including all abuse tags and all tags related to discharge or transfer in an attempt to find more than one F tag that was appropriate to the situation and would “stick.” Only F223 seemed to fit and the incident was cited as D; an isolated occurrence with the potential to cause more than minimal harm. This relatively benign S/S level did not express all team members’ view of the incident and their perception of the facility’s “lackadaisical” attitude towards it. The occurrence of the missing resident was a difficult situation that was not resolved to everyone’s satisfaction.’ FAC29SA1*

The practice of weakening or strengthening seldom provoked this much discussion or disagreement among team members and/or with their supervisors.

### 3.2.3.2. Downgrading

In contrast, designation of severity and scope level was often subjected to spirited discussions and extensive deliberations during the survey and called for serious scrutiny by supervisory staff at the SA. These deliberations and reviews often resulted in ‘downgrading’ - the selection of a S/S level lower than appeared warranted on first review. Downgrading was commonly done at both the level of the surveyor and supervisory (14/18 case studies). Downgrades often involved more than one citation, with as many as six downgrades executed in one case study. Downgrades were focused mainly around G-level citations, representing isolated cases of actual harm resulting from a deficient practice. Downgrades occurred from various origination scores, such as from G or E; the dominant downgrade was away from G. Comparatively, upgrades occurred relatively infrequently (in only 5/18 case studies), and reached the level of a G-level citation only once (1/5 case studies).

The following case is representative of the downgrading process at the survey level.

*‘During the F tag designation meeting the team leader stopped to pause after one of the surveyor trainees indicated that she had an actual harm citation. The team leader, placing her face in her hands and taking some time to think, finally commented: “Now let’s stop for a moment and think this through. Do we want to cite actual harm? What are the extenuating circumstances? How could we explain this differently, what could be other reasons?” The trainee eloquently stated her position to cite a particular instance at a G level. Her arguments were clinically sound and, from a regulatory perspective, warranted a G. The discussion was lengthy and was only brought to a close when one of the surveyors suggested that the team could not make a determination of actual harm since surveyors did not have the authority to diagnose. Therefore, the incident (discharge of an increasingly agitated resident to a psych unit following delayed medication for a UTI) that had resulted from the facility’s deficient care could not be assessed as actual harm. The decision was made to cite at a D-level.’ (Aborted site 7)*

This example illustrated two aspects of survey level decision-making that were apparent in multiple cases: a) the tendency toward increased questioning once a G-level citation was suggested; b) socialization of trainees to make lenient decisions. Trainee surveyors brought a fair share of citable events to the F tag designation meetings, where they were subsequently convinced to cite at a lower level or not cite at all. Trainees often argued vehemently, and to the observer’s eye with clinically sound reasoning, only to meet resistance. In general, a trainee

ultimately deferred to other team members, who inevitably argued against citing. In these discussions a tendency towards leniency on the part of the more established survey members was apparent and trainees were socialized into this tendency through the interaction that took place between the team members.

### 3.2.3.3. *Dropping an F tag*

Removal of an F tag from the SOD or ‘*dropping*’ an F tag was not an unusual occurrence, (11/18). These removals were in addition to the downgrades that may have occurred at the same site. *Dropping an F tag* occurred mostly as a result of supervisory scrutiny. The following case involved three G-level citations removed from the SOD following supervisory review.

*‘An 81-bed facility, surveyed for annual re-certification by a team of 4 RNs, was presented at the exit conference with 12 preliminary citations, including 3 G-level. The survey had been shorter than usual by one day due to surveyor training activities at the SA. The team had found many deficient facility practices, three of which were scored at G-level including F 309, F 314 and F 325. The RN responsible for the 3 Gs had been supported in her conviction to cite at G by one of the RN members, however, the team leader had expressed no opinion. The study’s independent assessment strongly agreed that indeed the facility’s practices had contributed to the development of several pressure ulcers (F 314); overall decline in status of one resident (F309); and several incidences of weight loss (F32) and had cited these F tags at G, concurring with the survey’s preliminary findings. The data collector remarked that especially the facility practices with respect to repositioning residents left a lot to be desired. Regular observations showed a failure to reposition residents every few hours according to facility policy and individual care plans. Subsequently, all G level citations were dropped on the SOD. Upon inquiring during interviews with SA staff, it had been the supervisor’s decision to remove all G-level citations: two were removed because of insufficient evidence; one F tag was removed because the case was not sufficiently made that actual harm had occurred. Despite the supervisor’s different perspective, the surveyor responsible for the citation held strong to her belief that in each of these F tags a G had been warranted.’ FAC49 SA1, NH1, SA2*

The reasons indicated for dropping these three F tags were by no means unusual. Similar rationale was frequently given for downgrading. The source of the disagreement was the Actual harm criteria, which seemed to generate ongoing debates that could not be resolved.

### 3.2.3.4. *Actual Harm Criteria: a Moving Target*

The case studies revealed that *actual harm criteria* were not consistently used between the state and district offices, or among SA staff. Actual harm citations start at G level; a G-level citation involves actual harm to at least one resident as the result of a deficient facility practice. Harm criteria were applied differently depending on the circumstances.

The most frequently cited requirement for an actual harm citation was *function loss*. In several interviews, SA staff mentioned *severe function loss* (rather than *function loss*) as a necessary requirement to cite at G-level. Additionally some SA staff indicated that the function loss had to be permanent, irreversible, and include pain and/or discomfort. The following excerpt illustrates one survey team’s application of the actual harm criteria.

*'Team leader calling out F324 during F tag designation meeting; following interaction ensues:  
RN1 This is resident #1. She fell out of her chair and broke her cheekbone. They had no measures in place to prevent her fall. She had a history of falls at home. She was assessed but they (the facility) did nothing. They did have a low bed. Afterwards they tried to do everything for fall prevention. She took the lap buddy off. Since then we can't say the facility didn't try. Citation for F324 D.*

*Note data collector: later I ask RN1 why they didn't cite at a level G since the resident broke her cheek bone as a result of the fall. RN1 stated the fracture healed and now the resident is better. She didn't lose any function.' FAC13 SA1*

Two factors are evident from this discussion: 1) pain and/or temporary function loss were not considered for the S/S level; 2) facility failure is not raised as a contributing factor.

The application of different criteria at different times created the appearance of reluctance to cite deficiencies at an actual harm level. It was obvious that actual harm criteria were elusive and little guidance was offered to surveyors as to what exactly constituted actual harm. Surveyors expressed their frustration at times as illustrated by the following interview excerpt:

*'RN1: One thing that I don't agree with is I've wanted to write harm citations but CMS and my supervisors say it is not harm unless there is loss of function.*

*Data collector: What do they mean?*

*RN1: A permanent downhill course of permanent harm. For instance somebody can keep falling and get bruises but that is not harm because their function is still the same. I had a case where I noticed a resident that was not doing well. It turned out that he had a UTI and they hadn't assessed him for it. He was having recurrent UTIs and I felt it was harm. But I went to my supervisors and CMS and they said it wasn't. Then a short time later he died. If that's not harm I don't know what is.' FAC13 SA1*

In addition to unclear and inconsistent application of actual harm criteria, the interviews also revealed that the criteria for a citable offense in the case of actual harm were not used consistently. The confusing factor appeared to be the negative resident outcome, such as a pressure ulcer. A pressure ulcer per se is only considered a citable offense if/when deficient facility factors can be established as a contributing factor in the development of the pressure ulcer or its failure to heal. However, when asked, SA staff readily indicated a variety of reasons why facility failure could not be established as the precipitating factor. For example, SA staff explained that a facility-acquired pressure ulcer should be excluded as an actual harm citation in the following situations: a) the wound is healing and therefore treatment is adequate; b) the facility has recently changed its pressure ulcer policy and therefore is complying with the regulations; c) management staff has identified the problem and is working on solutions; d) stage 1 and 2 pressure ulcers involve little healing time and/or discomfort. It is important to note that in all these justifications for not citing at an actual harm level, the most important issue (*avoidability of the negative resident outcome*, and by extension, responsibility of the facility) was not addressed. By turning the attention to the facility's ameliorative actions following pressure ulcer acquisition, the teams avert attention from the issue of avoidability and responsibility. It

seems irrelevant whether a facility is able to heal a pressure ulcer if deficient facility practices contributed to its development. Equally irrelevant are the healing time of a stage 1 or 2 pressure ulcer, or the relative intensity of discomfort in determining faulty facility practices.

