



**LOS ANGELES COUNTY
OFFICE OF INSPECTOR GENERAL**

**IMPROVING OVERSIGHT AND ACCOUNTABILITY
WITHIN SKILLED NURSING FACILITIES:
FINAL REPORT**

October 2021

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INTRODUCTION

Skilled nursing facilities (SNFs) provide long-term care (LTC) services to many of Los Angeles County's (County) frail, older adults with underlying chronic medical conditions.¹ The coronavirus disease 2019 (COVID-19) pandemic has had a devastating impact on SNF residents and staff across the country, with extraordinarily high death rates among SNF residents. As of September 19, 2021, 19,401 residents and 16,656 staff had tested positive for the virus, and 3,506 residents and 115 staff had died in the County.² The vast majority of cases and deaths occurred in the early months of the pandemic with another increase in cases and deaths during the winter surge of 2020/21.

SNF residents have not only had to experience first-hand the destructive nature of COVID-19, but also suffered having many of their activities curtailed in order to prevent virus transmission. For example, the Centers for Medicare and Medicaid Services (CMS) imposed strict visitation restrictions and limited group activities to prevent the spread of COVID-19. While these measures protected residents from exposures to COVID-19, they may have also resulted in unintended harm to the mental health and psychosocial well-being of this vulnerable population due to prolonged separation from loved ones and limited social interaction.

The COVID-19 pandemic has also exacerbated many longstanding issues with SNFs and the industry at large. Despite extensive regulation, substandard care is an ongoing and persistent problem in many SNFs. Staffing and workforce issues, insufficient training, poor infection control practices, inadequate facility infrastructure, and insufficient oversight and enforcement are some of the well-documented issues impacting quality of care. These issues, combined with gaps in knowledge at the beginning of the pandemic about modes of COVID-19 transmission and critical supply shortages of essential equipment for testing and protection, left almost every SNF ill-prepared to prevent and manage a highly infectious disease like COVID-19.

Since the 1960s, the California Department of Public Health (CDPH) has contracted with the Los Angeles County Department of Public Health (LACDPH) to perform various licensing and certification, inspection, and investigative activities in health care facilities, including SNFs, located in the County. LACDPH's Health Facilities

¹ A skilled nursing facility (SNF) is a type of long-term care health care facility (or a distinct part of a hospital) that provides continuous skilled nursing care and supportive care to residents whose primary need is for availability of skilled nursing care or rehabilitation services on an extended basis. This 24-hour inpatient care includes, at a minimum, physician, skilled nursing, dietary, pharmaceutical services and an activity program. See Title 22 CCR § 72103.

² County of Los Angeles Department of Public Health, Skilled Nursing Facilities COVID-19 Dashboard, Reporting Data for the Week of 09/13/2021 to 09/19/2021, at: <http://publichealth.lacounty.gov/snfdashboard.htm> (accessed on October 4, 2021).

Inspection Division (HFID), the branch responsible for performing the contracted regulatory work, currently oversees 4,188 health care facilities in the County, including 379 SNFs, with approximately 390 staff.

On May 26, 2020, in response to the devastating impact of COVID-19 on SNF residents and staff, the Los Angeles County Board of Supervisors (Board) passed a motion directing the Executive Officer to facilitate the appointment of an inspector general to conduct an evaluation of SNFs within the County and provide recommendations on operational and programmatic changes necessary to improve the County's monitoring and oversight of SNFs, as well as legislative and regulatory recommendations for improving operations within SNFs.³ The motion also directs the inspector general consult with the Auditor-Controller (A-C), directors of the health, social services, and other relevant County departments, Office of County Counsel (County Counsel), and subject matter experts. On June 26, 2020, the Executive Officer appointed the County's Inspector General as the inspector general called for in the motion.

The Board motion also directs the A-C to develop a publicly available SNF dashboard to provide COVID-19 and other metrics. In addition, the motion directs the A-C to assess HFID's ability to monitor and ensure compliance with COVID-19 Mitigation Plans while maintaining the required level of non-COVID-19-related investigations and meeting other critical oversight roles necessary to ensure the ongoing health and safety of SNF residents and staff.⁴ Finally, the motion directs the A-C to analyze HFID's staffing levels and ensure that necessary resources are available to support monitoring and enforcement efforts.

On October 14, 2020, the Office of Inspector General (OIG) issued its first interim report.⁵ At the time, ensuring that LACDPH was prepared to respond to the ongoing threat of COVID-19 and provide necessary support to SNFs was of the utmost importance. As such, the first interim report focuses largely on LACDPH's COVID-19 mitigation efforts in SNFs and provides an overview of existing SNF regulatory and oversight structures. The A-C's interim report, issued to the OIG on October 5, 2020, was included as an attachment to the OIG's first interim report and provides

³ Los Angeles County, Motion by Supervisors Mark Ridley-Thomas and Kathryn Barger, *Improving Oversight and Accountability Within Skilled Nursing Facilities*, May 26, 2020, Board Agenda Item #23, at: <http://file.lacounty.gov/SDSInter/bos/supdocs/145993.pdf> (accessed on January 10, 2021).

⁴ California Department of Public Health, AFL 20-52, *Coronavirus Disease 2019 (COVID-19) Mitigation Plan Implementation and Submission Requirements for Skilled Nursing Facilities (SNF) and Infection Control Guidance for Health Care Personnel (HCP)*, May 11, 2020. AFLs can be found at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx> (accessed on September 11, 2020).

⁵ Los Angeles County Office of Inspector General, *Improving Oversight and Accountability within Skilled Nursing Facilities: First Interim Report*, October 2020, at: https://oig.lacounty.gov/Portals/OIG/Reports/SNF_First%20Interim%20Report_October%202020.pdf?ver=HTEjWd5zLRyRUN7vXxXMYw%3d%3d (accessed on March 1, 2021).

a status update on the development of a publicly available dashboard and other Board directives.

On February 16, 2021, the OIG issued its second interim report.⁶ The second interim report provides an initial assessment of HFID operations by means of: (1) an analysis of two Pasadena SNF evacuations that took place in June and October 2020 as a result of facility-wide crises; (2) summary of HFID staff perceptions regarding HFID's operations and practices based on conversations with more than 40 HFID staff, supervisors, and managers; and (3) an overview of the complex ownership and business structures that govern the majority of SNFs. The OIG's second interim report provides 13 recommendations, including the recommendation that LACDPH develop a comprehensive county-wide SNF crisis mitigation and response plan that designates a crisis mitigation team within LACDPH to assess and determine the appropriate response for facility-wide crises. The A-C's final report, attached hereto (Attachment I), was issued to the OIG on February 8, 2021. The A-C's final report provides the results of the A-C's assessment of HFID with 18 corresponding recommendations for improvement.

This final report is the culmination of a year-long review by the OIG pursuant to the Board motion. Because this review was completed during a period when HFID was directed by both federal and California state governments to suspend most of its usual oversight tasks and concentrate on pandemic mitigation efforts, it was not possible to accurately assess HFID's ability to perform certain customary responsibilities. Nonetheless, specific gaps were noted in HFID's oversight and enforcement of SNF regulations and standards. Addressing the identified areas of concern and opportunities for improvement would improve the County's efforts to protect the health and safety of residents, patients, and staff in health care facilities and meet its contractual obligations with CDPH. The OIG also reviewed SNF ownership structures and identified certain business practices that raise concerns regarding the efficacy of administrative enforcement.

This report contains a total of 39 operational, programmatic, and legislative recommendations that can be undertaken by the County to address longstanding, systemic issues and yield greater transparency, accountability, and partnership. It is imperative that the County reach a turning point in SNF care, especially as the number of older adults continues to grow,⁷ and the recommendations that emerged

⁶ Los Angeles County Office of Inspector General, *Improving Oversight and Accountability within Skilled Nursing Facilities: Second Interim Report*, February 2021, at: https://oig.lacounty.gov/Portals/OIG/Reports/SNF_Second%20Interim%20Reports_February%202021.pdf (accessed on June 1, 2021).

⁷ SNFs are expected to play an increasingly important role in our health care system. By 2029, the entire baby boom generation—those born between 1946 and 1964—will be 65 years and older, and more than 20 percent of the total United States population is expected to be over the age of 65. See Colby, S. et al., *The Baby Boom Cohort in the United States: 2012 to 2060*, United States Census Bureau, May 2014.

from the OIG's and the A-C's reviews provide, at the very least, the foundation for instituting lasting reform.

In preparation of the OIG's reports, OIG personnel met with more than 200 stakeholders. Simply stated, this review and corresponding reports and recommendations would not have been possible without their generous and consistent consultation. The OIG and County owe these stakeholders a debt of gratitude both for their immeasurable contributions to this review and for the work they do on behalf of the County's SNF residents and staff.

METHODOLOGY

The OIG retained a subject matter expert, Debra Saliba, M.D., M.P.H., to assist in the review and the development of recommendations. Dr. Saliba is a Professor of Medicine at the University of California, Los Angeles (UCLA), a practicing board-certified geriatrician and an internationally recognized leader in geriatrics research and quality. She is also a senior natural scientist at the RAND Corporation and has served as an expert on multiple national advisory panels. Dr. Saliba's research has resulted in the creation of tools that can be applied to improving quality of care and quality of life for vulnerable elders and adults with LTC needs across the care continuum. Dr. Saliba completed fellowships in health services research and geriatric medicine at UCLA where she received a master's degree in public health in epidemiology. The OIG worked closely with Dr. Saliba throughout much of the review.

In conducting this review, OIG personnel met with: (1) industry experts, including resident advocates, SNF association representatives, medical professionals, and academics; (2) SNF administrators and direct care workers; (3) LACDPH and HFID staff, supervisors, managers, and executive leadership; (4) CDPH executive leadership; (5) representatives of state and local government agencies, including the California Department of Justice, the California Emergency Medical Services Authority, the Los Angeles County District Attorney's Office (LADA), County Counsel, A-C, Emergency Medical Services Agency, and the Los Angeles City Attorney's Office; (6) representatives of the WISE & Healthy Aging Long-Term Care Ombudsman Program (Ombuds);⁸ and (7) representatives from the city of Pasadena, including the Director of Public Health and Health Officer, the City Manager, the Assistant City Manager, the Fire and Police Chiefs, and the Chief City Prosecutor.

⁸ The representatives of the WISE & Healthy Aging Long-Term Care Ombudsman Program serve as advocates for the residents occupying the more than 76,000 beds in long-term care facilities in Los Angeles County. This program is authorized under the federal Older Americans Act and its California companion, the Older Californians Act. The goal of the program is to investigate and attempt to resolve complaints made by or on behalf of individual residents of long-term care facilities.

The OIG requested, reviewed, and analyzed thousands of pages of documents, including policies and procedures, training material, logs, correspondence, and closed investigation case files. The OIG also conducted a comprehensive review of relevant literature and research related to the regulation and oversight of SNFs. OIG personnel met with LACDPH and HFID executive leadership to obtain and clarify information, discuss findings, and develop recommendations. Lastly, OIG personnel visited 4 of the 5 HFID regional offices and participated in a total of 13 site visits to SNFs and an acute care hospital. Six of the site visits included HFID or other LACDPH staff, five included representatives from the Ombuds, and two were conducted by OIG personnel alone.

LACDPH maintained an open and collaborative approach throughout the OIG's review. Staff, supervisors, managers, and executive leadership were accommodating and transparent and made themselves available for inquiries, meetings, and follow-up at each step of the review. The OIG extends its gratitude to all LACDPH personnel who continue to work tirelessly to defeat the COVID-19 pandemic and to ensure safety at health care facilities across the County.

OVERSIGHT OF SKILLED NURSING FACILITIES

There are two general types of SNFs in California: (1) licensed, and (2) licensed *and* certified. All SNFs must meet specific standards and be licensed to operate under state law. All Medicare⁹ and Medicaid¹⁰ participating SNFs must be certified as meeting certain federal requirements. Most SNFs in the County are licensed and certified.

At the federal level, CMS is responsible for ensuring that SNFs nationwide meet federal requirements to participate in the Medicare and Medicaid programs. To help monitor whether SNFs are in compliance with federal regulations, CMS contracts with participating state health agencies (or other appropriate agencies), referred to as state survey agencies.

At the state level, CDPH's Licensing and Certification Program (L&C) serves as the state survey agency. As part of this role, L&C: (1) certifies SNFs that participate in the Medicare and Medicaid (i.e., Medi-Cal) programs; (2) conducts state licensing reviews to ensure compliance with state law; (3) investigates complaints and facility-reported incidents (FRIs); and (4) issues federal deficiencies and state

⁹ The Medicare program, established in 1965 under Title XVIII of the Social Security Act, is a federal health insurance program that primarily provides a wide range of benefits to individuals age 65 and older, regardless of income or health status.

¹⁰ The Medicaid program, established in 1965 under Title XIX of the Social Security Act, pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid is a cooperative venture jointly funded by the Federal government and state governments. In California, the Medicaid program, known as Medi-Cal, is jointly administered by CMS and the CDPH Care Services.

citations, imposes sanctions, and assesses monetary penalties on SNFs that fail to meet certain state and/or federal requirements. L&C also issues All Facilities Letters to provide guidance to SNFs, which may include changes in requirements or general information that affects SNFs.¹¹

At the local level, CDPH contracts with LACDPH's HFID to perform specific licensing and certification activities and investigations for 4,188 health care facilities, including 379 SNFs, located in the County. The current contract, for the period of July 1, 2019, through June 30, 2022, transfers to HFID the entire regulatory workload by the end of the contract period with increased staffing resources over the course of the three-year contract term to meet additional workload demands.¹² CDPH, both statutorily and contractually, retains responsibility for establishing program policies, standards, and enforcement actions related to licensure, including denials, revocations, and suspensions.

As part of the current contract, CDPH agreed to accept responsibility for completing a portion of backlogged investigations. HFID is responsible for completing backlogged SNF complaints and FRIs received on or after July 1, 2015. HFID is also responsible for addressing a percentage of the projected annual caseload of all new SNF complaints and FRIs received on or after July 1, 2019. CDPH is responsible for completing all backlogged SNF complaints and FRIs received prior to July 1, 2015, and the remaining percentage of the projected annual caseload of all new SNF complaints and FRIs received on or after July 1, 2019. The current contract includes metrics that are used to evaluate HFID's performance and sets forth conditions for financial withholdings via a reduction of the fiscal year end invoice should HFID not meet the metrics. Lastly, the current contract allows for amendments and changes to the scope of work by agreement of the parties. LACDPH reports that it met or exceeded all CDPH contractual performance metrics for the July 1, 2019, through June 30, 2020, contract period.

COVID-19 MITIGATION EFFORTS

The combination of an extremely vulnerable resident population, the lack of scientific understanding of transmission routes of COVID-19 in the early months of the pandemic, the congregate nature of SNFs, the lack of an adequate stockpile of essential personal protective equipment (PPE) at the federal and state level, and longstanding challenges at many facilities created increased risk of COVID-19 transmission in SNFs. These challenges were compounded by real-world limitations

¹¹ An All Facilities Letter (AFL) is a letter from the California Department of Public Health, Licensing and Certification Program (L&C) to health facilities that are licensed or certified by L&C. The information contained in the AFL may include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility.

¹² Standard Agreement 19-10042, July 1, 2019, through June 30, 2022.

on infrastructure, supplies, training, and COVID-19 testing, as well as the evolving understanding of the virus.

As detailed in the OIG's first interim report, LACDPH and HFID have extended extraordinary efforts to intervene and support residents and staff in the County's SNFs since March 2020. For example, on April 24, 2020, in an effort to reduce the transmission of COVID-19 and protect vulnerable residents, as well as staff, LACDPH issued a comprehensive Health Officer Order¹³ to all congregate health care facilities containing several measures, such as limited entry and access to facilities, universal masking and PPE requirements, frequent temperature checks, testing of staff and residents, and reporting of cases and deaths to LACDPH.¹⁴ In early-May 2020, LACDPH contacted SNFs with active COVID-19 outbreaks to schedule baseline testing of all residents and staff at no cost to facilities. LACDPH reports that by mid-May 2020, LACDPH expanded its capacity to support SNFs without active COVID-19 outbreaks, and that all SNFs within its jurisdiction completed baseline testing by June 19, 2020.¹⁵

In recognition of the difficulties initially experienced by health care facilities in obtaining PPE, LACDPH created a county-wide emergency response distribution network to assist facilities and service providers with accessing PPE from state and national stockpiles, as well as procurement from commercial vendors. LACDPH also expanded its technical assistance and ongoing training/educational opportunities for health care workers in LTC settings, and several LACDPH units engaged in ongoing activities to monitor, prevent, and manage COVID-19 in SNFs. LACDPH reports that for much of the pandemic, HFID conducted site visits within 24 hours of the Acute Communicable Disease Control Unit identifying an outbreak, and then contacted SNFs daily during active outbreaks to monitor and advise on infection prevention and control. LACDPH also reports that physicians from its Outbreak Management Branch conducted multiple onsite and virtual facility tours to provide COVID-19 control directives to individual SNFs. These are just some of the many efforts taken by LACDPH to help mitigate the spread of COVID-19 in SNFs.

In April 2020, the A-C with LACDPH and other County departments designed a publicly available SNF COVID-19 dashboard. The dashboard provides COVID-19-related data that is self-reported by SNFs through weekly surveys. Self-reported data includes the number of COVID-19 tests performed, new and cumulative COVID-19-related deaths and COVID-19 cases among residents and staff, and the

¹³ During a declared emergency, such as the current pandemic, the local Health Officer has broad regulatory control by way of Health Officer Orders. The Health Officer can issue Orders to SNFs and other long-term care facilities to direct and guide them accordingly.

¹⁴ County of Los Angeles Department of Public Health, Order of the Health Officer for Control of COVID-19, *Prevention of COVID-19 Transmission in Licensed Congregate Health Care Facilities*, April 24, 2020.

¹⁵ This excludes SNFs under the jurisdiction of Long Beach and Pasadena since each of these cities has its own health department.

availability of PPE. The final version of the dashboard was made public on September 30, 2020.¹⁶

The OIG's second interim report detailed LACDPH's COVID-19 vaccine rollout efforts in SNFs. In December 2020, the first COVID-19 vaccines in the United States were authorized for emergency use by the Food and Drug Administration and recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).¹⁷ The ACIP recommended, as interim guidance, that both health care personnel and residents of LTC facilities be the first to receive the vaccine.¹⁸ In response, CDPH created a three-tiered allocation plan that prioritized SNF residents and staff in the highest tier.¹⁹

The Federal Pharmacy Partnership for Long-term Care Program (FPP) was created to help distribute and administer the COVID-19 vaccine to residents in SNFs and assisted living facilities at no cost to facilities.²⁰ LACDPH reports that it had initially enrolled 340 SNFs in the FPP.²¹ However, in December 2020, when the first COVID-19 vaccines received authorization for emergency use, the County was experiencing an increase in newly reported COVID-19 cases in SNFs. Given the urgent need for distributing vaccines, LACDPH reports that it consulted with SNF chain operators and made the decision to withdraw all 340 SNFs from the FPP and facilitate enrollment in California's COVID-19 vaccine program to have more control over vaccine distribution and ensure immediate local delivery to SNF residents and staff.

Since LACDPH guided SNFs with early vaccination implementation for residents and staff, case rates in SNFs have been lower than those seen in the County as whole. LACDPH reports that it began distributing vaccines to SNFs on December 22, 2020. To determine how many residents and staff received a COVID-19 vaccine, LACDPH conducts weekly surveys among SNFs to assess the number of residents and staff

¹⁶ County of Los Angeles Department of Public Health, Skilled Nursing Facilities COVID-19 Dashboard, at: <http://publichealth.lacounty.gov/snfdashboard.htm> (accessed on September 20, 2021).

¹⁷ Dooling, K., et al., *The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine — United States, December 2020*, Centers for Disease Control and Prevention, January 1, 2021, at: https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_w (accessed on February 5, 2021).

¹⁸ *Id.*

¹⁹ California Department of Public Health, *CDPH Allocation Guidelines for COVID-19 Vaccine During Phase 1A: Recommendations*, December 5, 2020, at: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Allocation-Guidelines-for-COVID-19-Vaccine-During-Phase-1A-Recommendations.aspx> (accessed on December 8, 2020).

²⁰ According to the Centers for Disease Control and Prevention, there will be no cost to the facility for participation in the pharmacy partnership program. It is anticipated that participating pharmacies will bill public and private insurance for the vaccine administration fees. See *Leading Age, FAQs and Resources on COVID-19 Vaccines and Issues Surrounding Vaccinations*, December 10, 2020, at: <https://leadingage.org/sites/default/files/FAQs%20and%20Resources%20on%20COVID-19%20Vaccines%20-%20Dec%2010.pdf> (accessed on February 8, 2021).

²¹ Vaccine distribution for SNFs located in the City of Pasadena and the City of Long Beach was coordinated by their respective health departments.

who are unvaccinated, partially vaccinated, and fully vaccinated. LACDPH reports that as of September 22, 2021, 88 percent of residents and 90 percent of staff are reported to be fully vaccinated. LACDPH continues to encourage SNFs to work directly with contracted LTC pharmacies that receive vaccines from the Federal Retail Pharmacy Program to obtain doses for residents and staff.²² LACDPH reports that SNFs have been instructed to contact their contracted LTC pharmacy to request vaccinations immediately upon admission of new residents. If a contracted LTC pharmacy is unable to vaccinate a resident within one week of admission, LACDPH has provided information to SNFs on how to request a LACDPH mobile team that will report to the facility and administer a vaccine. Lastly, LACDPH reports that it has initiated conversations with local hospitals to determine whether the hospitals can administer vaccines prior to discharging patients to SNFs.

OPERATIONAL REVIEW OF HFID

Under the current contract between LACDPH and CDPH, HFID has a total contracted budget of approximately \$258 million over a three-year period to conduct a wide range of licensing and certification activities aimed at ensuring the health and safety of residents, patients, and staff in health care facilities. The OIG and the A-C conducted operational reviews of HFID and identified several potentially significant issues that hinder HFID's ability to perform its oversight and enforcement responsibilities.

Pursuant to the board motion, the A-C: (1) evaluated HFID's ability to conduct all required COVID-19 mitigation activities while maintaining other critical oversight roles; (2) conducted an operational assessment of HFID, including a review of the backlog of SNF investigations; and (3) performed a benchmarking analysis comparing staffing structures and levels between HFID and CDPH.²³ The A-C's final report provided 18 recommendations for improvement, including a recommendation that HFID management consider conducting, or hire a consultant to conduct, a comprehensive assessment to evaluate the problems identified in the A-C's report, determine appropriate staffing needs, identify causes and solutions for delays in completing investigations and addressing deficiencies, and develop corrective action plans for addressing and resolving any other areas of improvement identified through the assessment.²⁴ The A-C's recommended assessment is an important

²² Centers for Disease Control and Prevention, *Understanding the Federal Retail Pharmacy Program for COVID-19 Vaccination*, April 12, 2021, at: <https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html> (accessed on May 17, 2021).

²³ Los Angeles County Auditor-Controller, *Improving Oversight and Accountability within Skilled Nursing Facilities (May 26, 2020, Board Agenda Item #23) – Auditor-Controller's Final Report*, February 8, 2021.

²⁴ *Id.* at 38.

step in ensuring that HFID can fulfill its mission to adequately protect the health and safety of residents and staff in the health care facilities it oversees.

As detailed in the OIG's second interim report, the OIG conducted an initial assessment of HFID's operations by way of an analysis of two Pasadena SNF evacuations that took place in June and October 2020. Although each evacuation was precipitated by different underlying circumstances, both appear to have been preceded by several weeks of unsuccessful efforts to rectify potentially life-threatening issues. The evacuations revealed issues with state and local mechanisms for triggering a crisis response, efficacy of HFID's oversight and enforcement actions, and coordination and communication between HFID and partner agencies.

HFID is required to conduct its oversight activities in accordance with the policies and procedures established by CDPH, and LACDPH does not currently have the discretion to modify or tailor such policies and procedures based on local needs. In addition, HFID does not have the independent authority to initiate an evacuation in the event of a facility-wide crisis and is limited to recommending evacuations and other emergency responses to CDPH. The OIG requested and reviewed all CDPH policies and procedures regarding the depopulation/evacuation of residents from SNFs and found that they do not provide sufficient guidance for determining when the scope and severity of a danger to the health and safety of residents rises to the level of requiring an evacuation, which may have contributed to a delay in initiating an emergency response. The OIG presented several recommendations to address these issues, including the recommendation that LACDPH develop a comprehensive county-wide SNF crisis mitigation and response plan that designates a crisis mitigation team with appropriate expertise to assess and recommend the proper response to facility-wide crises.

