Skilled Nursing Homes:
Care Without Dignity

Report #109
April 1991

State of California

LITTLE HOOVER COMMISSION

March 25, 1995

The Honorable Pete Wilson
Governor of California

The Honorable David Roberti
President Pro Tempore of the Senate
and Members of the Senate

The Honorable Kenneth L. Maddy
Senate Republican Floor Leader

The Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the Assembly

The Honorable Ross Johnson
Assembly Republican Floor Leader

Dear Governor and the Legislature:

Close to 120,000 elderly Californian's living in skilled nursing facilities find that all aspects of their daily lives are dependent on federal policy makers, state regulators and private facility operators. After 15 years of investigations, the Little Hoover Commission continues to be dismayed at the quality of care received by this vulnerable, fragile population despite the expressed good intentions of each of those parties.

In the report that is being transmitted today to you, the Commission focuses on the state's refusal to implement federally mandated reforms, the rights of the elderly to informed consent processes before physical and chemical restraints are used, and the state's flawed enforcement efforts of a citation and fine system that has failed to protect the elderly. But the true focus is on human suffering and the lack of dignity that

overshadows the lives of too many residents of skilled nursing facilities.

Statistics tell one aspect of the story:

- Sixty-eight percent of nursing home residents are chemically or physically restrained, a percentage that greatly exceeds any other state's.
- Over a five-year time span, fines for failing to meet state standards increased 443 percent, but the collection of those fines increased only 87 percent.
- Last year, the State reached a settlement with a skilled nursing facility conglomerate to accept $616,107 for almost $2 million in fines resulting from 587 citations at the company's 58 California facilities.

Statistics, however, are not the only measure of what is occurring in nursing homes. Anecdotes, especially in the volume that the Commission has gathered, paint a compelling picture of misery and suffering, including these stories:

- A woman who was placed in a facility for just a few months for rehabilitation after breaking a leg can no longer walk and is still in the home two and one-half years later.
- A woman recuperating from an ankle sprain was given Haldol and within one week was unable to sit up, was hallucinating and was unable to control her bodily functions.
- A man who was restrained so tightly that his wrists swelled and he screamed in pain when he was touched. The man was described by his family as a zombie from the use of Haldol, which it was later discovered caused an allergic reaction in the man.
- A man who choked to death after he fell from a bed while he restrained in a Posey vest.
- A man whose leg had to be amputated after he injured his toes and nursing home staff failed to alert doctors to his spreading gangrene.
- A woman whose bedsores were so massive that she died from infections. In a Keystone Cops scenario, the facility was not issued the serious citation usually associated with deaths. After almost two years of maneuvers, the facility paid $3,750 fine.

These are but a few of the specific cases cited in the Commission's report. Based on stories like these, interviews with experts and investigations of records, the Commission made three findings and seven recommendations for improving the quality of care in nursing homes.

FINDING #1: California has failed to implement nursing home reforms dictated by federal law, and in so doing has threatened the health, safety and well-being of an unknown number of nursing home residents and jeopardized the State's federal Medi-Cal funding.

> **Recommendation #1: California should take immediate steps to implement federal nursing home reforms in the manner prescribed by the Health Care Financing Administration.**

FINDING #2: The Department of Health Services has failed to clearly define a skilled nursing facility resident's right to give or withhold consent for a physical and chemical restraints.

Recommendation #2: The Governor and the Legislature should fulfill federal nursing home reform mandates by guaranteeing residents the right to participate in treatment planning and to grant or withhold informed consent for physical and chemical restraints.

Recommendation #3: The Governor and the Legislature should restrict the use of "as needed" prescriptions for medications that are subject to abuse in nursing homes.

Recommendation #4: The Governor and the Legislature should direct the Department of Health Services to create a Medi-Cal drug approval system that will meet the needs of long-term care patients.

Recommendation #5: The Department of Health services should gather statistics annually on the number of nursing home residents who are physically or chemically restrained and on the number who are incapable of giving informed consent and have no representative to make decisions on their behalf.

Finding #3: California's citation and fine system has not proven effective as a deterrent to poor quality care in skilled nursing facilities.

Recommendation #6: The Governor and the Legislation should reform the citation and fine system to streamline the process and increase its deterrence value.

Recommendation #7: The Governor and the Legislature should direct the Department of Health Services to investigate and respond to complaints promptly and to keep complainants informed of all steps taken.

An underlying theme throughout the report is the conflict between policy and reality. The State has made it clear it believes it is doing a good job of regulating nursing homes residents. But no amount of good intentions and fine policies can change the fact that people continue to suffer neglect and abuse in nursing homes. That is the reality that the Little Hoover Commission continues to find in nursing homes. And that is the reality that the Commission urges the State to address immediately by implementing the changes that we are recommending.

Sincerely,

Nathan Shapell, Chairman
Haig Mardikian Vice Chairman
Senator Alfred Alquist
Mary Anne Chalker
Arthur F. Gerdes
Albert Gersten
Senator Milton Marks
Assemblywoman Gwen Moore Angie Papadakis
Abraham Spiegel
Barbara S. Stone
Richard R. Terzian
Assemblyman Phillip D. Wyman

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INTRODUCTION

One of the State's most pressing obligations is to provide protection for its citizens who cannot help themselves. Nowhere is this need more evident than among the frail elderly who can no longer live independently and who need constant care. Close to 120,000 Californians are spending their final days in 1,200 skilled nursing facilities that are licensed, regulated and monitored by the Department of Health Services. The State's ability to perform effectively, efficiently and uniformly in its activities concerning skilled nursing facilities is crucial to their quality of life and, in some instances, may be a matter of life and death for these vulnerable citizens.

In addition to the humane aspect of the State's duties, there are fiscal responsibilities as well. Approximately 80,000 of the residents in skilled nursing facilities are covered by Medi-Cal or Medicare. The State spends almost $2 billion in reimbursements to nursing homes for elder care, a significant portion of the $8.1 billion Medi-Cal budget. In fact, while long-term care residents represent only 2 percent of the Medi-Cal caseload, their care costs 25 percent of the program's health care budget.

Thus, the State has parallel obligations both to protect its citizens and to ensure that it receives full value and quality services in exchange for its limited tax dollars.

Little Hoover and Commission Policy Role

Under its mandate to investigate state programs and Commission promote effective and efficient methods to meet the policy Role goals of those programs, the Little Hoover Commission since 1976 periodically has examined the Department of Health Services' rolein regulating skilled nursing facilities. The first report,

"Supplemental Report on Licensing and Certification, Department of Health", was an outgrowth of a comprehensive study of the administration of all the State's health programs.

But the key study came in August 1983 when the Commission issued "The Bureaucracy of Care: Continuing Policy Issues for Nursing Home Services and Regulation." That report's recommendations served as the cornerstone for the Nursing Home Patients Protection Act, a package of more than a dozen bills that strengthened the citation and fine system, increased criminal penalties for willful and repeated violators, protected the rights of complainants and created better public access to information about nursing homes.

This was followed by "New and Continuing Impediments to Improving the Quality of Life and Quality of Care in California's Nursing Homes" in May 1987, which gave riseto legislation to improve fine collection efforts, increase consumer information services and protect patients in facilities that drop out of the Medi-Cal program.*

While previous reports focused on the State's role as a regulator and enforcer, in February 1989 the Commission turned its attention to a new direction in a report entitled, "The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight." In essence, the report determined that high quality medical care is not the top priority of any state agency or any industry group involved with nursing homes and that, as a result, the care provided to residents is inadequate. The findings from this report, for the most part, remain unresolved and are a continuing concern of the Commission. These include important policy changes such as outlawing the abandonment of patients in nursing homes by doctors, providing a peer review mechanism to monitor the quality of care and developing standards for medical practice in nursing homes.**

Some Issues Unresolved

While the Commission has been successful in sponsoring reform in many areas relating to spskilled nursing facilities, issues from past reports remain a priority. For instance, as previously noted in a Commission report, skilled nursing facilities are not required to fingerprint or perform background checks on people they employ. This is a problem that plagues in-home care programs for the elderly as well. An Auditor General's review in 1987 found that almost 7 percent (709) of those employed to take care of the elderly in three Bay Area counties had criminal convictions.1 Similarly, a recent Sacramento Bee investigation found that more than 45 people out of 630 on a list of available in-home workers had criminal recods. These people would be identified if they applied for work at a residential care facility for the elderly cause that category of long-term care program does require fingerprinting. But because of the disparity in the way these different long-term programs are treated, the elderly who are in spskilled nursing facilities or who are receiving care at home can be endangered while those in residential care facilities enjoy a greater level of protection.

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* Please see **Appendix A** for a summary of legislation adopted in the wake of the 1993 report and the 1987 report.
** Please see **Appendix B** for the summary of the 1989 report's findings and recommendations

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Continuing Problems Mar Progress

Despite the unfulfilled recommendations, substantial legislative progress can be pointed to by the Commission in several areas, such as the authority for greater enforcement efforts by the State. But what is troubling for the Commission is that despite these legislative victories there are continuing and persistent indications that the system is still faltering and the elderly are still being subjected to abuse and neglect. From

the time the Commission announced its intention to hold a hearing on skilled nursing facilities issues in September 1990 until this report was nearing completion, letters, telephone calls and documents arrived to alert the Commission that there are ongoing concerns. They contained personal anecdotes, documented abuses and bureaucratic horror stories.

One example is the case of a woman who died in July 1989 before the State investigated her husband's complaint about life-threatening and substandard care given to her in a nursing home. Although the original death certificate showed she died from sepsis due to decubitus ulcerations--general body infection due to bedsores--a second death certificate stated the cause of death as Alzheimer's Disease. The State issued a citation and a $5,000 fine to the facility for failing to care for the woman's bedsores and failing to alert her doctor to her changing condition. The State, heeding the second death certificate, chose not to issue the far more serious and costly type of citation that is given when a facility contributes directly to the cause of death, despite efforts by the woman's husband and advocacy groups to have the citation increased to that level. Yet in the court case filed in November 1990 after the facility contested the citation, the State argued that the woman had died from her bedsores.

In a further procedural problem with the case, $2,500 was added to the fine at one point when it was discovered that the facility had also allowed the woman to become dehydrated. But this amount was later dropped when it was noted that fines can only be upheld, dismissed or lessened during the State's review--but not increased even when new information comes to light.

In the end, a court settlement was reached allowing the facility to pay 75 percent of the fine. By the end of February 1991, 19 months after the woman died, the facility had paid $3,750 for grossly neglecting her health care needs.

The Commission received more generalized complaints from a variety of sources. These included:

- Ombudsmen who worry that there are too few in their ranks to act effectively as "the eyes and ears" that are needed to monitor all state-regulated institutions for the elderly. They also report that complaints to state investigators about various facilties don't always yield results, leading to discouragement and distrust of the State's commitment to enforcing regulations.

- Advocacy groups that are frustrated by the ineffective safety net that ombudsmen are providing seniors, and that are convinced the State licensing process is too closely aligned with the nursing home industry to act effectively as a policing agency.

- Despite laws and regulations directed at providing comprehensive consumer information, family and friends of nursing home residents say they don't know where to turn with complaints and demands for better treatment.

- The nursing home industry, which argues strongly that more and better care can only come with higher payments that will allow homes to attract better staff through higher pay, reduce employee turnover and provide more direct caregiving.

Study Focuses On Three Areas

Against this background of discontent, the Commission embarked on its latest study, concentrating on areas that have proven the most problematic over the years, as well as reviewing major federal efforts to reform the nursing home system. In the report that follows, the Commission evaluates the State's posture regarding the federal reforms, explores the issue of a patient's right to informed consent before physical or chemical

restraints are used, and revisits the State's troubled system of citations and fines.

One of the most comprehensive reform packages for skilled nursing facilities was passed by Congress in December 1987, with a full implementation date set for October 1, 1990. Adopted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), these federal reforms radically altered requirements for Medicaid- and Medicare-licensed nursing homes, focusing on improving the quality of care and the quality of life for nursing home residents.