The repercussions of unclear criteria were obvious in missed citations, downgrading, and F tag removal. In addition, the act of downgrading and dropping F tags contributed to the nursing home's perception that certain deficiencies should not be cited, setting the stage for a potential IDR.

*'Just prior to a major holiday weekend, a midsize, multi chain facility is surveyed for annual re-certification. Shortly into the survey, a glaring problem is noted with pressure ulcers and one resident with multiple pressure ulcers is selected for the survey's resident review. This resident is subsequently discharged to a nearby hospital for 'wound debridement', leaving the team with a half-day of observations and an individual resident record review. Although there are clear indications that the facility provides deficient pressure ulcer care citable under F 314, the surveyors, during the F tag designation meeting remain on the fence. They mention that they do not have enough time to gather documentation and do observations. In addition, they are overwhelmed by the quantity of citations (this is a shortened survey, 3 days instead of the usual 4 because of an in-service day); and, the surveyors are eager to wrap up because of the upcoming holiday weekend. During the "write-up" of tags, the citations are watered down; one RN is ill, the second RN is concerned because there are co-morbidities for her case and she wants a cite that is "plain as the nose on your face." In addition, the supervising SA staff is afraid of losing in arbitration. F 314 is dropped entirely. The independent study assessment reveals that the records provide enough evidence for a harm citation. In an unexpected turn of events, a complaint is levied against the facility for insufficient pressure ulcer care and the complaint investigation substantiates the complaints and cites F 314 at G. The nursing home now feels that there is a case for an Informal Dispute Resolution because the two SA assessments (survey and complaint investigation) are contradicting. Ultimately the facility loses this argument and the IDR maintains the complaint investigations original F 314 at G.'* FAC04

#### 3.2.3.5. Underreporting; Causes and Consequences

Underreporting was a common practice taking on many forms for the case studies. The Statement of Deficiencies as the formal representation of a facility's compliance often portrayed the facility in a better light. The incentives to underreport were ample. The most frequently mentioned reasons for downgrading and/or dropping an F tag were insufficient supporting evidence to maintain the citation, closely followed by the need to be able to uphold a citation under the scrutiny of *Informal Dispute Resolution*.

Data collectors invariably agreed with the original survey citation, which could conceivably (but not necessarily) mean disagreement with the supervisor's assessment that insufficient corroborating evidence was presented to support the citation. Data collectors on several occasions commented that surveyors spent ample time reviewing records and documenting. This may have been at the expense of direct observations of resident care, although the study cannot be definitive on this issue, since the data collectors were only on-site during one day of the survey. Yet the independent study assessment often indicated that direct observations over

an extended period of time could have easily yielded sufficient evidence to support the original citation.

Surveyors frequently mentioned that insufficient time or a shortened survey had hampered their efforts to obtain adequate supporting evidence. Surveys are complex investigations and surveyors must meet many procedural demands within a limited time frame. Meeting all these demands while supporting multiple citations made it difficult to make all citations ‘stick’. In addition, higher-level citations were said to be more easily singled out for IDRs, and therefore were held to higher standards of evidence. This could explain the tendency to downgrade Gs level citations. Several remarks, such as ‘*the surveyors should have focused on the Gs rather than chasing all these other F tags*’, alluded to this fractured focus as a possible explanation for failures to provide sufficient supporting evidence. In addition, an off-hand comment that: ‘*Gs are mostly the result of a complaint investigation*’ pointed in a similar direction, as supported by the last example.

Thus, the standards for supporting evidence were high and often impossible to meet given the constraints of the process. However, the consequences of the resulting practice of downgrading and F tag removal eroded the credibility of the surveyors, placed the legitimacy of the survey outcome at stake and had the opposite effect of what the regulation hoped to accomplish. In the words of one of the data collectors:

*‘The management’s perception of the survey team having a “vendetta” against the home is substantiated in their minds by the fact that the State dropped the Gs. Any hint that there may have been substandard care is dismissed because the credibility of the surveyors is not there.’ FAC49 SA2*

### 3.3. Enforcement Actions

#### 3.3.1. CMS Enforcement Regulations: Remedies and Penalties

The enforcement process involves the selection and potential execution of enforcement actions. Enforcement actions are determined based on the formal survey outcome reflected on the SOD.

Enforcement actions are sanctions, penalties or remedies invoked to encourage a facility to return to compliance within a specified timeframe. The SA selects all enforcement actions and presents these as *recommendations* to CMS and the facility. Enforcement decisions are strongly guided by federal regulation.

CMS’ enforcement actions are classified in three main categories increasing in severity, each containing several alternative enforcement options: category I, including *Directed In-Service and Directed Plan of Correction*; category II including *Denial of Payment for New Admissions and Civil Monetary Penalties*; category III, including *Termination of facility* (see CMS enforcement grid). The SA in selecting an enforcement action *must* select one remedy from a mandatory category

and *may* additionally select from an optional category as well. Mandatory enforcement actions include:

- *Plan of Correction (POC)* for all facilities with deficiencies warranting an SOD
- *A Civil Monetary Penalty (CMP)* for all  $\geq$  G-level citations
- *Immediate Jeopardy (IJ)* cases which must receive a per instance CMP

The SA in selecting an enforcement action has some maneuverability; the mandatory category has several alternatives to choose from. In addition, the SA can opt to select additional enforcement actions from the optional category.

Recommended enforcement actions, unless mandatory, will be *executed* only when the facility does not comply by a specified date. CMS mandates *Denial of Payment for New Admission (DPNA)* when a facility has not reached compliance within 3 months after survey date, and termination of the facility if compliance is not achieved six months following original survey date.

### 3.3.2. Enforcement – Case Study Findings

All 25 case study facilities were mandated to submit a *Plan of Correction (POC)*; eight facilities (8/25) were additionally subjected to enforcement actions consisting of a monetary action of some kind. These additional enforcement actions consisted of *Civil Monetary Payments (CMPs)* for eight facilities; of which two facilities incurred an additional *Denial of Payment for New Admissions (DPNA)*.

Civil Monetary Penalties were levied either *per instance* or *per day*. CMPs *per day* were mandated in seven facilities (7/8); of these six facilities had at least one G level citation and one facility had 21 citations (all <G). In the case of the last facility, it was clearly the high number of citations that provoked the CMP, since no G citations were made. Per day fines ranged from \$50 to \$700/per day for 30 – 60 days. In addition to CMPs per day, CMPs *per instance* were mandated for three facilities (3/8), all of which had been issued an *Immediate Jeopardy* citation. In contrast to the *per day* fines, the *per instance* fines ranged from \$3,500 to \$7,500.

Most SA *recommended* enforcement actions were never executed (17/25); for these seventeen facilities only the federally mandated Plan of Correction went into effect.

**Table 7: Executed Enforcement Actions**

<u>Enforcement</u>	<u>State 1</u>	<u>State 2</u>	<u>State 3</u>	<u>State 4</u>	<u>Occurrences</u>
POC	7	4	8	7	26 *
CMP p/day	1	0	2	4	7
CMP p/instance	0	1	1	1	3
DPNA	0	0	0	2	2

\* Includes complaint investigation

### 3.3.2.1. Relationship of Statement of Deficiency to Executed Enforcement Actions

The relationship between the final SOD and executed enforcement actions was surprising in that facilities with very different SODs ended up with very similar enforcement actions; either a POC or a CMP. Only one case study facility had a DPNA executed.

Facilities with very different citation rates ended up with very similar enforcement actions; e.g. one facility with 15 citations and one facility with 5 deficiencies were both subjected to the mandatory POC, but no other enforcement actions were executed. These two facilities had a similar S/S distribution range in common, each ranging from B – E.