Over the course of this review, the OIG spoke with 51 of approximately 390 (13 percent) staff, supervisors, and managers from across HFID to gather information regarding their perceptions of HFID's operations and practices. The demanding nature of HFID's oversight responsibilities necessarily exposes HFID staff to intense pressure. Stress experienced in the regular course of HFID's work has certainly been exacerbated throughout the pandemic when work demands reportedly tripled. In order to ensure that issues reported were not limited to perceptions of a particularly exhausted few and were sufficiently serious to warrant further review, the OIG only reported issues that were consistently echoed by staff across HFID regions and positions in HFID's and LACDPH's chains of command. Perceptions were communicated both by staff who contacted the OIG and by staff whom the OIG contacted at random from HFID staff rosters.

More than half of those the OIG spoke with expressed feeling pressure to rush cases, and close to one-third reported prematurely closing complaint and FRI

investigations as a result. More than one-third communicated the belief that HFID leadership at times appears to prioritize closing investigations over the wellbeing and safety of SNF residents. Multiple staff also stated that, at times, supervisors have downgraded their deficiency findings against their recommendations. Most staff expressed feeling inadequately trained to perform of their job duties. The majority of staff and supervisors who spoke with the OIG reported feeling overworked and exhausted and some stressed the need for additional staffing and higher supervisor-to-staff ratios. These accounts raise concerns about HFID's ability to oversee SNFs with its existing structure and resources and require prompt attention of LACDPH leadership.

During site visits to HFID regional offices, OIG personnel reviewed a selection of 90 case files of complaint and FRI investigations regarding SNFs and other health care facilities that were closed between January 2019 and January 2021.²⁵ Most of the cases selected for review involved allegations of sexual or physical abuse of residents. The OIG's review revealed issues with: (1) the quality of investigations and recordkeeping; (2) elder abuse referrals; and (3) improper backdating of records.

Quality of Investigations and Recordkeeping

During the review of case files at HFID's regional offices, OIG personnel identified issues with the quality of investigations and recordkeeping. For example, approximately one-fifth of the 90 case files reviewed by OIG personnel contained illegible handwritten surveyor notes. One program manager stated that unless typed notes were mandated by CDPH, LACDPH could not require staff to type them. In addition, 78 of 90 case files were not well organized and appeared to be lacking documentation such as initial and final letters to complainants, neglect/abuse referral letters, the "ACTS Complaint/Incident Investigation Report,"²⁶ surveyor notes, complaint summary/outcome forms, the Survey Team Composition and Workload Report (Form CMS-670),²⁷ and the Statement of Deficiencies and Plan of Correction (Form CMS-2567).²⁸ An investigative case file should be detailed and organized such that others can understand its contents and decision makers are provided with sufficient information to determine what if any further action is

²⁵ The 90 cases were opened between 2015 and 2020.

²⁶ The ASPEN Complaints/Incidents Tracking System (ACTS) is designed to track, process, and report on complaints and incidents reported against health care providers and suppliers regulated by CMS. It is designed to manage all operations associated with complaint/incident processing, from initial intake and investigation through the final disposition. CMS State Operations Manual, Section 5060 – ASPEN Complaints/Incidents Tracking System (ACTS), Rev. 18, Issued 03-17-06. The ACTS Complaint/Incident Investigation Report is a document that contains all the information received from a complainant regarding allegations and all the actions taken by HFID in response to the complaint.

²⁷ Form CMS-670 documents time spent completing specific investigative tasks.

²⁸ Form CMS-2567 documents the deficiencies identified and the facility's plan to correct them.

needed. It was difficult for OIG personnel, and would be as well for auditors or oversight to identify HFID's specific investigative steps and the methods used to support findings.

One July 2015 investigation includes documentation by a surveyor that appears to suggest the case may have been closed prematurely. HFID received the complaint alleging that a resident pushed another resident to the floor. The resident admitted to SNF staff to pushing the other resident who had repeatedly wandered into his room. The original HFID surveyor who was assigned the file investigated the allegation, identified possible deficiencies, and conducted an exit interview. However, it appears as though the investigation was not closed because HFID had not received a plan of care to manage residents who wander from the SNF. Nearly five years later, in May 2020, the investigation was assigned to another HFID surveyor. The surveyor documented consulting with supervisors and being instructed to close the case without contacting the facility and obtaining the outstanding care plan. The supervisor reportedly did not find it necessary to obtain the plan since the resident was not injured and directed the surveyor to close the case. The investigation was deemed unsubstantiated and was closed. It is unclear from the investigative file why HFID neither ascertained why the facility did not have a plan of care to safely manage wandering residents or ensure that one was created prior to closing the investigation.

This example is consistent with reports from more than one-third of HFID staff who spoke with the OIG and reported closing investigations prematurely due to ongoing pressure to meet workload demands. Similar findings were noted by the A-C during a 2014 audit of HFID. The A-C evaluated a sample of cases to determine the quality and integrity of SNF investigative files and found that 5 of the 30 case files reviewed were inappropriately closed without conducting or completing the investigations.²⁹ As a result, the A-C recommended that HFID ensure onsite investigations are appropriately completed for all complaints and FRIs. LACDPH agreed with the A-C's recommendations but did not provide a plan for ensuring all investigations are appropriately completed before they are closed.

In some instances, open investigations were still assigned to HFID surveyors who were no longer employed with HFID. During a regional office site visit in February 2021, OIG personnel identified a single box of case files on the floor beside a desk. Upon further inquiry, OIG personnel learned that the files were assigned to an employee who had retired in September 2020. OIG personnel cross-referenced the case files with logs of open and closed investigations and found that, although the

²⁹ On March 4, 2014, the Auditor-Controller was instructed by the Board of Supervisors to conduct an audit of the quality and integrity of nursing home investigations in Los Angeles County and to report back in 30 days. The Board of Supervisors directed the Auditor-Controller to focus their efforts on the backlog of SNF complaint investigations. After a 30-day review, the Auditor-Controller provided LACDPH with 10 recommendations to improve HFID operations.

cases inside the box were closed, 10 open investigations were still assigned to the retired employee. Some HFID staff indicated that this was not an isolated incident and that at times it takes HFID management several months to reassign cases.

OIG personnel attempted to pull specific case files at the regional offices visited; however, HFID's filing system made it difficult to locate files. There were rows of stacked boxes approximately four feet high containing closed case files waiting to be filed at one regional office. Some HFID staff expressed the need to institute an electronic records system to help streamline recordkeeping and review.

HFID staff also reported that there were numerous case files scattered throughout regional offices in drawers and additional boxes. OIG personnel attempted to identify and inventory case files during regional office site visits. Due to the volume of case files, it was difficult to log them all during site visits. Nonetheless, OIG personnel documented 143 case files found outside of the proper filing system across three regions. HFID management expressed the belief that the files were "old cases" that were not being worked or cases that were assigned to CDPH's Los Angeles Monitoring Unit (LAMU) for investigation in an effort to assist HFID with the backlog. OIG personnel cross-referenced the 143 inventoried investigation case files with case logs provided by HFID and LAMU³⁰ and found that 52 were assigned to LAMU, 62 were open and assigned to HFID,³¹ and 59 were closed. Of the 62 cases that were open and assigned to HFID, 26 were assigned to staff who were no longer employed with HFID. These 26 cases were opened between January 2014 and June 2018.

The A-C identified similar issues during its 2014 audit of HFID. The A-C discovered an open investigation that was assigned to a surveyor who had retired four months earlier, but the case had not been reassigned to another employee. As a result, the A-C recommended that HFID management ensure that open investigations are reassigned promptly when surveyors retire or transfer. At the time, LACDPH acknowledged the failure to reassign the cases and accepted the recommendation but indicated the belief that it was a one-time occurrence.

LACDPH now indicates that, going forward, it plans to ensure that HFID managers generate regular reports that track exiting surveyors' workload and that cases are reassigned as appropriate. LACDPH also indicates that aged cases cannot be reassigned until HFID is able to address the backlog but anticipates the issue being fully resolved by the end of 2021.

³⁰ CDPH's Los Angeles Monitoring Unit (LAMU) provided the OIG with a spreadsheet of all cases assigned to the LAMU on March 2, 2021.

³¹ Forty-nine of the cases that are open and assigned to HFID also appeared on the log of cases assigned to LAMU.

Lastly, one region reported that 1,836 of their cases were assigned to LAMU for investigation. The OIG cross-referenced the list of 1,836 cases assigned to that region with the case log provided by LAMU and determined that while all 1,836 cases were in fact assigned to LAMU and accounted for on LAMU's case log, 1,681 of the cases also remained on HFID's open case log. It is unclear whether investigative efforts are being duplicated on the cases that appeared on both LAMU's and HFID's case logs but given the volume of HFID's backlog and record keeping practices, it raises questions about redundancy.

Elder Abuse Referrals

An estimated 1 in 10 older adults are victims of elder abuse each year in the United States both in and out of SNF settings.³² It has been estimated that only 1 in 24 elder abuse cases are identified and reported to the appropriate authorities.³³ As the population of older adults continues to increase in the County, so too do reports of elder abuse.³⁴ In 2019, the Los Angeles County Adult Protective Services received and responded to an all-time record of nearly 50,000 referrals of elder and dependent adult abuse.³⁵

To address this growing issue, California law requires that certain persons—referred to as “mandated reporters”—report known or suspected incidents of elder³⁶ or dependent adult³⁷ abuse or neglect to the appropriate authorities. Elder and dependent adult abuse can occur in many forms and to varying degrees, including

³² Makaroun, L., et al., *Elder Abuse in the Time of COVID-19—Increased Risks for Older Adults and Their Caregivers*, *The American Journal of Geriatric Psychiatry*, 28(8), at 876–880, August 2020.

³³ Lachs, M., et al., *Under the Radar: New York State Elder Abuse Prevalence Study*, May 2011, at: <https://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf> (accessed on May 7, 2021).

³⁴ Raghavan, M., *LA County Is Reporting More Elder Abuse Than Ever Before*, *LAist*, June 10, 2019, at: https://laist.com/2019/06/10/its_not_just_stan_lee_reports_of_elder_abuse_are_on_the_rise_everywhere.php (accessed on May 5, 2021).

³⁵ Motion by Los Angeles County Supervisor Kathryn Barger, *Proclaim June 2020 as Elder and Dependent Adult Abuse Awareness Month, and June 15, 2020 as World Elder Abuse Awareness Day*, June 9, 2020, at: <http://file.lacounty.gov/SDSInter/bos/supdocs/146341.pdf> (accessed on May 5, 2021).

³⁶ California Penal Code § 368(g) defines an elder as a person who is 65 years of age or older.

³⁷ A dependent adult is any person residing in California, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. California Welfare and Institutions Code § 15610.23.

physical abuse,³⁸ abandonment,³⁹ abduction,⁴⁰ isolation,⁴¹ financial abuse,⁴² and neglect.⁴³ Failure to report elder or dependent adult abuse in LTC facilities is a crime.⁴⁴ Under California's mandated reporter laws,

[a]ny person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or local law enforcement agency is a mandated reporter.⁴⁵

A "care custodian" is defined as an administrator or an employee of a public or private facility who provides care or services to elders and dependent adults as part of his or her official duties, including support and maintenance staff.⁴⁶ In effect, all staff in LTC facilities are mandated reporters.⁴⁷

HFID staff are also mandated reporters under California law as health care practitioners and/or care custodians working for state licensing divisions.⁴⁸ There are different ways in which HFID staff may become aware of potential elder abuse. For example, HFID surveyors may witness first-hand signs of elder abuse during

³⁸ Physical abuse can include assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, sexual assault, unreasonable physical constraint, improper use of a physical or chemical restraint or psychotropic drugs. California Welfare and Institutions Code § 15610.63.

³⁹ Abandonment is the desertion or willful forsaking by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. Welfare and Institutions Code § 15610.05.

⁴⁰ Abduction is the removal from and/or the restraint from returning to this state of any elder or dependent adult who does not have the capacity to consent to the removal or restraint or without the consent of the conservator or the court if the individual is conserved. California Welfare and Institutions Code § 15610.06.

⁴¹ Isolation includes acts intentionally committed for the purpose of preventing an elder or dependent adult from receiving his or her mail, telephone calls or meeting with visitors. California Welfare and Institutions Code § 15610.43.

⁴² Financial abuse occurs when a person takes, or assists in taking, secretes, appropriates, obtains, or retains real or personal property for a wrongful use or with intent to defraud. California Welfare and Institutions Code § 15610.30.

⁴³ Neglect means either the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise or the negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise. California Welfare and Institutions Code § 15610.57.

⁴⁴ California Welfare and Institutions Code § 15630(h).

⁴⁵ California Welfare and Institutions Code § 15630.

⁴⁶ California Office of the Attorney General, *Your Legal Duty...Reporting Elder and Dependent Adult Abuse*, at: https://oag.ca.gov/sites/all/files/agweb/pdfs/bmfea/yld_text.pdf (accessed on April 14, 2021).

⁴⁷ *Id.*

⁴⁸ California Welfare and Institutions Code §§ 15610.37, 15610.17(p).

site visits to SNFs or HFID may receive allegations of elder abuse directly from residents, their friends and families, health care practitioners, and other members of the public through the complaint intake process. The 90 cases reviewed by the OIG were complaints and FRIs received through the complaint intake process.

CDPH's complaint intake policy requires that district offices refer all allegations of "abuse, neglect, or misappropriation of resident funds and/or property" to the California Department of Justice's Division of Medi-Cal Fraud and Elder Abuse (DMFEA),⁴⁹ the local LTC ombudsman,⁵⁰ and local law enforcement by way of submitting a referral packet and/or making a telephone report within prescribed timeframes based on the presence of extenuating circumstances.⁵¹ If after review by a supervisor an allegation of abuse meets specialized criteria, the report must be referred to the DMFEA via email and flagged to indicate that it is a high priority for investigation.⁵² If the allegation concerns a certified nursing assistant (CNA), home health aide, or hemodialysis technician, the district office must also refer the report to CDPH's Professional Certification Branch (PCB) for investigation.⁵³ LACDPH reports that HFID most recently conducted a refresher training on March 10, 2021, that addressed referral requirements.⁵⁴

Of the 90 cases reviewed by the OIG, 81 were categorized as abuse allegations by HFID and thus required referrals to the DMFEA, the Ombuds, and local law enforcement. In efforts to determine whether HFID was making required referrals, OIG personnel completed a cursory review of the case files to identify whether they contained the required agency referral letters, complaint intake forms, and/or notes indicating the appropriate referrals had been made. Of the 81 case files that required referrals, 72 did not appear to contain sufficient evidence that referrals were made by HFID to the DMFEA, the Ombuds, and/or local law enforcement.

⁴⁹ On January 27, 2021, the California Attorney General announced directing additional resources toward the California Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse and elevating the bureau to a full-fledged division, now called the Division of Medi-Cal Fraud and Elder Abuse (DMFEA). See California Office of the Attorney General, *Attorney General Becerra Announces Establishment of Division of Medi-Cal Fraud and Elder*, January 27, 2021, at: <https://oag.ca.gov/news/press-releases/attorney-general-becerra-announces-establishment-division-medi-cal-fraud-and> (accessed on May 7, 2021).

⁵⁰ The WISE & Healthy Aging Long-Term Care Ombudsman Program (Ombuds) serves as the local long-term care ombudsman for residents occupying facilities in Los Angeles County.

⁵¹ California Department of Public Health, Center for Health Quality, Policy and Procedure Bulletin, Section 100.02.01, July 10, 2020.

⁵² *Id.*

⁵³ Under California law, the California Department of Public Health's Professional Certification Branch may suspend or revoke a certificate issued to the certificate holder for "unprofessional conduct, including, but not limited to, incompetence, gross negligence, physical, mental, or verbal abuse of patients, or misappropriation of property of patients or others." California Department of Public Health, *Professional Certification Branch*, March 17, 2020, at: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/PCB.aspx> (accessed on May 7, 2021).

⁵⁴ Email from LACDPH Executive Management, May 21, 2021 (on file with the OIG).

In one case, an anonymous complaint was received alleging that a male counselor at a facility was sexually assaulting a conserved, developmentally delayed 29-year-old resident. The file reflects a statement made by the resident that she “felt like she had to perform oral sex [on the counselor] or [the counselor] would get her in trouble.” Although the case file reviewed by OIG personnel did not contain referral letters, HFID staff were able to confirm via ACTS that the Ombuds, PCB, and the DMFEA were notified. However, HFID did not document that local law enforcement was contacted. Given the nature of the allegations, a telephone report followed by a written report should have been made to local law enforcement within 24 hours of receiving the anonymous complaint.⁵⁵ This case was ultimately unsubstantiated by HFID reportedly due to a lack of sufficient evidence.

In another case, a CNA alleged that a resident who was diagnosed with muscle weakness, dysphagia,⁵⁶ aphasia,⁵⁷ altered mental status,⁵⁸ and vascular dementia⁵⁹ could be heard yelling from a hallway outside the room and was then suddenly muffled. The CNA entered the resident’s room and witnessed another CNA on the resident’s bed with both hands forcefully placed over the resident’s mouth trying to suppress the resident’s cries of distress and stating, “shut up!” Although the records reflect that local law enforcement was notified and responded to the incident, the allegations of abuse in this case met the specialized criteria for immediate referral to the DMFEA.⁶⁰ Therefore, the incident should have been referred to the DMFEA and flagged as a high priority investigation.

The case file contained documentation indicating that HFID correctly identified that a DMFEA referral was required but lacked documentation reflecting that the referral was made. The case was substantiated by HFID, and federal and state deficiency citations were issued for the failure to ensure residents were free from abuse and neglect. The DMFEA has reported that it did not receive the required referral consistent with CDPH policy and that it first received notification of the incident more than five months later by way of the related CDPH deficiency citation. In addition, this allegation required notification to the PCB since it concerned a CNA. The case file lacked documentation confirming that HFID referred the case to PCB

⁵⁵ California Department of Public Health, Center for Health Quality, Policy and Procedure Bulletin, July 10, 2020, Section 100.02.01 at 30.

⁵⁶ Dysphagia is when an individual has difficulty swallowing (noted in case file).

⁵⁷ Aphasia is when an individual has loss of ability to understand or express speech, caused by brain damage (noted in case file).

⁵⁸ Altered mental status is a disruption in how the brain works and may cause changes in behavior (noted in case file).

⁵⁹ Vascular dementia is decline in brain function caused by an impaired supply of blood to parts of the brain. It can be characterized by a decline in memory, language, problem-solving, or thinking skills (noted in case file).

⁶⁰ A document created by the California Department of Justice, Division of Medical Fraud and Elder Abuse that lists the types of incidents that require high priority for investigation. All incidents of physical abuse by an employee to a resident qualify as high priority cases. Verbal abuse is excluded unless it is extreme or repeated.

within the five-business day required referral timeframe. The case file contained documentation indicating that the facility referred the case to PCB after seven business days; however, it does not appear that HFID made the referral directly, as required by current CDPH policy.

The OIG requested confirmation of receipt for 37 referrals, including the two examples above, directly from the DMFEA, the Ombuds, and local law enforcement agencies for which the OIG and HFID were unable to identify in case files or ACTS sufficient evidence that referrals were made.⁶¹ Of the 12 required DMFEA referrals, the DMFEA indicated it did not have record of receipt for 7 referrals. Of the 10 required Ombuds referrals, the Ombuds indicated it did not have record of receipt for 7 referrals. Lastly, of the 15 required law enforcement referrals, the agencies contacted indicated they did not have record of receipt for 9 referrals. Information pertaining to the 37 referrals was provided to LACDPH in efforts to identify documentation that exists outside of the case file or ACTS that confirms whether the referrals were made. LACDPH provided documentation for 3 of the 37 referrals; however, the documentation provided suggests that the referrals were not made timely.

County Counsel reports that it communicated with state counsel for CDPH, and that state counsel advised L&C's practice is to not require local law enforcement referrals be made if a district office: (1) receives a report from another mandated reporter, and (2) verifies that a report was submitted to local law enforcement. This practice is inconsistent with current CDPH/HFID policy, as well as HFID training. State counsel has reportedly advised that it is currently revising CDPH policy to reflect this practice. If so, the OIG recommends that the state and the County ensure that revisions are sufficiently prescriptive regarding required documentation and other evidence that referrals were in fact made by reporting parties, and that the verification process does not impede HFID's ability to meet reporting timeframes under California's mandated reporter laws.

Failure to make timely referrals to required entities may impede investigations, compound risk or trauma to victims, and enable abuse of other vulnerable residents. LACDPH reports that in May 2021 HFID implemented a process to monitor and track all new complaint and FRI intakes that require referrals to outside agencies. HFID has designated a "Local Monitor" to each district office to track intakes and ensure that all referrals are made timely and properly logged. HFID has also a designated "Lead Monitor" for the division who is responsible for overseeing the logs and ensuring Local Monitors are thoroughly and accurately

⁶¹ The 37 referrals stem from 26 of the 72 case files that did not contain sufficient documentary evidence that referrals were made by HFID.

documenting referrals. Lastly, the Lead Monitor reviews a sample of intakes from each district office to verify the work of the Local Monitors and address any issues.

Improper Backdating of Records

As discussed above, on July 1, 2019, a new contract went into effect between LACDPH and CDPH. The contract contains metrics for CDPH to measure HFID's performance in the following areas: quality, customer service, and quantity/workload.⁶² If HFID is unable to meet the metrics after the first year of the contract,⁶³ CDPH may elect to withhold a certain percentage of the budgeted funding.⁶⁴ In addition, if federal fiscal sanctions are imposed on CDPH as a result of HFID's non-compliance, CDPH may pass 100 percent of the sanctions directly to the County via a reduction of funding.⁶⁵

Timely processing of initial and final notification letters to complainants are two of the customer service metrics CDPH uses to measure HFID's performance.⁶⁶ Upon receipt of a complaint, HFID must mail an initial notification letter to the complainant acknowledging receipt of the complaint within two working days. To remain in compliance, HFID must show that 80 percent of all initial notification letters were sent within prescribed timeframes.⁶⁷ In addition, once the investigation is completed, HFID must send a final notification letter to the complainant within ten working days.⁶⁸ To remain in compliance, LACDPH must show that 80 percent of all final letters were sent within 10 working days from the investigation completion date.⁶⁹

In speaking with HFID staff, the OIG learned that information stored in ACTS is manually entered and can be easily changed or edited. In effect, if HFID staff are unable to generate initial and final letters to complainants within the mandatory timelines, the dates of the letters in ACTS can be manually backdated to incorrectly indicate the letters were generated within mandated timelines and without creating any electronic evidence of when the record was altered or by whom. OIG personnel reviewed the "Mandatory Support Staff In-Service for Complaint Process" training that was conducted on March 2, 2021, by an HFID Staff Assistant. Approximately 44 employees attended the training, including a Regional Office Program Manager.

⁶² Standard Agreement 19-10042, July 1, 2019, through June 30, 2022.

⁶³ According to the current contract, compliance rates will be calculated for Year 1 of the contract, but no penalties will be invoked to allow time for the Los Angeles Department of Public Health to make adjustments in planning for future workloads.

⁶⁴ Standard Agreement 19-10042, July 1, 2019, through June 30, 2022.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ The investigation completion date is the date Form CMS-2567 – Statement of Deficiencies and Plan of Correction is sent to the provider.

The trainer instructed attendees that if they forget to generate letters and backdating is necessary, “corrections are allowed.” The trainer then demonstrated how to backdate and reminded attendees of the two-day requirement for generating initial letters. In the example provided, the date of the initial letter was changed from March 2, 2021, to February 3, 2021.