The key reform of OBRA 87 is the requirement that each nursing home resident be given a comprehensive personal needs assessment, based on a "Minimum Data Set" that includes information in 13 different areas of functioning. From this, a blueprint of care is designed that, when followed by the nursing home, will provide the resident with the highest practicable physical, mental and psycho-social well-being. The ongoing quality of care is assured by requiring nursing homes to carefully monitor the status of each of more than a dozen different areas of functioning and to create care plans designed to eliminate deterioration in those areas or restore any diminished functioning whenever possible. Among the areas are: activities of daily living, vision and hearing, pressure sores, incontinence, range of motion, psycho-social functioning, use of naso-gastric tubes, accidents, nutrition, hydration, dental condition, discharge potential, special needs and drug therapy.

OBRA 87 also prohibits the use of physical and chemical restraints for reasons of discipline or convenience or if the patient refuses to grant informed consent for the use of such restraints. Other patient rights issues in the reform act ensure that patients will be involved in the planning of their own treatment, will be provided notice about a change in room or roommate, and will be given an accounting of personal funds. In addition, nursing home residents cannot be asked to waive their participation in Medicare or Medi-Cal and cannot be forced to find a third-party guarantor of payment as a condition of admission or continued stay.

Other provisions of OBRA 87 require detailed discharge plans and adequate notice to residents whenever a discharge or transfer is planned, and full-time social workers at facilities with at least 120 beds.

State Failed To Comply

On October 1, 1990 when all the provisions of OBRA 87 became fully effective, California was one of five states (along with South Carolina, West Virginia, Maryland and Pennsylvania) that the federal government said had not met the new requirements. By early 1991, only California remained out of compliance. As this report is being written, California has been unsuccessful in its efforts to convince anyone that its existing programs are already in substantial compliance with the dictates of OBRA 87. Patient advocacy groups are using court action to press the State to comply. Nursing home industry groups are joining in court action to seek more funding to implement federally required changes. And the federal Health Care Financing Administration (HCFA), which oversees states in the regulation of Medicaid and Medicare-funded programs, is threatening the State with sanctions.

FINDING #1: California has failed to implement nursing home reforms dictated by federal law, and in so doing has threatened the health, safety and well-being of an unknown number of nursing home residents and jeopardized the State's federal Medi-Cal funding.

Since mid-1990, California has taken the stance that its current regulations and laws effectively meet the intent of reforms mandated by OBRA 87 and, in fact, served as the model for many of the innovations in OBRA 87. The State has further argued that to carry out the reforms in the way the federal government has prescribed would cost $400 million to $600 million more than the current $2 billion that is spent through

Medi-Cal on some 80,000 nursing home residents. Finally, the State has said that the additional expenditures would largely go to administrative procedures and paperwork rather than to improved care for the patients. The State, therefore, has refused to implement OBRA 87, instead taking various actions administratively, in court and through state and federal legislative systems in an attempt to be placed outside the requirements.

The State's position has met with strong reaction from nursing home reform advocates and patient rights groups, as well as from the federal government. What follows is a chronology of events drawn from court documents, letters and interviews.

Between 1987 when OBRA 87 was passed and late Spring 1990, the Department of Health Services was working toward changing California's rules, laws, procedures and provider agreements to meet the new federal requirements.

Then in June 1990, a nursing home reimbursement reform bill (SB 1087) was amended to declare that the existing state program was in substantial compliance with OBRA 87. The bill, which restructured the way nursing homes are paid to encourage better care for Medi-Cal patients with heavy nursing needs, was intended to pump an additional $100 million in payments to skilled nursing facilities and had been the focus of intense State-industry-advocate negotiations for many months. The final bill, which was passed by the Legislature and signed into law by the Governor, contained a "poison pill" provision. The Mello reforms and added funds would not occur if the federal government refused to recognize the State's declaration of compliance with OBRA 87 or if any court ordered the State to take steps to implement OBRA 87 that would result in an increase in state spending

At about the same time, the Department of Health Services pulled more than 600 employees out of federal training sessions on the OBRA 87 requirements, and State officials began to speak openly about the fact that no further action was planned to comply with OBRA 87.

By September 28, 1990, HCFA had notified the State that it was rejecting the annual plan submitted earlier in the year, based on California's intent to ignore OBRA 87. HCFA warned the State that failure to comply with OBRA 87 by October 1, 1990, could lead to sanctions ranging from the decertification of nursing homes (thus rendering them ineligible to receive Medi-Cal and Medicare payments for residents) to forfeiture of the federal share of Medi-Cal funding. HCFA also pointed out that the State's plan to spend about $100 million on SB 1087 improvements was an admission on the part of the State that the existing nursing home program is not in compliance with OBRA 87. A side-effect of the HCFA rejection of the state plan was to put the funding reform bill on hold since this was one of the conditions amended into the bill.

On October 1, 1990, the National Senior Citizens Law Center, Legal Assistance to the Elderly, California Law Center on Long-Term Care, Legal Services of Northern California and attorneys for Congressman Pete Stark filed suit in the United States District Court against the California Department of Health Services and its director, the federal Department of Health and Human Services, and the Health Care Financing Administration. The plaintiffs, on behalf of all Medi-Cal- and Medicare-funded nursing home patients, sought an injunction that would force the State to immediately implement OBRA 87 and force the federal government to ensure that the State complied.

This action became known as the Valdivia case, after Richard Valdivia, who the suit argued was being denied needed therapy and treatment in a nursing home. The other named plaintiff in the case, Eldora Kaski, was described as being physically restrained and medicated with anti-psychotic drugs against her will in another nursing home. "As a result of California's and HCFA's flagrant violation of federal law," the suit said, "each day elderly and disabled nursing home residents are suffering irreparable harm." The suit further argued that the federal government was illegally continuing to pay Medicaid funds to California even though the Medi-Cal program "fails to meet the requirements of federal law and nursing home residents in California are being deprived of their rights to care and services."

Nursing Homes Seek More Funds

The nursing home industry, meanwhile, had been strenuously arguing that implementation of OBRA 87 would cost an additional $1.2 billion to $1.4 billion. By mid-summer 1990, these figures had been scaled down to $400 million to $500 million, echoing the State's estimates of cost. "Historically the push for nursing home quality has been predicted on the simplistic concept that you can create policy, law and regulations that will change things even if the primary purchaser of services won't provide more resources," wrote the executive vice president of the California Association of Health Facilities. "It is obvious that this approach produces unfulfilled promises and conflict. We are absolutely determined that this time, we will all deal with reality and the truth. Our estimate [of the costs of OBRA 87] was targeted at that reality."

In October, the California Association of Health Facilities successfully sought the judge's permission to join the patient advocates' lawsuit, arguing that any judicial decision should include an order for the State to provide funding for OBRA 87 procedures that nursing homes would be required to implement.

The State during this time was hardly inactive. It turned to Congress, seeking legislation that would exempt California from the OBRA 87 requirements. But on October 16, the State-sponsored bill to give the State's plans the green light was killed in committee. The State also filed a revised plan with HCFA on December 5, 1990 that still sought to avoid taking further action to implement OBRA 87, and it began negotiations with HCFA to stave off any sanctions.

Judge Ordered State To Comply

Then on January 11, 1991, the federal judge issued a preliminary injunction in the Valdivia case, saying that the failure of the State to act was likely to cause irreparable harm to nursing home residents and that the facts and law clearly favored the plaintiffs. The State was ordered to immediately implement all provisions of OBRA 87, including the conduct of full and complete patient assessments, the monitoring of the 13 areas of patient functioning, the protection of patients' rights including informed consent to the use of physical and chemical restraints, and the full enforcement through survey and certification procedures required in OBRA 87.

The judge also responded to the nursing home industry concerns, ordering the State to submit "an approvable Medicaid plan amendment which takes into account the facilities' costs of complying with the provisions of the nursing home reform law."(This last provision made it even more unlikely that the rate-reforming SB 1087 would ever emerge from limbo, since a judge's order was the second part of the "poison pill.")

Despite the clear-cut nature of the judge's order (which is expected to be followed by a detailed memorandum of decision at a later date), the OBRA 87 issue is not settled. In mid-March, as this report is being written:

- HCFA is holding a compliance hearing to consider California's revised plan and the State's failure to follow federal procedures for certifying nursing homes since October 1, 1990. A main element for discussion is the State's unwillingness to use "Interpretive Guidelines" that HCFA has issued to deal with how portions of OBRA 87 are implemented.

- The State, as directed by the judge, will file a report on the steps it has taken to comply with his injunction.

- The Governor has authorized the Department of Health Services to sue HCFA, arguing that the federal government cannot force the State to use the Interpretive Guidelines since they are not regulations that have been promulgated according to federal procedures.

- Advocates are compiling evidence and tracking the State's efforts in the wake of the judge's order, with an eye to returning to court to argue that the State is in contempt of court for not following the dictates of the preliminary injunction.

State Argues Standards Are Tough Enough

While everyone agrees that, so far, California is not complying with the federal concept of how reforms should be implemented, a key divergence of opinion exists over whether the State already meets the intent and spirit of OBRA 87. In a "Nursing Home Reform Talking Points" paper prepared by the Department of Health Services on September 5, 1990 the State argues:

> *California law and regulations and federal law and regulations are very similar. Indeed, many of the OBRA 87 nursing home reform provisions are actually modeled after existing California requirements. On its own, California has already put in place specific staffing minimums, nurse aide training/ certification and recertification standards, an enforcement/sanction system, and other program enhancements which surpass the national norm, reflecting a long-established commitment to quality nursing home care. California has also established an aggressive licensing and certification staff of more than 600 health professionals to ensure compliance with these advanced regulatory requirements. This unique program and the State's uncommon enforcement effort clearly set California apart from the majority of states in the overall commitment to quality nursing home care.*

The State's position was further detailed in a letter from the Health and Welfare Agency Secretary to a congressman on August 14, 1990:

> *There is no doubt that elements of [OBRA 87] legislation can make significant contributions to improved quality of care for patients residing in nursing homes. The focus on actual facility performance in providing care (outcome rather than process), staff training requirements and more definitive guidelines for the administration of drugs and the application of physical restraints are standards we must all strive to meet. Here in California, we have made significant progress with the implementation of our own nursing home reforms, particularly since 1985....*
>
> *Because of the significant nursing home improvements California has already implemented, I am concerned that the large additional costs to implement OBRA 87 in California does not match the limited "value added" for California's nursing home residents... We are proposing a more cost-effective alternative to comply with the intent of OBRA 87 and improve the quality of care.*
>
> *Our plan, embodied in Senator Henry Mello's legislation, SB 1087, will provide quality of care incentives, particularly by targeting additional funds to facilities that spend more dollars on direct patient care, and make disproportionate share adjustments for those facilities serving a high number of low-income patients....*
>
> *We believe that the implementation of the provisions of SB 1087, within the State's existing statutory and regulatory framework, will place California in substantial compliance with the requirements of OBRA 87.*

State's Case

Despite the State's persistent claims to be Challenged equivalent to or beyond the standards set in OBRA 87, there is substantial evidence to the contrary, from patient rights advocates, from expert witnesses and from anecdotal materials.

"Analysis of OBRA Requirements v. Current California Law" compares many of the key federal reforms that directly affect patients with existing state law. Compiled by the California Advocates for Nursing Home Reform, highlights from the document include:

Please see **Appendix C** for complete text of "Analysis of OBRA requirements v. Current California Law."

- Existing California Patient Rights provisions do not include many of the new rights specified under OBRA 87, including the right to the notice of a change of room or roommate, written description of legal rights and the right to informed consent to to treatment.

- OBRA 87 requires a comprehensive resident assessment based on a nationally uniform minimum data set. Resident assessment under current California law provides no criteria for content, frequency or accuracy of assessments, nor is there a uniform assessment tool that is used.

- OBRA 87 requires a comprehensive care plan individualized for each resident to meet the needs reflected in the resident assessment. State-mandated care plans are not comprehensive, however, and do not reflect resident assessment.