In addition, facilities with different citation rates *and* additionally different S/S distributions could also end up with similar enforcement actions as long as the S/S was below G. One facility with 8 citations (4 D; 3 at E; 1 F) and a facility with just 1 D-level citation were each issued a mandatory POC, no other enforcement actions were executed.

Facilities with G or higher-level citations were *all* subjected to similar enforcement actions; monetary penalties of some kind. Citation rates could be comparatively low or high as long as a facility had issued a citation at G-level or higher sanctions were executed. Only two facilities did not fit this pattern: 1) one outlier facility with a higher than usual citation rate (21) was subjected to a daily penalty, despite the fact that the highest scope and severity level reached only E; 2) one facility that had not reached substantial compliance by the 3 months timeline had DPNA imposed.

**Table 8: Relationship between SOD and Executed Enforcement Actions**

Case Study ID	# of Cites	Statement of Deficiency							Executed Enforcement Actions			
		B	C	D	E	F	G	IJ	POC	CMP p/day	CMP p/instance	DPNA
FAC24	14	8		3	3				YES	NO	NO	NO
FAC43	13	3		8	2				YES	NO	NO	NO
FAC64	10	5		5					YES	NO	NO	NO
FAC91	9	2	2	2	2		1		YES	\$100 (35 days)	NO	NO
FAC13	2		1	1					YES	NO	NO	NO
FAC97	15	5	1	8	1				YES	NO	NO	NO
FAC96	4		1	2	1				YES	NO	NO	NO

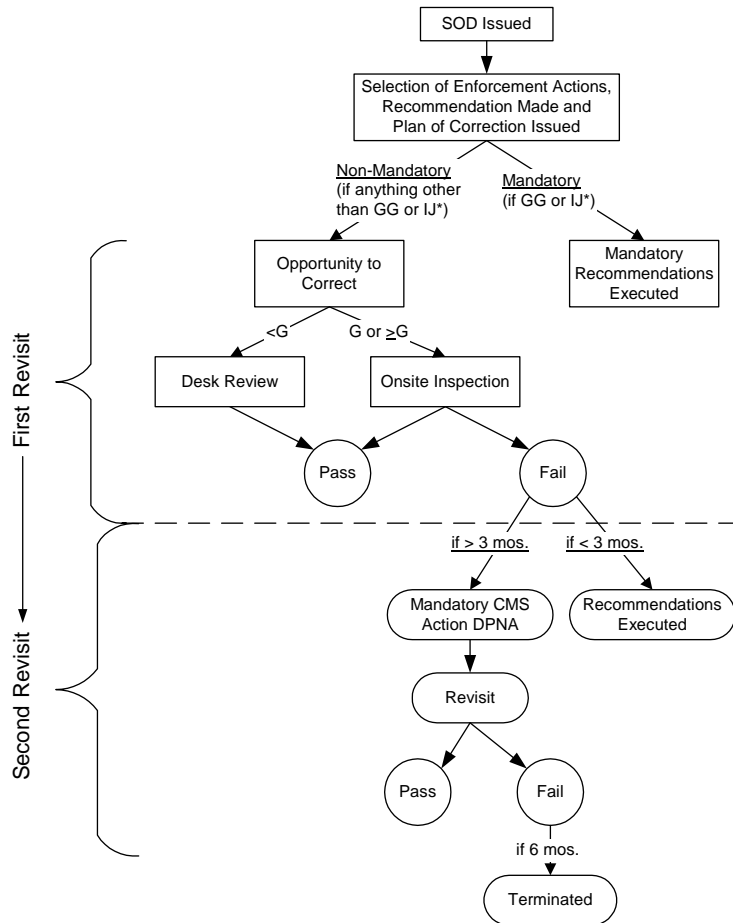
FAC94	9		1	5	3				YES	NO	NO	NO
FAC63	5			4	1				YES	NO	NO	NO
FAC18	10			6	3	1			YES	NO	NO	NO
FAC29	4	1		2	1				YES	NO	NO	NO
FAC01	4			2	2				YES	NO	NO	NO
FAC90	8			7		1			YES	NO	NO	NO
FAC21	9			6	2		1		YES	\$100 (35 days)	\$4,000 (1 instance)	NO
FAC49	6				1	2	3		YES	\$100 (60 days)	NO	NO
FAC49	10	4		2	2	2			YES	NO	NO	NO
FAC08	10	1		7	2				YES	\$100 (35 days)	NO	YES (5 days)
FAC17	4			1	1		1	1	YES	\$150 (30 days)	\$3,500 (1 instance)	NO
FAC04	21			14	5	2			YES	\$50 (60 days)	NO	NO
FAC47	8	2		2	3		1		YES	NO	NO	NO
FAC68	19	1		13	3		2		YES	\$700 (35 days)	NO	YES (1 day)
FAC62	4		1	1	1			1	YES	NO	\$7,500 (1 instance)	NO
FAC11	5			3	2				YES	NO	NO	NO
FAC03	8			4	3	1			YES	NO	NO	NO
FAC66	1			1					YES	NO	NO	NO

In summary, few case studies had enforcement actions imposed and all but two of the executed enforcement actions consisted of a penalty. A consistent relationship between citation rates and distribution of S/S level was non-existent unless the S/S was a G –level citation or higher which corresponded with the CMS mandatory requirements.

### 3.3.3. Enforcement Practices

Two CMS mandates heavily influence the selection and execution of enforcement actions: 1) the ‘*Opportunity to Correct*’, a privilege dispensed to facilities at the discretion of the SA; 2) the S/S level as the most important determinant for enforcement actions (Figure 4).

**Figure 4: Federal Enforcement and Compliance Process**



### 3.3.3.1. Opportunity to Correct

The SA is vested with the discretionary authority to grant a facility an ‘*Opportunity to Correct*’, something that is frequently administered. Twenty-two (22) of 25 case study facilities were granted an Opportunity to Correct. The three facilities that were excluded from this privilege had an IJ citation issued.

The Opportunity to Correct transformed a non-mandatory enforcement action into a future threat, an encouragement to accomplish corrections as demanded by regulation within the specified timeframe. Therefore, a non-mandatory enforcement action functioned as a deterrent rather than an immediate remedy or sanction. It allowed a facility some breathing room to comply; however, if the facility failed to institute appropriate corrections in a timely fashion the recommended enforcement actions would be activated. Facilities and management staff responded very differently to this threat: from complete indifference, through fear for potential

financial, employment or census repercussions, and/or fear for losing personal or facility reputation.

For the 25 case studies only one facility lost its Opportunity to Correct due to non-compliance within the regulatory time frame.

*'In this particular case, the facility had claimed to be in compliance by the specified date, however the State having inspected this facility already once on a revisit to verify actual compliance, was unable to meet the procedural guidelines for a timely second visit. The SA claimed insufficient manpower. The facility paid the price in an enforcement action of five days denial of payment for new admissions (DPNA). According to the data collector, this was a very high price to pay indeed, even though, in her assessment, the facility had by no means achieved the full regulatory compliance they claimed. However, adding financial hardship to this already financially troubled facility rather hindered, than assisted the facility in establishing the goal of regulatory compliance and improving its quality of care.'* FAC04

This example was evidence of some of the regulatory constraints to levy sanctions within very specific guidelines and the difficulty in selecting enforcement actions appropriate to the specific nursing home's situation. In this case, quality of care did not improve even though the facility tried. Unfortunately the mandatory enforcement action of DPNA did nothing to assist the facility improve its quality of care.

In summary, very few facilities were subjected to any enforcement actions, other than the mandatory POC, due to having been granted an Opportunity to Correct. Although that provided the facility a real chance to address problems, it creates a burdensome revisit process for SAs that must be extremely vigorous or, the Opportunity to Correct becomes synonymous with no citation.

#### 3.3.3.2. *Selecting Enforcement Actions: Exclusivity of S/S Level*

SODs vary considerably, yet enforcement actions show little variation other than what is mandated by regulatory statutes.