While there may be appropriate reasons for correcting errors, these findings suggest that HFID is not *correcting* but is rather improperly backdating records by falsely adding/changing dates in ACTS to reflect that letters, both initial and final, are being generated timely and appear as though HFID is meeting its contractual performance metrics. Several HFID staff reported that backdating is common practice, that they have been directed to backdate, and/or that they have themselves engaged in backdating. Similarly, the OIG identified two items of documentary evidence that confirm that some HFID supervisors and/or managers knew or should have known of the practice. Because the current configuration of the ACTS database allows for the permanent modification or deletion of manually entered dates, it may be impossible to determine the extent of this practice absent forensic examination.⁷⁰ The OIG recommends that LACDPH work with CDPH and CMS to ensure that ACTS records all manual date changes in an audit system that documents the change in the date, the reason for the date change, and the supervisor and/or manager who approved the change.

The A-C and the OIG reviewed targeted aspects of HFID’s operations. Nonetheless, the issues identified may impact some of HFID’s core functions in its oversight of the 4,188 health care facilities in the County and its ability to ensure the health and safety of the vulnerable patients and residents who rely on it. Like the A-C, the OIG recommends that LACDPH hire an independent consultant to conduct a comprehensive assessment of HFID.⁷¹ The assessment should address the issues raised by the A-C and the OIG, other important systemic challenges in HFID’s operations, as well as potential solutions to ensure that HFID is able to adequately oversee health care facilities and effectively protect the health, safety, and rights of residents and patients. In addition, the assessment should consider the extent to which HFID is integrated into LACDPH and identify organizational improvements necessary for LACDPH to provide the support, direction, and oversight needed to ensure HFID’s success.

⁷⁰ The improper backdating of records may constitute a crime under California law pursuant to California Government Code sections 6200 through 6203. The OIG has referred this matter to the Los Angeles County Office of County Investigations for further inquiry.

⁷¹ The A-C, in its 2014 review, included a similar recommendation that LACDPH hire an independent consultant to assist HFID with ensuring all recommendations from recent audit reports are addressed. LACDPH disagreed with the A-C’s recommendation, stating that it had an executive oversight team responsible for ensuring recommendations move forward.

Additionally, the County should initiate independent investigations into the above findings regarding elder abuse referrals and improper backdating of records. If in the course of the independent investigations additional potential misconduct or systemic deficiencies emerge, additional investigations should be initiated.

QUALITY OF SKILLED NURSING FACILITY CARE

While deficiencies in the systems created to oversee SNFs impact the County's ability to hold poor quality SNFs accountable, it is important to bear in mind that SNFs are ultimately responsible for maintaining compliance with federal, state, and local requirements. Despite extensive regulation, substandard care is an ongoing and persistent problem in many SNFs. The "quality" of SNF care is a complex concept that is generally assessed using several indicators. Care quality may be impacted by several types of systemic or individual deficiencies; however, staffing and workforce problems are cited by stakeholders and throughout the literature as chief among them.

Numerous studies have found a strong positive correlation between nurse staffing levels, particularly licensed staff such as registered nurses (RNs), and outcomes of care.⁷² Higher nurse staffing levels have also been associated with lower survey deficiencies and improved resident quality measures.⁷³ Research findings issued during the pandemic also show a positive relationship between nurse staffing levels and better COVID-19 outcomes in SNFs. Analyses of SNF data from across the country shows that higher nurse aide hours and higher total nursing hours are associated with fewer COVID-19 deaths and lower risk of COVID-19 outbreaks in the facility once a case occurs.⁷⁴ In a 2020 study, University of California San Francisco researchers examined the relationship between staffing levels and resident infections in California SNFs and found that SNFs with RN staffing levels under the recommended minimum standard were twice as likely to have COVID-19 resident infections.⁷⁵

Under California law, all SNFs are generally required to maintain sufficient nurse staffing with appropriate qualifications to meet the needs of each resident.⁷⁶ In 2018, new minimum staffing requirements were passed in California to require that

⁷² Harrington, C., et al., *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*, Health Services Insights, April 2016, Vol. 9, at 13–19; see also Bostick, J., et al., *Systematic Review of Studies of Staffing and Quality in Nursing Homes*, Journal of the American Medical Directors Association, April 2006, 7(6), at 366–376.

⁷³ Castle, N., *Nursing Home Caregiver Staffing Levels and Quality of Care: A Literature Review*, Journal of Applied Gerontology, August 2008, Vol. 27(4), at 375–405.

⁷⁴ Gorges, R., et al., *Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes*, Journal of the American Geriatrics Society, August 2020, 68(11), at 2462–2466.

⁷⁵ Harrington, C., et al., *Nurse Staffing and Coronavirus Infections in California Nursing Homes*, Policy, Politics, & Nursing Practice, August 2020, Vol. 21(3), at 174–186.

⁷⁶ 22 CCR § 72329(a).

SNFs⁷⁷ provide a minimum of 3.5 total nursing hours per resident day (hprd) and 2.4 CNA hprd.⁷⁸ SNFs licensed for 100 or more beds are required to staff one RN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing.⁷⁹ Lastly, federal regulations require that SNFs adjust nurse staffing levels based on resident acuity to ensure sufficient staffing to meet the care needs of all residents.⁸⁰

California's minimum nurse staffing requirements are below the levels recommended by experts and research studies. A 2001 study by CMS found that, to prevent harm and jeopardy to long-stay residents (stays of 90 days or longer), it is important to maintain a minimum of 0.75 RN hprd, 0.55 licensed nurse (LVN/LPN) hprd, and 2.8 CNA hprd, for a total of 4.1 nursing hprd.⁸¹ Although several organizations and experts have endorsed the minimum 4.1 hprd standard, some experts believe a minimum of 4.55 hprd is required to improve SNF care.⁸² A recent study found that approximately 80 percent of California SNFs do not meet the recommended minimum of 0.75 RN hprd and 55 percent did not meet the recommended minimum of 4.1 total nursing hprd.⁸³ Given the abundant evidence of the importance of adequate nurse staffing in SNFs, the County should consider developing a state-level legislative priority and policy to advocate for increasing nurse staffing requirements to the recommended minimum of 0.75 RN hprd, 0.55 licensed nurse (LVN/LPN) hprd, and 2.8 CNA hprd, for a total of 4.1 nursing hprd. In addition, the County should advocate for requiring all SNFs to provide 24-hour RN staffing, regardless of bed count.

Throughout the OIG's review, OIG personnel monitored the quality of care and life for residents at SNFs. On April 9, 2021, OIG personnel accompanied a representative from the Ombuds on an unannounced visit to Legacy Healthcare Center (Legacy Healthcare) located in Pasadena. The goal of this site visit was to observe the work of Ombuds representatives in their role as resident advocates and in attempting to rectify identified lapses in care and violations of residents' rights.

Legacy Healthcare is a two-story building with a 54-resident capacity and has offices on the ground floor and resident rooms on the second floor. At the time of site visit, the second floor was undergoing remodeling that was visible upon entry

⁷⁷ Subacute care units and Distinct Part SNFs have higher minimum nurse staffing requirements. See 22 CCR § 51215.5.

⁷⁸ 22 CCR § 72329.2.

⁷⁹ 22 CCR § 72329.

⁸⁰ Centers for Medicare & Medicaid Services, State Operations Manual, Appendix PP – guidance to surveyors for long term care facilities, Rev. 11-22-17.

⁸¹ Centers for Medicare & Medicaid Services, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Phase II Final Report*, December 24, 2001.

⁸² Harrington, C., et al., *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*, Health Services Insights, June 2020, Vol. 13, at 1–14.

⁸³ Harrington, C., et al., *Nurse Staffing and Coronavirus Infections in California Nursing Homes*, Policy, Politics, & Nursing Practice, August 2020, Vol. 21(3), at 174–186.

and extended into occupied resident rooms. The intent of the renovations may have been to improve living conditions; however, resident rooms were in various stages of interior construction. Residents' windows were covered with thin white bedsheets rather than blinds, curtains, or other more effective and insulating coverings. Sheets were secured to walls with strips of blue painter's tape and, in several rooms, failed to cover the entire window, exposing those residents to the glare of streetlights and visibility by foot or vehicle traffic on Fair Oaks Avenue, a busy Pasadena thoroughfare. Baseboards had been removed from resident rooms exposing black, dirty walls and dusty sheetrock, and rooms were devoid of homelike touches such as photos, artwork, or other décor.

During the exit meeting, the facility administrator reported that renovations had been underway for four months, since December 2020, and cited poor performance on the part of the construction company as the reason for the delay. The administrator reported anticipating the arrival of window coverings "soon," but stated they would not be installed in resident rooms until the floors were completed after another two weeks, assuming construction resumed as anticipated.

SNFs are required to have a communications system that allows residents to call for assistance, and which must be accessible to all residents.⁸⁴ The Ombuds representative noted that, in several rooms, call lights were not within residents' reach, hanging along walls behind beds or other furniture. In one room with three residents, only two call lights were available, leaving one resident with no independent means to call for assistance. Several residents appeared to require specialized "light touch" call lights for those who lack the dexterity or strength to use traditional call lights but did not have them.

One resident could be heard screaming continuously for several minutes. When the Ombuds representative approached, staff were tending to the resident and indicated that the screaming occurs every time the resident is moved from the bed and suggested it was due to cognitive decline. This resident shared a room with two other residents who were therefore being regularly subjected to piercing, distressed screaming, so loud that it can be heard throughout the entire second-floor resident area. When the Ombuds representative questioned why the facility failed to accommodate this resident in a single room with a door to protect other residents who may be frightened, frustrated, or traumatized, the administrator responded simply that Legacy Healthcare does not offer individual rooms. Indeed, the rooms at Legacy Healthcare can accommodate two or three beds each, but at the time of the site visit, the census reflected that only 36 of 54 available beds were occupied. The Ombuds representative indicated that all available information suggests that resident-centered accommodations could and should have been established. Despite best efforts on the part of the Ombuds representative, the administrator

⁸⁴ 42 CFR § 483.90.

gave no indication that Legacy Healthcare would identify more appropriate accommodations for these residents.

The only outdoor areas available to Legacy Healthcare residents were two small, fully enclosed cement patios located at the center of the building with a view to the upward sky only. One of the two patios was completely bare without chairs, a table, or any furniture or other items. The adjacent patio contained an outdoor table and chairs as well as a barbecue, which the administrator indicated had been utilized twice in recent months. When pressed for details, the administrator acknowledged that the barbecue was used for staff meals and not for the benefit of residents. The proximity of the patios to the surrounding resident rooms virtually ensures that residents could see, smell, or otherwise be aware that a barbecue was being prepared though they were not permitted to participate.

The administrator reported that since October 1, 2020, Legacy Healthcare had experienced high leadership turnover with two administrators and four directors of nursing. The administrator cited various performance issues and multiple HFID deficiency and immediate jeopardy findings as some of the reasons for the turnover. It appears that the owners' solution was to require the current administrator, who also managed the Foothill Heights Care Center located nearby, to manage both facilities at once. As of October 6, 2021, CDPH's California Health Facility Information Database (Cal Health Find) website, one of few publicly available research tools, lists only one Director of Nursing since August 20, 2020, not the four reported to the Ombuds and OIG. In addition, the most recent administrator listed shows a tenure of just over one month, from August 20, 2020, to September 30, 2020, and no current administrator is listed. Therefore, a consumer or potential resident may be unable to identify facility leadership or independently assess potential instability or other issues that are shown to impact care quality.

On April 26, 2021, OIG personnel accompanied a representative from the Ombuds on an unannounced visit to Chandler Convalescent Hospital located in Glendale. Chandler Convalescent Hospital is a two-story building with a 106-resident capacity with resident rooms on the ground floor. SNFs must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. While Ombuds and OIG personnel were required to use a separate entrance for the facility's yellow zone, facility staff were observed stepping over barriers and moving from one zone to another without following proper infection prevention and control protocols. For example, one staff member was observed stepping over a barrier from a yellow to the green zone, and then returning to the yellow zone without first performing adequate hand hygiene. In addition, Ombuds and OIG personnel observed a small medical container filled

with what appeared to be cream next to a resident's bed that was not covered, labeled, or dated. The resident reported that it is common practice for facility staff to leave cream out for staff over various shifts to use on the resident's wounds.

Some resident rooms had visibly dirty or sticky floors, and most were devoid of personal touches despite residents reporting that they have repeatedly requested them. Residents also reported missing personal property and facility staff confirmed that the facility stores property on the second floor of the facility, away from residents. Ombuds and OIG personnel also observed staff attempting to enter the facility from the patio by passing through a resident's room without first requesting the resident's permission. Residents' rooms should not be used as passageways for the convenience of facility staff. Lastly, some residents reported incompatibility with their roommates. One resident, for example, reported being verbally abused by a roommate. Staff acknowledged that the facility was aware of a conflict, but could not articulate what, if any, steps had been taken to resolve it.

Finally, on April 29, 2021, OIG personnel accompanied a representative from the Ombuds on an unannounced visit to Griffith Park Healthcare Center located in Glendale. Griffith Park Healthcare Center is a one-story building with a 94-resident capacity. Several Griffith Park Healthcare Center residents were left in dimly lit rooms without any form of entertainment such as a radio or a television. One resident had a television, but the picture was distorted, and the resident was physically unable to reach the antenna to attempt to adjust the signal. In addition, residents' beds were spaced mere inches apart, raising both privacy and infection control concerns.

Like Legacy Healthcare, Griffith Park Healthcare Center has a fully enclosed cement patio located at the center of the building with an upward view only. Residents reported that nonsmokers are required to utilize the patio area while residents who smoke can utilize another outdoor area, which has more open space and a view. At the time of the site visit, the patio area was closed because it had recently been painted.

One resident appeared to have been left in bed after requesting to get up. Initially, facility staff stated that the resident "slides" out of the wheelchair and therefore cannot get out of bed. Thereafter, facility staff stated that the resident is only permitted to get out of bed at the direction of the resident's physical therapist. Upon further inquiry, staff indicated that the resident was in fact permitted to get out of bed upon request. Another resident verbally reported to the Ombuds representative feeling claustrophobic because of privacy curtains placed on either side of the resident's bed, obscuring the window, sunlight, and a view to anything but the wall in front of the resident's bed. When Ombuds personnel inquired, facility staff appeared surprised that the resident had verbalized anything and indicated the belief that the resident was nonverbal.

In another instance, Ombuds and OIG personnel noted a PPE cart outside of a resident's doorway, suggesting that the resident may have had COVID-19 or another infectious disease. Because the room was located in the facility's designated green zone, the Ombuds representative inquired whether it was necessary to don PPE prior to entry. The facility's administrator indicated that PPE was unnecessary and that the cart had been left there by mistake. However, the Director of Nursing later indicated that the resident had indeed been diagnosed with Methicillin-resistant *Staphylococcus aureus* or "MRSA." Ombuds personnel reviewed another resident's medical records and noted that the resident had not been seen by a physician in more than four months though the physician continued to write telephone orders for wound care, therapy, and other treatments without physically examining the resident. Ombuds and OIG personnel heard a resident screaming and described experiencing a high level of pain and was requesting transfer to an acute care hospital setting. Upon closer examination, it appeared that the resident, in distress, had strewn belongings all about the room.

After concluding the site visit and exiting the facility, Ombuds and OIG personnel observed a resident simply walk through a facility exit door into the middle of an adjacent street and sit down on the concrete. Staff were clearly concerned for the patient's welfare and after several frantic minutes and significant negotiating, the resident returned safely to the facility.

The site visits during which the OIG accompanied Ombuds representatives were among the most informative of the OIG's review. Ombuds representatives are by any measure highly skilled SNF experts and fierce resident advocates. Ombuds representatives and residents know one another by name and Ombuds representatives have intimate knowledge of many residents' specific care needs. Evidenced by residents' reactions when approached by Ombuds representatives—which typically ranged from warm, delighted greetings to urgent pleas for assistance—residents clearly view Ombuds representatives as essential advocates. Though the 34 Ombuds staff and 25 volunteers are far fewer than necessary for the more than 1800 LTC facilities in the County, they serve a critical function in the lives of many residents, particularly those without family or anyone else to advocate for their needs. The County should consider providing ongoing support through direct funding to the Ombuds and supporting future state and federal legislative proposals that increase funding for the Ombuds to ensure that it has adequate resources to continue its extraordinary work on behalf of SNF residents.

OWNERSHIP STRUCTURES OF SKILLED NURSING FACILITIES

The OIG conducted a review of SNF ownership and identified three broad areas of concern. First, a large body of research has linked for-profit ownership of SNFs with more deficiencies and poorer care than in nonprofit facilities. Second, the

emergence of corporate chain ownership of SNFs, primarily through the acquisition of existing facilities or chains of facilities, has introduced concerns about the licensing and oversight of these large chains. Of particular concern, large for-profit chains may be treating monetary penalties as “costs of doing business,” which calls into question the actual deterrent effect of monetary penalties used by the current system of state and federal oversight. Third, ownership groups of large chains sometimes use complex and overlapping layers of related companies to create confusing corporate structures that may cloud transparency of ownership, obscure financial relationships, transactions, and profits, and impede the efficacy of governmental accountability efforts.

For-profit vs. Nonprofit Ownership

There are three general types of SNF ownership: for-profit, nonprofit, and government.⁸⁵ For-profit SNFs are owned and operated as businesses by individual owners, partnerships, corporations, or other business entities.⁸⁶ Nonprofit SNFs are owned by religious groups, community groups, or agencies and operate as non-profit organizations.⁸⁷ Unlike for-profit SNFs where revenue in excess of operating expenses may be distributed to equity holders, nonprofit SNFs are expected to use excess revenue for the benefit of residents in return for several government-conferred advantages such as tax exemptions.⁸⁸ Government SNFs are run by municipal, state, or federal bodies.⁸⁹ According to CMS data from January 2021, of the 382 SNFs in the County, 338 (88 percent) are registered as for-profit, 41 (11 percent) are registered as non-profit, and 3 (less than 1 percent) are registered as government-run.⁹⁰

The quality of SNF care in the County must be viewed in the larger context of what we know about the relationship between quality and ownership structures. A large body of evidence provides insight both at the national and the state level. Research suggests that for-profit SNFs may focus on maximizing profits for equity holders at

⁸⁵ Ronald, L., et al., *Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change?*, *PLOS Medicine*, April 2016, 13(4): e1001995, at: <https://doi.org/10.1371/journal.pmed.1001995> (accessed on May 12, 2021).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Omotowa, O., et al., *Profit Maximization and Nurse Staffing Standards/Levels in For-profit and Not-for-profit Nursing Homes*, *The Journal of Nursing Home Research Sciences*, May 2019, Vol. 5, at 21–23.

⁸⁹ Ronald, L., et al., *Observational Evidence of For-Profit Delivery and Inferior Nursing Home Care: When Is There Enough Evidence for Policy Change?*, *PLOS Medicine*, April 2016, 13(4): e1001995, at: <https://doi.org/10.1371/journal.pmed.1001995> (accessed on May 12, 2021).

⁹⁰ Centers for Medicare and Medicaid Services, Nursing Home Provider Information Dataset, January 2021.

the expense of care.⁹¹ A 2018 study found that for-profit SNFs generally exhibited significantly higher frequency of deficiencies, citations, and complaints than nonprofit SNFs.⁹² Research conducted during the COVID-19 pandemic has found that for-profit SNFs had COVID-19 case rates that were five to six times greater than the case rates at nonprofit or government SNFs.⁹³ In addition, studies have also associated for-profit SNFs with more quality of care issues, higher infection rates, and higher COVID-19 death rates.⁹⁴

A 2021 study conducted by University of Pennsylvania, University of Chicago, and New York University researchers evaluated data from SNFs across the United States to assess the effects of private equity buyouts of facilities on resident outcomes. Comparing facility performance before and after private equity buyout by large private equity groups, researchers found that private equity ownership increased 90-day mortality of short-stay Medicare residents by approximately 10 percent, which translated to an implied loss of 20,150 lives due to private equity ownership over the 12-year sample period.⁹⁵ Researchers also found a decline in resident mobility and increased pain intensity after private equity buyout and that admission to a private equity-owned facility increased the probability of being prescribed dangerous antipsychotic medication by 50 percent.⁹⁶ Other studies, however, have found no significant changes in staffing levels in the post-private equity purchase

⁹¹ Ross, L., et al., *California Nursing Home Chains By Ownership Type Facility and Resident Characteristics, Staffing, and Quality Outcomes in 2015*, *The Consumer Voice*, August 2016, at: https://theconsumervoice.org/uploads/files/general/CA-Chains-Report_20AUG2016.pdf (accessed on March 16, 2021).

⁹² Harrington, C., et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*, *The Kaiser Family Foundation*, April 3, 2018, at: <https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/> (accessed on March 16, 2021).

⁹³ Spurlock, B., et al., *COVID-19 in California's Nursing Homes: Factors Associated with Cases and Deaths*, *California Health Care Foundation*, December 2020, at: <https://www.chcf.org/wp-content/uploads/2020/11/COVID19CAsNursingHomesFactorsCasesDeaths.pdf> (accessed on May 19, 2021).

⁹⁴ See He, M., et al., *Is There a Link Between Nursing Home Reported Quality and COVID-19 Cases? Evidence from California Skilled Nursing Facilities*, *Journal of the American Medical Directors Association*, July 2020, 21(7), at 905–908; see also Li, Y., et al., *COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates*, *Journal of the American Geriatrics Society*, September 2020, 68(9), at 1899–1906; Abrams, H., et al., *Characteristics of U.S. Nursing Homes with COVID-19 Cases*, *Journal of the American Geriatrics Society*, August 2020, 68(8), at 1658–1656; Unruh, M., et al., *Nursing Home Characteristics Associated with COVID-19 Deaths in Connecticut, New Jersey, and New York*, *Journal of the American Medical Directors Association*, July 2020, 21(7) at 983–1003.

⁹⁵ Gupta, A., et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, *National Bureau of Economic Research*, Working Paper No. 28474, February 2021, at: https://www.nber.org/system/files/working_papers/w28474/w28474.pdf (accessed on March 16, 2021). The researchers studied residents who were discharged to a SNF from a hospital after an acute episode and examined deaths that occurred during the SNF stay or within the 90-day period after discharge from the SNF.

⁹⁶ *Id.*

period⁹⁷ and reported no differences in quality of care.⁹⁸ The variations in these findings may reflect differences in the SNF care environment and private equity markets or may imply that outcomes differ depending on the business strategies under which SNFs are operated (e.g., prioritizing the maximization of profits over resident care) and/or the characteristics of individual facilities. Nevertheless, the consequences of underlying profit motive for quality of care and the efficacy of the current system of administrative oversight raise concerns.

Corporate Chain Ownership

Corporate chains that own or manage two or more facilities have become the dominant SNF ownership structure in California. By 2016, over 50 percent of California SNFs were owned by corporate chains,⁹⁹ and over 80 percent of for-profit SNFs were owned by investors who own multiple facilities.¹⁰⁰ The growth of corporate ownership chains occurs primarily through the acquisition of existing facilities or chains of facilities.¹⁰¹

Although originally hailed as an effective means of delivering quality and efficiency improvements, the growth of SNF chains has precipitated low nurse staffing levels, the financing of considerable debt loads, and poor quality of care.¹⁰² A 2021 U.S. Government Accountability Office report found that for-profit SNF chains provided a lower quality of care than non-chain-owned facilities.¹⁰³ Researchers have found

⁹⁷ Harrington, C., et al., *Nurse Staffing and Deficiencies in the Largest For-profit Nursing Home Chains and Chains Owned by Private Equity Companies*, *Health Services Research*, February 2012, 47(1), at 106–128.

⁹⁸ Stevenson, D., et al., *Private Equity Investment and Nursing Home Care: Is It a Big Deal?*, *Health Affairs*, 2008, 27(5), at 1399–1408; see also, Braun R., et al., *Comparative Performance of Private Equity-Owned US Nursing Homes During the COVID-19 Pandemic*, *JAMA Network Open*, October 2020, 3(10), at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772306> (accessed on March 16, 2021). This cross-sectional study found significantly lower supplies of personal protective equipment in private equity SNFs.

⁹⁹ Harrington, C., et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2014*, The Kaiser Family Foundation, April 3, 2018, at: <https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/> (accessed on March 16, 2021).

¹⁰⁰ Ross, L., et al., *California Nursing Home Chains By Ownership Type Facility and Resident Characteristics, Staffing, and Quality Outcomes in 2015*, *The Consumer Voice*, August 2016, at: https://theconsumervoice.org/uploads/files/general/CA-Chains-Report_20AUG2016.pdf (accessed on March 16, 2021).