- New federal protections against the use of physical and chemical restraints without informed consent are not a part of existing California law.

While California Advocates for Nursing Home Reform has long been critical of the State's regulation of skilled nursing facilities, the group is not alone in believing the State falls short of OBRA 87 requirements. A senior policy analyst with Research Triangle Institute who was the project director for developing a national nursing home resident assessment system for HCFA submitted a declaration as part of the Valdivia lawsuit. She said that she had reviewed California regulations that relate to resident assessment and "had difficulty in understanding how the State of California can maintain that its regulations match either the OBRA 87 requirements or the HCFA-designated resident assessment instrument."

The analyst described the Resident Assessment Instrument as being composed of two parts: a Minimum Data Set (MDS) designed to help facilities identify the strengths, needs and preferences of residents in the major areas that affect a nursing home resident's functioning and well-being; and a Resident Assessment Protocol (RAP) that evaluates the resident in 18 different functional areas, and for problems in each area sets "trigger" points at which a facility must ensure that a care plan addresses the specific needs of the resident. The analyst elaborated:

> *For example, one of the Resident Assessment Protocols is in the problem area of falls, a common and potentially serious accident among nursing home residents. The RAP for falls would trigger for further assessment and care plan consideration both residents who have a history of falls and residents who, although they have not fallen in the past six months, are at high risk for falling within the next six months [because of] taking a psychotropic drug or having balance problems or poor leg control.*

While HCFA gives the states latitude to choose a Resident Assessment Instrument, it does mandate that the system identify residents who need special attention in the different functioning areas.

> *This is important since such a fully specified, systematic and standardized method to link assessment information to problem identification for care planning has not been part of regulation in the past. Facilities have been left to their own devices in terms of how to link assessment information to care planning decisions...*

The analyst said her review of California regulations shows that the State does not require assessment in each of the different functioning areas for all nursing home residents. Some areas, such as discharge potential and psycho-social well-being are not addressed in state law at all, she found. In regulations that did correlate with some of the areas, the analyst said there were not enough specifics to inform facilities of the types of information it must routinely collect in the assessment of the resident and of how the assessment should be used in determining whether the resident needs a new or different care plan.

> *For example, the section specifically cited by [the State] as related to assessment of resident's dental status actually refers to arrangements for an advisory dentist to "participate at least annually in the staff development program" and "to approve oral hygiene policies and practices for the care of patients." This section of the regulations does not specifically require assessment of the resident's oral status, including problems, risk factors and potential or need for rehabilitative/restorative interventions.*

The difference that the analyst perceived between the current state regulations and OBRA 87 requirements can be further measured using the results of a 1986 California Dental Association study of skilled nursing facilities. This study found that 55 percent of the residents needed treatment by a dentist or specialist, 17 percent needed immediate attention for acute conditions, 13 percent had decayed teeth and 7 percent had fractures in their teeth. As the California Dental Association noted, OBRA 87 not only requires dental conditions to be assessed, but regulations under the act also require the facility "to provide or obtain from an outside source routine and emergency dental care." Under California's current laws and regulations, such care does not occur.

The analyst in the lawsuit declaration also said that since the State does not require nursing homes to use a standard assessment instrument, she obtained four assessment forms used by different nursing homes and reviewed them:

> *These are used in facilities that are currently licensed and certified by the California Department of Health and apparently meet the criteria of that department for resident assessment. None of these instruments, however, meet the criteria for comprehensiveness, accuracy/ reliability, reproducibility, and clinical relevance to care planning that have been used in developing, testing and revising the [Resident Assessment Instrument and Minimum Data Set] required by HCFA. Further, they do not link the assessment information to the identification of potential problem areas and the need for care planning decisions.*

The analyst's testimony should be viewed in the context of coming from someone who believes the Resident Assessment Instrument developed by her own company is the best way of meeting HCFA's requirements. Nonetheless, the key points she makes about the lack of specifics in California's regulations are telling evidence that the State does not meet HCFA's new standards.

The State's central argument, on the other hand, is that its licensing and certification efforts already are stringent enough to ensure residents the high degree of care that is the goal of OBRA 87. The specific paperwork required by HCFA will not add to patient care but only to red tape and costs, according to the

State.

Human Suffering Still Persists

This argument can only be viewed with skepticism by the Little Hoover Commission; despite seven years of studies and Commission-sponsored reforms, well-founded complaints continue to reach the Commission at a rate that belies the State's insistence that nursing homes are producing quality care. Other sections of this report are replete with examples that demonstrate problems with different quality-of-care issues. The example that follows, taken from the court filings in the Valdivia case, is particularly illustrative since it encompasses many of the elements addressed by OBRA 87: rehabilitative therapy, discharge potential, chemical restraints, physical restraints and social activities. In the deposition, the Sacramento woman is speaking about her 82-year-old mother who, after surgery for a badly broken leg, was placed in a convalescent hospital for rehabilitative therapy that the doctor said would probably take three or four months. It has now been two and one-half years.

> *When Mom went into HyLond, she had one perfectly good leg and the other one with the fracture that needed to heal. She could move both her legs. Now, both her legs, her good leg and her hurt one, are stiff and contracted. She will not be able to use them right again.*
>
> *She never got a walker, even though [the doctor] told me that he had left an order for one. I asked day after day for that walker, but the HyLond nurse always told me that they did not have enough staff to do it. After Mom was in HyLond only two weeks, the director of nurses told me that my mother would "probably" never walk again. The closest thing Mom ever got to physical therapy was the help of an aide on and off for about a month and a half... I told them that her legs were contracting and that they ought to do something... They did nothing....*
>
> *She should have had therapy to get back her legs the way they were before the accident happened. There is no excuse for her legs being like this. And now the nurses tell me it's all in the past--just forget it. I can't forget it when I see those legs now. It's like taking away from her her right to walk, to live. That's what they have done at HyLond. They tell me they are short of staff, but that is no excuse....*
>
> *[The doctor], HyLond's medical director, approved them starting Mom on Thorazine. He is not a psychiatrist, and as far as I know, my mother had never been seen by a psychiatrist... I complained, to try to stop them from giving her the drugs, but they didn't pay any attention to me... When [the doctor] finally talked to me, he told me that my mother was not "overmedicated." I called it "drugged" or "doped up." He said, and these are his words, "We don't snow them. We keep them comfortable." From what I have seen, I believe that it is the nurses they are keeping comfortable....*
>
> *HyLond called me a couple of times because my mother had tried to get up out of bed and had fallen. Mom told me that she had had to go to the bathroom and had called with her call button because she didn't want to do it in the bed. No one came, and she was desperate not to foul her bed so she tried to get up and get to the bathroom on her own... So, they tied her to her bed for, they said, her safety. It was really just for the convenience of the nurses, who didn't have the time to assist her with getting to the bathroom every time she had needs.*
>
> *When they first tied Mom down, they gave her a bedpan, but with the placement of her fracture, it was too painful for her to sit on it. She could not use it. Finally, she gave up. She no longer has any bowel or bladder control. It's completely uncalled for, the messes I have gone in there and*

found her in--her own urine and feces dried on her. When I was still visiting her every night, she would tell me when she had to go for the main event, and I would get her up and take her to the bathroom. But a couple of weeks ago, I sensed that she had to be changed and asked why she had not asked me for my help to get up. She was very resigned. She told me, "I'm so used to laying in it now."...

The activities at HyLond do not stimulate my mother at all. Before she entered HyLond, she paid close attention to politics. She was always writing letters to senators and congressmen, even to the White House. Now when I visit I try to get the TV changed so she can at least watch the news. All they have at HyLond are baby activities, like cartoons and things for a child that aren't interesting for an adult. All the crafts and activities like that just bore her. They treat the adults here like children. Once as I waswalking down the hall, I saw a nurse putting another patient to bed. The way the nurse was holding the patient hurt the patient, so she was crying out. To calm her down, the nurse was singing, "Who's Afraid of the Big Bad Wolf"--to an alert adult woman in her 70s.

All of the terrible things I have gone through with my mother at HyLond have convinced me that there is no regard for a person's dignity there... My mother should have had therapy to get her legs back to their normal functioning. There is no excuse for her legs being like they are now. There is no excuse for the drugs. There is no excuse for trying to keep family out. There is no excuse for their inhuman treatment, or for letting Mom lie there in her own messes, dried and caked on her.<

I went to the State for help from the beginning. I have made complaint after complaint to the licensing office and nothing has ever happened. They shrugged their shoulders. They looked the other way when I came to them for help.

The clear intent of many of the reforms in OBRA 87 was to see that people like the woman described above would receive treatment and be cared for with dignity. It is possible that, as the State contends, OBRA 87 reforms are largely added paperwork that would make no difference in the care given to nursing home residents. But it is also clear that the State's existing system fails to ensure a high quality of care.

Recommendation #1: California should take immediate steps to implement federal nursing home reforms in the manner prescribed by the Health Care Financing Administration.

Despite California's claims that it already substantially complies with OBRA 87, nursing home operations do not meet the newstandards either on paper or in reality. While the State believes the cost of these changes would range from $400 million to $600 million, HCFA officials have said 49 other states are using the new system with only limited added costs that are no where near the magnitude California is predicting. Rather than finding ways to get around OBRA 87, the State should move aggressively to meet the federal mandate, fulfill the judge's order and improve the chances for better care for nursing home residents.

INFORMED CONSENT

The use of both chemical and physical restraints in skilled nursing facilities is a key quality-of-care issue for patients, their families and the industry. The industry frames the issue in terms of safety for residents who might harm themselves or others and maintains that alternatives to using restraints would greatly increase costs. Residents and their families object to drugs that leave the recipients little more than zombies and physical restraints that restrict mobility and lead to bedsores. For many people, in the end, the issue is one of rights: Should nursing home residents have the same right to control their own treatment that exists for others

in the state, including the mentally ill, the developmentally disabled and those who are incarcerated?

Studies nationwide have shown that roughly 50 percent of nursing home residents are given anti-psychotic medication at one time or another, and about 41 percent are physically restrained. A 1990 internal memo by the California Association of Health Facilities (a nursing-home industry organization) says that its own survey shows that 68 percent of patients are either physically or chemically restrained. The California Advocates for Nursing Home Reform says it believes 80 percent of patients are restrained in one manner or another. If one accepts the nursing home industry's own figures, that translates to more than 81,000 elderly Californians being tied down and/or drugged on any given day.

The human face of this widespread use of chemical and physical restraints was painted vividly for the Little Hoover Commission in an outpouring of letters and testimony. Some excerpts:

> *My 84-year-old mother had been in relatively good physical and mental condition when she fell and suffered a minor ankle sprain. Her doctor suggested that she would benefit from therapy administered in a convalescent hospital... Within a week, her overall condition changed dramatically! She was unable to sit up, began to hallucinate and was unable to control her bodily movements or functions. Unable to understand her swift deterioration, I asked to see her chart and discovered her doctor had prescribed Haldol as needed andobviously the staff administered it, needed or not. She had entered that hospital a cooperative, docile little lady and certainly was not a candidate for chemical restraint! We removed her immediately... With the removal of Haldol, she slowly regained her mental and physical abilities, but it took weeks for the cumulative effect of the drug to dissipate and, in truth, she was never really herself again.*
>
> --Moraga resident

> *I found out that on the night of entry she had been given Haldol in the amount of three milligrams within the first eight hours. The drug put her into a coma, which lasted longer than four days. They said she had become violent, but I knew she was a very even-tempered person and previous times she had been in the hospital she had been considered a perfect patient... A full dosage per the books even for a healthy person...and all within eight hours.*
>
> --Twain Harte resident about his wife

> *He was given the drug Haldol for his anxiety. He was restrained at his wrists and feet, quite tightly. At one point, his hands started swelling and were obviously painful. My daughter touched his hands and he screamed... We questioned the restraints and were told this was so he wouldn't remove the tube from his nose. My father's speech was quite slurred and most of the time he was like a zombie. We questioned the drug and were told this was for anxiety under the doctor's orders. The doctor's orders were "when necessary," but in our opinion they administered it too freely to keep their workload down... [The doctor] finally took my father off Haldol and put a red alert band around his wrist that read "allergic to Haldol." This drug was toxic to my father and they finally realized it after all that time... We did find another place and my father seems to be getting proper care. However, his body is just a shell of his former self. All of this happened in three months.*
>
> --San Bruno resident

> *I immediately observed the effects of Haldol on my mother. It began with excessive salivation. On June 20, she was losing her ability to function. Before she was able to push herself around in*

her wheelchair. Now she just sat in her wheelchair, head bent down and a vacantstare... When I visited her on June 26, she was sitting in her wheelchair in a stupor. I tried to wake her but I could not. I asked the charge nurse how my mother would be able to eat and was told they would have to feed her. Prior to this, she could eat by herself. Her condition continued to deteriorate and she was subsequently fed by using a syringe. She no longer recognized family members... She didn't appear to know what she was doing any more... She always seemed to be in a stupor... We changed doctors and we were able to get her into a different nursing home. My mother never recovered from this ordeal... We feel that the use of Haldol and Halcion directly contributed to my mother's death and that she suffered unnecessarily as a result.