For the case studies executed enforcement actions involved only monetary penalties. Selection of minimal enforcement actions was by regulation exclusively determined by the highest S/S level citation in the SOD. However, the SA or the Regional Office can in addition apply a number of optional remedies. Although a facility's deficiency history was mentioned by many SA respondents as a factor in the selection of enforcement actions, this was not apparent from the case studies.

The exclusivity of S/S level as determinant for selection of enforcement actions had the rather curious consequence that facilities determined to have only minor infractions according to the SOD faced similar enforcement actions as facilities that were determined to be out of compliance with respect to many federal requirements. In most case study facilities this meant

no enforcement, other than the POC. This is shown in the following example of two facilities contrasting considerably in their final the SOD:

*'The annual re-certification survey of facility I resulted in two citations including: F314 D for failure to implement a toileting program for one alert and oriented resident; F371C unsanitary conditions in kitchen. The recommended enforcement actions consisted of a Directed In-Service in case the facility was not found in compliance within 30 days after the survey. Facility returned to compliance within designated time frame and no enforcement actions ensued.*

*The annual re-certification survey for facility II resulted in 13 citations including among others F221 D for failure to obtain orders for a waist restraint; F 309 failure to administer pain medication as ordered; F314 for failure to provide an alternating pressure pad as ordered to a resident with multiple pressure ulcers; F317 for failure to prevent ADL decline; and, F323D failure to ensure an accident free environment for all residents. The last citation showed several occurrences each observed during the survey, one resulting in minor injuries (abrasions). The recommended enforcement actions consisted of a Directed In-Service in case the facility was not found in compliance within 30 days after the survey. Facility returns to compliance within designated time frame and no enforcement actions ensued.'*

For these two facilities, the number of citations did not influence the selection and execution of enforcement actions. This was in fact the case for the majority of case study facilities. Only once did the high number of citations (21) impact the selection of enforcement actions and a non-mandatory CMP was enforced. This facility could have escaped the execution of this penalty altogether since it had been granted an Opportunity to Correct, were it not that the deadline for implementation of the corrective actions had not been met.

The highest S/S level citation determined the selection of the enforcement action, however, the number of citations at the highest S/S was equally irrelevant. For enforcement purposes it did not matter whether one, two or three citations ended up with the highest S/S level. No enforcement actions followed in case of multiple citations under E or F as the highest S/S level. In cases of G-level citations the executed penalties were similar per state: either a CMP of \$100 per day for facilities with one or multiple G-level citations in one State; or, a CMP amount slightly higher in another State. In conclusion one can say that the total number of citations and distribution of S/S level were relatively unimportant.

### 3.3.3.3. Repeat Deficiencies

Repeat deficiencies, the same F tag citations occurring in two consecutive compliance cycles, were a major problem for the case study facilities. The majority, thirteen out of the twenty case study facilities for which the study had data revealed a repeat deficiency in one of the study F tags. This number increased to 19/20 when a two-year history was used for comparison; i.e. only one skipped compliance cycle.

The study established repeat deficiencies for the case studies by proxy, through the CMS Nursing Home Compare site. This CMS site does not reveal deficiencies by actual F tag, and as

such the study review was not complete. However, interviews with SA staff were used to corroborate a repeat deficiency for specific case study facilities. Most, but not all, respondents were willing and/or able to provide the study with answers. In general, the SA responses concurred with the study findings that repeat deficiencies occurred frequently.

Surprisingly repeat deficiencies did *not* impact enforcement actions for any of the case studies; neither was the Opportunity to Correct withheld, nor were more severe sanctions selected. Even though several of the case study facilities with repeat deficiencies had the Opportunity to Correct withheld and were subjected to sanctions, these sanctions were imposed because of the S/S level. The facility's deficiency history may have factored in but was not the cause for the imposition of sanctions as illustrated in the following interview excerpt:

*'Data collector: This facility has had several repeat deficiencies. How often does a facility get the opportunity to correct? How will similar deficiencies be prevented in the future?*

*Licensing Officer: This happens often because they (the facility) just put a Band-Aid on the problem and then go back to their old ways. It might be because the person who fixed it leaves and there is no continuity. Or there is a change in upper management and the replacements don't know the history. I don't always have a lot of recourse because once the cycle is closed it is done. In the worst cases I can do monitoring visits to try to be sure the correction sticks.'* Licensing Officer SA3 FAC04

This facility had 21 citations and because of that high quantity a per day fine of \$50 was imposed. The SOD indicated a citation for F 314 because of inadequate assessments and documentation. The independent study assessment indicated a severe problem with pressure ulcer prevention and treatment that warranted an actual harm citation at F314G. The facility had been cited for PU in two consecutive compliance cycles in the last three years prior to this survey. An obvious recurring problem with pressure ulcer care, yet no enforcement actions related to it.

When questioned, many SA staff indicated that repeat deficiencies were of great concern to them, and felt in general that the enforcement was inadequate in dealing with repeat deficiencies. Repeat deficiencies impact enforcement actions *only* in cases of: a) 'double G' citations, a G-level citation for the same F tag in two consecutive compliance cycles; or, b) a F level citation under specific F tags issued in two consecutive compliance cycles. SA staff expressed concern, frustration and in general felt powerless to influence the situation as revealed in the following interview excerpt:

*'If a repeat deficiency occurs we will look at the situation more closely....focus on it...enforcement actions could be different depending on the scope...possibly a directed in-service or a directed POC (I don't like a directed POC...time constraints...).....even a monitoring follow up visi...we can do a revisit without a G at the discretion of the surveyor...the providers don't like it.'* Licensing Officer, SA2 FAC91

In this case, no enforcement actions were executed because '*the ulcer is healing...*'. It was disheartening to see that so many citations could be repeated, placing the residents at risk on a recurring basis.

#### 3.3.3.4. Plan of Correction: Most Important Enforcement Tool

All facilities receiving a Statement of Deficiency must at minimum submit a POC. This fact, in combination with the finding that most case study facilities were granted an Opportunity to Correct, elevated the mandatory Plan of Correction (POC) to one of the most relied upon, and therefore, most important enforcement tools at the SA's disposal. The POC is a facility document outlining for each cited F tags, all the corrective steps that the facility will follow to return to regulatory compliance by a pre-determined date. The POC is reviewed for compliance by the SA.

### 3.4. Revisit: Compliance Determination

#### 3.4.1. Revisit Guidelines

The final step in the enforcement process is the determination of a facility's compliance following implementation of the POC. Compliance is determined through a revisit, a rather disguising term since the revisit may consist of either a desk review of the POC, or, an actual on-site inspection at the nursing home.

A desk review, also aptly named a '*no visit revisit*' or '*paper compliance*' consists of a review of a facility's Plan of Correction. The review involves an assessment of the suggested corrective actions with respect to four required elements:

- accomplishment of corrective actions for all residents affected by the deficient practice
- identification of residents at risk to be potentially affected by the same deficient practice
- prevention of recurrence of the deficient practice
- presence of a plan monitoring facility performance towards sustained compliance

If for each F tag the POC complies with these four elements, the POC will be approved and the facility is considered back in substantial compliance.

Alternatively, a revisit may consist of an on-site inspection to the facility conducted by one or more surveyors. An on-site revisit closely resembles a standard annual survey on a smaller scale. Revisit investigations are focused on but not limited to the original survey citations; if a new deficient facility practice presents itself it will be cited. Hence, re-visits may result in the same or additional citations as the original survey. On-site inspections are required for any ≥G-level citation.

#### 3.4.2. Revisit Findings

Most case studies (16/26) compliance was determined through a desk review; on-site inspection took place in the remaining ten cases. Although all states conducted some revisits through an on-site inspection, the majority of these inspections (6/10) were conducted in one state. In this

state on-site inspection revisits were conducted for all facilities having incurred a  $\geq C$  citation. This is a more stringent requirement than mandated by CMS, which requires on-site inspections for any  $\geq G$  citation.

Facilities were rarely found in continued non-compliance following a revisit. Only a few facilities with on-site inspections (2/10) were not cleared on first revisit; a second on-site inspection took place and subsequent compliance ensued. Both these cases occurred in the state with the highest number of on-site inspections. *All* desk reviews were cleared for compliance on first revisit.