¹⁰¹ Harrington, C., et al., *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains*, *Health Services Insights*, June 2017, Vol. 10, at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5467918/> (accessed on May 20, 2021).

¹⁰² Kitchener, M., et al., *Shareholder Value and the Performance of a Large Nursing Home Chain*, *Health Services Research*, June 2008, 43(3), at 1062–1084.

¹⁰³ U.S. Government Accountability Office, *CMS's Specific Focus Facility Methodology Should Better Target the Most Poorly Performing Facilities which Tend to be Chain Affiliated and For-profit*, August 2009, GAO-09-689, at: <https://www.gao.gov/products/gao-09-689> (accessed on March 16, 2021).

that for-profit SNF chains generally had more deficiencies and lower staffing than nonprofit facilities.¹⁰⁴

In 2018, the California State Auditor (State Auditor) published a report about the quality of care, financial practices, and state of oversight of the three largest SNF chains in California.¹⁰⁵ When a company submits an application to operate additional facilities, CDPH must conduct a comprehensive review of the applicant to ensure it has operated facilities in compliance with federal and state requirements in the past.¹⁰⁶ The State Auditor found that CDPH's licensing decisions appeared inconsistent due to a poorly defined review process and inadequate documentation.¹⁰⁷ The State Auditor also found that compliance histories of applicants were often incomplete and inconsistent because the evaluation process did not clearly specify the factors used to determine if an applicant has complied with federal and state requirements in the past.¹⁰⁸ This lack of clarity made it difficult to understand CDPH's decisions to approve or deny some of the applications reviewed.¹⁰⁹

Furthermore, the State Auditor found that CDPH failed to complete the state relicensing inspections which are required no less than every two years. The state relicensing inspections ensure that facilities are providing quality of care at the level mandated by state requirements, which can be higher than some federal requirements.¹¹⁰ Between 2015 and 2016, most of the required relicensing inspections for SNFs located in the County were not conducted due to CDPH's failure to include relicensing inspections in the previous contract.¹¹¹ The negative consequences of CDPH's inconsistent review and relicensing process are potentially magnified by the fact that SNFs with documented histories of poor care are often targets for chain-ownership-related acquisitions.¹¹²

The issues identified throughout this report highlight the need for an effective mechanism that thoroughly vets operators seeking to acquire SNFs in the County. The State Auditor's findings raise serious concerns about CDPH's licensing process that is meant to ensure that operators are qualified to provide quality care. One

¹⁰⁴ Harrington, C., et al., *Nurse Staffing and Deficiencies in the Largest For-profit Nursing Home Chains and Chains Owned by Private Equity Companies*, Health Services Research, February 2012, 47(1), at 106–128.

¹⁰⁵ California State Auditor, *Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued*, May 2018, Report No. 2017-109, at: <https://auditor.ca.gov/pdfs/reports/2017-109.pdf> (accessed on March 16, 2021).

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² Grabowski, D., et al., *Low Quality Nursing Homes Were More Likely Than Other Nursing Homes to be Bought or Sold by Chains in 1993-2010*, Health Affairs, May 2016, 35(5) at 907–914.

possible solution that has been proposed by resident advocates may be to implement a local licensing system via county ordinance that ensures the thorough vetting of applicants and county approval to operate a SNF. Additionally, the County may be able codify and enforce rules to address longstanding quality of care and quality of life problems such as enhanced minimum staffing and facility infrastructure requirements. Although federal and state preemption issues and other legal barriers may limit the scope of a local licensing system, the County should explore the feasibility of this and other options and determine the extent to which it can assume a more active role in improving the quality of care provided in SNFs.

Deficiency Citations as a Cost of Doing Business

A 2008 study of a large California SNF chain that had pursued a profit maximization strategy of expansion through mergers and acquisitions revealed a problematic managerial practice used by the chain: viewing administrative sanctions for poor quality of care and governance as a “cost of doing business.”¹¹³ The finding calls into question the true efficacy of the existing oversight infrastructure to safeguard and ensure quality care to residents. This concern persists to date.

The 2018 report by the State Auditor discussed above also found that state administrative penalties may not be adequate to deter facilities from providing poor care because state law reduces a state penalty amount if they are paid quickly.¹¹⁴ For example, from 2006 through 2015, CDPH assessed more than \$28 million in penalties for citations, but it collected approximately \$17 million, or 59 percent, of the total amount assessed due, in part, to facilities not contesting citations and making payment within 15 to 30 days, depending on the type of citation.¹¹⁵ When coupled with concerns regarding HFID’s ability to complete thorough and timely investigations, this raises additional questions regarding the extent to which regulatory oversight of SNFs is impeded in the County.

Although not definitively established as a common practice throughout the entire industry, the possibility that some SNFs are operated under a managerial practice of treating administrative monetary sanctions as simply a cost of doing business is deeply troubling. As discussed below, alternative means of enforcement and legislative solutions may be required to aid in ensuring quality care in SNFs.

¹¹³ Kitchener, M., et al., *Shareholder Value and the Performance of a Large Nursing Home Chain*, *Health Services Research*, June 2008, 43(3), at 1062–1084.

¹¹⁴ California State Auditor, *Skilled Nursing Facilities, Absent Effective State Oversight, Substandard Quality of Care Has Continued*, May 2018, Report No. 2017-109, at: <https://auditor.ca.gov/pdfs/reports/2017-109.pdf> (accessed on March 16, 2021).

¹¹⁵ *Id.*

Complex Chain Ownership Structures

A 2011 study examined the ownership, financing, and management of 10 of the largest for-profit SNF chains in the United States and found that these chains utilize strategies to enhance shareholder profits and reduce liability risk by establishing multiple layers of corporate ownership, developing real estate investment trusts, and creating limited liability companies (LLCs).¹¹⁶ Large for-profit chains create complex structures of layers of related companies which separately own, manage and operate their component facilities. These ownership layers are made up of separate management companies and service providers owned by the same ownership group usually via a series of LLCs.¹¹⁷ This can result in a web of related ownership groups, management companies, property companies, finance companies, and service providers that obscures the chain ownership of facilities and clouds the financial relationships between the facilities and the various related companies with which they do business.¹¹⁸

For example, Company #1 is controlled by an ownership group and buys a facility. Company #1 then sells the facility to Company #2, which is also ultimately controlled by the ownership group, garnering a profit on the sale for the ownership group. The sale of the facility is financed by Company #3, which is also controlled by the ownership group. Company #2 then leases the property back to Company #1, creating rental income for the ownership group. Company #1 then contracts with a management company which again is controlled by the ownership group to run the facility. The management company then contracts with various companies that are also controlled by the ownership group to provide various goods and services (e.g., pharmacy, cafeteria, and custodial) necessary to run the facility. This process can then be repeated for every facility that is a part of the ownership group.

These agreements between various business entities all controlled or related to the ownership group are called “related-party transactions.” Advocates for SNF operators have argued that such business structures are a necessary protection against civil liability and to protect Medicare payment streams. For example, when all facilities within a chain of facilities are held and operated by one corporation and just one of the corporation’s component facilities suffers a significant deficiency such as a criminal elder-abuse conviction, the entire group of component facilities

¹¹⁶ Harrington, C., et al., *Ownership, Financing and Management Strategies of the Ten Largest For-profit Nursing Home Chains in the United States*, International Journal of Health Services, 2011, 41(4), at 725–746.

¹¹⁷ *Id.*, see also Stevenson, D., et al., *Nursing Home Ownership Trends and Their Impacts on Quality of Care: A Study Using Detailed Ownership Data from Texas*, Journal of Aging & Social Policy, 2013, 25(1), at 30–47.

¹¹⁸ Harrington, C., et al., *Hidden Owners, Hidden Profits and Poor Nursing Home Care: A Case Study*, International Journal of Health Services, 2015, 45(4), at 779–800.

risks losing government funding.¹¹⁹ However, patient advocates argue that some SNF operators intentionally strive to obscure facility ownership such that consumers are unable to determine who really owns a SNF and use these complex structures to funnel away excessive profits through related-party transactions.¹²⁰

A study of one of California's largest SNF chains, Country Villa Services Corporation (CVSC), found that corporate profits were hidden in related party transactions in the form of management fees, lease agreements, and various payments for ancillary support services that were made to companies related to the chain.¹²¹ This study further notes that following multiple civil lawsuits alleging poor quality of care and charges brought by the U.S. Department of Justice alleging care violations and the misuse of psychotropic drugs, CVSC filed for bankruptcy and sought permission to sell a number of its facilities to cover potential legal and business liabilities.¹²²

Following CVSC's bankruptcy petition, a company named Brius Healthcare Services (Brius) sought approval from the bankruptcy court to purchase 19 CVSC facilities for approximately \$62 million in cash.¹²³ However, the bankruptcy court's pending approval of Brius was not without opposition. The California Attorney General's Office filed an emergency motion to block the sale, reportedly calling Brius' owner, Shlomo Rechnitz (Rechnitz), a "serial violator of rules within the skilled nursing industry" and citing "multiple enforcement actions," including a Brius facility that faced termination from Medicare for violations of federal standards.¹²⁴ Nevertheless, the sale was approved and Brius was allowed to purchase and operate the facilities.

Brius provides a quintessential example of how an ownership group can create complex structures that include layers of related companies which separately own, manage, and operate their component facilities. A 2017 study of Brius' organization

¹¹⁹ Lundstrom, M., et al., *Unmasked: Who owns California's nursing homes?* The Sacramento Bee, November 9, 2014, at: <http://media.sacbee.com/static/sinclair/Nursing2/> (accessed on May 30, 2021); see also Cenziper, D., et al., *Profit and pain: How California's largest nursing home chain amassed millions as scrutiny mounted*, *The Washington Post*, December 31, 2020, at: <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/> (accessed on May 30, 2021).

¹²⁰ *Id.*

¹²¹ Harrington, C., et al., *Hidden Owners, Hidden Profits and Poor Nursing Home Care: A Case Study*, *International Journal of Health Services*, 2015, 45(4), at 779-800; see also Cenziper, D., et al., *Profit and pain: How California's largest nursing home chain amassed millions as scrutiny mounted*, *The Washington Post*, December 31, 2020, at: <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/> (accessed on May 30, 2021).

¹²² *Id.*

¹²³ Lundstrom, M., et al., *Unmasked: Who owns California's nursing homes?* The Sacramento Bee, November 9, 2014, at: <http://media.sacbee.com/static/sinclair/Nursing2/> (accessed on May 30, 2021).

¹²⁴ Cenziper, D., et al., *Profit and pain: How California's largest nursing home chain amassed millions as scrutiny mounted*, *The Washington Post*, December 31, 2020, at: <https://www.washingtonpost.com/business/2020/12/31/brius-nursing-home/> (accessed on May 30, 2021).

and related-party transactions by the National Union of Healthcare Workers (NUHW) found that, in 2015, Brius operated approximately 80 for-profit SNFs in California.¹²⁵ These 80 SNFs paid approximately \$67 million in related-party transactions for goods and services to more than 65 other companies, and owed \$23.2 million to financial/real estate companies that were controlled by Rechnitz and/or his family members.¹²⁶ Furthermore, the study found that the SNFs paid rental prices that were 36.6 percent higher per bed than non-Brius SNFs in the same counties.¹²⁷ The NUHW study argues that Brius used related-party transactions to significantly increase lease payments on properties. In other words, Brius transferred taxpayer funded revenue (i.e., Medicare and/or Medicaid reimbursements) to itself while keeping reported “profits” low through related-party transactions.

The study noted that in 2012, Brius entered into an agreement with a facility owner in Marin County to manage the facility. Rechnitz used an intermediary company, which was controlled by the Rechnitz family, to lease the facility from the owner and then sublease it to Brius. According to copies of the lease agreements reviewed by NUHW, the Rechnitz-controlled middleman firm paid \$259,200 a year in rent to the owner, then subleased the facility to the Brius-managed SNF for \$388,800 a year, a 50 percent profit.¹²⁸ According to the lease agreements, the middleman firm was not required to perform any services in exchange for the 50 percent profit.¹²⁹ Brius later bought the facility outright. The NUHW study further noted that after Brius bought the facility, government investigators fined the facility \$15,000 for violating California’s minimum nursing staffing requirements and lacking basic supplies to provide care.¹³⁰

In an effort to better understand the convoluted nature of SNF ownership groups, the Joint Legislative Audit Committee of the California State Legislature requested that the State Auditor conduct an audit of the quality of care, financial practices, and state of oversight of Brius and two other large SNF chains in the state.¹³¹ The State Auditor found that between 2007 and 2015, Brius increased related-party expenses per resident by 600 percent, but found no evidence that the related party transactions were illegal or resulted in increased costs to the state. In fact, the State Auditor found that related-party transactions were common in the industry

¹²⁵ National Union of Healthcare Workers, *Brius Healthcare’s Insider Transactions, How California’s Largest Nursing Home Chain Funnels Millions to Insider Companies*, August 2017, at: <https://nuhw.org/wp-content/uploads/2017/08/Brius-Paper.pdf> (accessed on March 16, 2021).

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ California State Auditor, *Skilled Nursing Facilities, Absent Effective State Oversight, Substandard Quality of Care Has Continued*, May 2018, Report No. 2017-109, at: <https://auditor.ca.gov/pdfs/reports/2017-109.pdf> (accessed on March 16, 2021).

and allowable. The State Auditor further opined that the Medi-Cal audit process ensured that the state did not pay for the profits realized by related-party transactions.¹³²

Despite finding that related-party transactions were legal and commonplace in the SNF industry, the State Auditor did recommend that state law be amended to “require nursing facilities to submit annually their related-parties’ profit and loss statements to Health Care Services when total transactions exceed a specified monetary threshold,” to assist the California Department of Health Care Services¹³³ in its audits.¹³⁴ The State Auditor noted that the state of Connecticut requires SNFs to include a profit and loss statement from each related-party business that received \$50,000 or more for goods or services that it provided to the SNF that year in their cost reports.¹³⁵ Enhanced financial disclosure requirements would not only improve transparency, but also improve the state audit process in reviewing related-party transactions to ensure that they are legal and do not increase costs to the state or federal governments.

ALTERNATIVES TO ADMINISTRATIVE ENFORCEMENT

Despite overlapping systems of federal and state oversight, studies have criticized CMS and state survey agencies for weak administrative enforcement of SNFs. At the federal level, a U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) report found that between 2016 and 2018, state survey agencies continued to struggle with meeting required timeframes for investigating SNF complaints.¹³⁶ The HHS-OIG questioned the ability of state survey agencies to address serious SNF complaints, as well as CMS’ ability to effectively oversee them.¹³⁷ In California, a 2018 audit by the State Auditor found that state administrative licensing, inspection, and enforcement mechanisms had not adequately addressed quality of care deficiencies in SNFs.¹³⁸ The State Auditor’s

¹³² *Id.*

¹³³ The California Department of Health Care Services is a department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal.

¹³⁴ California State Auditor, *Skilled Nursing Facilities, Absent Effective State Oversight, Substandard Quality of Care Has Continued*, May 2018, Report No. 2017-109, at: <https://auditor.ca.gov/pdfs/reports/2017-109.pdf> (accessed on March 16, 2021).

¹³⁵ *Id.*

¹³⁶ U.S. Department of Health and Human Services, Office of Inspector General, *States Continued to Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018*, Data Brief, September 2020, OIG OEI-01-19-00421, at: <https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf> (accessed on March 29, 2021).

¹³⁷ *Id.*

¹³⁸ California State Auditor, *Skilled Nursing Facilities: Absent Effective State Oversight, Substandard Quality of Care Has Continued*, May 2018, Report No. 2017-109, at: <https://auditor.ca.gov/pdfs/reports/2017-109.pdf> (accessed on March 16, 2021).

findings echo many of the OIG's and A-C's observations and findings detailed above.

Furthermore, the COVID-19 pandemic has exacerbated existing challenges with overseeing SNFs. Early in the pandemic, CMS and CDPH implemented several measures in response to the rapid spread of COVID-19 in SNFs, including suspending certain inspection and survey activities, waiving the 75-hour nurse aide training requirement, and banning visitors at facilities.¹³⁹ While these measures were introduced in order to enhance support for SNFs in preventing and controlling the spread of COVID-19, they also resulted in a gap in the oversight of SNFs during a period of staffing challenges, increased care needs, changes in care routines, and limited monitoring by residents' loved ones due to visitation restrictions.

Given the number of SNFs in the County, the inherent vulnerability of residents, and the potential magnitude and systemic pervasiveness of the issues discussed in this report, the OIG recommends that the County expand its civil and criminal enforcement capabilities through the LADA and County Counsel and establish a Skilled Nursing Facility Task Force to better coordinate enforcement efforts with state and local partners and stakeholders.

State and Local Enforcement Entities

At the state level, the DMFEA investigates and prosecutes, both criminally and civilly, fraud committed against the Medi-Cal program, as well as physical or financial abuse or neglect of elders and dependents in care facilities.¹⁴⁰ The DMFEA may bring charges against an individual or a corporate entity. The DMFEA may also refer cases to county district attorneys or work jointly with district attorneys in prosecuting cases.¹⁴¹ The DMFEA is comprised of three units: (1) the Criminal Law Unit; (2) the Civil Law Unit; and (3) the Facilities Enforcement Team (FET).

The Criminal Law Unit primarily investigates and prosecutes crimes against elders and dependent adults committed by employees in care facilities. These crimes include physical abuse, homicide, sexual assault, false imprisonment, assault, and

¹³⁹ See, e.g., Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, *Memorandum: Prioritization of Survey Activities*, QSO-20-20-All, March 20, 2020, at: <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0> (accessed on March 29, 2021).

¹⁴⁰ See State of California Department of Justice, Office of the Attorney General, *Division of Medi-Cal Fraud & Elder Abuse*, <https://oag.ca.gov/dmfea> (accessed on March 29, 2021).

¹⁴¹ California Welfare and Institutions Code § 15630(b)(1)(A)(iv).

battery.¹⁴² The Criminal Law Unit also investigates and prosecutes financial abuse against elder and dependent adults, as well as fraud by Medi-Cal providers.¹⁴³

The Civil Law Unit investigates and prosecutes fraud by Medi-Cal providers, at both state and national levels. The Civil Law Unit frequently works with other federal and state prosecutors to combat fraud on the Medicaid system using the California False Claims Act and other civil enforcement statutes.¹⁴⁴ Causes of action pursued by the Civil Law Unit may involve unfair/deceptive business practices, false claims, or any other civil cause of action authorized under state or federal statutes.

Lastly, the FET investigates and prosecutes owners and operators of facilities, such as SNFs, hospitals, and residential care facilities for the elderly, for adopting policies and/or promoting practices that lead to neglect and poor quality of care. The subjects of FET investigations are frequently corporate entities that own facilities engaging in institutional neglect or substandard care.¹⁴⁵ The FET can prosecute these entities with both criminal and civil causes of action. The FET works with county district attorneys to leverage its prosecutorial efforts.¹⁴⁶

At the local level, criminal and civil enforcement of SNFs is conducted by district attorneys, city attorneys, and, at times, county counsels. In the County, LADA's Elder Abuse Unit prosecutes crimes against elderly and developmentally disabled victims. Much like the DMFEA's Criminal Law Unit, the Elder Abuse Unit primarily investigates and prosecutes physical and financial abuse crimes committed by individual suspects, such as murder, sexual assault, false imprisonment, fraud, assault, and battery.¹⁴⁷ When the target of prosecution is a corporate entity rather than an individual, the case is typically handled by LADA's Consumer Protection Division (CPD). Although the CPD is budgeted to have six line prosecutors, it is currently staffed at half capacity with only three line prosecutors. Since the CPD prosecutes a wide range of unfair or dishonest business practices, not just those

¹⁴² See State of California Department of Justice, Office of the Attorney General, *Elder Abuse Laws (Criminal)*, at: https://oag.ca.gov/dmfea/laws/crim_elder (accessed on March 29, 2021).

¹⁴³ See State of California Department of Justice, Office of the Attorney General, Division of Medi-Cal Fraud & Elder Abuse, *Elder Abuse*, <https://oag.ca.gov/dmfea/elder> (accessed on March 29, 2021).

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ For example, in March 2021, a joint action was filed against Brookdale Senior Living, Inc., the largest senior living operator in the nation by a coalition that includes several district and city attorneys, and the California Attorney General. The lawsuit alleges that Brookdale fraudulently increased its CMS star rating in several categories to attract prospective patients and their families. See California Office of the Attorney General, *Attorney General Becerra Sues Nursing Home Chain for Misrepresenting its Quality of Care and Putting Seniors, People with Disabilities at Risk*, March 15, 2021, at: <https://oag.ca.gov/news/press-releases/attorney-general-becerra-sues-nursing-home-chain-misrepresenting-its-quality> (accessed on March 29, 2021).

¹⁴⁷ Conversation with Los Angeles County District Attorney's Office's Elder Abuse Unit, February 16, 2021.

stemming from SNFs, the CPD currently has only one prosecutor working on SNF cases as part of their greater consumer protection caseload.¹⁴⁸

The Los Angeles City Attorney's Office's Consumer and Workplace Protection Unit (CWPU) also prosecutes SNFs for poor quality of care. One of the prosecutorial tools effectively used by the CWPU to file civil cases against SNFs is the Unfair Competition Law (UCL) pursuant to Business and Professions Code sections 17200 through 17210 (collectively "B&P 17200"). B&P 17200 prohibits five types of broadly defined wrongful conduct that can be alleged as causes of action against SNFs: (1) unlawful business practices; (2) unfair business practices; (3) fraudulent business acts practices; (4) unfair, deceptive, untrue, or misleading advertising; and (5) acts prohibited under Business and Professions Code sections 17500 through 17577.5.¹⁴⁹ Courts have construed B&P 17200 to provide plaintiffs with a right of action to seek redress for violations of federal or state law even where no private right of action is implied in those laws.¹⁵⁰ This provides plaintiffs with broad authority to bring an "unlawful practice" cause of action based on a violation of federal or state law, so long as the alleged statute does not specifically bar it.¹⁵¹

Earlier this year, the Los Angeles City Attorney settled a civil lawsuit against Lakeview Terrace Skilled Nursing Facility (Lakeview Terrace) based on a B&P 17200 cause of action.¹⁵² This case involved allegations of unlawful discharges, abuse and neglect, denial of care, and efforts to conceal its conduct under federal and state laws and regulations.¹⁵³ The Lakeview Terrace settlement called for the filing of a permanent injunction and appointment of a monitor to ensure that remedial measures set forth in the settlement to address the many violations of state and federal SNF rules alleged in the lawsuit were implemented. The final judgement in this case further mandated a payment of \$275,000 in penalties, costs, and expenses tied to ongoing monitoring of the SNF's practices.¹⁵⁴ In addition, the final judgment expanded nurse staffing requirements, conferred broad powers on the appointed monitor to improve care, and imposed additional civil penalties on any future immediate jeopardy findings.¹⁵⁵ Cases such as Lakeview Terrace show that civil cases brought pursuant to B&P 17200 may offer an effective means of

¹⁴⁸ Conversation with Los Angeles County District Attorney's Office's Consumer Protection Division, March 9, 2021.

¹⁴⁹ Business and Professions Code §§ 17200–17210, 17500–17577.5.

¹⁵⁰ *Committee on Children's Television, Inc. v General Foods Corp.* (1983) 35 C3d 197, 210, 211.

¹⁵¹ *See Stop Youth Addiction, Inc. v Lucky Stores, Inc.* (1998) 17 C4th 553, 561; see also *People v E.W.A.P., Inc.* (1980) 106 CA3d 315, 319.

¹⁵² Los Angeles City Attorney, *Feuer Settles with Lakeview Terrace Nursing Home Over Allegations of Pandemic Patient Dumping*, March 17, 2021, at: <https://www.lacityattorney.org/post/feuer-settles-with-lakeview-terrace-nursing-home-over-allegations-of-pandemic-patient-dumping> (accessed March 29, 2021).

¹⁵³ *People v. Lakeview Terrace Skilled Nursing Facility*, Case No. 20STCV25436, Final Judgment and Permanent Injunction, February 19, 2021.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

enforcing SNF laws and regulations and remedying deficiencies of care in problematic facilities.