--Napa woman who gave permission for the use of anti-psychotic drugs only after a nursing home threatened to evict her mother without them

When she was first brought into the [nursing home], she was very mobile. Toward the end of her stay, she was very subdued... We found her sitting in a chair and simply staring. She did not speak to anyone (had a thick tongue). We noticed that she had lost all bladder control. We questioned the nurses about this and they said that she was on no medication... The nurses also said they knew of no reason why she was just sitting and staring... She fell and broke her hip. Because surgery was required, she was brought to [the hospital] where the physician diagnosed her as "having a massive accumulation of Haldol."... When Haldol was stopped, [she] began to be aware of her surroundings.

--Napa residents about their aunt

My father was the victim of not one but two incidents of misuse of physical restraints in a nursing home. The second one cost him his life... A faulty [bed] railing that the nursing home had failed to maintain was down. The railing being down allowed my father to fall off the bed, which, because he was in a Posey restraint, caused him to choke.

--Palo Alto resident

Every time my husband resisted forced treatment or abuse, he was drugged. My husband was overdrugged until he could not fend for himself. I had to constantly watch what medicine was being given to him. I had to constantly check "The Physician's Desk Reference" for ingredients and side-effects of drugs. At one point, his hands became paralyzed and he was having convulsions. I made them quit giving the drugs that resulted in this side-effect, Cogentin with Haldol. This overdrugging and neglect were responsible for the many injuries inflicted on him.

--Palo Alto resident

I was willing to sign anything to take care of any liability if they would just stop tying him up. I was willing to take the risk that he might fall, and I know my husband also would be willing to take that risk. He just hated being tied up like an animal. It was so degrading. But the nursing home told me that I'd have to take him somewhere else if I didn't allow him to be tied up, that they would be cited by the State if he fell without restraints and that there was no way I could sign something that would protect the nursing home. I couldn't find anywhere else that could accept him.

--Sonoma resident

The details of the many cases differ, but the common complaint from most people who contacted the Little Hoover Commission was that they could find no state law, regulation or mechanism to ensure that their desires were heeded when it came to treatment options.

FINDING 2: The Department of Health Services has failed to clearly define a skilled nursing facility resident's right to give or withhold informed consent for physical and chemical restraints.

Although California has a nursing home patient's bill of rights that states that a resident is free to assume risks, it is also stated that this must be balanced against the responsibilities of the facility to provide patient care. As this report is being written, there are no specific statutes or regulations that detail how a resident can give or withhold informed consent to the use of physical and chemical restraints. The one written policy that the Department of Health Services has affects only physical restraints and postural supports and has never received wide circulation in the industry or among residents' advocate groups.

The result of this silence on the part of the State has been a widespread reliance on physical and chemical restraints in nursing homes and a corollary widespread frustration on the part of residents and families who seek to control their own destinies. In addition, there is a substantial body of evidence that the use of physical and chemical restraints may seriously impair the quality of life for the elderly and may even shorten it.

Looking at physical restraints alone, their use has increased in the United States between 1977 and 1989 from 25 percent to 41 percent of all people living in nursing homes. Restraints can be something as simple as a "postural support" wedging the body upright or cloth ties around wrists to keep patients from pulling out feeding tubes to more sophisticated restraints, such as Posey vests that go around a patient's body to tie them into a chair or bed.

Reasons for using physical restraints include maintenance of medical treatment, such as preventing patients from removing intravenous tubing; restricting movement to protect other patients and staff from aggressive behavior; and maintaining body alignment. By far the most common reason, however, is to prevent the patient from injury that might occur if he fell or wandered away. But there is substantial irony behind the theory of using restraints for this reason: If you don't tie the patient down so he can't move, he may fall, break a hip and not be able to move.

Physical restraints are not without side effects. The destructive effects can include loss of bone mass and muscle function (so that the patient becomes incapable of independent movement through muscle atrophy), changes in metabolism, increase in incontinence, depressed psychological states and injuries that occur when patients attempt to remove restraints. According to a rigorously researched and documented series of articles in a Minneapolis newspaper, at least 200 Americans die each year in restraints. Many strangle or suffocate because they slip into positions where restraints press on their neck or chests. Misuse is often a factor, according to the newspaper, but many die even when restraints are used properly.

In testimony to the Little Hoover Commission, the president of the California Long Term Care Ombudsman Association, spoke about the ill effects of physical restraints:

> *Studies show that restraints have certain appeals, such as an immediate impact on behavior, easy application without much training, ready accessibility and administrative sanction. Restraints are used to punish patients or out of frustration, or because of insufficient staffing, staff attitudes and also administrative pressures to avoid possible litigation. However, there have been no reported U.S. cases that demonstrate that lack of restraints was the basis of successful litigation. There is greater risk of liability if restraints are used despite the protest of patient and/or family. Use of restraints may give rise to claims of false imprisonment or assault. Use of*

restraints has been known to cause death by strangulation or asphyxiation....

Physical restraints reduce functional capacity as a resident quickly loses steadiness and balance when restricted to a bed or chair. Use of restraining devices can cause problems of chronic constipation, incontinence, circulatory obstructions, cardiac stress, [curtailing] the ability to ambulate independently, skin abrasions or breakdown, poor appetite and dehydration and accidental death by strangulation. We have residents tell us that staff tells them to go ahead and urinate in their diapers because it takes too much time to untie a resident, take them to the bathroom and then tie them back up.

And what happens to the spirit of the resident who has been tied up? There is fear. Residents have said to me: "If there were a fire, I'd be caught. How could I get out?" There is demoralization. "I felt like a dog and cried all night. It hurt me to have to be tied up." And there is rage and anger. Restraints are usually put on when the resident is in distress. There is little possibility the resident will understand why he is tied to the bed or in the wheelchair. He hasnot asked to be confined. He becomes increasingly more anxious as he pulls at the restraints. He calls out for help and anxiety becomes terror and anger. Caregivers see his reaction and are convinced the restraints are necessary for his own good. When his protests do not result in freedom, due to sheer exhaustion the fighting often subsides and resignation and withdrawal set in....

Restraints cause frustration, anxiety, fear, anger and then lethargy. What remains for the resident is rote custodial care. The resident is viewed as an object rather than a human being. This type of care always takes more time for the staff and is punishing and uninteresting work. Because of this, facilities will always have trouble retaining qualified staff.

The use of chemical restraints in nursing homes can lead to problems similar to those discussed above about physical restraints. Dr. Mark H. Beers, a professor of geriatric medicine at the University of California, Los Angeles, spoke about this in testimony to the House Ways and Means Subcommittee on Health at a hearing in 1989. He said that psychoactive medications are used to sedate, to induce sleep, to treat depression and anxiety, and to control behaviors often associated with dementia.

When used judiciously, they can be effective treatment, and when prescribed and monitored intelligently their side-effects can be minimized. The problem with their use is that they are commonly overused and frequently lead to serious side-effects. Those side-effects include confusion, over-sedation, unsteady gait, dizziness, falls and fractures, movement disorders such as Parkinson's Syndrome, inability to pass urine and blurred vision. Not only are these medications overused, they are also misused; that is, even when a medication is needed, physicians often fail to choose the safest and most effective drug, thereby adding unnecessary risk without additional benefits.

The overuse and misuse of psychoactive medications in nursing homes are among the most serious quality-of-care issues for the institutionalized elderly. By robbing the most frail elderly of further physical and mental function, these medications condemn some to a life of increased dependency, diminished enjoyment and decreased participation. By causing side-effects that lead to injury and a need for increased care, they may increase the cost of caring for nursing home residents.

Beers conducted a study of 850 patients in 12 nursing homes in the Boston area during the course of one month. Nearly two-thirds of the patients had orders for at least one psychoactive medication and 53 percent were given the drugs. More than one-quarter of the patients were given anti-psychotic medication (major tranquilizers), even though only 13 percent had a diagnosis that might indicate psychotic behavior.

This last finding is particularly significant, Beers says, because these medications, which include Haldol and Mellaril, cause side-effects that may continue even after the use of the drug is halted.

> *They are still commonly used to treat non-psychotic demented persons in nursing homes without informed consent, even though there are no good data to establish that they are effective for treating behavior disorders. In fact, there are no data to show that they are better than some safer alternatives for treating non-psychotic persons suffering from dementia who might wander, make noise, cooperate poorly or have insomnia. That they are toxic is not in doubt....The quantity of prescriptions for these drugs suggested serious overuse...Doctors frequently wrote orders "as needed," thereby allowing the nursing staff to decide when to use the drugs.*
>
> *It is a sad aspect of the care of the institutionalized elderly in America that in the last months and years of life so many will be given medications that impair their ability to think and to participate, that make them shake and become stiff and unable to walk, and that make them dizzy when they stand and fall and fracture their bones. In the final analysis, these medications are too often given to meet the needs of the institution housing them rather than to help elders live their lives in comfort and with dignity.*

Beers is not alone in his analysis. At an American Psychological Association forum in April 1989, the country's "other drug problem"--the misuse and overuse of drugs by the elderly--was discussed. Speakers attributed a large portion of the problem to nursing home staffers who sometimes use drugs to calm or induce sleep as a chemical restraint to keep older patients quiet and manageable. Also cited was a study that showed only 36 of the 221 residents in a nursing home receiving antipsychotic medication actually had a diagnosis of psychosis. Another research team discovered that 42 percent of Medicaid patients in a Tennessee nursing home were taking antipsychotic medication.

The Little Hoover Commission also received testimony from a Sacramento pharmacist who works as a consultant to long-term care facilities and who said the problems with the use of drugs in nursing homes are compounded by two factors. One is that the elderly react more strongly to drugs because their bodily functions have slowed, the kidneys and the liver may be slower to eliminate toxics and other organs may have become more sensitized with age. A second factor is the reimbursement policy of Medi-Cal (California's Medicaid program). Medi-Cal does not cover milder tranquilizers that might be more suitable for nursing home residents who are not psychotic, but it does cover the more powerful anti-psychotic medication, like Haldol.

While the national statistics reflect that physical and chemical restraints are not just a California problem, there are states that are making changes. Vermont and New Hampshire have moved to become restraint-free states, proposing to have no more than 6 percent of their nursing home residents restrained. Florida has also made strides, and other states have expressed interest in the concept.

In California, although spokesmen for two nursing home associations acknowledged the benefits of restraint-free policies, both told the Little Hoover Commission there are difficulties in moving in that direction. Among the difficulties cited were the risks to the safety of the patient, increased staffing costs when alternatives to restraints are used and liability on the part of institutions if patients are injured. In addition, there is the question of who will decide about risks and choose among alternative treatments when the patient is incapable of making choices and no representative has been designated. Finally, nursing home representatives question what can be done with patients who are unruly or assaultive but who refuse to give consent for the use of either chemical or physical restraints.