**Table 9: Revisit Frequency and Compliance Determination by State**

<u>Re-visit</u>	<u>State 1</u>	<u>State 2</u>	<u>State 3</u>	<u>State 4</u>
Desk review	6	3	6	0
Timely approval	6	3	6	NA
On-site Inspection	1	1	1	6
1 <sup>st</sup> time approval	1	1	1	4
2 <sup>nd</sup> time approval	NA	NA	NA	2

The differences between the states in the case studies is clear with stricter standards in determining compliance for one of the four states (state 4). On-site inspections after all include verification of actual implementation of the corrective actions suggested in the POC; a desk review can only scrutinize the Plan itself. In most states the effect of the enforcement process was diminished because almost every facility was given the opportunity to correct and approval was then granted based on desk review of a POC.

### 3.4.3. Enforcement Practices

#### 3.4.3.1. Paper Compliance – a Matter of Trust

Mostly, although not always, the POC was reviewed by one of the original survey team members, but not necessarily the surveyor who had issued the original citation. Desk reviews were often perfunctory reviews, assessing whether the presented corrective actions met the four required elements. Desk reviews always resulted in timely approval of the POC, and although surveyors may not approve a POC on first round, the Opportunity to Correct was never at risk.

Desk reviewers were at a clear disadvantage in assessing compliance when compared with on-site inspections; actual implementation of the corrective actions presented in the POC could not be verified. Most reviewers were keenly aware that *‘the POC is just paper, and... a piece of paper will not tell you compliance’*. Desk reviewers did at times demand amendments to the POC or required evidence to corroborate the veracity of claimed implementation; yet when questioned

surveyors admitted that they had to believe the facility 'at their word', or simply stated that they 'had faith'. The basis of their 'faith' was often an explicit trust in at least one of the management staff, either the administrator or the DON.

Alternatively, if no trust in the facility management team was present, many SA staff indicated a strong degree of trust in the system, either through increased questioning of the facility's POC or through complaint investigations. The strategy of increased questioning of the facility's POC was believed to signal that the facility 'was on notice' or that 'the SA was watching them', a tactic hoped to promote compliance. In addition, many SA staff considered the number of complaints and/or reportable incidents, against the facility to be a strong indicator of a facility's compliance status to which the SA would respond with a complaint investigation. The effectiveness of such a strategy was not apparent. Three states relegated many complaint investigations to the standard annual re-certification survey, if deemed appropriate following triage for severity. In this scenario complaints could end up being investigated many months after the fact. Besides the obvious disadvantage of this time delay, many complaints may have accumulated adding to the workload of the survey. The following example illustrates such a scenario:

*'Multiple complaints and incidents, several involving injuries had accumulated for a midsize facility till the time of the standard annual re-certification survey when the actual investigation into each complaint was conducted. All complaints were substantiated, indicating that the incidents occurred, however, none resulted in a citation. During the F tag meeting, the designated complaint nurse reported that she "knew something was wrong, but could not put her finger on it". The subsequent independent study assessment revealed that the facility had many resident-on-resident incidents and falls resulting in injuries and hospitalizations. Due to staff turnover and the thinning of individual charts it was difficult and time consuming to piece the actual circumstances of each case together. Nonetheless, a pattern relating deficient facility practices to resident altercations emerged, many relating to insufficient behavior modification management. The facility failed entirely to maintain behavior logs, therefore, strategies to deal with behaviors were ad hoc and staff was not prepared to anticipate and/or intervene appropriately. Care plans showed these inadequacies clearly; either care plans did not list the behavior problems as a concern and did not specify any interventions, or alternatively, care plans did specify intervention, but the efficacy could never be established. Resident-on-resident behaviors occurred frequently and repeatedly.'* FAC03 SA1

In general, many SA staff maintained a strong belief that the enforcement system would work either through complaint investigations or through strong facility leadership. However, if the system failed and a facility did not return to compliance as expected, the SA staff were resigned to the belief that those deficiencies would surely be found and cited at the next annual re-certification survey.

#### 3.4.3.2. Trust, Turnover and Compliance

Belief in the facility's leadership was not always misplaced, although it is a risky strategy given the high turnover of facility management staff following the survey. The case studies showed many management staff, either the administrator or DON, leaving their position in the first three months following the survey. Surveyors may be astute in assessing the leadership

abilities of a facility's management team during the survey, and, they may even accurately anticipate who may resign, however, no one can be certain of the leadership qualities of the individual(s) replacing a vacated position. The dice may roll either way as the following two case studies illustrate:

*'Midsized facility's annual re-certification survey resulted in nine citations including F 309 D for facility failure to appropriately assess, monitor and manage pain. Several management staff, including the DON, resigned their positions following the survey, which prompted corporate headquarters to assign a corporate nurse to assist the facility with its response to the SOD. The corporate nurse was instrumental in writing the POC, which unfortunately addressed only some of the issues indicated on the SOD. Compliance determination was completed by desk review and the facility was cleared on first review, returning its status to substantial compliance. The data collector, having completed an on-site inspection noted that most aspects of the POC had not been implemented. Following several interviews with the Administrator the data collector concluded that the Administrator had no intention to implement any of the POC's corrections, reasoning that that was the responsibility of the new DON. The study followed this facility for two more visits, each one month apart, in order to come to a final conclusion regarding implementation of the POC. Only at the last visit, NH4 conducted four months after the original survey, and two months after the facility had been recertified, the study review assessed the facility to be in full compliance with respect to pain management. The new DON possessed strong leadership and clinical skills. In addition to obtaining the staff's full cooperation to implement the POC, fully understood the original citation, was willing and able to make the necessary improvements so that original citation concerns were addressed and added audits and monitoring of staff to assure long-term compliance. The facility with this DON at the helm stands a good chance to remain in compliance.'* FAC94 NH2, 3 and 4.

In this case a newly hired strong and very capable DON instituted the corrective actions as specified in the POC, albeit many months after the facility had been re-certified. This is unfortunately not always the case. In the following example a strong management team hired as 'turn around' team show signs of disintegration at 2<sup>nd</sup> study visit. In the words of the data collector:

*'There were signs that the POC's elements of auditing the direct caregivers was helping part of the time but there are still problems with consistent supervision of caregivers. The fact that the "numbers" have improved (1% acquired pressure ulcers vs. 5 %) does not give the DON reason to believe her root problems are over. She is well aware that they have "a long way to go" in getting the direct care givers to give consistently good care and to genuinely care about the residents. However, she does believe the survey team should take her efforts into account and trust that she will continue to improve. This management team is frustrated and demoralized. They are casting around and looking for reasons and mention that the survey team is "opinionated, can't trust them and biased against them". It hinders them in some ways to really accept the legitimacy of the citations although they seem on the other hand to realize their root problem: inconsistent care by the direct line staff. The DON openly recognizes that many direct caregivers are not motivated. The staff development coordinator recognizes that the nurses don't give direction to the direct caregivers. The supervisor knows she must be "out there watching" and working to get them to give the care she wants them to.'* FAC 86 NH2

In this facility the entrenched and long-time direct care staff continued to make it very difficult to accomplish changes as per the POC; no additional changes were made at NH3, one month

later. Management turnover is an unstable transitional period for a facility, accomplishing corrective actions initiated by the enforcement process during that time could be insurmountable.

### **3.5. Effectiveness Enforcement in Changing Nursing Home Care?**

Despite the survey's flaws in detection ability and accuracy and despite lenient enforcement practices at the SA, many nursing homes attempt to be in compliance with regulation either immediately prior to an anticipated survey and/or through the POC immediately following the survey. Study assessments conducted during two on-site inspections to the facility following implementation of the POC, revealed a high rate of only partial implementation of the POC.

In general, tangible problems such as protective covers over heating vents and new pressure relieving mattresses on beds were corrected. In addition, care improvement occurred mostly, but not always for those residents identified in the SOD as recipients of deficient facility practices. However, system changes that would ensure continued compliance for *all* residents were rarely effective, even if the facility made a strong attempt.