Lastly, County Counsel recognized issues related to COVID-19 in SNFs and created an *ad hoc* team of four attorneys to track them. As the County's legal services provider, County Counsel is well-situated to augment the County's enforcement efforts with its broad experience in civil litigation and appellate law. Specifically, County Counsel's Affirmative Litigation and Consumer Protection Division (ALD) could be expanded to file UCL enforcement actions pursuant to B&P 17200. However, current law states that the County Counsel may only bring a B&P 17200 case if the action is authorized by an agreement with the district attorney and the action is for a violation of a county ordinance. As a result, any enforcement efforts by County Counsel are limited in jurisdiction and subject matter.¹⁵⁶

This limitation may change with the passage of SB 461 – *Unfair Competition Law: enforcement* (2021 – 2022) that was recently signed into law. This bill will allow county counsels in counties with a city that has a population greater than 750,000 (e.g., Los Angeles, Santa Clara, and San Diego) to file B&P 17200 actions without a district attorney agreement and for the same violations as other prosecutorial entities as authorized by the statute.¹⁵⁷ SB 461's sponsors note that enabling county counsels independent authority to bring B&P 17200 actions will enhance protections for state and county consumers and fill enforcement gaps that exist given limited existing prosecutorial resources.¹⁵⁸ The passage of this bill greatly expands the County's potential enforcement capacity by allowing independent investigation and filing of B&P 17200 actions against facilities by not only LADA and the Los Angeles City Attorney, but also County Counsel.

Enhancing County Enforcement Capabilities

The current statutory scheme allows the County to work closely with the DMFEA in prosecuting cases, as well as to utilize the DMFEA's expertise to enhance the County's civil and criminal enforcement capabilities through coordination with, and training by, the DMFEA. Pursuant to California Government Code section 12528, *et seq.*, local law enforcement and prosecutorial agencies have concurrent jurisdiction

¹⁵⁶ See California Business and Professions Code § 17204; see also Conversation with Los Angeles County Office of County Counsel's Affirmative Litigation and Consumer Protection Division, February 25, 2021.

¹⁵⁷ California Legislature—2021-2022 Regular Session, SB-461 Unfair Competition Law: enforcement (2021-2022), Introduced by Senator Cortese, February 16, 2021, at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB461 (accessed on May 30, 2021).

¹⁵⁸ California Legislature—2021-2022 Regular Session, SB-461 Unfair Competition Law: enforcement (2021-2022), Introduced by Senator Cortese, February 16, 2021, Bill Analysis, at: https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB461 (accessed on May 30, 2021).

with the DMFEA to investigate and prosecute violations of all applicable laws pertaining to fraud in the administration of the Medi-Cal program, the provision of medical assistance or medical supplies, or the activities of providers of medical assistance or medical suppliers under the Medi-Cal plan. The DMFEA may also refer cases to, assist or work jointly with, or prosecute cases in lieu, or upon denial, of local prosecutorial entities.

Furthermore, the DMFEA must cooperate with local prosecutions of cases reported to the DMFEA. When a local prosecuting authority chooses to prosecute a case reported to the DMFEA, upon request of the local prosecutor, the DMFEA is required to ensure that those responsible for the prosecutive decision and the preparation of the case for trial have the opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.¹⁵⁹

However, filing cases jointly or with the assistance of the DMFEA is generally preferable because the DMFEA is afforded significant advantages over local prosecuting authorities under the current statutory scheme. Chief among these advantages is access to prelitigation discovery. California Government Code section 12528.1(a) mandates that “any agent, investigator, or auditor of DMFEA within the office of the Attorney General shall have the authority to inspect, at any time, the business location of any Medi-Cal provider for the purpose of carrying out the duties of the bureau as set forth in Government Code section 12528.” As such, the County should strengthen its relationship with the DMFEA and identify ways to expand the number of cases that can be brought jointly or with DMFEA assistance.

Another key component to enhancing the County’s SNF enforcement capacity is ensuring that the County has the requisite expertise to file and aggressively pursue these highly specialized cases in civil and criminal courts. Here again, the County can utilize the DMFEA’s established expertise in investigating and prosecuting problematic facilities in civil and criminal courts to augment its own training programs. The DMFEA is mandated by statute to offer training to local law enforcement and prosecutorial personnel in investigating and prosecuting crimes against elders and dependent adults, and to representatives from LACDPH, Department of Social Services, Adult Protective Services, and the LTC Ombudsman in evaluating and documenting criminal abuse against elders and dependent adults.¹⁶⁰ Such training must also include determining when to refer instances of abuse for possible criminal prosecution.¹⁶¹

The OIG spoke with DMFEA representatives from the Criminal Law Unit and FET. Both units are willing to work with the County to enhance the County’s SNF

¹⁵⁹ California Government Code § 12528(e).

¹⁶⁰ California Government Code § 12528(h).

¹⁶¹ Welfare and Institutions Code § 15653.5.

enforcement capacity.¹⁶² The Los Angeles City Attorney's CWPU also indicated a willingness to share its experience in filing B&P 17200 cases with the County.¹⁶³ The County would benefit from strengthening its relationship with, and leveraging the subject matter knowledge of, the DMFEA and the Los Angeles City Attorney's Office to facilitate training for County investigators and prosecutors to enhance the County's civil and criminal enforcement capabilities regarding SNFs.

Skilled Nursing Facility Task Force

Any county expansion of SNF enforcement actions must be coordinated with all government entities and relevant community stakeholders to ensure that issues discovered at problematic facilities are aggressively enforced and that enforcement cases are tracked throughout the process. During the OIG's review of the Golden Cross Health Care evacuation,¹⁶⁴ a Pasadena City Prosecutor noted that the deficiencies identified at Golden Cross Health Care could have served as the basis for criminal elder abuse prosecution by his office.¹⁶⁵ Elder abuse crimes charged under California Penal Code section 368 can be filed either as felonies or misdemeanors. As a result, the case was first presented to the LADA because only the LADA can prosecute felony cases in the County. If the LADA declines to file felony or misdemeanor charges, the Pasadena City Attorney's Office has independent jurisdiction to file misdemeanor charges if it deems a criminal filing is warranted. The Pasadena City Prosecutor reported that the status of cases submitted to the LADA for filing is difficult to track. As a result, some cases that are declined by the LADA and therefore could be filed by city attorneys as misdemeanors are potentially not being prosecuted.

In order to ensure adequate coordination and collaboration between state and local partners and stakeholders, the County should establish a Skilled Nursing Facility Task Force. The Skilled Nursing Facility Task Force should be coordinated and maintained by the LADA, in collaboration with County Counsel, and serve as a forum for prosecutorial entities and law enforcement agencies to raise issues regarding problematic SNFs, seek guidance, and coordinate prosecutorial efforts.

¹⁶² Conversation with the Acting Supervising Deputy Attorney General of the Facilities Enforcement Team, February 23, 2021; Conversation with DMFEA's Senior Assistant Attorney General over criminal prosecutions, February 26, 2021.

¹⁶³ Conversation with the Los Angeles City Attorney's Consumer and Workplace Protection Unit, February 19, 2021.

¹⁶⁴ Los Angeles County Office of Inspector General, *Improving Oversight and Accountability within Skilled Nursing Facilities: Second Interim Report*, February 2021, at: https://oig.lacounty.gov/Portals/OIG/Reports/SNF_First%20Interim%20Report_October%202020.pdf?ver=HTEjWd5zLRyRUN7vXxXMYw%3d%3d (accessed on March 1, 2021).

¹⁶⁵ Pursuant to Penal Code § 368, et seq., criminal elder abuse occurs when a person, knowing that person in an elder, willfully causes or permits that elder to suffer, or inflicts unjustifiable physical pain or mental suffering on the elder. This statute also penalizes willfully causes or permitting an elder to be placed in a situation in which their health is endangered. Conversation with Chief Prosecutor Michael Dowd of the Pasadena City Attorney's Office, October 9, 2020.

HFID should also designate staff to coordinate and collaborate with members of the Skilled Nursing Facility Task Force to ensure that all necessary information, materials, and support are provided when required.

RECOMMENDATIONS

Pursuant to the Board motion, the OIG presents the following operational, programmatic, and legislative recommendations based on its review of the oversight and operations of SNFs in the County. Included below are the recommendations from the OIG's second interim report, some of which may be implemented in the short term to improve HFID operations and SNF crisis response planning while efforts are taken to implement broader systemic and legislative recommendations.

Second Interim Report Recommendations

Recommendation 1: LACDPH should develop a comprehensive county-wide SNF crisis mitigation and response plan. The crisis mitigation and response plan should:

- a. designate a crisis mitigation team within LACDPH that coordinates closely with HFID with appropriate expertise in geriatric medicine, SNF care and administration, residents' rights and disabilities access, infection control and prevention and environmental health and safety to provide support to HFID staff and assess and determine the appropriate response in the event of facility-wide crises;
- b. provide clear thresholds for when the crisis mitigation team should be deployed to SNFs that fail to abate immediate jeopardy findings and if necessary, formulate and implement crisis response plans;
- c. establish protocols for the crisis mitigation team to exchange information and coordinate response planning with partner agencies and stakeholders;
- d. prescribe the engagement of additional experts as necessary in areas such as emergency management, forensic accounting and criminal investigation and prosecution; and
- e. require an enhanced annual review of disaster and emergency preparedness plans of all operating SNFs in the County to ensure that they include adequate emergency operations plans that account for facility and community-based risks, including both human-induced and natural hazards.

Recommendation 2: LACDPH, in coordination with CDPH, should evaluate the CDPH Policy and Procedure Manual to determine whether revisions are necessary to provide sufficient guidance, clear thresholds and adequate discretion to identify crises, initiate responses and address local needs.

Recommendation 3: LACDPH should ensure that HFID is properly integrated into LACDPH operations. LACDPH should remain closely apprised of and monitor the status of HFID’s investigations backlog and other operational problems as well as any critical incidents/crisis situations that arise in health care facilities within HFID’s jurisdiction. LACDPH employs an array of experts in medicine, public health, and administration who should be engaged as necessary to support HFID in improving the quality of its SNF oversight. LACDPH should consider whether changes to its current organizational structure are necessary to ensure that HFID receives adequate oversight, direction, and support.

Recommendation 4: LACDPH and HFID should consistently engage the Ombuds as an additional layer of oversight and as a resource to strategize solutions, deficiency remediation, and other corrective action in order to improve SNF accountability.

Recommendation 5: LACDPH and HFID should ensure that the Ombuds’ reporting and accounts of abuse, neglect or other residents’ rights violations are treated as credible information sources and evidence in making determinations and issuing findings.

Recommendation 6: If no legal barriers exist, LACDPH, in coordination with CDPH, should take measures to notify the Ombuds whenever an immediate jeopardy determination is made.

Recommendation 7: LACDPH, in coordination with CDPH, should establish policies for HFID to frequently and consistently communicate and exchange information with agencies that conduct SNF site visits, such as the Ombuds and local health departments, and cultivate transparent and meaningful partnerships.

Recommendation 8: LACDPH and County Counsel should determine whether the current contract for County SNF licensing and oversight requires term modifications or supplemental language to better ensure that HFID is effective. Any contract discussions should be attentive to balancing the goals of operational and budgetary efficiency with the imperative of improving care and safety.

Recommendation 9: LACDPH, in coordination with CDPH, should ensure that HFID surveyors who handle investigations are adequately trained to thoroughly and timely investigate FRIs and complaints. Training should include identifying and examining available evidence, interviewing residents and other witnesses, and maintaining communication with complainants throughout investigations. Periodic retraining should also be expanded to ensure that perishable investigation skills do not deteriorate. In addition, LACDPH, in coordination with CDPH, should reevaluate the mentorship program to offer meaningful, real-time training for new surveyors.

Recommendation 10: LACDPH, in coordination with CDPH, should evaluate its current systems for identifying and analyzing patterns of complaints against SNFs to ensure that they are effective in identifying patterns of quality-of-care and residents' rights violations.

Recommendation 11: In order to improve accountability and ensure compliance with the County's contractual obligations, LACDPH should establish an effective system to promptly review all complaint and FRI investigations to determine whether they qualify for deficiency citations and, if so, to ensure that they are promptly issued at the highest level supported by the evidence.

Recommendation 12: LACDPH should conduct ongoing and periodic audits of select samples of closed complaint and FRI investigations to ensure that HFID's investigations are conducted thoroughly and timely and to confirm that adequate enforcement action was taken to address identified deficiencies.

Recommendation 13: LACDPH should assess HFID staff perceptions and morale in order to identify whether the division's culture or other issues reported to the OIG impact employee wellness or productivity. LACDPH should ensure that its complaint and grievance mechanisms are adequate for HFID staff to raise concerns directly to LACDPH.

Operational Review of HFID

Recommendation 14: LACDPH should hire an independent consultant to conduct a comprehensive assessment of HFID that accounts for all issues and concerns highlighted in the A-C's and the OIG's reports. This assessment should include a broad review of HFID's organizational structure, integration into LACDPH, staffing levels, management practices, workload, training, recordkeeping and tracking systems, and accountability mechanisms to identify procedural and operational issues and/or inefficiencies. The assessment should also review HFID's ability to meet CMS and CDPH programmatic requirements and all metrics under the current contract. The assessment should provide recommendations for addressing all identified issues and other areas for improvement, including additional staffing and other necessary resources.

Recommendation 15: The County should initiate independent investigations into the above findings regarding elder abuse referrals and improper backdating of records. If in the course of the independent investigations additional potential misconduct or systemic deficiencies emerge, additional investigations should be initiated.

Recommendation 16: The County should utilize the results of the comprehensive assessment, independent investigations, the A-C and OIG reports, and other available information as appropriate to ensure the implementation of systemic reforms that are specifically designed to ensure adequate oversight of County SNFs.

Recommendation 17: The County should work with CDPH to amend the current contract to formally account for the COVID-19 mitigation activities, adjust future workload and budgeted staffing hour projections where necessary, and ensure that HFID has the resources necessary to adequately meet its contractual obligations.

Recommendation 18: LACDPH should revise HFID's mission statement to prioritize resident and patient health and safety above all else and commit HFID to transparency, accountability, and public engagement.

Recommendation 19: LACDPH should work with CDPH to establish policies that require surveyors to type or transcribe investigative notes and include them as part of the electronic file in ACTS.

Recommendation 20: LACDPH should work with CDPH to create and transition to an electronic records system for all investigation case files.

Recommendation 21: LACDPH should inventory all investigation case files found in drawers and boxes throughout HFID's regional offices and ensure they are properly accounted for and investigated.

Recommendation 22: LACDPH should review HFID's open investigations spreadsheet to ensure that it is complete and accurate. LACDPH should work with LAMU to determine which cases are being investigated by LAMU and ensure that LACDPH and LAMU are not duplicating efforts. In addition, LACDPH should ensure that all open investigations are assigned to *current* HFID staff.

Recommendation 23: LACDPH should review existing policies and procedures and implement appropriate safeguards to ensure that all allegations of abuse are being referred to appropriate outside agencies and adequately documented.

Recommendation 24: LACDPH, in coordination with CDPH, should consider implementing a centralized database to ensure that all mandated referrals are stored and tracked. At a minimum, the County should consider adopting the confidential internet reporting tool to generate confidential internet reports of abuse.¹⁶⁶

¹⁶⁶ A confidential internet reporting tool is an optional system a county may choose to implement to generate confidential internet reports of abuse. Los Angeles County currently has not implemented this system. Los Angeles County uses form SOC 371 adopted by the State Department of Social Services to document reports of abuse. See Welfare and Institute Code § 15658 (a)(2).

Recommendation 25: LACDPH should promulgate policies that strictly prohibit improper backdating of LACDPH, CDPH, or other public records and ensure that violations are reported for appropriate investigation. LACDPH should continue to retrain all personnel in new or revised policies and state and federal laws that govern the handling and production of public records.

Recommendation 26: LACDPH should work with CDPH and CMS to ensure that ACTS records all manual date changes in an audit system that documents the change in the date, the reason for the date change, and the supervisor and/or manager who approved the change.

Quality of Skilled Nursing Facility Care

Recommendation 27: The County should consider developing a state-level legislative priority and policy to advocate for increasing nurse staffing standards to the recommended minimum of 0.75 RN hprd, 0.55 licensed nurse (LVN/LPN) hprd, and 2.8 CNA hprd, for a total of 4.1 nursing hprd. In addition, the County should advocate for requiring all SNFs to provide 24-hour RN staffing.

Recommendation 28: LACDPH should continue to expand its training and educational opportunities for direct-care providers and actively engage with SNFs for participation. The training and educational opportunities should focus on improving SNF quality of care and quality of life and protecting residents' rights. Additional LACDPH staffing and other resources should be identified and funded as appropriate. LACDPH should implement this recommendation immediately, and the County should negotiate state funding for training and education in the next contract period.

Recommendation 29: The County should consider providing ongoing support through direct funding to the Ombuds and supporting future state and federal legislative proposals that increase funding for the Ombuds to ensure that it has adequate resources to continue its extraordinary work on behalf of SNF residents.

Ownership Structures of Skilled Nursing Facilities

Recommendation 30: The County should work with CDPH to establish clearly defined metrics and an objective threshold to determine whether an applicant seeking to operate a SNF has demonstrated adequate expertise and experience to meet quality of care, life safety, and emergency service requirements to safely operate a SNF and minimum financial standards for the purchase and management of a SNF, including sufficient financial reserves and appropriate insurance. Such metrics should clearly establish the minimum criteria for the purchase or management of a SNF to receive state approval. In addition, the metrics should be structured to prevent individual or corporate owners from purchasing, operating, or

managing additional SNFs if they have a history of poor compliance with safety and quality of care requirements in any state. Companies with corporate settlements with state attorneys general or the US Department of Justice for fraud or worthless services should be barred from purchasing new SNFs. Additional LACDPH staffing and other resources should be identified and funded as appropriate.

Recommendation 31: The County should work with CDPH to ensure meaningful opportunities for the public to have a voice in change of ownership or management and certification decisions. Additional LACDPH staffing and other resources should be identified and funded as appropriate. The County should also support any legislative proposals that enhance accountability to and input from the public regarding ownership, management, and certification issues.

Recommendation 32: The County should support the passage of AB 1502 – *Freestanding skilled nursing facilities (2021 – 2022)* which would specifically prohibit an entity from operating a SNF in this state, without first obtaining a license on its own behalf and would further prohibit in any way using a license issued to another person or entity. AB 1502 would prohibit the current practice of allowing purchasing companies to take over control of facilities while change of ownership applications are pending, under a temporary provisional license, before a full review and licensing decision has been made by CDPH. The passage of AB 1502 will ensure that all SNF owners are fully vetted through a comprehensive review.

Recommendation 33: The County should explore the feasibility of implementing a local licensing system through a local ordinance to ensure that SNF operators are thoroughly vetted and approved by the County before they operate a facility and determine the extent to which it can assume a more active role in improving the quality of care provided in SNFs. Additional staffing and other resources should be identified and funded as appropriate.

Alternatives to Administrative Enforcement

Recommendation 34: The County should coordinate with the California Department of Justice to identify ways to expand the number of SNF enforcement cases prosecuted jointly or with the assistance of the DMFEA.

Recommendation 35: The County should fully staff LADA's CPD, as well as fund four additional full-time prosecutor positions specifically designated to prosecute SNFs and other long-term care providers. These specifically designated prosecutors should also be tasked with coordinating SNF enforcement actions with the DMFEA, County Counsel, Los Angeles City Attorney, the Ombuds, Adult Protective Services, and other appropriate stakeholders.

Recommendation 36: The County should coordinate with the DMFEA to provide training on investigating and prosecuting crimes against elders and dependent adults to county prosecutorial entities pursuant to Government Code section 12528(h).

Recommendation 37: The County should establish a permanent Skilled Nursing Facility Task Force to serve as a mechanism for prosecutorial entities, law enforcement agencies, and other stakeholders to raise and address issues with problematic facilities. The Skilled Nursing Facility Task Force should track the progress of all criminal and civil enforcement actions related to those facilities and ensure that such enforcement actions are properly resolved.

The Skilled Nursing Facility Task Force should be coordinated and maintained by the LADA, in consultation with County Counsel, and comprised of SNF oversight and enforcement entities, including representatives of the DMFEA, LADA's Elder Abuse Unit and CPD, Los Angeles City Attorney's Office's CWPU, Adult Protective Services, Medical Examiner, the Ombuds, the Los Angeles Police Department, the Los Angeles Sheriff's Department, and other interested city attorneys and first responders.

Recommendation 38: LACDPH should designate HFID staff to support the work of the Skilled Nursing Facility Task Force and provide necessary information, materials, and investigative support. Additional staffing and other resources should be identified and funded as appropriate.

Recommendation 39: LACDPH should periodically report to the Board, in writing, on its progress in implementing reforms pursuant to recommendations contained in the A-C's and the OIG's reports. Report backs should address any recommendations that LACDPH deems inappropriate or infeasible with discussion of any alternative implementation plans, budget requests, etc.

ATTACHMENT I

IMPROVING OVERSIGHT AND ACCOUNTABILITY WITHIN SKILLED NURSING FACILITIES (MAY, 26, 2020, BOARD AGENDA ITEM #23) – AUDITOR-CONTROLLER’S FINAL REPORT



**COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER**

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**PETER HUGHES
KAREN LOQUET
CONNIE YEE**

February 8, 2021

TO: Max Huntsman
Inspector General

FROM: Arlene Barrera *Arlene Barrera*
Auditor-Controller

SUBJECT: **IMPROVING OVERSIGHT AND ACCOUNTABILITY WITHIN SKILLED NURSING FACILITIES (May 26, 2020, Board Agenda Item #23) – AUDITOR-CONTROLLER’S FINAL REPORT**

On May 26, 2020, the Board of Supervisors (Board) directed the Office of Inspector General (OIG) to provide a report on the Oversight and Operations of Skilled Nursing Facilities (SNFs) in Los Angeles County (County) in consultation with the Auditor-Controller (A-C) and other appropriate department leaders. The Board also directed the A-C to:

- Develop a publicly available dashboard that provides COVID-19 related data for SNFs;
- Assess the Department of Public Health’s (DPH) Health Facilities Inspection Division’s (HFID’s) ability to meet all COVID-19 Mitigation and other critical oversight roles; and,
- Compare HFID’s staffing level to other counties in the State, and work with the Directors of DPH and other County departments to ensure there is the necessary staffing, expertise, training, enforcement protocols, and other functions required to support this monitoring and enforcement effort.

The A-C’s proposed scope of work was provided to the Board, along with the OIG’s, on July 30, 2020. Our first interim report was issued to the OIG on October 5, 2020, which reported that the final version of the dashboard was made public on September 30, 2020. This report constitutes our final report to the OIG on the A-C’s assessment of HFID.

Results Summary

Assessment of DPH's HFID

Based on our assessment, HFID management does not currently have the ability or capacity to adequately assume the additional responsibility of monitoring compliance with all COVID-19 Mitigation Plan requirements should the California Department of Public Health (CDPH or State) require HFID to complete the non-COVID related essential functions stated in their original State/County contract. For example, HFID's original State/County contract requires them to complete investigations and provide oversight to ensure the ongoing health and safety of residents and staff within the 4,188 health care facilities in Los Angeles County. During our assessment, we noted that as of June 30, 2020, HFID reported 11,635 backlogged¹ investigations, 5,407 (46%) of which were for complaints and Facility Reported Incidents (FRIs) related to SNFs, a type of Long-Term Care (LTC) health care facility. 3,717 (69%) of the 5,407 SNF investigations were over one year old, and 547 (10%) were prioritized at the level of Immediate Jeopardy (IJ). IJ is a situation in which a provider's non-compliance with one or more requirements has caused or is likely to cause serious injury, harm, impairment, or death to a resident. In addition, we noted other significant areas of concern and numerous opportunities for improvement. For example, HFID management:

- Did not demonstrate that they adequately manage or track the various phases/stages of all their current² and backlogged LTC and Non-Long-Term Care (Non-LTC) complaint and FRI investigations.

Immediately prior to the issuance of this report, HFID management provided their unfiltered Complaints Tracker Report which inventories all opened and closed investigations, totaling over 70,000 cases, that tracks the various phases/stages of their current and backlogged investigations, and identifies dates of when extensions were granted and the dates and number of citations issued. However, HFID's Complaints Tracker Report does not identify which cases were re-assigned to the State, report the disposition of the citations issued or relevant enforcement actions.