Kendal Corp., which operates two not-for-profit facilities in Pennsylvania, was an early pioneer in moving away from restraints 15 years ago. Kendal, which has almost no poor patients and which operates facilities

that might be considered luxurious, has argued strenuously that it doesn't take more money or staff time to cope with patients who are restraint-free. In facilities that use restraints properly, expenses for staff are already at a high enough level for them to spend the necessary and considerable time required to enforce the use of restraints, to monitor patients so that restraints are not removed, and to untie patients to move them to prevent bedsores, to take them to dining areas and to assist them in using bathroom facilities.

Kendal also maintains that the rate of injury does not increase when patients are untied. Studies in Kendal facilities that show no higher rate of falls and injuries have been bolstered by a recent Yale University study that found restrained residents actually suffer injuries three times more frequently than those who were never restrained.

Kendal can also point to an inner-city Philadelphia nursing home that followed its example two years ago, removed almost all restraints and found that the Kendal system works even when the patient base is largely Medicaid-funded. Workers at the facility, Stapeley in Germantown, say it is no more work for them than it was before. Some, in fact, say it is easier because patients are less agitated and more cooperative. "We probably could have been doing it all along, but you just didn't think about it because the residents were restrained, were already stationary, and you knew they weren't going to 'get in your way,'" says one Stapeley official. "I'm looking at each person now as a total functioning human being, and not someone who is just sitting in God's waiting room."

Those who urge a move away from restraints point out that residents cannot be simply untied or taken off drugs. Other alternative methods of coping with their problems must be explored and used. In an article entitled "Let's Untie the Elderly," several cases are cited where examination of the reasons behind the behavior that prompted the use of restraints led to alternative solutions. In one case, a man with Alzheimer's Disease was frequently restrained because he caused disruptions at mealtime by stealing other patients' food. The simple reason was that he was hungry; the solution was to provide him with more food, and the disruptive behavior disappeared. In another case, a man with Parkinson's Disease wanted to maintain his independence, but with little control over his motions he would often bang his head into the bathroom walls or sink when he was trying to seat himself on the toilet. The solution: Place foam padding in areas he was likely to hit rather than restraining him and forcing him to use a bedpan or diaper. In other instances, lack of enough pain-killing medications when patients were being moved and the indignity of the restraints themselves caused patients to become combative. Other solutions included alarm systems to alert staff when residents wandered away and placing beds lower to the floor so falls would be less likely.

In California, the restraint-free approach is limited to 5 to 10 percent of the facilities, according to industry testimony. As noted at the beginning of this chapter, estimates of the number of patients restrained in one manner or another range from 68 percent to 80 percent. But there are no firm figures because no state entity gathers data on how nursing home patients are treated. In addition, there are no statistics that reflect either how many residents have the capacity to grant informed consent to the use of restraints (although the industry estimates that 62 percent of its patients are confused or disoriented), how many who lack that capacity have designated representatives who could make decisions for them or how many are in a no-man's land of having no one to speak on their behalf. Patient rights advocates, however, estimate that at least 50 percent, if not more, can speak for themselves or are represented by someone else.

Attempts in the past to provide informed-consent procedures for nursing home residents have foundered at least partly over the question of what to do about patients who are incompetent, have no representative and who have not been placed in a conservatorship by the courts. Public guardians have argued they cannot afford to take on the added responsibility of all who might need representation, and court adjudication of incompetency is another added cost frequently cited. But the end result of the prolonged debate over this question is that the 50 percent-plus of the nursing home population who could make decisions about restraints are held hostage by the inability of the State to form an inclusive informed-consent policy.

The Department of Health Services does have a single-page "DHS Restraint Policy: Patient's Right to Refuse Restraint" that deals with physical restraints. But nursing home facilities seem unaware of the "policy," which has less force than either a statute or a regulation, and even DHS officials have said the undated document is difficult to track down, although they have not denied its existence. Clearly the policy, which includes a provision requiring the physician to concur with the patient's decision to refuse restraints, is not in general use and falls somewhat short of autonomy for the patient in deciding what treatment will be pursued.

Regardless of whether one believes restraints are necessary or are inhumane, federal law clearly prescribes a move away from the wholesale use of restraints. Under the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which was discussed in the previous chapter, patients are guaranteed freedom from the use of restraints that are imposed for reasons of discipline or convenience and not for treatment of medical symptoms. Restraints are not to be used except to ensure the physical safety of the resident or other residents, and then only upon written order of the physician, specifying the duration and circumstances. Patient involvement in and consent to treatment plans is also a key requirement of OBRA 87.

In response to OBRA 87 and under pressure from a lawsuit filed by the California Advocates for Nursing Home Reform in February 1989 to force the State to provide nursing home residents with informed consent procedures, the Department of Health Services began promulgating regulations in late 1990. Negotiations between the State and the California Advocates for Nursing Home Reform over details of the regulations are nearing completion as thisreport is being written, with at least another six months of public hearings and procedural requirements still anticipated.

Recommendation 2: The Governor and the Legislature should fulfill federal nursing home reform mandates by guaranteeing residents the right to participate in treatment planning and to grant or withhold informed consent for physical and chemical restraints.

The crucial right to informed consent should be made clear in statute, although the details of how the consent will be documented and what procedures should be followed when a resident is incapable of granting consent can be left to the regulatory process now in progress. Residents of nursing homes should have rights that are no less than those guaranteed to others in our society who are no longer independent, such as the mentally ill, the developmentally disabled and the incarcerated.

Recommendation 3: The Governor and the Legislature should restrict the use of "as needed" prescriptions for medications that are subject to abuse in nursing homes.

The decision about which drugs will be used and when they are needed should be left to the patient and the doctor. Devolving the responsibility to rotating shifts of nurses and other nursing home staff leaves too much room for error and does not ensure protection for the patient's right to informed consent.

Recommendation 4: The Governor and the Legislature should direct the Department of Health Services to create a Medi-Cal drug approval system that will meet the needs of long-term care patients.

Medi-Cal barriers that may discourage doctors from prescribing suitable medications for the elderly should be identified and removed. The Department may consider adding needed, milder drugs to the list of those that are paid for without special authorization, creating a special category of drug authorization for long-term care residents or any other alternative that meets the goal of encouraging the prescribing of medications best suited for the elderly.

Recommendation 5: The Department of Health Services should gather statistics annually on the number of nursing home residents who are physically or chemically restrained and

on the number who are incapable of giving informed consent and have no representative to make decisions on their behalf.

Without tracking treatment now delivered to nursing home residents, it is difficult for the State to proceed with sound policy decisions. Since annual assessments of residents are already required, this information should be easily abstracted and available for policy makers.

The statistics, the effects and even the horror stories above deal with the specifics of restraining patients through the use of either chemical or physical means. But the central issue is one of human rights. In some cases, restraints may be the best choice and the optimum treatment, but the resident should have the ultimate say in how his life is shaped and controlled. Only an informed consent procedure that gives the resident a clear picture of the risks and the benefits, and then gives the resident control over his destiny, will safeguard dignity and the quality of life for the elderly in their last years.

Citations

From the time of its first study on skilled nursing facilities in 1983, the Little Hoover Commission has pressed hard for a meaningful system of citations and fines to put teeth into the State's efforts to control the quality of care provided to the elderly. One of the Commission's prime accomplishments was the creation in 1985 of a new citation class for nursing home actions that contributed to the death of a resident ("AA" citations), increases in other allowable fines and the authority for the State to treble fines when violations were repeated within 12 months.

Seven years later, however, the Commission continues to find evidence that State enforcement efforts are uneven and that the perception persists that citations and fines can be bargained away and are rarely paid.

FINDING 3: California's citation and fine system has not proven effective as a deterrent to poor quality care in skilled nursing facilities.

California has extensive laws and regulations that require skilled nursing facilities to meet the needs of residents. Backing up those laws and regulations is a system of annual inspections, citations and fines that was designed to make it clear that skilled nursing facilities must comply and deliver quality care. But when fines are routinely dismissed, negotiated away or not pursued when appealed, the system loses its credibility and those who should be able to rely on the system for protection lose faith in the State's willingness and ability to enforce its standards. A review of the system of inspections, citations and fines shows it has been undermined by massive amounts of uncollected fines, a pattern of non-responsiveness to complaints, and some systemic barriers to efficient and effective enforcement.

In general, the citation system involves three levels that pertain directly to patient care and two that pertain to administrative functions. The "AA" citation is for a violation of standards that leads to a death. The fine for "AA" citations ranges from $5,000 to $25,000. The "A" citation is for a violation of standards that seriously endangers the safety of a patient, with a substantial probability of death or serious physical harm. The fine for "A" citations is $1,000 to $10,000. The "B" citation involves violations that affect a patient's health, safety or security, including financial abuse or emotional trauma such as humiliation, indignity or anxiety. The fine for "B" citations ranges from $100 to $1,000, but if the situation is corrected within 12 months, the fine is waived. Finally, Willful Material Falsifications and Willful Material Omissions are for information either being falsified on or omitted from patient records.

The amount of fines assessed and the number of citations issued have increased greatly since the Commission began looking at skilled nursing facilities in 1983, but the actual amount of fines collected has consistently

come up short, as Chart 1 on the next page demonstrates.

CHART 1

Summary of Nursing Home Citations Issued and Fines Assessed and Collected 1983-89

Year	Type of Citation	Number Issued	Dollars Assessed	Dollars Collected	Percent of Total Dollars Collected
88/89	AA	22			
	A	358			
	B	1,390			
	Total	1,770	$6,936,442	$892,718	12.9%
87/88	AA	25			
	A	364			
	B	1,392			
	Total	1,781	$5,830,895	$558,620	9.6%
86/87	AA	45			
	A	439			
	B	1,535			
	Total	2,019	$6,430,675	$1,293,233	20.1%
CY 86	AA	47			
	A	366			
	B	1,430			
	Total	1,843	$4,719,550	$631,185	13.4%
CY 85	AA	32			
	A	318			
	B	1,612			
	Total	1,962	$5,319,620	$449,635	8.4%
CY 84	A	187			
	B	1,074			
	Total	1,271	$1,415,150	$335,850	23.7%
CY 83	A	190			
	B	967			
	Total	1,157	$1,277,525	$476,344	37.3%

Source of information: Department of Health Services

As can be seen from Chart 1 above, the amount of fines collected has not kept pace with the amount of fines

assessed. For instance in 1988-89, the $892,718 collected represents only 12.9 percent of the $6,936,442 assessed. One should be cautious, however, about viewing the amount collected as a percentage of the fines assessed in a particular year since the collected amounts can be from fines from previous years. In other words, even a smaller percentage than 12.9 percent of the 1988-89 assessed fines were collected that year, largely because most of them still would have been in some part of the adjudication process. Historically, it can be seen that fine collection significantly lags behind fine assessments. Comparing the 1983 figures with the 1988-89 figures, assessments increased 443 percent while collections only increased 87 percent.

A better way of comparing the fines collected with the fines assessed would be to track citations from a year, such as 1983, and see how many of them have been collected by a later year, such as 1989. But the Department of Health Services has reported that its computer system does not allow it to track fines in that manner, an observation that the Little Hoover Commission has confirmed repeatedly in its previous reports on the regulation of skilled nursing facilities.

As the Commission has said in findings in previous reports, the Department's computer capabilities are not adequate for it to keep abreast of key information. Instead, individual citations have to be tracked by hand, a time-consuming process. In addition, the Department does not centrally collect and keep current annual information on fines and collections. Thus, the Department informed the Commission that it knows it has collected $2.7 million in fines in 1989-90, a huge jump in fee collections. But the Department was unable to report the numbers of each type of citation and the amounts assessed during the same year without undertaking a two-week count by hand.

The lack of this type of information, which a typical business in the private sector would routinely compile, contributes to the perception that the Department does not have a whole-hearted commitment to enforcement of its own regulations. In the absence of ongoing statistical tracking it is difficult to determine where the source of the problem of uncollected fines lies.