Some facilities achieved full compliance at time of SA re-certification, at least in reference to the selected study F tags that had been subject to citation. Some case study facilities continued to improve over time and were in full compliance at the second study revisit (one month after facility re-certification by SA). However, many facilities did not achieve compliance at first or second study visit. Several factors contributing to the success or failure of a facility's full compliance, will be presented here. None can be singled out as the leading cause; in fact both enforcement practices and facility circumstances contributed to either failure or success. Nonetheless, it appeared that facility corrections, if achieved, were more directly a result from identification of deficient practices and the subsequent threat of enforcement actions rather than that enforcement actions per se made the difference.

#### **3.5.1. Enduring Changes: A Major Challenge**

Facilities face many challenges at all times and in general these increase during and following the time of survey. Management staff turnover occurred frequently, and this impacted the facility's attempt at correction most often negatively. In general, strong and stable leadership was necessary for a facility to achieve compliance within the specified time frame following the survey. However the facility's leadership can never accomplish this task by itself; well-motivated, well-trained and caring direct care staff, willing to follow the directions of good leadership, were an additional necessary ingredient to achieve compliance. Multiple factors may contribute to impede compliance; for the case studies denial of the validity or legitimacy of the survey findings; misinterpretation of the SOD; extraneous pressures; and, lack of staff expertise and resources were found contributing factors.

### 3.5.1.1. *'We Provide Good Care'*

Many facilities did make a concerted effort to provide good care; and, many facility staff were committed to the residents and their welfare. The belief that *'care is good here'* was echoed by many nursing home staff at all levels and positions. This belief, which may be valid to some extent, resulted in two distinct reactions from nursing homes. Either the survey findings were invalidated by explaining away some citations; or, more negatively, the SA was accused of *'being inconsistent'*, of *'playing favorites'* or even worse, *'being out to get us'*. These latter two beliefs were *not* supported by the study. On the contrary, the study found the surveyors in general to be professional, supportive and more likely to give the facility the benefit of the doubt. Both reactions by nursing home staff, however, prevented the staff from viewing the SOD findings as valid.

Nursing home management staff at times indicated their belief that the citations were minor issues or, *'just documentation issues'*. Occasionally the finger was pointed at one particular staff member as the source of the citation or alternatively at one particular unit or department. These reactions served as impediments to serious reflection on the actual events and often systemic issues that caused the citation. Instead, the citation was often addressed by creating a new piece of paperwork; designing and instituting an in-service to explain the application of the new paperwork protocol; terminating a staff member; and/or replacing a department head. These responses constitute surface changes; systemic change was extremely unlikely to occur when the attitudes described above prevailed.

On many occasions facility management denied the validity of a particular citation, less frequently a facility questioned the legitimacy of the entire process or of the survey team in particular. Lastly the occasional facility demonstrated a blatantly defiant attitude, asserting that only they knew what was best. A defiant attitude in combination with the belief that a citation is unjustified sometimes resulted in *'dodging'* or *'fighting the system'* rather than focusing on improving the quality of resident care.

### 3.5.1.2. *The Bigger Picture*

Some facilities misinterpreted a citation on the Statement of Deficiencies, and at times the SOD provided fertile ground for this. At times, however, a facility, for whatever reason framed a citation according to pre-conceived notions of the issue and failed to recognize the essentials of the citation, as in the following example.

*'Large, >200-bed, facility incurred 8 clinical citations during the annual re-certification survey including F 314 E for failure to provide basic preventive pressure ulcer care resulting in the development of in-house acquired pressure ulcers. In addition the facility was cited for failure to develop comprehensive nursing care plans under F279 E, all substantiating evidence for this F tag referred back to F 314. Since, on the SOD, F314 was related to F279, facility management staff reframed the issue as a care plan issue rather than a pressure ulcer issue. By correcting the care plans the facility felt it had 'fixed' the problem, entirely missing the essential concerns raised under F314 which referred to basic preventive bedside care such as*

*provision of pressure relieving devices, timely repositioning of residents. In fact, one resident's pressure ulcer had not improved since the survey due to the facility's failure to provide pressure relieving devices.'* FAC 18 NH3.

Many facilities failed to see the bigger picture presented by a citation and its supporting cases, often resulting in corrections for immediate problems, rather than system changes resulting in sustained compliance. Some facilities emphasized just one or two citations, failing to give other citations equal attention, which then as time moved on, were easily forgotten by direct care staff.

#### 3.5.1.3. 'Life Goes On'

At times a facility was so overwhelmed by extraneous challenges that the entire focus was directed away from the POC and the necessary corrections. When a facility's attention was contracted in such a way, the entire POC was at risk. Staff could only see the latest challenge as apparent in the following illustration.

*'Case study FAC13 with 2 citations on the SOD for the annual re-certification survey including, F 316D (inadequate bladder training); and, F371 C (unsanitary kitchen). A desk review of the POC placed the facility back into compliance at first review. The data collector indicated that the facility at time of re-certification had made some corrective changes relative to specific residents, but overall the changes were perfunctory; the underlying issues were not addressed. When visiting the facility one month later, the facility staff was experiencing major upheaval due to a change in ownership. The new owners, a corporation, focused on the census and indeed census had increased by at least 10 new admissions since the latest visit one month prior. Direct care staff felt stressed and overburdened, which was apparent in the daily care; call bells were ringing incessantly as the day progressed. The MDS nurse, responsible for the bladder training program, was asked about continued action as indicated in the POCs she admitted as much as a complete breakdown of the program since new admissions were her current focus. In addition, the new DON, named in the POC as completing audits and observation of the resident as related to their continence, was entirely unaware of her responsibilities. The data collector in asking her questions alerted her to her role as indicated in the POC. This new DON was overwhelmed and very frustrated; even though her former position was as ADON, that position will not be refilled, effectively cutting out an assistant to her new position.'* FAC13 NH3

This example shows a facility where ultimately the enforcement process failed for reasons including the extraneous stressors in addition to turnover of facility management staff.

#### 3.5.1.4. Resources and Expertise

In a few facilities either the resources or professional expertise were missing to adequately implement the POC. These facilities were unable to focus on much other than the immediate day-to-day needs and care. At times all hope was pinned on one or two staff members who then were faced with multiple responsibilities and subsequently could not meet the unrealistic expectations. In the following case the data collector provides a rather grim picture of the way a nursing home is coping with its day-to-day problems, negatively impacting the implementation of the corrective actions indicated on the POC:

*'On this third visit to the nursing home, my conclusions with respect to correcting several of the many citations remained largely the same. There were half-hearted attempts to use new lab monitoring tools, new infection control processes and the MDS were somewhat better but still behind. What was shocking to me was the fact that the so-called "QA nurse" has not been going to the QA meetings. She is mentioned repeatedly in the POC as being the person who is going to monitor that the improvements are in place. The QA nurse is a rather timid individual who admits to giving the unit managers and charge nurses suggestions, which they do not receive well from her. She appears to have to get her authority by directing it through the DON. Additionally the QA nurse is totally overwhelmed by her role as MDS nurse. Last month she took a week off and went to a large city in a neighboring state to take an MDS course, which she paid for herself. She believes she learned enough to help improve the RUG scores for reimbursement. Her work process is impeded because she must share the computer with the other members of the interdisciplinary team. She also has to cover weekends as supervisor twice a month. She admits that many times instead of using some of her time doing MDS she ends up working as a staff nurse because of "call-ins". When I questioned her about her MDS process, she commented that she left it up to the charge nurses and unit managers to create the care plans. She tries to instruct them to correspond the care plans to the RAPs but they don't always do that. Many of the nurses are LPNs who have worked here 20-30 years and who have few skills with the assessment process. FAC04, NH3*

At times it was the direct care staff that made implementation of the corrective actions all but impossible; resisting and obstructing every possible change and blocking any avenue for improvement. Even strong leadership will ultimately succumb to such a situation and in general implementation of the POC failed.

### 3.5.2. Obstacles in the Regulatory Process

The enforcement process takes place between two major players and each of their actions calls forth a reaction from the opposite player. This section will review some of the responses that the enforcement actions may provoke as evident from the case studies. In conducting these case studies it became apparent that one of the most important objectives of the regulatory process in nursing facilities, which ultimately is provision of resident care at an acceptable professional standard, was lost.