- Did not demonstrate they have a clear understanding of their current total workload at the staff or divisional levels. Specifically, HFID does not have a comprehensive

¹ For the purpose of this report, "backlog" is defined as any required activity (e.g., LTC and Non-LTC complaint and FRI investigations, etc.) that was opened/initiated in prior fiscal years but not yet closed/completed.

² For the purpose of this report, "current" is defined as any required activity (e.g., LTC and Non-LTC complaint and FRI investigations, etc.) that was opened/initiated in the current fiscal year but not yet closed/completed, and limited to HFID's proportionate share based on the annual contract percentage of the projected full caseload amounts as outlined in Exhibit A-1 in the State/County contract (also shown in Table 1 of Attachment I).

inventory of the individual staff's or division's workload. HFID provided numerous reports but none that include a listing of all current and backlogged investigations, outstanding federal and State Surveys they are required to complete, outstanding enforcement remedies that require follow-up for resolution and closure, and inventory of all of the COVID-19 related activities HFID performs or needs to perform. This impairs HFID management's ability to evaluate staffs' responsibilities, effectively re-assign work, or identify and resolve inefficiencies or bottlenecks within their processes to ensure timely completion of their required workload.

- Did not initially have a clear understanding of their contractual obligations with the State. For example, HFID management initially asserted they were only contractually required to complete "current" investigations that have been received and opened during the current FY; thus implying the State was responsible for completing the 11,635 backlogged investigations. According to their contract with CDPH, HFID is also responsible for all backlogged LTC complaints and FRIs received *on or after* July 1, 2015, and Non-LTC complaints and FRIs received *on or after* July 1, 2019. As a result of our inquiries and DPH's subsequent discussions with the State, HFID now acknowledges they are responsible for completing 6,219 of the 11,635 backlogged investigations.
- Does not track any federal enforcement citations issued to the health care facilities for violating the Centers for Medicare and Medicaid Services (CMS or federal) requirements, or the non-monetary enforcement remedies (e.g. directed in-service training, state monitoring, and directed Plan of Correction) issued to facilities for violating State requirements. Rather, HFID only tracks monetary enforcement remedies issued to facilities for violating State requirements. As a result, HFID could only report that they assessed 249 monetary citations, totaling approximately \$1.8 million, to LTC and Non-LTC health care facilities in Fiscal Year 2019-20 for violating State requirements. As of October 27, 2020, 76 (31%) of the monetary citations, totaling approximately \$1 million, remained open/unresolved. According to HFID management, they are not responsible for imposing enforcement actions.

Benchmarking Analysis

Los Angeles County is the only county in California with a State/County contract to perform the required activities³ for all the health care facilities in the County, including SNFs. In addition, in our discussions with CDPH, we were unable to identify any other comparable counties within the United States that had a similar State/County contract. Therefore, we attempted to benchmark against CDPH, where possible. We compared staffing structures and levels, evaluated the levels of expertise, training, and roles and

³ Required activities are defined in Exhibit A-1 of the State/County contract (also shown in Table 1 of Attachment I) as LTC and Non-LTC complaint and FRI investigations, federal Recertifications, State Re-Licensure Surveys, State Initial and Change of Service Surveys, and Miscellaneous work.

responsibilities of each staffing level, and compared the standard average hours of the required activities of both CDPH and HFID. We noted that the roles and responsibilities of each staffing level, required training, and the levels of expertise, minimum years of experience, and licensure requirements for their respective staff levels between CDPH and HFID were comparable. We also noted that:

- In comparison, HFID has a higher total staff-to-number of facilities ratio (1:14) than the State (1:9), and a higher Evaluator-to-number of investigations ratio (1:33) than the State (1:10). Whether HFID's higher ratios contributed to the significant delays in completing the older investigations is unknown at this time.
- HFID generally required less hours to complete their required activities than CDPH. However, we did not attempt to determine whether HFID is performing the required activities more effectively or efficiently than CDPH since this is an area outside our scope and expertise.

Limitations to Benchmarking Analysis

Due to CDPH having to prioritize their workload to address COVID-19 responsibilities, CDPH was unable to provide the requested documentation/information on their total workload and management oversight responsibilities. As a result, we were unable to complete our analysis on whether HFID has the appropriate staffing structure and levels in comparison to the State, or whether the State's staffing structure and levels are the best model to emulate. However, based strictly on DPH's methodology and the data we received to date, the available information suggests that HFID would need between 22 and 29 additional staff to meet their *original* State/County contractual workload obligations and the COVID-19 Mitigation requirements. However, we do not recommend hiring additional staff until a comprehensive analysis/study, including a plan to address the deficiencies noted above and throughout this report, has been conducted.

See Attachment I for the details pertaining to all the results and recommendations made in our review.

Review of Report

Since May 2020, we reviewed and analyzed a significant amount of documentation (including electronic data files), and met with DPH and HFID management on numerous occasions to obtain a thorough understanding of their processes and to discuss the results of our review. More recently, as we prepared to issue this report, DPH provided additional supporting documentation along with their feedback. On January 15th, 19th, and 25th, 2021, we met with DPH and HFID management to explain why the electronic data files and other documentation HFID provided to date did not adequately support many of their assertions.

DPH management indicated they generally *concurred* with our recommendations, but disagreed with some characterizations made throughout the report. HFID management asserts they have the ability and capacity to meet all of the COVID-19 Mitigation requirements and their amended⁴ State/County contractual obligations. Due to the COVID-19 pandemic, CMS issued their Quality, Safety, and Oversight Memo (QSO) 20-12, a federal directive, suspending non-emergency inspections across the country, allowing Evaluators to turn their focus on the most serious health and safety threats, and limited survey activities. According to DPH management, in order to meet their current COVID-19 requirements and amended contractual obligations, HFID has extended extraordinary efforts (i.e. working seven days a week and holidays, and utilizing staff from DPH's other divisions) to meet their modified responsibilities.

However, despite numerous meetings and our review of additional documentation provided to support their assertions, DPH was unable to clearly demonstrate that HFID management adequately manages and tracks their current and backlogged investigations, or has a clear understanding of their current workload, to sufficiently assume the additional responsibility of monitoring compliance with all COVID-19 Mitigation Plan requirements should CDPH require HFID to complete the non-COVID related essential functions stated in their original State/County contract.

DPH management will provide their written response to the Board within 60 days from the issuance of this report. We thank DPH management and staff for their cooperation and assistance during our review. If you have any questions please call me, or your staff may contact Terri Kasman at tkasman@auditor.lacounty.gov.

AB:OV:PH:TK:YP:dc

⁴ The original State/County contractual obligations were informally amended as a result of CMS' QSO 20-12.

**DEPARTMENT OF PUBLIC HEALTH
HEALTH FACILITIES INSPECTION DIVISION
ASSESSMENT AND BENCHMARKING ANALYSIS**

I. Background

On May 26, 2020, the Board of Supervisors (Board) directed the Office of Inspector General (OIG) to provide a report on the Oversight and Operations of Skilled Nursing Facilities (SNFs) in Los Angeles County (County) in consultation with the Auditor-Controller (A-C) and other appropriate department leaders. The Board also directed the A-C to:

- Develop a publicly available dashboard that provides COVID-19 related data for SNFs;
- Assess the Department of Public Health's (DPH) Health Facilities Inspection Division's (HFID's) ability to meet all COVID-19 Mitigation and other critical oversight roles; and,
- Compare HFID's staffing level to other counties in the State, and work with the Directors of DPH and other County departments to ensure there is the necessary staffing, expertise, training, enforcement protocols, and other functions required to support this monitoring and enforcement effort.

On October 5, 2020, we provided the OIG our first interim report, and reported that the final version of the dashboard was made public on September 30, 2020. This report constitutes our final report to the OIG on the A-C's assessment of HFID.

Department of Public Health's Health Facilities Inspection Division

Since the 1960's, the California Department of Public Health (CDPH or State) has contracted with DPH's HFID to perform investigations and oversight duties of the health care facilities in the County. Attachment III includes a breakdown of the 4,188 health care facilities, including 379 SNFs that currently operate in the County. The State performs these functions for all other California counties.

As a State Survey Agency¹, HFID is required to ensure health care facilities are in compliance with State licensing laws and federal certification regulations by performing the required surveys². HFID is also responsible for responding to and investigating complaints and Facility Reported Incidents (FRIs) at Long-Term Care (LTC) and Non-Long-Term Care (Non-LTC) health care facilities. LTC health care facilities include SNFs,

¹ A State Survey Agency is the entity responsible for conducting surveys (see Attachment II for survey definition), on behalf of the Centers for Medicare and Medicaid Services (CMS), and to certify compliance with the CMS' requirements for receiving Medicare funds.

² Surveys are defined as periodic inspections (i.e., federal Recertifications, State Re-licensure, and State Initial and Change of Services Surveys) conducted at the health care facility site that gather information about the quality of service to determine compliance with applicable State and federal regulations.

congregate living health facilities, and intermediate care facilities. Non-LTC health care facilities include home health agencies, hospices, and ambulatory surgical centers.

The current State/County contract is for three years beginning July 1, 2019, and has a total contract budget of approximately \$258 million. As of August 2020, HFID had four district offices with 289 staff, consisting of 8 Managers, 36 Supervisors, 191 Evaluators, 11 Consultants, and 43 Support Staff.

State/County Contract Requirements

The terms of the State/County contract establish, in part, the contracted workload based on an estimated number of complaint and FRI investigations, and other required activities. Table 1 illustrates the Year 2 (Fiscal Year (FY) 2020-21) projected full caseload amounts and HFID's proportionate share of LTC and Non-LTC complaint and FRI investigations, federal recertifications, State surveys (e.g., initial licensure and re-licensure surveys), and other miscellaneous work, as agreed upon and indicated in Exhibit A-1 of the State/County contract. CDPH is responsible for investigations, and other required activities, in excess of HFID's proportionate percentage of the projected full caseload amounts.

As part of the current State/County contract, CDPH agreed to accept responsibility for backlogged³ LTC complaint and FRI investigations received *prior to* July 1, 2015, and all non-LTC complaint and FRI investigations received *prior to* July 1, 2019. At the time of contract development, CDPH and HFID projected there would be 10,259 "Open and Backlog Complaints and FRIs" (as shown in Table 1). This represents the total *estimated* number of backlogged investigations HFID would be responsible for completing based on HFID's agreement with CDPH to complete all backlogged LTC complaints and FRIs.

³ For the purpose of this report, "backlog" is defined as any required activity (e.g., LTC and Non-LTC complaint and FRI investigations, etc.) that was opened/initiated in *prior* fiscal years but not yet closed/completed.

Table 1⁴

State/County Contract Projected Workload (with Total Staff Hours Required for Completion) Year 2 - FY 2020-21 (1)				
Required Activities (2)	Projected Full Caseload (3)	Annual Contract % Required	HFID's Contracted Caseload	Total Hours Required to Complete
LTC Complaints	4,071	100%	4,071	77,751
LTC FRIs	4,903	58%	2,843	49,514
Non-LTC Complaints	1,552	100%	1,552	27,239
Non-LTC FRIs	1,682	47%	790	11,556
Open and Backlog Complaints and FRIs (4)	10,259	25%	2,530	44,511
Federal Recertification	834	100%	834	187,957
State Re-Licensure Survey	672	5%	34	6,140
State Initial and Change of Service Surveys	1,992	27%	539	5,402
Miscellaneous (5)	-	-	210	1,096
Totals	25,965		13,403	411,166

(1) This Table presents the projected workload for Year 2 of a three-year contract term. It is in Year 2 HFID is required to begin working on "Open and Backlog Complaints and FRIs" as outlined in their State/County contract. As further detailed in footnote 4 of Table 1 below, the "Open and Backlog Complaints and FRIs" line item represents the total estimated number of backlogged investigations HFID will be responsible for completing. Year 1 (FY 2019-20) did not include a line item for, "Open and Backlog Complaints and FRIs."

(2) For definitions, see Glossary of Terms in Attachment II.

(3) The Projected Full Caseload amounts are *estimated* projections determined by HFID and approved by the State.

(4) This line item represents a portion of the "backlog", as previously defined, but *only* the portion that applies to HFID. Specifically, the Projected Full Caseload amount for this line item represents the total *estimated* number of backlogged investigations HFID would be responsible for completing based on HFID's agreement with CDPH to complete all backlogged LTC complaints and FRIs received *on or after* July 1, 2015, and Non-LTC complaints and FRIs received *on or after* July 1, 2019. As such, the Projected Full Caseload amount for this line item does not include the *estimated* number of backlogged investigations CDPH has agreed to complete.

(5) "Miscellaneous" consists primarily of work related to Informal Dispute Resolutions, which provide facilities an opportunity to informally dispute cited deficiencies HFID identified during their survey visits.

⁴ Source: All information in Table 1 is directly from Exhibit A-1 of the State/County contract. We were unable to validate HFID's standard average hour calculations since HFID did not provide documentation to support the methodology used to calculate their standard average hours.

Based on the projected full caseload amounts and the annual contract percentages outlined in Table 1, HFID is required to complete 5,623 (4,071 + 1,552) complaint investigations and 3,633 (2,843 + 790) FRI investigations in FY 2020-21. CDPH is responsible for investigating complaints and FRI investigations in excess of these amounts in FY 2020-21. Similarly, HFID is responsible for performing other required activities up to the annual contract percentage of the projected full caseload amounts as shown in Table 1, with one exception (i.e., the “Open and Backlog Complaints and FRIs” line item in Table 1 above). The exception being that CDPH is *not* responsible for the excess of HFID’s proportionate share (based on the annual contract percentage of projected full caseload amount) for the “Open and Backlog Complaints and FRIs” investigations line item. Any excess of HFID’s proportionate share for the fiscal year will be carried forward to subsequent fiscal years until completion. Meaning, HFID is responsible for completing 100% of all backlogged LTC complaints and FRIs received *on or after* July 1, 2015, and Non-LTC complaints and FRIs received *on or after* July 1, 2019.

For example, in Year 2, HFID is contractually obligated to complete 25% of the “Open and Backlog Complaints and FRIs” projected full caseload amount (as shown in Table 1). However, instead of the remaining 75% falling under CDPH’s responsibility, HFID will carry these forward to subsequent fiscal years until they have completed all backlogged LTC complaints and FRIs. According to CDPH, all current⁵ investigations HFID opens and initiates but cannot close in Years 1 through 3 of this contract term, will be carried forward by HFID to subsequent fiscal years until completion.

HFID projected requiring 411,166 staff hours, with a budget of \$86 million in FY 2020-21, to meet all of the original State/County contract requirements. It should be noted that HFID’s annual contract budget increased after each year of the three-year contract term, from \$65 million in Year 1 (FY 2019-20), to \$86 million in Year 2, and to \$105 million in Year 3, to support expanded staff and oversight activity required to accommodate the increases in both the projected full caseload amounts and HFID’s annual contract percentage of responsibility of all the required activities listed in Table 1. Table 1A illustrates a few examples of increases in both the projected full caseload amounts and HFID’s annual contract percentage of responsibility from Year 1 through Year 3:

⁵ For the purpose of this report, “current” is defined as any required activity (e.g., LTC and Non-LTC complaint and FRI investigations, etc.) that was opened/initiated in the current fiscal year but not yet closed/completed, and limited to HFID’s proportionate share based on the annual contract percentage of the projected full caseload amounts as outlined in Exhibit A-1 in the State/County contract (also shown in Table 1).

Table 1A

Examples of Increases from Year 1 to Year 3					
Fiscal Year		Projected Full Caseload	Annual Contract % Required	Projected Full Caseload	Annual Contract % Required
		LTC FRIs		Open and Backlog Complaints and FRIs	
Year 1	2019-20	4,566	51%	5,325	0%
Year 2	2020-21	4,903	58%	10,259	25%
Year 3	2021-22	5,241	90%	11,411	43%

II. Meeting COVID-19 Requirements

CDPH issued an All Facilities Letter (AFL) 20-52 on May 11, 2020, requiring all SNFs to develop and implement an approved COVID-19 Mitigation Plan (Plan). The AFL required SNFs to submit their Plans to CDPH by June 1, 2020, for review and approval, and CDPH would subsequently conduct COVID-19 Mitigation on-site survey visits (COVID-19 Mitigation visits) of each SNF every six to eight weeks to ensure each facility continues to implement their approved Plans. According to the AFL, if CDPH determines that a facility is not implementing its *approved* Plan and identifies unsafe practices that have or are likely to cause harm to patients, CDPH may take enforcement action including calling an Immediate Jeopardy⁶ (IJ) situation which may result in a civil penalty.

The 379 SNFs under the County’s purview were required to submit their Plans directly to HFID for their review and approval. HFID is also required to conduct COVID-19 Mitigation visits of each SNF every six to eight weeks, until further notice from CDPH, to ensure the SNFs implemented their Plans.

We assessed whether HFID complied with the COVID-19 Mitigation requirements of reviewing and approving all 379 SNFs’ Plans, and conducting the required COVID-19 Mitigation visits every six to eight weeks of all SNFs to ensure compliance with their Plans. In addition, we evaluated whether HFID had sufficient staffing resources to meet all COVID-19 Mitigation requirements while maintaining the required level of non-COVID-19-related investigations and meeting other critical oversight roles necessary to ensure the ongoing health and safety of residents and staff within these facilities.

⁶ Immediate Jeopardy (IJ) is a situation in which a provider's non-compliance with one or more requirements has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Failing to prevent a cognitively impaired resident from leaving a secured facility unsupervised or maintain essential heating and air conditioning equipment in the resident’s room in a safe, operating condition are example of IJ situations. The definition for non-Immediate Jeopardy priority rankings is in Attachment IV, which provides a listing of all priority rankings, and descriptions and required timeframes in which investigations have to be initiated once received based on the priority ranking.

COVID-19 Mitigation Plans and On-Site Survey Visits

According to HFID, all 379 SNFs under the County's purview submitted their Plans to HFID for review and approval by June 1, 2020, as required, and as of August 25, 2020, HFID finalized the approval of all 379 SNFs' Plans. Currently, HFID utilizes a spreadsheet to schedule their COVID-19 Mitigation visits for the 379 SNFs under their purview.

In our October 5, 2020 Interim Report, we reported that the State agreed to complete 30 of the required 379 COVID-19 Mitigation visits and there was confusion about the completion of one. However, HFID and the State subsequently provided documentation that demonstrated the State's staff completed the COVID-19 Mitigation visit.

To avoid scheduling overlaps and/or conflicts with the State, we assessed HFID's communication protocols. HFID now updates their schedule at least weekly, to include necessary information, such as COVID-19 Mitigation visit dates, organization (i.e., HFID, CDPH) assigned, and names of the Evaluators who conducted these visits. HFID also assigned a liaison who is responsible for meeting with CDPH weekly to discuss both HFID's and CDPH's COVID-19 Mitigation visit schedules, identify which survey visits need to be completed by HFID or CDPH, and discuss any changes to the list of SNFs COVID-19 Mitigation visits CDPH has agreed to conduct indefinitely.

Since our review, HFID has taken the necessary steps to ensure all required COVID-19 Mitigation visits are completed as scheduled, and the risk of possible duplication of work by HFID and the State is reduced. HFID recently implemented a protocol to compile the results of their COVID-19 Mitigation visits. However, HFID could further enhance their management oversight by routinely analyzing the results of their COVID-19 Mitigation visits, coupled with the federal and State reports⁷ HFID already receives, to help identify trends and needs of the SNFs in the County in order to better and more quickly facilitate changes and/or provide critical assistance where needed.

Recommendation

- 1. Department of Public Health's Health Facilities Inspection Division's management consider routinely analyzing the results of their COVID-19 Mitigation visits, coupled with the federal and State reports, to help identify trends and needs of the SNFs in the County in order to better and more quickly facilitate changes and/or provide critical assistance where needed.**

⁷ As discussed later, under the "Other Oversight Activities - Analysis and Risk Assessments" section of our report, these federal and State reports, distributed to all State Survey Agencies to take corrective action, include CMS' Special Focus Facilities Report, CMS's weekly "3-5 Day Focused Infection Control Survey Report", and the State's Predictive Analytics Report.

Resources Required to Meet New COVID-19 Mitigation Plan Requirements

HFID provided us with their projected COVID-19 workload calculation that indicated the required staffing hours necessary to complete the Plan activities, including COVID-19 Mitigation visits. Based on HFID's calculation for FY 2019-20, they would need to complete between 2,496 and 3,328 COVID-19 Mitigation visits, every eight or six weeks respectively, requiring an estimated 38,458 to 51,277 hours (Table 2).

Effective March 4, 2020, the Centers for Medicare and Medicaid Services' (CMS or federal) Quality, Safety, and Oversight Memo (QSO) 20-12, a federal directive, suspended non-emergency inspections across the country, allowing inspectors to turn their focus on the most serious health and safety threats, and limited survey activities to the following (in priority order):

- All IJ complaints and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and Intermediate Care Facilities for Individuals with Intellectual Disabilities facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the IJ level in the last three years; and,
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than IJ.

According to CDPH and HFID management, it was agreed that HFID would only work on fulfilling COVID-19 Mitigation requirements and IJ investigation cases, suspending the remaining activities noted above. As a result, the following line items in Exhibit A-1 of the State/County contract, which lists all of the required activities HFID is obligated to perform (as shown in Table 1), were suspended until further notice:

- Open and Backlog Complaints and FRIs (non-IJ only)
- Federal Recertifications
- State Re-Licensure Survey
- State Initial and Change of Service Surveys
- Miscellaneous

This resulted in the total workload remaining from the original State/County contract being reduced from 411,166 (from Table 1) to 166,060 hours in FY 2020-21 as illustrated in Table 2:

Table 2

Resources Required to Meet New COVID-19 Mitigation Requirements and Amended Contract Workload		
Amended Contract Workload	Hours Required	
Original Contract Workload (1)	411,166	
- Suspended Workload Due to Federal Directive (2)	(245,106)	
Total Hours Required for Amended Contract Workload	166,060	
Conduct COVID-19 Mitigation Visits (3)	Every 8 Weeks	Every 6 Weeks
	38,458	51,277
Total Hours Required to Meet COVID-19 Mitigation Requirements and Remaining Workload	204,518	217,337

(1) Source: Exhibit A-1 of the State/County contract (also shown on Table 1).

(2) Sum of total hours required for the following required activities: Open and Backlog Complaints and FRIs, federal Recertifications, State Re-Licensure Surveys, State Initial and Change of Service Surveys, and Miscellaneous from Table 1.

(3) Calculations provided by HFID management.

As shown in Table 2, the hours required to meet the COVID-19 Mitigation requirements and complete all *amended*⁸ work in the State/County contract for FY 2020-21 ranged between 204,518 and 217,337 hours. Based on the range of total hours required to complete HFID’s total *amended* workload and their functional hours (1,744⁹), HFID would need between 117 and 125 full-time staff¹⁰ in FY 2020-21. HFID currently has 289 full-time staff assigned to perform the contracted required activities. Therefore, HFID has sufficient staffing to meet the COVID-19 Mitigation requirements and their *amended* State/County contractual obligations, and should consider developing a plan on how they will effectively use the remaining staff hours as a result of the federal directive.

Immediately prior to the issuance of this report, HFID management indicated federal directive QSO 20-31 (issued June 1, 2020 and revised January 4, 2021) also requires them to perform additional COVID-19 related activities in addition to the COVID-19 Mitigation visits, which are required to be performed every six to eight weeks. According to QSO 20-31, HFID is also required to perform the following on-site visits:

⁸ State/County contractual obligations were informally amended as a result of CMS’ QSO 20-12.

⁹ According to HFID management, each staff has approximately 1,744 annual “functional” hours, which represent productive labor hours.

¹⁰ Our estimated range of staff needed (ranging from 117 to 125) is inflated since our calculations included all complaint and FRI investigations even though the federal directive suspended HFID from conducting investigations not prioritized as IJ. This was due to the State/County contract not differentiating between IJ and non-IJ investigations in their budget.

- COVID-19 Focused Infection Control (FIC) surveys of SNFs with previous COVID-19 outbreaks.
- FIC surveys of any SNF with three or more new COVID-19 confirmed cases since the last National Healthcare Safety Network's (NHSN) COVID-19 Report¹¹, or one confirmed resident case in a facility that was previously COVID-free.