One element that affects the total fines collected is the law that allows nursing homes to pay only half the fine if they do so immediately rather than appealing the citation and fine. Theoretically, if none of the citations shown in Chart 1 for 1988-89 were contested by the facility involved, the State would collect only half of the amount assessed--potentially $3,468,221 instead of the $6,936,442 assessed. This reduced amount is still almost four times what was actually collected in 1988-89; halved fines, therefore, do not explain the small amount of collections.

Since "B" citation fines can be waived if the facility rectifies the situation within 12 months, part of the uncollected fines stems from the forgiveness of "B" fines. While more "B" fines are levied than any other type, it should be noted that the maximum amount is only $1,000 compared to the maximum fines of $10,000 and $25,000 for "A" and "AA" fines,respectively. As Chart 2 below shows for two years for which data was available, the smaller "B" fines are quickly outweighed by fewer but more expensive "A" fines.

CHART 2

Breakdown of Fines by Type of Citations
1986-87 and 1987-88

Year	Type of Citation	Number Issued	Total Dollar Amount Assessed	Total Dollar Amount Collected

87/88	AA	25	$565,050	
	A	364	$3,905,845	
	B	1,392	$1,360,000	
	Total	1,781	$5,830,895	$558,620
86/87	AA	45	$840,850	
	A	439	$4,190,000	
	B	1,535	$1,399,525	
	Total	2,019	$6,430,675	$1,293,233

Source of information: Department of Health Services

As Chart 2 indicates, even when the possibility of waived "B" fines are taken into account, there are still large amounts of uncollected fines. For instance, in 1987-88, if one subtracts all of the $1.36 million in "B" citations and the $558,620 in collected fines, there is still $3,971,375 in uncollected fines. Similarly, in 1986-87, subtracting $1,399,525 in "B" citations and $1,293,233 in collected fines leaves $4,004,717 in uncollected fines.

If halved fines for prompt payment and waived "B" fines don't explain the large amount of uncollected fines,neither does the dismissal rate of citations. Chart 3 on the next page shows the outcome of court cases on appeals during a two-year period.

CHART 3

Results of Citations Appealed in Court
October 1, 1987 through September 30, 1989

Type of Dismissed Citation	Number Issued	Number Appealed	Number Completed	Upheld (Number/ Percentage)	Dimissed (Number/ Percentage)
AA&A	768	432	264	237/90%	27/10%
B	3,013	508	383	369/97%	14/3%
Total	3,781	940	647	606/94%	14/6%

Source of information: Department of Health Services

As Chart 3 above indicates, of the 3,781 citations issued in a two-year period between October 1, 1987 and September 30, 1989, 94 percent of those that were appealed to court and were completed were upheld, with only 6 percent of the cases being dismissed.

Tracking down the source of uncollected fines is not merely a bookkeeping exercise. The citations and their

accompanying fines each represent a case, frequently wherehuman suffering at some level has occurred, often where relatives, families or advocates have complained. To understand the human face of this problem, the Little Hoover Commission selected 26 "A" citations in 1988 and 1989 and asked the Department of Health Services for the status of the fines. These included cases where:

- A 69-year-old woman was dropped and her leg was broken. Despite her complaints of leg pain and her insistence that her leg was broken, 21 days elapsed before her doctor was notified and an X-ray confirmed the break. She required an operation and a long leg cast. The facility was given an $8,000 "A" citation (03-0380-00879).

- An 83-year-old woman with Parkinson's Disease was taken to an acute care hospital where attendants found the fragments of pills in her mouth that apparently were placed there two hours earlier even though she was unresponsive, as well as undigested food from her breakfast. She was severely dehydrated, was semi-conscious and was suffering from malnutrition. The facility was issued a $7,500 "A" citation (03-0376-00718).

- Another facility was fined $15,000 in trebled penalties for an "A" citation (05-0352-00538) because of staff who were slapping patients, forcing syringes between patients' teeth, stripping a patient of clothes to keep her in her room, verbally assaulting patients, dragging a patient across the floor and pushing patients.

- An 80-year-old man had to have his right leg amputated below the knee after developing gangrene. He had been found outside the facility out of his wheelchair and kicking at car doors in a parking lot. The facility failed to note his injured toes or keep his doctor apprised of the progress of his bruises. The facility was issued a $10,000 "A" citation (03-0299-00736).

In response to the Little Hoover Commission's request for information on the citations, the Department of Health Services produced the chart on the following page in September 1990.

Chart 4

As Chart 4 on the preceding page shows, of the 26 citations from 1988 and 1989 that the Commission requested information about, in September 1990 almost 68 percent were still in the process of being adjudicated, close to 10 percent had been paid or were being recouped by reducing the facilities' Medi-Cal payments, slightly more than 10 percent were waived fines for "B" citations and just over 10 percent of the fines involved were eliminated through halving for prompt payment.

In the five specific cases detailed earlier, only the one involving staff performance has not been settled: The trebling of the fine for repeated violations was eliminated during the Department's Citation Review Conference, but the facility has appealed the citation to binding arbitration. In all the other cases, the facilities paid half the fines rather than dispute the citations, as allowed under state law. That meant that the fine for the woman with the broken leg was $4,000; the facility paid $15,000 for the woman with the six severe bedsores; the fine for the woman who was fed when she was unresponsive was $3,750; and the man whose leg was amputated caused a fine of $5,000.

While the complaints selected were not a statistically valid random sample, the Department of Health Services said they appeared to be fairly representative of the overall collection process. What that means is

that interested parties on the outside of the system see citations and fines that go for years without being resolved, or that are waived or halved. Those interested parties include the families of nursing home residents who have been injured or harmed, patient rights advocacy groups, ombudsmen and the media.

The perception is that fines go uncollected because skilled nursing facilities bargain their way out of them. Ombudsmen, who operate under State authority as a check-and-balance in the nursing home regulation efforts, have complained that fines are inconsistently levied and appear to be waived on a whim. This perception, whether valid or not, undercuts State enforcement efforts.

An example of this came in an anonymous telephone call to the Little Hoover Commission from a woman who associated herself with small nursing homes. She wanted to tip off the Commission to a "global" settlement between the Department of Health Services and a large nursing home company that reportedly allowed the company to pay "20 or 30 cents on the dollar" for a large amount of levied fines. The woman said it infuriates her that large companies can get away with bargaining down fines.

In its testimony to the Little Hoover Commission, the Department of Health Services described "global settlements," where large numbers of citations against a single company are settled as part of a single negotiation process, as advantageous to the State. In the case the woman was speaking about, CARE Enterprises West, which was undergoing bankruptcy reorganization, was allowed to pay $616,107 to settle 587 citations in the 58 long-term care facilities it operates in California. The Department notes that 465 of the citations had no balance due at the time of settlement, leaving 122 citations with money owed. While the settlement agreement states this takes the place of citations totalling $1,056,300, the actual list of citations attached to the settlement add up to $1,938,580. In addition, the settlement agreement also resolved five license-revocation actions. Licenses were revoked for two facilities that had already closed, while three other facilities were allowed to remain on probation for three years.

As the Department points out, the global settlement allows the State to avoid the cost of long-running litigation and also allows the Department to impose other restrictions and obligations, as they did on CARE, that including training, probationary periods and communications with outside interests. But it should be noted that such settlements also continue the impression that fines can be gotten around. If fines are meant to punish wrong-doing and in the future deter poor performance, one might question the message that is sent when citations instead are allowed to multiply and then are reduced as part of a bargaining session.

Uncollected fines are not the only black mark against the State. Some view the State's responsiveness to complaints as uneven, sluggish or non-existent. Ombudsmen from different parts of California have written to the Commission to say that complaints to the Department of Health Services frequently go unheeded. In a declaration filed in support of the Valdivia case, the head of a patient rights advocacy group said:

> *The State never responds in two days...to the filing of a complaint. It is common to wait three or four months for a complaint investigation, unless repeated calls are made to Licensing. Licensing and Certification often does not even respond to complaints of life-threatening activity or serious injury within the 10 days mandated by law. Complaints about the use of chemical restraints are not given priority by the Division....*
>
> *What routinely happens to complaints under California law is...illustrated by the facts in a lawsuit brought by my organization against the State... In that case, [Donna] Gilmour's father resided in a nursing home where he was restrained with a postural support. The day after he was physically restrained, his dosage of Haldol was nearly doubled to 7 milligrams per day, and a PRN or "as needed" order of an additional 10 milligrams per day to be given for agitation. His eating decreased, and a few days later he was found in a stupor. Seven days after theincrease in Haldol, Ms. Gilmour's father died of pneumonia, a side-effect of the use of Haldol. The Department of Health Services cited the facility for failure to notify the attending physician of*

any sudden adverse changes in the patient's condition and for failure to assess the patient's change in behavior and food consumed. It included no citation...for failure to implement alternatives to the use of physical and chemical restraints. Licensing rarely cites facilities for inappropriate drug use where physician's orders exist... The citation was dismissed personally by TeresaHawkes, the Deputy Director of Licensing and Certification in the Department of Health Services.

Another case shows a pattern of non-responsiveness. In a case involving a woman who died in an Auburn facility, the Department of Health Services failed to investigate a complaint about life-threatening conditions before the woman died and then took more than a year to respond to an official request for an upgrading of the facility citation from an "A" to an "AA." The chronology of dates:

7/20/89:
A complaint is filed with Licensing and Certification about life-threatening conditions, including "stage 4" (the most severe stage) bedsores.

7/28/89:
The woman dies before Licensing investigates.

10/11/89:
Advocates call Licensing and are told a $5,000 "A" citation has been issued to the facility.

10/18/89:
Advocates request in writing that a hearing be held to raise the citation to "AA" based on their belief that the facility's action were a proximate cause of the woman's death.

11/9/89:
Conference is held. Licensing and Certification doctor says records show woman suffered dehydration in addition to bedsores.

11/21/89:
Advocates notified that the citation will remain an "A" but will be increased to $7,500 because of the dehydration.

11/24/89:
Advocates send formal request to Teresa Hawkes, deputy director of Licensing and Certification, contesting the "A" citation and asking for an investigation.

3/22/90:
After numerous calls to Licensing, advocates reach person in charge of the review who says he should have an answer within two weeks.

4/15/90:
Advocates receive a letter saying the appeal should be finalized in two weeks.

8/20/90:
Advocates write to Hawkes again requesting that the review be completed.

11/21/90:
Letter sent to advocates from Hawkes apologizes for the delay and states that after reviewing the records, the citation will remain an "A."

In this case, Licensing and Certification failed to investigate the initial complaint in a timely manner and then failed to respond for more than a year to a formal request for a review.

In addition to uncollected fines and the State's level of responsiveness, there are features built into the citation and fine system that cause it to operate less than efficiently and effectively. Three examples are the inability of fines to be upgraded when new information is found, the questionable value of a citation level that is easily waived and the process that requires the state to file appeals in courts.

In the case chronology above, it is noted that the fine for the "A" citation was increased from $5,000 to $7,500 when additional information was uncovered during the Citation Review Conference and dehydration was added to the citation. However, this was later reduced to the original $5,000. (The citation was appealed for court action by the facility and has since been settled for 75 percent of the $5,000.) The advocates were told that conferences can only be used to dismiss or uphold citations, or lessen the fines. No law allows the fine to be increased at that point, regardless of additional information that may come to light. This means a skilled nursing facility can use the conference process as a procedural stumbling block, contesting all citations without fear that they will emerge from the conference worse off.

The second issue deals with "B" citations. These are issued when a patient's health, safety or security are harmed, including emotional and financial elements and situations likely to cause significant humiliation, indignity, anxiety or other emotional trauma. If the facility convinces the Department of Health Services that it has corrected the situation within 12 months, the fine--which can range from $100 to $1,000--is waived. This means a facility can have repeated violations, make repeated "corrections" and never suffer any penalty.