#### 3.5.2.1. SOD, Who Does It Serve?

Citations were listed under the regulatory F tag that closely described the deficient facility practice. However, a regulation often incorporated many different aspects under one F tag; i.e. F 314 refers to the failure of the facility to *prevent* the development of new pressure ulcers *and/or* the failure to adequately and/or timely *treat* a pressure ulcer. Usually only one or a few aspects are represented in the cited deficiency. Although the F tag is not ambiguous, the citation may refer to either the prevention or treatment of pressure ulcers and, in addition, may refer to one particular aspect of prevention (*inadequate assessment*) or treatment (*failure to document consistently*). Specifics were often relayed in the substantiating evidence and this at times resulted in misinterpretations. In the following case, tying two F tags together allowed

one nursing home to reframe the issue, while entirely missing the essential problem provided under one of the F tags.

Facilities at times misinterpreted what was cited. The substantiating evidence provided with each F tag did specify, often in great detail, which practices resulted in the citation. However, the minutiae provided, referring to each involved resident (by survey ID); specific staff; date, time, and type of data collection; and, the specifics that were spoken or observed, were at times so overwhelming that a reader may have great difficulty determining what exactly was the issue. On many occasions SA staff told the data collectors that the SOD is written with the Informal Dispute Resolution in mind; SA-staff, in writing the SOD, placed all 'its ducks in a row'. This tactic may serve well in case of an IDR, in fact the SA reportedly lost very few IDR disputes; it does not improve the clarity of the document, a complaint heard from many facility staff. One data collector minced no words: 'nursing facility personnel do **NOT** understand the legalese in the SOD.

SA staff used similar reasoning to explain the actions of downgrading and removal of an F tag. Downgrading and removal of F tags because of '*insufficient evidence to hold up in IDR*' really only served the enforcement process rather than the residents whose interests it purportedly had in mind. Downgrading and removal of F tags invalidated survey findings, which then in turn supported the already existing attitude of denial that substandard care may exist. Since the study assessment supported, in all cases of downgrading, the original citation (pertaining to the study F tag) it must be concluded that this may have an unintended effect on the facility's quality improvement. The nursing home had no reason to believe that substandard care may be a problem, therefore no corrections will be made. This was a serious, undoubtedly unintentional, side effect of these actions.

#### 3.5.2.2. *Enforcement Process*

The enforcement process was experienced by almost all facility management staff as punitive and unrelenting. Even though the enforcement actions executed against the case study facilities hardly supported this perception, it existed nonetheless. The fact that many management staff resigned or was terminated within a couple of months following the survey, although not necessarily attributable to the survey, was rather disheartening.

This turnover was often portrayed by interviewed respondents as having little or nothing to do with the survey. Nonetheless, interviews with the resigning person often revealed a feeling of defeat, one had worked so hard and there was so little to show for it. These feelings of defeat indicate a basic flaw in any type of audit where the focus is exclusively on the negative, i.e. deficient care. Some survey teams tried to compensate for this negativity during the exit conference and attempted to stress some of the good things they had seen in the facility. Yet the SOD does not make mention of what might have been accomplished, and the survey results does not give the nursing home an actual sense of its comparative ranking among its peers and in its own deficiency history. Surveyors were keenly aware of where a facility ranked and how

it had progressed with its quality of care history. Surveyors, when asked, have no compunction in rating a facility.

This unintended effect of the survey has considerable implications for the subsequent process of quality improvement in the nursing home. Management staff were most instrumental in accomplishing relevant changes in the facility following a survey; they knew the facility and its problems intimately and thus could assist in establishing improvement most appropriate to the particular situation and with the best potential to reach the bedside. These improvements were now postponed and in some cases did not happen at all.

The case studies revealed that enforcement actions were rarely executed, and if administered consisted of monetary penalties either in the form of CMPs or DPNA. Even though many SA staff strongly believed in penalties as an effective tool to enforce compliance this was certainly not confirmed by the case studies. Nursing homes face many different challenges and a one – size enforcement action (monetary penalties) may not fit all. Even though the penalties were rarely exorbitant, it may exacerbate some of the already existing problems. SA staff often indicated that alternative enforcement options such as Directed Plan of Care or Facility Monitoring were too time-consuming or too involved for the SA. Still, the varied options for enforcement were certainly underutilized. Because they were underutilized, we have no way of estimating how effective they may or may not have been.

#### **4. DISCUSSION**

Given the limited rate of detection of care deficiencies, poor identification of specific care issues and under citation of these findings, the on-site survey was again found lacking. Despite good intentions, the surveyors proved unable to appropriately choose areas for focus and failed to identify some of the most blatant care problems. The survey, as presently designed and implemented, requires heavy investment of time and resources to detect deficient care. At the same time, the heavy emphasis on procedural exactitude often prevents surveyors from pursuing full investigation of deficient care that is of real importance, such as G-level citations.

The case studies revealed that enforcement actions, if executed, have only a limited positive effect. Some nursing homes responded well to the identification of deficient practices and made improvements accordingly. However, it must be recognized that nursing home behavior changes seldom occurred without a formal citation. Further, some nursing homes responded to the detection of deficient practices and the issuance of a formal citation with denial and/or indignation and made only perfunctory gestures that resulted in minor changes or no change whatsoever.

Variation in nursing home responses had little apparent relationship to the enforcement process, be it detection, citation and/or enforcement actions. The most consistent factors associated with changes (in accordance with regulations) were the willingness and ability of management staff to enact change and, to a lesser degree, willingness of direct care staff to

accept the survey's verdict and respond accordingly. The enforcement process unwittingly and unintentionally undermined its own authority by downgrading and removing preliminary survey findings, effectively decreasing the legitimacy of the survey and the Statement of Deficiency.

Facility leadership and the willingness to accept the survey verdict as legitimate was but one factor influencing nursing home behavior changes in accordance with regulatory mandates. Equally important were the presence of the expertise and resources necessary to implement the required changes. It is at this level that the regulatory process can play an important role in encouraging nursing home behavior changes in the direction of compliance by selecting enforcement actions that assist a facility rather than hinder it. The case studies revealed that enforcement was determined according to CMS mandated actions, but the alternate options (which could be tailored to meet a facility's specific problems and needs) were not used. This self-imposed limitation may be understandable in light of the regulatory agency's own limited resources, but it ultimately does little to benefit the goal of sustained and enduring compliance. The fact that many citations were repeated year after year indicated that many facilities do not establish enduring compliance and suggest an ineffective regulatory system.

Enforcement in response to the survey is anticlimactic and almost nonexistent. If enforcement occurred, it was generally monetary in nature and was not determined on a facility-by-facility basis. Enforcement actions were selected by rote, with little imagination or differentiation between the needs or problems of facilities. When employed in this manner, enforcement sanctions do not make use of their full potential and prove relatively ineffectual. Further, the perfunctory re-visit does not do justice to the substantial effort of the survey, nor does it support the nursing home in quality improvement. While the case study facilities subjected to these sanctions may have increased their efforts to come into compliance, they did not show improved quality of care and/or a higher rate of sustained compliance. This finding suggests that the current enforcement actions can be interpreted as temporary and minimally effective with respect to the goal of effecting sustained improvement in the quality of care. Admittedly, the facilities' inability to remain in sustained compliance is the result of a variety of factors, many of which are entirely extraneous to the enforcement process. However, it is within the capacity of CMS and the state agencies to adjust their practices to improve quality of care for the nursing home residents protected by the federal regulations.

The primary failing in the current implementation of enforcement sanctions lies in an inherent contradiction between the facility-level focus of the survey process and the generic, one-size-fits-all approach of the enforcement process. Further, the enforcement process is stymied by an unresolved tension between competing roles: is enforcement a legalistic regulatory process or is it to be conceptualized and operationalized as a collaborative quality improvement process? The current approach takes a middle ground that accomplishes neither set of objectives.