According to DPH management, in addition to the above, HFID performs other COVID-19 related activities which are listed in Attachment VI. However, HFID was unable to provide any documentation that tracked or quantified the total number of these other COVID-19 related activities HFID performed to date, or the estimated/actual hours incurred to complete these activities. Therefore, we did not have sufficient data to determine whether HFID has the resources to meet all of the COVID-19 Mitigation requirements and their *amended* State/County contractual obligations. According to DPH management, HFID has extended extraordinary efforts (i.e., working seven days a week and holidays, and utilizing staff from DPH's other divisions) to meet their modified responsibilities given the resources provided in the contract. As such, HFID management should consider conducting a time study of all COVID-19 and non-COVID-19 activities performed to assist in determining the allocation of their current resources and what additional resources, if any, are needed to meet all COVID-19 requirements and their State/County contractual obligations.

Recommendations

Department of Public Health's Health Facilities Inspection Division's management consider:

- 2. Working with the State to formally amend their State/County contract to redefine their contractual obligations, as a result of CMS' QSO 20-12 and QSO 20-31, for FYs 2020-21 and 2021-22.**
- 3. Conducting a study of all COVID-19 and non-COVID-19 activities performed to assist in determining the allocation of their current resources and what additional resources, if any, are needed to meet all COVID-19 requirements and their State/County contractual obligations.**

¹¹ The National Healthcare Safety Network (NHSN) is the Centers for Disease Control and Prevention's healthcare-associated infection tracking system that provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections. The NHSN's COVID-19 Report is a weekly federal report which assesses the impact of COVID-19 through facility reported information.

Total Hours Required to Meet Both Original State/County Contract and COVID-19 Requirements

According to HFID management, they developed comprehensive budgets for FYs 2019-20 through 2021-22 that considered several factors, including projected growth and the related staffing needs. HFID management compiled and summarized the actual workload data for FYs 2014-15 through 2017-18, and used the analysis to forecast their future workload requirements through FY 2021-22 and to determine the total full-time equivalents (FTEs) needed each FY to meet their contractual obligations. In addition, HFID developed a budget template outlining the annual budget requirements for each year of the contract. The budget template details the line items for all contracted services under the State/County agreement and the associated costs, including incremental FTE increases from Year 1 (FY 2019-20) through Year 3 (FY 2021-22). The budget template also accounted for incremental increases based on cost of living adjustments, County employee step increases, and employee benefit expenses for each FY. Based on the above, we determined HFID's methodology was reasonable for developing their budget and staffing needs to meet the requirements in their original State/County contract, pre-COVID-19 Mitigation requirements.

As shown in Table 1, the County would need 411,166 staff hours for HFID's total contracted (original) workload in FY 2020-21. In addition, as noted in Table 2, HFID indicated they will need an additional 38,458 to 51,277 hours to complete the COVID-19 Mitigation visits every eight or six weeks, respectively. Using HFID staff's functional hours (1,744), HFID would need between 22 and 29 additional staff, bringing HFID's total number of staff to 311 (289 + 22) or 318 (289 + 29) to meet their original State/County contractual workload and the COVID-19 Mitigation requirements.

We do not, however, recommend hiring additional staff until the following factors have been thoroughly considered:

- How HFID is currently utilizing their staffing resources/hours as a result of CMS' QSO 20-12, which suspended all non-COVID 19 related complaint and FRI investigations that are not critical (non-IJ cases) and other oversight duties, such as federal Recertifications, State Re-Licensure Surveys, State Initial and Change of Service Surveys, and QSO 20-31, which required HFID to perform additional COVID-19 related activities.
- How long HFID will be required to conduct the COVID-19 Mitigation visits, and when these visits are no longer required, how HFID will utilize available staffing resources if additional staff were hired.
- The impact the suspension of all non-COVID-19 related investigations that are not critical (non-IJ cases), and other required activities, will have on HFID's total workload when all required activities are to be resumed.

- How HFID will utilize available staffing resources, if any, once a significant portion of the “Open and backlog Complaint and FRI” investigations, as indicated in Table 1 are completed. According to CDPH, one objective of the State increasing their budget each year is to accommodate for the increases in staffing to take on higher percentages of the required activities, including the “Open and Backlog Complaints and FRIs”, which aims at reducing the total number of older backlogged investigations.
- What the challenges and needs are, if any, within HFID, to help identify and determine the appropriate staffing positions and levels needed long-term (e.g., to address the number of open investigations, etc.).
- The need to coordinate with the County’s Chief Executive Office and Department of Human Resources to determine the types and amounts of positions needed (regular, part-time, seasonal, or contract employees) to meet current and future workload requirements.

In addition, as noted above and in the “Assessment of DPH’s HFID” section that follows, we noted various significant areas of concern and numerous opportunities for improvement. For example, HFID did not demonstrate they adequately track the phases/stages of all current and backlogged investigations, complete investigations within established timeframes, or fully understand the State/County contractual requirements. These issues potentially impact HFID’s need for organizational structure changes and adjustments to the number of required staff to ensure HFID adequately monitors and ensures compliance with all Plan requirements, while completing the required level of non-COVID-19-related investigations and meeting other critical oversight roles necessary to ensure the ongoing health and safety of residents and staff within the 4,188 health care facilities in the County.

We recommend HFID management consider internally conducting, or hiring a consultant to conduct, a comprehensive study, considering all recommendations addressed in both this and the OIG’s reports. The study should determine the appropriate number of Evaluators, Supervisors, Consultants/Experts, Managers and Support Staff HFID needs to meet their current and/or future contractual needs and goals. This study should consider all applicable issues/concerns identified in this report, and as such, please refer to Recommendation 18.

Recommendation

Refer to Recommendation 18

III. Assessment of DPH’s HFID

DPH entered into a new contract in 2019 with CDPH to fully transfer responsibility of health care facility investigations and monitoring activities to the County, with the objective of creating more operational efficiencies and improving the quality of enforcement

activities. Despite this new arrangement, thousands of complaints continue to be registered with the County each year. Staff deployment to focus on COVID-19-related issues may be warranted given the severity of the current crisis. However, other serious quality control issues within the health care facilities are growing and persisting without appropriate intervention. It is critical that the County learns from this crisis and the range of internal and external factors that have contributed to ongoing inadequate conditions within the health care facilities, especially the SNFs.

We reviewed the current State/County contract terms, and State and federal guidelines and requirements. We also reviewed and assessed HFID's policies and operational processes, including their processes for tracking, monitoring and managing, and timely completing all current and backlogged investigations. We also reviewed their follow-up on the implementation of enforcement recommendations, and ensuring all State/County contractual obligations related to their overall workload and required activities are tracked and completed.

According to DPH, CDPH is contractually obligated to provide monitoring reports to DPH, and CDPH's reports, to date, have indicated HFID's compliance with contractual obligations. HFID management continues to assert that they have sufficient staffing to meet all of the COVID-19 Mitigation requirements in addition to their amended State/County contractual obligations. However, based on our assessment, HFID management does not currently have the ability or capacity to adequately assume the additional responsibility of monitoring compliance with all Plan requirements should CDPH require HFID to complete their non-COVID-19-related essential functions as outlined in their original State/County contract. According to DPH management, HFID has extended extraordinary efforts to complete their current modified responsibilities. For example, HFID management indicated their staff are currently working seven days a week and holidays, and they are utilizing staff from DPH's other divisions to meet their COVID-19 Mitigation requirements. During our assessment, we also noted significant areas of concern and numerous opportunities for improvement as follows:

A. Actual Backlogged Investigations as of June 30, 2020

The State/County contract requires HFID to conduct various required activities, such as complaint and FRI investigations, federal Recertification, State Re-Licensure Survey, and State Initial and Change of Service Surveys. A significant portion of HFID's contractual workload pertains to conducting complaint and FRI investigations related to all the LTC and Non-LTC health care facilities within the County's purview. We evaluated HFID's policies and operational processes for ensuring their required workload is completed as specified in their State/County contract.

Based on the datasets and documentation provided during our review, HFID did not demonstrate they adequately manage or track the various phases/stages of all their current and backlogged investigations, including the 11,635 investigations backlogged as of June 30, 2020, or ensure corrective actions were implemented as required at the

health care facilities. In addition, HFID did not demonstrate they have a clear understanding of their current total workload (including the other required activities), at the staff or divisional levels, or contractual obligations with CDPH.

Table 3 illustrates the lengths of time the 5,407 SNF investigations have remained open (at various stages in their investigation process):

Table 3

Skilled Nursing Facilities Backlogged Investigations			
Length of Time Investigations Remained Open (as of 6/30/20)	SNF Complaints	SNF Facility Reported Incidents	Totals
Less than 1 year	816	874	1,690
1 to less than 2 years	58	520	578
2 to less than 3 years	56	460	516
3 to less than 4 years	399	381	780
4 to less than 5 years	193	661	854
Over 5 years	627	362	989
Totals	2,149	3,258	5,407

As of June 30, 2020, HFID reported 547 (10%) of the 5,407 backlogged SNF investigations were prioritized at the level of IJ. As previously mentioned, investigations prioritized as IJ are situations in which the facility's non-compliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Table 4 illustrates the lengths of time the 547 IJ SNF investigations have been in-progress (at various stages in their investigation process):

Table 4

Skilled Nursing Facilities Immediate Jeopardy Investigations			
Length of Time IJ Investigations Remained Open (as of 6/30/20)	SNF Complaints	SNF Facility Reported Incidents	Totals
Less than 1 year	304	134	438
1 to less than 2 years	11	21	32
2 to less than 3 years	8	39	47
Over 3 years	20	10	30
Totals	343	204	547

In addition to the 379 SNFs, HFID is responsible for overseeing 3,809 other LTC and non-LTC health care facilities in the County. In addition to the 5,407 backlogged SNF investigations, HFID reported an additional 6,228 backlogged investigations related to the other LTC and Non-LTC health care facilities, bringing the grand total number of backlogged complaints and FRI investigations to 11,635 as of June 30, 2020. 628 (547 for SNFs and 81 for other LTC and Non-LTC health care facilities) of the 11,635 backlogged complaints and investigations were determined to be at the IJ level. Table 5 illustrates the lengths of time the 11,635 investigations have remained open:

Table 5

All LTC and Non-LTC Health Care Facilities in the County Backlogged Investigations			
Length of Time Investigations Remained Open (as of 6/30/20)	All Complaints	All Facility Reported Incidents	Totals
Less than 1 year	1,515	1,732	3,247
1 to less than 2 years	170	813	983
2 to less than 3 years	83	632	715
3 to less than 4 years	417	441	858
4 to less than 5 years	210	725	935
Over 5 years	2,409	2,488	4,897
Totals	4,804	6,831	11,635

As stated previously, in their current State/County contract, starting with FY 2019-20, CDPH agreed to accept responsibility for LTC complaint and FRI investigations received prior to July 1, 2015, and all Non-LTC complaint and FRI investigations received prior to July 1, 2019, and HFID is responsible for completing all other remaining backlogged investigations. Based on the State/County contract guidelines and the datafile HFID provided of all backlogged investigations as of June 30, 2020, we determined HFID and the State are responsible for completing 6,219 and 5,416 backlogged investigations, respectively. Table 6 illustrates the breakdown of the total number of complaints and FRIs related to the SNFs and for all of their other LTC and Non-LTC health care facilities that fall under HFID's or CDPH's jurisdiction:

Table 6

HFID or State Breakdown of Total Number of Backlogged Complaints and FRIs						
Open # of Backlogged Investigations Assigned to (as of 6/30/20):	SNF Complaints A	SNF Facility Reported Incidents B	SNF Totals A+B=C	Other LTC/Non-LTC Complaints D	Other LTC/Non-LTC FRIs E	Grand Totals C+D+E
HFID (1)	1,522	2,896	4,418	723	1,078	6,219
State (2)	627	362	989	1,932	2,495	5,416
Totals	2,149	3,258	5,407	2,655	3,573	11,635

(1) Represents the total *actual* number of backlogged investigations HFID is responsible for completing based on HFID's agreement with CDPH to complete all backlogged LTC complaints and FRIs received *on or after* July 1, 2015, and all Non-LTC complaints and FRIs received *on or after* July 1, 2019.

(2) Represents the total *actual* number of backlogged investigations CDPH is responsible for completing based on the State's agreement with HFID to complete all LTC complaint and FRI investigations received *prior to* July 1, 2015, and all Non-LTC complaint and FRI investigations received *prior to* July 1, 2019.

Tracking All Current and Backlogged Investigations

HFID management did not demonstrate that they adequately manage or track the various phases/stages of all of their current and backlogged investigations, including the 11,635 total backlogged investigations as of June 30, 2020. At the time of our review, HFID indicated they utilized their Stages of Completion LTC Complaints and FRIs Report (SOC Report) to track some of the phases/stages of their current investigations related to their LTC health care facilities, such as when the complaints and FRIs were received, and whether the investigations are pending initiation, under investigation, under supervisory review, and are closed. However, the SOC Report does not provide the status on complaint and FRI investigations related to Non-LTC health care facilities, and *only* provides the status for LTC related complaint and FRI investigations that have been received *starting* July 1, 2020. As a result, the 11,635 total backlogged investigations (reported as of June 30, 2020 in Table 5) relating to all LTC and Non-LTC health care facilities were not included on HFID's SOC Report.

In addition to the SOC Report, HFID also now maintains an internal, separate log of all current investigations assigned to the State when HFID exceeds their current year contracted number of investigations for the FY¹². HFID ensures a State Evaluator has

¹² Unlike the current State/County contract terms, the prior State/County contract terms did not specify annual contractual percentages of projected full caseload amounts HFID was required to complete, with the excess being the responsibility of the State. As such, HFID entered all complaints and FRIs received, related to the health care facilities within the County, into ACTS as required, and assigned HFID's Evaluators to the investigations when the 11,635 backlogged investigations were initially received and opened in prior fiscal years.

been assigned to the investigation in the Automated Survey Process Environment (ASPEN) Complaints/Incidents Tracking System (ACTS), a federal system used to track complaints and FRIs involving all health care providers (including SNFs), which reduces the likelihood of an HFID staff working on any current complaint or FRI investigation assigned to the State. However, HFID does not maintain an internal log, or utilize another mechanism, to track the 5,416 of the 11,635 backlogged investigations (as shown in Table 6) that were re-assigned to the State, starting FY 2019-20, as part of the State/County contract.

According to HFID management, they use ACTS to identify which specific backlogged investigations have been re-assigned to the State, by the dates specified in the State/County contract (*prior to July 1, 2015* for all (non-IJ) backlogged LTC complaints and FRIs received, and *prior to July 1, 2019* for all (non-IJ) backlogged Non-LTC complaints and FRIs). However, ACTS is not capable of generating a report that lists the 5,416 backlogged complaint and FRI investigations that were re-assigned to the State. As a result, there is a risk that HFID's staff will complete investigations that were originally assigned to them but have been re-assigned to the State. In addition, HFID does not follow-up and/or track the statuses of the investigations that were re-assigned to the State. Although the re-assigned investigations are now the responsibility of the State, HFID should advocate for the State to, or provide HFID with additional resources necessary to, ensure all transferred complaint and FRI investigations, which were originally initiated by HFID staff and related to the health care facilities residing in the County are completed and resolved in a timely manner.

Overall, HFID's SOC Report and their internal tracking log, lacked critical information that could assist HFID to better track and manage all of their current and backlogged investigations. For example, neither of these reports included or identified:

- HFID's total current and backlogged LTC and Non-LTC complaint and FRI investigations related to the health care facilities in the County;
- The organization (HFID or State) responsible for completing each investigation;
- Investigations that were granted extensions and reasons/justifications for the extensions (which will be discussed in the "Not Completing Investigations within Required Timeframes" section below);
- Enforcement issuance dates and status of enforcement resolutions when enforcement remedies/citations are issued (which will be discussed in the "Enforcement Tracking" section below); or,
- Dates exit meetings occurred, Statement of Deficiencies Notices¹³ were sent, and on-site visits were conducted to verify that the facilities' corrective actions were implemented.

¹³ Statement of Deficiencies Notice: An official notice, provided to the facility, that lists the deficiencies cited by an Evaluator during an investigation or survey that require correction.

Immediately prior to the issuance of this report, HFID management provided their unfiltered Complaints Tracker Report which inventories all opened and closed investigations, totaling over 70,000 cases, tracks the various phases/stages of their current and backlogged investigations, and identifies the dates extensions were granted and the dates and number of citations that were issued. HFID's Complaints Tracker Report does not, however, identify which cases were re-assigned to the State, report the disposition of the citations issued or the enforcement actions taken, if any.

HFID management should consider establishing one comprehensive report that inventories, provides relevant information, and tracks the various phases/stages of all current and backlogged complaint and FRI investigations related to both LTC and Non-LTC facilities. This report should also include relevant information cited above.

Recommendations

Department of Public Health's Health Facilities Inspection Division's management consider:

- 4. Establishing one comprehensive report that inventories, provides relevant information, and tracks the various phases/stages of all current and backlogged complaint and FRI investigations, related to both LTC and Non-LTC facilities. This comprehensive report should also include other relevant information as indicated in this report.**
- 5. Advocating for the State to, or provide HFID with the additional resources necessary to, ensure all complaint and FRI investigations that were transferred to the State, which were originally initiated by HFID staff and related to the health care facilities in the County, are completed and resolved in a timely manner.**

Completing Investigations within Required Timeframes

HFID is required to comply with federal and State regulatory timeframes for completing various phases/stages of all LTC and Non-LTC complaint and FRI investigations. For example, there are specific time frames for starting the investigation, notifying the facility of findings of non-compliance, obtaining the facility's response, and completing the investigation. The most significant time frame to note is related to the completion of an investigation.

Starting FY 2017-18, federal regulations required investigations be completed within 90 calendar days. Beginning July 1, 2018, federal regulations reduced the completion requirement to 60 calendar days. Federal regulations did not differentiate IJ and non-IJ priority levels when they established investigation completion timelines. Additionally, an investigation may be extended up to an additional 60 days due to extenuating circumstances identified in Senate Bill 75, such as waiting for a death certificate, law

enforcement records, and/or to interview additional parties. Senate Bill 75, however, does not address the number of extensions that may be granted by the State, but requires all State Survey Agencies to document the circumstances for the extension and notify the facility and the complainant in writing. Table 7 illustrates the required timelines for each phase/stage of the investigation process:

Table 7¹⁴

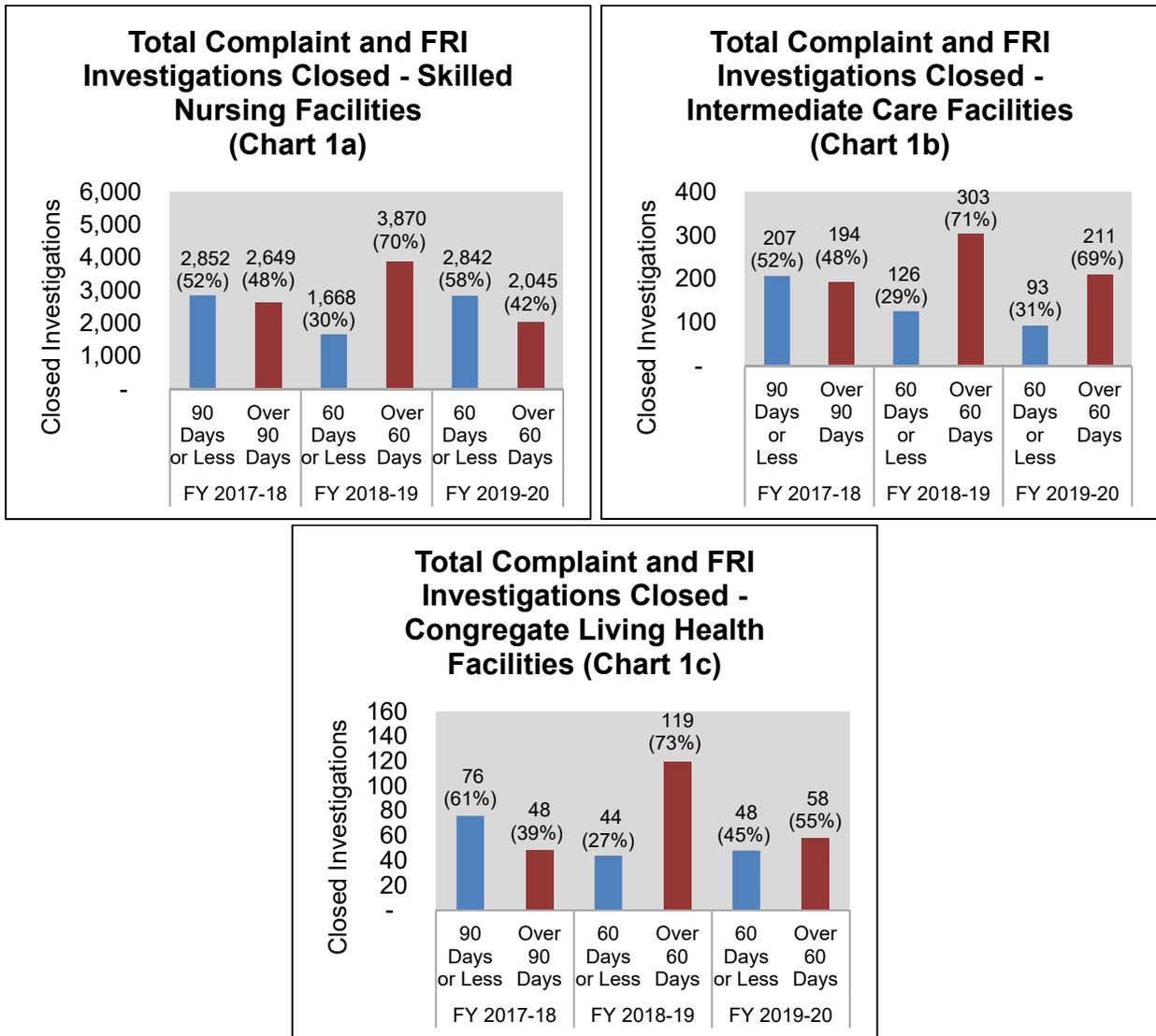
Required Timeframes for Investigations Starting July 1, 2018		
Investigation Process	Type of Investigation	
	Immediate Jeopardy (IJ)	Non-IJ
Initiate Investigation (upon receipt)	24 Hours	10 Business days
Exit Conference with facility	(1)	(1)
Statement of Deficiencies Notice issued to facility	Two days after Exit Conference (Unless abated while the evaluator is onsite)	10 days after Exit Conference
Plan of Correction (due from facility)	10 days after Statement of Deficiency Form Received	10 days after Statement of Deficiency Form Received
Complete Investigation	60 days after Receipt of Complaint	60 days after Receipt of Complaint

(1) The Federal government, State, and HFID do not currently have established timeframes to exit the findings with the facility.

We obtained HFID’s inventory of all *closed* complaint and FRI investigations for LTC and Non-LTC health care facilities between July 1, 2017 through June 30, 2020. Charts 1a, 1b, and 1c illustrate the number and percentage of total complaint and FRI investigations that were closed within or exceeded the applicable 90- and 60- day requirement during FYs 2017-18, 2018-19, and 2019-20 for HFID’s LTC health care facilities (i.e., the SNFs, Intermediate Care Facilities, and Congregate Living Health Facilities):

¹⁴ Required timeframes for investigations were obtained from the CMS’ State Operations Manual (SOM) and Senate Bill 75.