A Burbank man who sought an inspection after his father died in a nursing home on August 26, 1990 said he found the Provider's Plan of Correction for various violations "nothing more than rhetoric". The same complaints or similar ones can be found on previous complaints and/or inspections." The Department of Health Services' citation to the facility in response to the man's request for an inspection listed the following deficiencies and corresponding plans of correction:

Deficiency	Plan of Correction
Two out of six residents did not have any pillows or other anti-contracture devices to protect pressure points or to alleviate contractures.	Residents with contractures will be provided with pillows or any other assisting device to prevent further progression of existing contractures....
Upon interview, four out of four alert residents stated that the food for the lunch meal served was cold.	The temperature will be properly maintained so that residents will have hot foods....
Upon interview and demonstration, two nurse's aides did not know the proper technique to be utilized in reading or taking temperatures. Additionally, they did not know how to separate clean from dirty thermometers or the difference between an oral and rectal thermometer.	Return demonstration done by the two nurse's aides of the proper technique in reading and taking temperatures. Inservice given to nursing assistants to separate clean and dirty thermometers and difference between oral and rectal thermometers....
In one instance, the treatment cart was left unlocked and unattended in the hallway. There were ambulatory residents in close proximity to the medication cart.	Treatment cart will be locked at all times when not within nurse's sight....

The facility failed to provide good daily hygiene as evidenced by the following: a) Seven out of 14 residents had a thick white coating either on their dentures or in their oral cavity. b) One out of 14 residents received a bedside sponge bath with cold water.	It is the policy of Beverly Manor to provide maximum hygiene to all residents including bathing, oral care, hair care, nail care and facial care. All residents receiving bedside sponge bath will have warm water. Inservice given to nurse's aides.
Five out of five bedfast residents were not turned every two hours as required. Three of the residents had decubitus ulcers.	It is the policy of the facility that residents will be turned and repositioned every two hours for comfort, be checked for dryness and cleanliness.
There was a strong urine odor in four of six restrooms.	It is the policy of Beverly Manor to keep the facility free from odor at all times. New tile has been put in the bathrooms. Housekeeping will strip all bathrooms.
The infectious waste freezer was left unlocked and was accessible to unauthorized personnel.	It is the policy of Beverly Manor to keep the infectious waste freezer locked at all times....
In three of six instances, privacy curtains were not pulled while surveyor was making patient rounds with a nursing staff.	It is the policy of Beverly Manor that privacy will always be provided to all residents. Inservice given to nurse's aides....

Although none of the violations were life-threatening in the eyes of the investigators, they were items that made life uncomfortable, unsafe or unpleasant. Paper compliance was relatively easy.

Another example of what is perceived as a casual attitude toward "B" citations was cited in testimony to the Placer County Grand Jury. Speaking about Hilltop Manor Convalescent Hospital in Placer County, the witness said that the facility stacked up repeated violations each year from 1983 to 1988. The facility was cited for 77 violations in March 1983, 40 violations in June 1983, 10 in March 1984, 77 in May 1985, 83 in April 1986, 44 in June 1987 and 98 in March 1988. Some of the repeat violations were:

- Administrator has not enforced all the rules and regulations relative to the safety of patients.
- Evidence was lacking that attending physicians visited patients at least every 30 days and some patients were not under continuing supervision of a physician.
- Nursing services were not sufficient to meet total nursing needs.
- Policies to ensure that each patient received care to prevent decubitus ulcers were not followed consistently.
- Procedures to ensure that all patients are identified prior to administration of a drug was not enforced.Hilltop was not providing a sanitary environment.
- Hilltop was not changing the position of bedfast and chairfast patients with preventive skin care needs.<
- Hilltop was not employing an adequate number of qualified personnel to carry out all the functions of the facility.

With "B" citations so easily corrected and punishment so routinely waived, there can be little credibility given to the seriousness of the violations involved.

Finally, the present system requires a skilled nursing facility to notify the State if it wants to appeal a citation and fine. The State then has one year to prepare the case and file it in court. Before early 1990 when staff was augmented, the Attorney General's unit handling these cases was so overwhelmed that nursing homes stood a good chance of seeing the citation dissolve when the year deadline had passed with no court filing. In one example, a facility notified the State on December 22, 1989 that it wanted a court hearing on a $5,000 "A" citation. On August 20, 1990 the advocate involved in the case checked with the Attorney General's Office but was told they had not received the case. Her intervention with the Department of Health Services finally caused the case to be sent to the Attorney General's Office, with eight months of the year-long timeline wasted. Enhanced efforts by the Attorney General's Office and the Department of Health Services reportedly are resulting in better coordination.<

If the State's citation and fine system is to work effectively and efficiently as a deterrent to violations of standards, problems with enforcement of the existing system need to be addressed.

Recommendation 6: The Governor and the Legislature should reform the citation and fine system to streamline the process and increase its deterrence value.

Reforms that should be included are:

- Instead of halving fines if facilities pay without appealing them, set up a system in which fines automatically double if the facility chooses to appeal and then loses.
- Do not allow "B" fines to be waived if they are corrected within 12 months. If violations have occurred that affect patients, fines should be paid.
- Allow fines to be increased in Citation Review Conferences if new information is presented or discovered at the hearing.
- The process of appeal should be shifted to the skilled nursing facilities rather than leaving the burden with the State once the facility has given notice that it wants to appeal the fine. The facility should have 90 days to file an ppeal in court.

Recommendation 7: The Governor and the Legislature should direct the Department of Health Services to investigate and respond to complaints promptly and to keep complainants informed of all steps taken.

Laws already require timely responses to complaints. The Department should log its activities in this regard for one year, reporting to the Legislature about the elapsed time for responses, the number of cases pending at the end of each month and the status of all citations and fines monthly.

Since 1985 when the citation and fine system was overhauled, the State has attempted to enforce its laws and regulations regarding the care that should be provided in skilled nursing facilities with varying degrees of success. The joint problems of uncollected fines, non-responsiveness to complaints and some systemic barriers have contributed to a perception that the State is not committed to ensuring the highest quality of care. The State needs to take aggressive steps to erase that perception and to safeguard the health and well-being of the State's elderly.

Conclusion

California enjoys a perennial reputation as the center of youth culture. But this does not mean the State should be known as a place where old or deteriorating people are shoved aside, disregarded and abandoned. The State should be a haven for all of its citizens, including the elderly who can no longer care for themselves and who are in their declining days, months and years. After a rigorous examination of the State's regulation of skilled nursing facilities, the Little Hoover Commission is forced to conclude that this is not the case for far too many of this frail and helpless population.

In this report, the Commission urges the State to embrace reforms that may make a dramatic difference in the quality of life for nursing home residents. Chief among those is the set of federal reforms known as OBRA 87. These dictate an approach to nursing home care that makes the resident's quality of life the central concern of the nursing home facilities and government agencies. Although the State has complained that these reforms are largely a matter of paperwork, the spirit and intent of OBRA 87 is to look at the outcome of treatment given to a resident. Does the treatment and care given allow the resident to function at the fullest level that he or she is capable and desirous of reaching? Only when the answer is "yes" can the State relax its vigilance and know that its mission in regulating and monitoring nursing homes has been fulfilled. With that goal in mind, the Commission believes it is vital that OBRA 87 be instituted fully and without delay.

The Commission also gives a particularly high priority to the right of a patient to informed consent for all treatment, but especially for the use of chemical and physical restraints. The last bastion of dignity is self-determination. Nursing home residents should have the right to be involved in the planning of their care. When they no longer have the capacity for this involvement, they should have the comfort of knowing that those they have designated will be making decisions on their behalf, rather than a faceless bureaucracy or institutions that have financial concerns. In particular, residents should have the assurance that they will not be tied down or drugged against their wishes, but that alternative methods will be found to protect their safety and deal with their dysfunctional problems. The Commission believes the State should take immediate steps to delineate, protect and enforce the right to informed consent for treatment.

Finally, the Commission finds that uniform, fair and vigorous enforcement of the State's laws and regulations needs to be continually emphasized. Coupled with clear policies and educational outreach, swift and sure punishment is the most effective deterrent to violation of state standards. Unfortunately, neither the perception nor the reality of the State's enforcement efforts have reached the level where consumers, patient advocates and ombudsmen express confidence in the State's ability to perform as a guardian of nursing home residents' safety. The Commission recommends that the State continue to reform its licensing, citation and fine system until it runs smoothly, effectively and efficiently.

By adopting the recommendations in this report, the State can move into a new era of care for nursing home residents, one where human dignity and concern for the quality of life is emphasized and protected for all of the State's vulnerable elderly citizens.

APPENDIX A

Summary of Legislation Arising From Previous Reports

The Little Hoover Commission's "The Bureaucracy of Care," issued in 1983, resulted in the enactment of the Nursing Home Patients Protection Act, a package of more than a dozen bills. Further changes in law came out of recommendations in "New and Continuing Impediments to Improving the Quality of Life and Quality of Care inCalifornia's Nursing Homes," issued in 1987. Those two reports can be briefly summarized as follows:

The Bureaucracy of Care

Specific recommendation areas included eliminating Medi-Cal patient "dumping;" overhauling the enforcement/fining system; better defining the oversight role of the Department of Health Services; increased criminal penalties for willful and repeated violators; greater statutory rights for complainants; and creating better information systems and public access to that information. Among the changes achieved were a new class of penalties ranging from $5,000 to $25,000 when the facility is responsible for the death of a resident.

Legislation from 1983 Report

AB 180 (Isenberg) Chapter 10, 1985 Statutes	Redefines and strengthens penalty system and increases fines for violation of patient rights and endangering patient health and safety (A and B citations).
AB 3580 (Duffy) Chapter 1351, 1986 Statutes	Revises membership of committee on nursing homes that advises the director of the Department of Health Services.
AB 3644 (Stirling) Chapter 588, 1986 Statutes	Gives priority status to criminal cases where the elderly are victims or material witnesses.
SB 3923 (McClintock) Chapter 1126, 1986 Statutes	Makes falsification of skilled nursing facility records a Class "A" or "B" citation (as defined).
SB 53 (Mello) Chapter 11, 1985 Statutes	Requires acceptance of Medi-Cal patients in licensed skilled nursing facilities.
SB 26 (Mello) Chapter 856, 1986 Statutes	Increases penalties for repeat facility offenders from $1,000 to $2,500.
SB 274 (Watson) Chapter 119, 1986 Statutes	Requires the Department of Health Services to develop programs for facilities to contract with or employ geriatric nurse practitioners.
AB 1834 (Connelly) Chapter 816, 1987 Statutes	Requires Department of Health Services to report enforcement actions to the Board of Examiners for Nursing Home Administrators for disciplinary action.

AB 2047 (Katz) Chapter 1235, 1987 Statutes	Requires facilities to reimburse for or replace articles lost or stolen if facility did not have reasonable safeguards.
SB 73 (Lockyer) Chapter 1125, 1987 Statutes	Mandates expeditious resolution of contested "B" citations and permits families to meet privately with residents.
SB 526 (Mello) Chapter 637, 1987 Statutes	Designates Attorney General's Office responsible for investigation and prosecution of cases of abuse in nursing homes.
SB 1220 (Mello) Chapter 666, 1987 Statutes	Allows State to place insolvent homes in receivership so as to continue caring for the patients.
SB 1330 (McCorquodale) Chapter 625, 1987 Statutes	Specifies contents, terms and conditions for admissions agreements.

New and Continuing Impediments To Improving the Quality of Lifeand the Quality of Care in California's Nursing Homes

Significant recommendation areas included increasingenforcement and penalty collection efforts by the State, allowing state receivership for certain skilled nursing facilities as an intermediate sanction, ensuring that voluntary Medi-Cal decertification would not penalize current residents, and increasing consumer information services.

Legislation from 1987 Report

AB 258 (Wyman) Chapter 1226, 1987 Statutes	Requires the Department of Health Services to develop theft and loss protection and recovery policies for facilities.
AB 688 (Isenberg) Chapter 1141, 1987 Statutes	Requires facilities that voluntarily decertify from Medi-Cal to continue to care for all patients in the facility at the time of decertification.
SB 860 (Campbell) Chapter 84, 1987 Statutes	Expedites the hearing process on AA, A and B citations.