While CMS clearly states that the role of the surveyor is that of determining compliance to standards and that is the only appropriate role,<sup>(5)</sup> states and survey teams may elect a different

interpretation. State surveyors bring their backgrounds and training with them when they become surveyors. Some surveyors may come from a regulatory perspective and act in accordance. Other surveyors are hired with prior experience working in nursing home settings. These individuals may have empathy with the nursing home sites and want to help them or educate them. This desire may lead them to view and perform their roles as more than just regulators. As further inquiry is made into the survey and enforcement process, it will be important to recognize that there may exist a continuum of belief systems and approaches being employed by surveyors, whether implicit or explicit.

The case study findings corroborate and augment prior work by providing an in-depth view of participants' perspectives and attitudes towards the survey and enforcement process. Respondents were candid in sharing their thoughts with the UCHSC research team. Both the nursing homes and the state agencies seemed to welcome the opportunity to express their perspective, revealing some of the problems and pitfalls they encounter. The case studies provided a clear opportunity to uncover what affected the interplay between the two involved institutions and how this dance affected the quality of care in nursing homes.

## 5. CONCLUSIONS AND IMPLICATIONS

It would be easy to infer from this study that the current regulatory enforcement process is a failure. But that interpretation would overlook some very important positive findings and qualifications:

- Survey-identified deficiencies were real problems and confirmed independently by the data collectors – i.e., there were essentially no false positives;
- The often heard accusation that the surveyors were “out to get” the providers was not supported by the data collectors' observations. The surveyors acted fairly and professionally;
- Although “the case studies revealed that enforcement actions, if executed, have only a limited positive effect . . . it must be recognized that nursing home behavior changes seldom occurred without a formal citation”;
- The State Agency survey staff were doing the best they could with the tools and resources (staff, budget) available and some of the choices they made – e.g., desk review vs. on-site follow-up review, or downgrading to avoid having to do follow-up) - were at least reportedly driven by lack of resources to do appropriate follow-up;
- G or higher level citations consistently led to similar enforcement actions, suggesting at this higher level of harm there was consistency in enforcement action.<sup>2</sup>

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<sup>2</sup> Also, it should be noted that subsequent to the data collection for this study, CMS established a joint State-Federal workgroup to develop an analytic tool that will assist in assessing whether States are imposing Civil Money Penalties (CMPs) consistently. Pilot test of the tool has been conducted and the preliminary findings are positive.

It is also important to be mindful of the problems and limitations of all enforcement systems, including the criminal justice system, meat and poultry inspection, and environmental health and safety.<sup>3</sup>

The findings suggest that despite its many and sometimes serious failures, the regulatory enforcement process in nursing facilities has the potential to play a major role in determining the quality of care in nursing homes. Nursing facilities prepare in anticipation for an upcoming annual re-certification survey, attempting to comply with as many regulatory statutes as possible. This anticipatory attitude on the part of the nursing facilities encourages compliance with minimum regulatory standards, ultimately affecting the quality of care.

Nursing facilities are mandated to make changes in response to a survey if deficiencies are established and citations are issued, resulting in enhanced quality of care for the facility and for residents. However, it is also at this level that the enforcement process shows its greatest weaknesses: impaired detection ability, a tendency to minimize deficient practices, and a perfunctory process of compliance approval. Compounding (or perhaps driving) these problems is the legalistic frame of mind (fear of IDR) at the supervising Survey Agency level. This approach undermines the legitimacy of survey findings, undermines the authority of the surveyors, and ultimately fails to assure quality improvement for residents. Finally, many nursing facilities experience the enforcement process as punitive and unrelenting and would prefer a more consultative approach.

The case studies demonstrate that there is a great deal of subjectivity throughout the current survey process including: care problem identification, the decision to cite, the F tag to cite, scope and severity, what to document, the revisit process, and ultimately enforcement action decisions. This subjectivity makes the surveyor's job stressful and time consuming as they try to make the "right" decisions and generate the supporting documentation. This subjectivity leaves the nursing home constantly questioning citations, and, consequently, they invest less in responding to the survey findings.

Fortunately, CMS realizes that this is the root of the problem. With the Quality Indicator Survey (QIS), they are testing a more objective process for problem identification, investigation leading to citation decisions, identification of appropriate F tags, documenting findings throughout the process, and revisits. By virtue of this objective information, the QIS forces greater clarity relating to scope and severity. Anecdotal results from the demonstration suggest that both surveyors and nursing home staff find the QIS process more objective and consistent. Surveyors appear to be more confident with their citations and fewer citations are both challenged through and reversed in IDR.

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<sup>3</sup> It is interesting to note the problems with coal mine safety inspection that became public after the data collection for this study was concluded. See "Senators say mine safety agency needs more money." GOVEXEC.COM, <http://www.govexec.com/dailyfed/0106/012306cdpm1.htm>, January 23, 2006.

Moving toward a quantitative and structured quality assurance process on the survey side could result in quality systems for nursing homes that would help them respond to citations with quality improvement, and ultimately, provide higher quality care throughout the year.

## Reference List

- (1) American Health Care Association. Facts and trends: the nursing facility sourcebook 2001. 2001. Washington, DC, American Health Care Association.
- (2) Institute of Medicine. Improving the Quality of Care in Nursing Homes. 1986. Washington, National Academy Press.
- (3) Kramer AM, Grigsby J, Cooper D. Analysis of the Validity of Quality of Care Determinations. Chapter 4 in Evaluation of the Long-Term Care Survey Process. 1996. Bethesda, Maryland, Abt Associates.
- (4) United States General Accounting Office. California nursing homes: care problems persist despite federal and state oversight. Report to the Special Committee on Aging, U.S. Senate. GAO/HEHS-98-202. 1998. Washington, D.C., United States General Accounting Office.
- (5) Health Care Financing Administration. Report to Congress: Study of Private Accreditation (Deeming of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System). Volumes 1-4. 1998. Baltimore, MD.
- (6) Office of Inspector General. State Referral of Nursing Home Cases. OEI-06-03-00400. 2005. Washington DC, Department of Health and Human Services.
- (7) Office of Inspector General. Nursing Home Enforcement: Application of Mandatory Remedies. OIG-06-03-00410. 2006. Washington DC, Department of Health and Human Services.
- (8) United States General Accounting Office. Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117. 2005. Washington DC, United States General Accounting Office.
- (9) Kramer AM, Hrinkevich CA, Pool JS, Cooper D, Carter D. Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles. 1994. Denver, CO, Center for Health Policy Research.
- (10) Kramer AM, Zimmerman D. Evaluating the Use of Quality Indicators in the Long-Term Care Survey Process: Final Report. 2005. RTI International.
- (11) Centers for Medicare & Medicaid Services, UCDHSC Division of Health Sciences Center. CMS Quality Indicator Survey Demonstration Project Brochure. 2007.

- (12) Harrington C, Carrillo H. The regulation and enforcement of federal nursing home standards, 1991-1997. *Medical Care Research and Review* 1999; 56(4):471-494.
- (13) Centers for Medicare & Medicaid Services. *Nursing Home Data Compendium*. Centers for Medicare & Medicaid Services. 2006.
- (14) United States General Accounting Office. *Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*. GAO/HEHS-99-46. 1999. Washington DC, United States General Accounting Office.
- (15) United States General Accounting Office. *Nursing Homes: Sustained Efforts are Essential to Realize the Potential of Quality Initiatives*. GAO/HEHS-00-197. 2000. Washington DC, United States General Accounting Office.
- (16) Committee of Improving Quality in Long-Term Care, UCDHSC Division of Health Care Policy and Research, Institute of Medicine. *Improving the quality of care of long-term care*. Wunderlich GS, Kohler PO, editors. 2000. Washington, D.C., National Academy Press.
- (17) Morgan D. Practical strategies for combining qualitative and quantitative methods: applications to health research. *Qual Health Res* 1998; 8(3):362-376.
- (18) UCDHSC Division of Health Care Policy and Research, Centers for Medicare & Medicaid Services. *Quality Indicator Survey (QIS) Surveyor Resource Manual*. Denver, CO: University of Colorado at Denver and Health Sciences Center, 2006.