APPENDIX B

Summary of 1989 Report's Findings and Recommendations

The Little Hoover Commission's report entitled "The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight," issued in 1989, included 18 findings and 18 corresponding recommendations.

FINDING 1: There is no regular formal procedure or process to regularly and systematically review and evaluate the quality of medical care provided to nursing home patients. Although the process of peer review is standard in acute care facilities, there is no similar procedure in place for chronic care settings.

> **Recommendation: A formal system of physician peer review should be established as a requirement for licensure and operation of all nursing homes in California.**

FINDING 2: There has been little attempt made to develop guidelines for standards of medical practice in nursing homes. While there are multiple state and federal regulations regarding the nursing home and its employees, there is a comparative dearth of guidance concerning the acceptable standards of medical care.

> **Recommendation: An ad hoc committee should be convened to develop guidelines and standards of practice for medical care in nursing homes.**

FINDING 3: For a number of people in nursing homes, effective contact with their physician is extremely difficult to either establish or maintain. Typically, physicians do not follow their patients from outpatient or hospitalized status to nursing homes. This means the nursing home resident must not only adjust to new surroundings, but also to a new physician. Often the treating physician in the nursing home may have never seen the resident prior to his or her arrival in the facility.

> **Recommendation: Patient neglect, or de facto patient abandonment and mistreatment, should be clearly defined in law and substantial penalties for such conduct should be prescribed.**

FINDING 4: Despite the fact that the Board of Medical Quality Assurance has the legal authority to issue citations and fines, this has not been done. While nursing homes are subject to fines and citations, doctors are not. These means that the professional directly responsible for the quality of care is not subject to any mechanism for sanctions if they are needed.

> **Recommendation: The Board of Medical Quality Assurance should establish regulations for the issuanceof citations and fines for poor medical care of nursing home residents.**

FINDING 5: To a certain extent, the Board of Medical Quality Assurance has been hampered in its oversight activities by restrictive guidelines and enabling legislation andregulations. The board is not able to obtain a waiver of confidentiality of medical records when it is investigating cases. And the board cannot conduct a "blind" (names deleted) review of patient records to see if there is a pattern of poor care by a physician.

> **Recommendation: Investigators from the Board of Medical Quality Assurance should be granted a waiver of confidentiality for medical records for investigatory purposes.**

FINDING 6: There is a lack of coordination between the Licensing and Certification Division and the Board of Medical Quality Assurance. While finger-pointing goes in both directions, the fact is that neither the Division nor the Board handles medical care complaints in a timely and professional manner.

> **Recommendation: The Licensing and Certification Division should immediately coordinate and centralize all reports from its regional offices concerning medical care cases that are to be referred to the Board of Medical Quality Assurance.**

FINDING 7: The Licensing and Certification Division does not have a centralized referral process for complaints about medical care in nursing homes. Without this monitoring mechanism, the Division cannot track cases and be aware of time delays in resolution.

> **Recommendation: Both the Licensing and Certification Division and the Board of Medical Quality Assurance should rapidly improve their management information and tracking systems.**

FINDING 8: It is difficult for the ordinary citizen to determine where or how to complain about conditions or treatment in long-term care facilities. Several people who testified at Little Hoover Commission hearings spoke of their frustration in trying to reach the proper authorities to lodge complaints.

> **Recommendation: An attachment to the current Admissions Agreement for every long-term care facility in the state should be developed by the Board of Medical Quality Assurance and the Licensing and Certification Division describing how to access and follow up with requests for information and complaint-filing procedures.**

FINDING 9: There are an inadequate number of "eyes and ears" observing the care needs of the residents of long-term care facilities. The state-federal Ombudsman Program may be the sole link for some nursing home residents to the outside world.

> **Recommendation: The Ombudsman Program should mandate that as part of its training for all professional and volunteer staff, a portion of the curriculum shall be devoted to describing in detail the procedures for filing requests for information or complaints with the Board of Medical Quality Assurance and with the Licensing and Certification Division.**

FINDING 10: There is an insufficient number of physicians who work effectively in long-term care settings. There is a lack of physicians trained in geriatric medicine and there is little educational emphasis on geriatrics for practicing professionals.

Recommendation: The Board of Medical Quality Assurance in cooperation with the University of California, the California Association of Medical Directors and the California Medical Association should develop additional training and continuing education in geriatric medicine.

FINDING 11: Although there may be a substantial oversupply of physicians in the United States, it is unlikely that this will, of itself, guide physicians to work in geriatric medicine in long-term care settings. Present training programs to right this situation are usually small and have little impact.

Recommendation: Every effort should be made to increase the number of physicians with skills in gerontology and geriatrics. The Governor and the Legislature should establish a California Health Services Corps to partially fund physician education for those willing to specialize in geriatrics at the University of California medical schools.

FINDING 12: Given the shortages in available physicians to work in long-term care settings, the use of physician extenders has not been adequately explored.

Recommendation: Programs that enhance the role of physician extenders (physician assistants and geriatric nurse practitioners) need to be further developed. Medi-Cal requirements should be modified to permit direct payment for services provided by licensed physician assistants, geriatric nurse practitioners and other qualified nurse practitioners.

FINDING 13: The position of Medical Director of a long-term care facility is a critically important one. These medical personnel should be the model of accessible and high-quality medical care for the residents.

Recommendation: Medical Directors contracted by any California long-term care facility after September 1, 1989, should be required to have completed a specified number of Continuing Medical Education hours in gerontology and geriatric medicine as a contractual condition of initial and continued employment.

FINDING 14: The role of the Medical Director needs to be expanded in terms of the training and experience that he or she must have in order to provide medical leadership for the facility.

Recommendation: Title 22 of the California Code of Administrative Regulations should be amended in order to significantly broaden the responsibilities of the Medical Director of any long-term care facility.

FINDING 15: The number of patients and nursing homes that a Medical Director can be responsible for is unlimited.

Recommendation: No Medical Director should be responsible for more than four separate facilities or a total of 400 beds.

FINDING 16: alifornia long-term care facilities are the home for a large number of persons who present some of the major bioethical discussion, decisions and dilemmas of

our time. Decisions concerning the best interest of a patient--including such major issues as withholding treatment, the discontinuance of feeding and hydration and resuscitation--frequently take place in the long-term care setting.

> **Recommendation: Long-term care facilities should establish either regional or institutional Ethics Committees.**

FINDING 17: Many residents of nursing homes are receiving too many psychoactive drugs. Too many residents either suffer from reactions to the interplay of various drugs or are over-drugged to make them more manageable.

> **Recommendation: Policy standards regarding the maintenance of mental health and the treatment of mental illness in nursing home patients need to be developed.**

FINDING 18: The severe and ongoing nursing shortage has resulted in nursing homes having to depend on nursing registries to secure the services of part-time nurses. These nurses may be unfamiliar with the needs of long-term care patients.

> **Recommendation: Standards for the operation of nursing registries that provide part-time nurses to long-term care facilities should be quickly and cooperatively developed.**

APPENDIX C

Analysis of OBRA 87 Requirements Compared to Current California Law(Prepared by California Advocates for Nursing Home Reform)

ENDNOTES

1. **"The Department of Social Services Could Reduce Costs and Improve Compliance with Regulations of the In-Home Supportive Services Program," Auditor General, March 1987.**
2. **"Use of Convicts to Care for Elderly, Disabled Under Fire," Sacramento Bee, February 3, 1991.**
3. **Complaint to Enforce Citation and Collect Civil Penalty, Kizer v. Auburn Ravine Terrace, November 29, 1990.**
4. **Harry Barba, Associate Regional Administrator for the Health Care Financing Administration, in an interview, February 21, 1991.**
5. **Complaint for Mandamus and Declaratory of Injunctive Relief, Valdivia and Kaski v. California Department of Health Services, et al. October 1, 1990.**
6. **Ibid.**

7. Ronald M. Kurtz, Executive Vice President, California Association of Health Facilities, in a July 13, 1990 letter.
8. Preliminary Injunction Order, Valdivia v. HSDCA, United States District Court for the Eastern District of California, January 11, 1991.
9. Ibid
10. August 14, 1990 letter to Congressman Jerry Lewis from Clifford L. Allenby, California Health and Welfare Secretary.
11. Declaration of Catherine Hawes, November 20, 1990, filed in support of preliminary injunction request in Valdivia v. California Department of Health Services.
12. bid.
13. Ibid.

14.Ibid.

14. California Dental Association study of skilled nursing home residents, 1986.
15. Ibid.
16. Interview with John Rodriguez, Deputy Director for Medical Care Services, Department of Health Services, on February 21, 1991.
17. Declaration of Nancy Knutsen, Plaintiff's Declarations in Support of Their Motion for Preliminary Injunction, pps. 22-31, Valdivia v. California Department of Health Services. Following the filing of her declaration, Knutsen's mother was placed in a county conservatorship after the nursing home argued successfully in court that Knutsen had misused her mother's funds and had physically abused her mother in the process of performing physical therapy on her legs. Knutsen and her representatives believe that the nursing hometook the matter to court in retaliation for Knutsen's repeated complaints and efforts to improve care for her mother.
18. Harry Barba, Associate Regional Administrator for the Health Care Financing Administration, in an interview, February 21, 1991.
19. ."Liberation: Alternative to Physical Restraints," Gerontologist, Volume 29, No. 5, 1989.
20. Ibid.
21. Releasing Restraints: A Nursing Dilemma," Journal of Gerontological Nursing, Vol. 15, No. 2, 1989.
22. Op cit.
23. "Safeguards That Kill," Star Tribune, December 2, 1990.
24. Kathy Badrak, President, California Long Term Care Ombudsman Association, testimony to the Little Hoover Commission, September 18, 1990.
25. Dr. Mark H. Beers, Assistant Professor of Medicine, Division of Geriatric Medicine, University of California, Los Angeles, statement to the House Ways and Means Subcommittee on Health, "Psychoactive Medication Use in Nursing Homes," March 6, 1989.
26. Ibid.
27. "America's Other Drug Problem Overwhelms Thousands, Experts Say," AARP News Bulletin, April 1989.
28. Jack Markovitz, President Elect of the California Association of Health Facilities, and Darrell Kelch, Vice President of Public Policy, California Association of Homes for the Aging, in separate testimony to the Little Hoover Commission, September 18,

1990.
29. Patricia L. McGinnis, California Advocates for Nursing Home Reform, testimony to the Little Hoover Commission, September 18, 1990.
30. "Finding Alternatives to Restraints: Innovators Learning to Balance Safety and Freedom," Star Tribune, December 4, 1990.
31. Lynne Mitchell-Pedersen, Lois Edmund, Elliot Fingerote and Colin Powell, "Let's Untie the Elderly," Quarterly Journal of Long-Term Care, Ontario Association of Homes for the Aged, October 1985.
32. Teresa Hawkes, Deputy Director of Licensing and Certification, Department of Health Services, testimony to the Little Hoover Commission, September 18, 1990.
33. Letter from Teresa Hawkes, Deputy Director of Licensing and Certification, Department of Health Services, to the Little Hoover Commission, August 31, 1990.
34. Op Cit.
35. Settlement Agreement Accusation Numbers 5-0031, 9-0002 and 8-0002, CARE Enterprises West et al, before the Department of Health Services, April 24, 1990.
36. Declaration of Patricia McGinnis, California Advocates for Nursing Home Reform, Plaintiff's Declarations in Support of Their Motion for Preliminary Injunction, pps. 32-38, Valdivia v. California Department of Health Services.
37. Interview with Carole Herman, Foundation Aiding the Elderly, about the case of Christine Dillard.
38. v"Statement of Deficiencies and Plan of Correction," Beverly Manor Convalescent Hospital, Burbank, Ca., September 7, 1990.
39. Statement by Carole Herman, Foundation Aiding the Elderly, and Charlie Fish, Consumer's Ombudsman Program, to the Placer County Grand Jury, November 15, 1988.
40. Interview with Carole Herman, Foundation Aiding the Elderly, about the case of Christine Dillard.