Chart 1

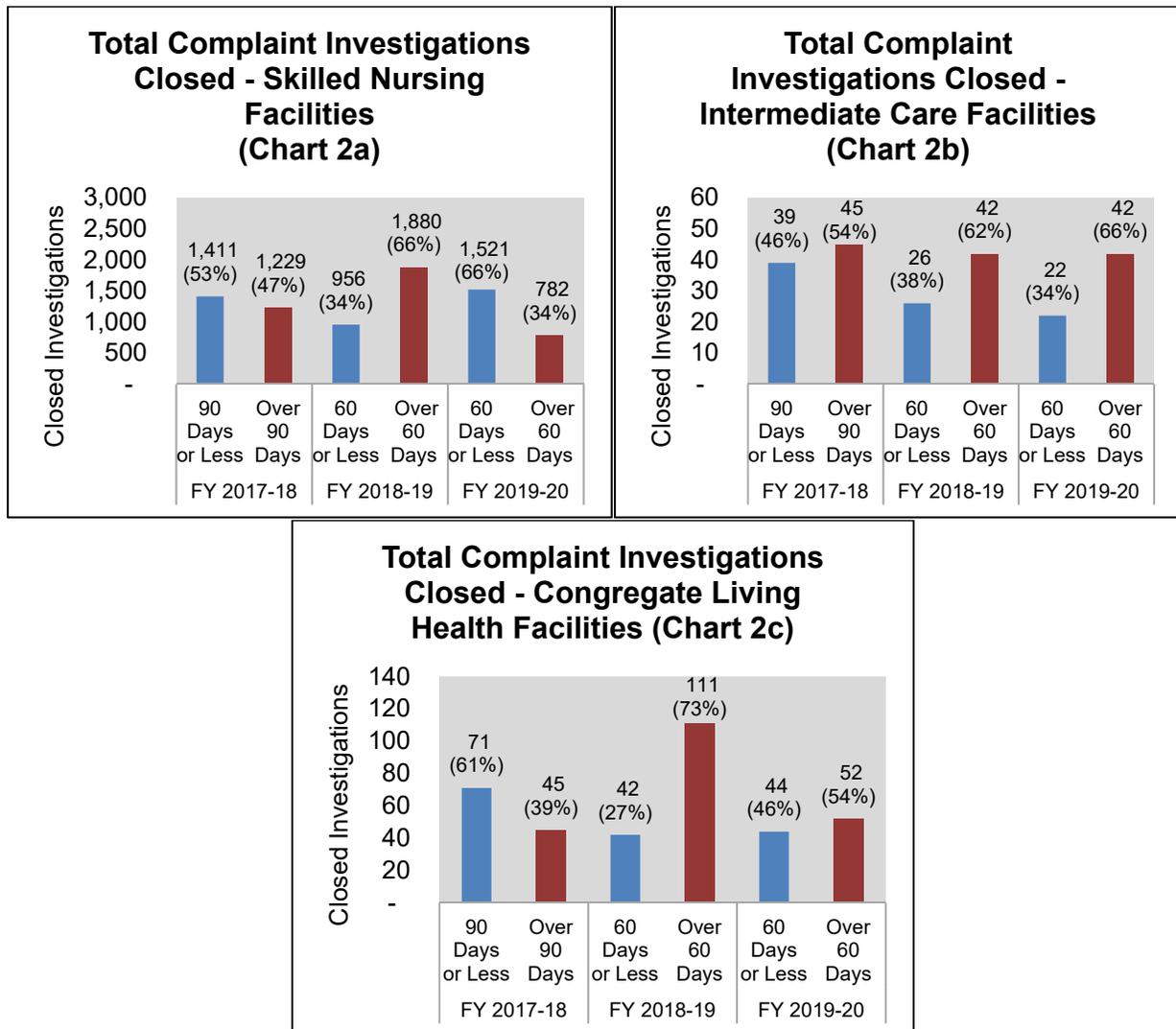


According to the State/County contract, a specific percentage of HFID’s LTC and Non-LTC investigations have to be completed within 60 days. For example, in Year 1, FY 2019-20, 75% of all LTC complaint investigations are required to be completed within 60 days. In Years 2 and 3, 90% and 95%, respectively, of HFID’s LTC complaint investigations must be completed within 60 days.

HFID’s inventory of all *closed* complaint and FRI investigations for LTC and Non-LTC health care facilities between July 1, 2017 through June 30, 2020, did not identify which investigations were granted extensions or the new deadlines resulting from the extensions. Therefore, we could not determine whether HFID met their FY 2019-20 contractual obligation of closing 75% of their LTC investigations within 60 days.

Immediately prior to the issuance of this report, HFID management asserted there are different timeframes for completing FRI investigations, and the referenced 90- or 60- day timeframes (based on the fiscal year) above are for complaint investigations only. Charts 2a, 2b, and 2c illustrate the percentages of only completed complaint investigations within the required timeframes. Although the percentages increased for each of the years reported, HFID did not meet the minimum requirement of closing 75% of complaint investigations within the 60-day timeframe in FY 2019-20.

Chart 2



According to CDPH, while there are no specific regulatory timelines for completing an FRI investigation, CDPH’s practice is to make every effort to follow the required regulatory guidelines and timelines for completing complaint investigations when completing FRI

investigations. This is further substantiated by CDPH's Field Operations Dashboard¹⁵ (www.cdph.ca.gov/Programs/CHCQ), under the "Percent of Cases Completed Timely" module, when the State used the same completion timeframes for both complaint and FRI investigations when determining the performance outcomes for the County. As such, HFID management should consider adopting the completion timeframes used by CDPH, and/or establishing internal timeframes for FRI investigations that are consistent with CDPH's practice to ensure timely completion.

CDPH can assess fiscal penalties and withhold the amount(s) from HFID's budgeted funds if HFID does not meet the required contractual workload and performance requirements (as noted above). In addition, HFID's performance directly impacts CDPH's performance thresholds with CMS, and the State can also face federal fiscal sanctions from CMS as a result of non-compliance by HFID. The current State/County contract allows CDPH to pass on 100% of the sanctions attributable to the County's non-compliance and withhold the amount(s) on their fiscal year end invoice.

HFID management asserted that, to date, they have met all of their contractual obligations and have not been sanctioned by CMS or the State, nor required to pay any penalties as a result of not meeting their contractual obligations or performance requirements. However, as shown on Table 5, there are over 11,000 backlogged investigations related to the health care facilities in the County, and many are over five years old. According to HFID management, the delays in completing their investigations were caused by insufficient funding in the prior years, including limited staffing resources, which also affected HFID's ability to meet the demands of the overall workload. In addition, HFID indicated investigations can take longer to resolve depending on the type and complexity of the allegations in the complaint, and whether the complainants or facilities appealed the results. It should be noted that HFID did not identify obtaining extensions from the State as one of the causes for exceeding the 60-day requirement to complete their investigations.

To aid in ensuring all investigations are conducted and closed within the required timelines, as mentioned in Recommendation 4, HFID management should consider enhancing their tracking mechanism of their current and backlogged investigations by clearly identifying which investigations are pending extension approvals and/or were delayed due to extensions granted by the State, and their corresponding new deadlines resulting from granted extensions. In addition, HFID management should consider

¹⁵ CDPH's Field Operations Dashboard is a publicly available dashboard on the State's website that provides various data on complaint and FRI investigations by priority level (i.e. IJ, non-IJ, etc.) for LTC and non-LTC facilities across all districts within California. The dashboard provides data by district, such as the number of complaint and FRI investigations received, number of deficiencies cited, percentage of investigations completed within required timeframes, and percentage of LTC complaint related citations issued within 30 days.

conducting a study, or hire a consultant to conduct a study, to identify the cause(s) and solution(s) for the significant delays in closing out investigations, and develop a plan, whether procedurally/operationally and/or modifying HFID's organizational structure and/or staffing levels, to ensure all investigations are closed within established timeframes as required.

Recommendation

Refer to Recommendations 4 and 18.

- 6. Department of Public Health's Health Facilities Inspection Division's management consider adopting the completion timeframes used by CDPH, and/or establishing internal timeframes for FRI investigations that are consistent with CDPH's practice to ensure timely completion.**

Enforcement Protocols

HFID is required to follow the CMS and State enforcement guidelines when they identify incidents of non-compliance with regulatory requirements during their COVID-19 Mitigation visits and other required activities (as defined in Table 1), and make enforcement recommendations. The guidelines also require HFID's Evaluators to enter all incidents of non-compliance requiring enforcement under Federal and/or State regulations into ASPEN and/or the State's Electronic Licensing Management System (ELMS). Depending on the level of enforcement and whether the facility violated federal and/or State requirements, the incidents of non-compliance could be entered into one or both systems. HFID Supervisors are required to review and approve the enforcement recommendations made by their Evaluators prior to submission to the State and CMS.

According to CMS' State Operations Manual (SOM), when a facility is found not to be in "substantial compliance" with the CMS requirements, HFID is required to cite the facility and initiate the relevant enforcement remedies. The State and HFID are not required to recommend the type of remedies to be imposed but are encouraged to do so since they may be more familiar with a facility's history and the specific circumstances of the incident. CMS reviews and considers the State and HFID proposed recommendations, and makes their final decision¹⁶ on the appropriate enforcement remedies to be imposed. Once the final decision on the enforcement remedy has been made, HFID is required to issue a Formal Notice of Remedies (Notice) to the facility, which must include:

- Nature of the non-compliance;
- Remedy imposed;
- Effective date of the remedy;
- Rights to appeal the determination; and,

¹⁶ CDPH is authorized, however, to both recommend and impose one or more of the following remedies: directed in-service training, state monitoring, and directed Plan of Correction.

- That remedies will continue until substantial compliance has been met.

Facilities are expected to correct deficiencies timely and HFID is required to follow up with the facility until all the deficiencies have been satisfactorily resolved. Additionally, CMS establishes due dates for certain items, such as submission of Plan of Correction and due dates for CMS to approve, modify or deny the Plan of Correction. If the facility does not take action according to its approved Plan of Correction and does not achieve substantial compliance by the end of the specified period, the CMS regional office may transfer residents, discontinue funding, and/or terminate a provider's (i.e., health care facility) agreement for funding.

CMS' SOM also contains guidelines and required timeframes for certain critical phases of the enforcement process pertaining to IJ and non-IJ complaint and FRI investigations. In addition, CMS' SOM provides guidelines and certain timeframes for conducting other required activities, such as federal Recertifications, State Re-licensure, and State Initial and Change of Services Surveys. According to HFID management, their Evaluators, Supervisors, and Managers mainly utilize CMS' SOM, which is approximately 5,000 pages, for reference when conducting all of their required activities. According to HFID management, their staff also reference the CDPH's District Office Memorandums, CDPH's Policies & Procedure Guides, California Code of Regulations Title-22, Health & Safety Code Regulations, and Life Safety Code Regulations, many of which are complex. HFID does not currently have any quick reference guides to assist their staff in effectively and efficiently conducting their work.

We noted CMS' SOM does not always provide the required timeframes for all phases of their required activities, or enforcement protocols for when deficiencies or issues of non-compliance are identified during *non-investigation related surveys*. For example, CMS' SOM does not have procedures/guidelines/timeframes for when:

- Deficiencies and issues of non-compliance are identified during their other surveys (i.e., federal Recertifications, State Re-licensure, and State Initial and Change of Services Surveys). Specifically, there are no established timeframes for when these noted deficiencies and issues of non-compliance should be entered into ASPEN or ELMS, by what dates these incidents should be resolved, or when specific enforcement remedies should be issued when deficiencies are not resolved.
- The Evaluator should submit IJ findings into ASPEN, when the Supervisor should review the IJ findings, or when the Statement of Deficiencies and Plan of Correction should be submitted to the facility for deficiencies and issues of non-compliance identified during their non-investigation related surveys.

In addition, CMS' SOM does not have procedures/guidelines/timeframes specifying when HFID should:

- Notify the CMS Regional Office when the facility does not submit an acceptable Plan of Correction.
- Exit the findings with the facility after the initial survey/investigation.
- Follow-up with the facility and resolve the monetary and non-monetary penalties.

According to HFID management, they are not required to establish key timeframes and milestones not already specifically addressed by CMS' SOM. However, HFID management should consider advocating for the State to, or provide HFID with additional resources necessary to, establish key timeframes and milestones not already specifically addressed by CMS' SOM. In addition, HFID management should consider developing and distributing a quick reference guide of the most applicable requirements from all relevant County, State and federal guidelines to ensure staff are effectively and efficiently completing their work.

Recommendations

Department of Public Health's Health Facilities Inspection Division's management consider:

- 7. Advocating for the State to, or provide HFID with additional resources to, establish key timeframes and milestones not already specifically addressed by CMS' SOM.**
- 8. Developing and distributing a quick reference guide of the most applicable requirements from all relevant County, State, and federal guidelines to ensure HFID staff are effectively and efficiently completing their work.**

Enforcement Tracking

HFID is required to enter enforcement recommendations made to the State or CMS into ELMS or ASPEN, respectively. HFID indicated they have a Citation Coordinator reviewing ELMS Citation Registration Logs (ELMS Logs) to monitor citation status, ensure timely processing of citations, and verify that all required information/documentation has been collected and forwarded to appropriate HFID staff and CDPH so citations can be closed in ELMS after the facilities have resolved the deficiencies. The ELMS Log only reports monetary citations and does not include non-monetary enforcement remedies issued. In addition, a similar log/report or tracking process does not currently exist for federal enforcement citations/penalties assessed.

The most recent ELMS Log, dated October 27, 2020, reported that during FY 2019-20, 249 State monetary penalties¹⁷ were assessed, totaling approximately \$1.8 million, of

¹⁷ According to HFID management, the State is responsible for collecting the monetary penalties.

which 76 (31%) penalties, totaling approximately \$1 million, remained open/unresolved. Some of the open/unresolved citations dated back as far as July 3, 2019.

In order to adequately track and monitor all State and federal enforcement citations/penalties imposed, and strengthen their oversight of the health care facilities in the County, HFID should consider developing and distributing a comprehensive report, comprised of the status/phase (e.g., open, unresolved, etc.) of each State and federal citation, and key dates, such as dates:

- Citations were issued;
- Facilities' corrective action plans were received and approved;
- Of re-visits to verify implementation and compliance with corrective action plans;
- Citations were appealed and their results; and
- Citations were resolved and closed.

However, according to HFID management, they should not be required to track or ensure all State and federal citations/remedies are implemented and resolved timely since they are not responsible for imposing enforcement actions. DPH management should consider advocating for the State to, or provide HFID with additional resources to, develop a better tracking/monitoring protocol to ensure all State and federal citations/remedies are implemented and resolved timely.

Recommendation

- 9. Department of Public Health's Health Facilities Inspection Division's management consider advocating for the State to, or provide HFID with additional resources to, develop a better tracking/monitoring protocol to ensure all State and federal citations/remedies are implemented and resolved timely.**

Continuous Increases in Complaints and FRIs

The number of complaints and FRIs could continue to increase as they have over the last five fiscal years if deficiencies noted within HFID's processes, and non-compliance issues identified during investigations and other required activities at the health care facilities, are not addressed timely. Specifically, based on the actual number of complaint and FRI intakes HFID reported from FY 2015-16 to FY 2019-20, we noted increases each fiscal year, including an accumulated increase of approximately 39% from FY 2015-16 to FY 2019-20, as illustrated in Table 9:

Table 9

Total Number of Complaint and FRI Intakes Received by Fiscal Year								
Fiscal Year	LTC			Non-LTC			Total LTC and Non-LTC Complaints and FRIs	Total % Increase from Prior Year
	Complaints	FRIs	Total LTC Complaints and FRIs	Complaints	FRIs	Total Non-LTC Complaints and FRIs		
2015-16	2,098	3,078	5,176	1,040	942	1,982	7,158	-
2016-17	2,424	3,143	5,567	1,107	997	2,104	7,671	7%
2017-18	2,901	3,701	6,602	1,271	1,001	2,272	8,874	16%
2018-19	3,125	3,718	6,843	1,285	1,117	2,402	9,245	4%
2019-20	3,308	3,861	7,169	1,452	1,310	2,762	9,931	7%
Total % Increase from FY2015-16 to FY 2019-20								39%

In addition to the continuing increases in the number of complaints and FRIs, over the last five fiscal years, the *actual* number of LTC and non-LTC FRI intakes have far exceeded HFID’s contractual percentage share of their projected full caseload amounts. For example, Exhibit A-1 of the State/County contract reported HFID was required to complete 2,306 LTC FRI investigations in FY 2019-20. However, as shown on Table 9, the total number of *actual* LTC FRI intakes for FY 2019-20 was 3,861, a difference of 1,555 (3,861 – 2,306) or 67%, which according to the State/County contract, would be the responsibility of the State. However, according to CDPH management, after the current contract term expires, the State intends to require HFID to take responsibility for all current and backlogged investigations related to the health care facilities in the County, and not just to the annual contract percentage of the projected full caseload.

We did not conduct an analysis to determine whether the increases in complaint and FRI intakes are attributed to the increasing number of patients at the health care facilities or complaints and FRIs not being investigated and resolved timely. However, the number of complaints and FRIs could continue to increase if investigations are not completed and corrective actions are not implemented timely.

Therefore, HFID management should consider conducting, or hiring a consultant to study improvements or changes in their processes that can be made to ensure deficiencies and other non-compliance issues are timely and effectively resolved. In addition, the study should identify the common deficiencies and non-compliance issues identified during their complaint and FRI investigations and other required activities, to determine whether a systemic approach would help reduce the number of similar complaints.

Recommendation

Refer to Recommendation 18.

Understanding Contractual Responsibility of All Current and Backlogged Investigations

HFID management initially asserted they are only contractually required to complete “current” investigations that have been received and opened during the current FY and they are meeting their contractual obligations; thus implying the 11,635 backlogged investigations are not part of their current three-year State/County contract, and that CDPH was taking the responsibility for all backlogged investigations. However, according to their contract with CDPH, HFID is also responsible for all backlogged LTC complaints and FRIs received *on or after* July 1, 2015, and Non-LTC complaints and FRIs received *on or after* July 1, 2019. This was solidified when CDPH added capacity for this work in Year 2 in Exhibit A-1 of their State/County contract (also shown in Table 1), under the “Open and Backlog Complaints and FRIs” line item, in which HFID would begin to assume some responsibility (25% in Year 2 and 43% in Year 3) of the backlogged investigations with complete responsibility to be transferred to HFID after the current three-year State/County contract.

As a result of our inquiries and DPH’s subsequent discussions with the State, HFID management confirmed their responsibility to complete all backlogged LTC complaint and FRI investigations, as represented in this report.

Recommendation

10. Department of Public Health’s Health Facilities Inspection Division’s management consider developing a plan to actively and aggressively work on tracking, completing, and closing out their backlogged investigations to avoid further contributing to the increasing amount of incomplete investigations.

B. HFID’s Other Required Activities

As mentioned earlier, a federal directive suspended all non-COVID-19 related investigations that are not critical. To assess whether HFID has the ability and capacity to monitor and ensure compliance with Plan requirements while maintaining the required non-COVID-19-related investigations and meeting other critical oversight roles, we need to fully identify and understand HFID’s total workload and oversight responsibilities and requirements related to the 4,188 healthcare facilities under their jurisdiction.

Tracking HFID's Overall Workload

HFID management did not demonstrate, or provide documentation to support, their understanding of each staff's overall workload. HFID uses their SOC Report to track the various phases/stages of their current investigations related to LTC health care facilities, and generates reports on current investigations by Evaluator for each of HFID's four District offices, which are used by Managers and Supervisors to re-assign current investigations, based on each Evaluator's workload. However, as previously mentioned, the SOC Report does not provide the status on current or backlogged complaint and FRI investigations related to Non-LTC health care facilities, and appears to only provide the status for current LTC related complaint and FRI investigations that have been received *starting* July 1, 2020. In addition, these reports do not clearly identify backlogged investigations that were recently transferred to the State as part of the State/County contract, or staff's other workload (e.g., number of outstanding federal recertifications and State re-licensure surveys, etc.) that they are responsible for completing. HFID management also did not provide documentation to support their understanding of HFID's overall pending/incomplete workload to date for all HFID's 289 employees.

Instead, HFID provided numerous reports but none that inventory HFID's complete total workload. Specifically, the reports HFID provided did not inventory their in-progress or pending Licensing and Re-licensing Surveys, or the "State Initial and Change of Service Surveys" and other "Miscellaneous" activities, that are required to be completed by their State/County contract. In addition, the reports did not inventory the other COVID-19 related activities they asserted they are now performing in addition to the COVID-19 Mitigation visits. Without a complete inventory and status of HFID's current and in-progress workload, HFID management may not be able to effectively manage their resources. Specifically, HFID management may not be able to evaluate staffs' responsibilities, effectively re-distribute work, or identify and resolve inefficiencies or bottlenecks within their processes which could negatively impact the health and safety of residents at the health care facilities in the County. For example, if a significant number of investigations are pending approval, HFID may want to identify the number of pending approvals per Supervisor and identify if any approvals can be re-assigned to another Supervisor to ensure timely completion. In addition, analyzing the workload of each employee and the re-distribution of work may highlight areas for improvement in both their staffing and processes currently in place.

In addition, when we reconciled CDPH's report that identified the total LTC and non-LTC backlogged investigations for the County to HFID's internal report, we noted a significant variance. Specifically, CDPH's report indicated the County had approximately 9,050 backlogged investigations as of July 7, 2020. However, HFID's internal report indicated the County had 11,635 backlogged investigations as of June 30, 2020, a variance of 2,585 investigations. At the time of our review, HFID management did not know what caused the variance. After working with CDPH, HFID management determined the variance was due to HFID including the investigations related to medical record breaches when CDPH's summary report did not, and the timing difference (one week) of when

CDPH's and HFID's reports were generated. It wasn't until January 2021, that HFID management indicated that part of the variance was also attributed to CDPH's report only including aged intakes (non-LTC intakes older than six months and LTC intakes older than 60 days), whereas HFID's report included all open intakes. HFID management has yet to provide documentation to support that these variances have been investigated and dispositioned. Therefore, HFID management should consider routinely working with the State to determine and resolve the cause(s) for discrepancies timely to ensure both the State's and HFID's reports are complete and accurate.

Recommendations

Department of Public Health's Health Facilities Inspection Division's management consider:

- 11. Routinely working with the State to determine and resolve the cause(s) for discrepancies within their reports timely to ensure both the State's and HFID's information is complete and accurate.**
- 12. Compiling and developing a comprehensive report that identifies HFID's overall required workload, sorted by District Office, Manager, Supervisor, and Evaluator, and analyzing the data to assist HFID in effectively reevaluating each staff's roles and responsibilities, re-distributing work, and identifying and resolving inefficiencies or bottlenecks within their processes to ensure timely completion of their required workload.**

Other Oversight Activities - Analysis and Risk Assessments

HFID management indicated they currently do not compile or internally track and analyze the results of all incidents and deficiencies, including enforcement remedies issued to health care facilities in the County to identify trends and areas for improvement to appropriately address reoccurring and/or systemic issues. In addition, HFID currently does not conduct their own risk assessments of their health care facilities or their activities required under their State/County contract. Instead, HFID management utilizes the following CMS and CDPH reports they receive as a recognized State Survey Agency to identify trends and areas for improvement:

- The CMS' Special Focus Facilities (SFF) Report, a data analysis of deficiencies noted during all inspections, identifies trends and areas for improvement. Results from approximately three years of inspections are analyzed based on the number of deficiencies cited and the scope and severity level of those citations. Facilities ranked as higher risk in the State are candidates for the SFF program¹⁸. HFID provided CMS'

¹⁸ CMS's Special Focus Facility (SFF) Program focuses extra attention on nursing homes with a record of poor survey (inspection) performance by requiring the State Survey Agency, on CMS's behalf, to conduct a full, on-site inspection of all Medicare health and safety requirements every six months and recommend

SFF Report for October 2020, which included ten SNFs in the County eligible for the SFF program.

- CDPH's Predictive Analytics Report, which is based on data submitted by the SNFs to the State, assesses recent changes in SNF administration, past infection control deficiencies, past incidents, staffing, available personal protective equipment (PPE), location of SNF in proximity to other facilities with an outbreak, and number of beds. HFID management indicated they may conduct additional monitoring and/or follow-up at the SNF based on the risks identified by the State.
- CMS' 3-5 Day Focused Infection Control Survey Report, which is based on data collected for their COVID-19 Module Data Dashboard, identifies facilities, on a weekly basis, that require Targeted Infection Control Surveys¹⁹ to be performed. As of October 26, 2020, the County had six facilities on CMS' list and was designated as a "Hot-Spot County," requiring HFID to conduct an on-site inspection within two days (vs. 3-5 days) from the report date.

These reports do not assess non-COVID-19 related risks/issues, or identify COVID-19 related risks/issues specific only to the facilities residing within Los Angeles County.

HFID management should consider obtaining and internally analyzing the results of all incidents and enforcement remedies issued to health care facilities in the County to identify trends and areas for improvement to appropriately address reoccurring or systemic issues within the County. In addition, HFID management should consider conducting their own internal risk assessments of their health care facilities and the required activities they are obligated to complete under their State/County contract to help prioritize and reallocate resources and help ensure high risk facilities and critical responsibilities are appropriately and timely completed.

Recommendations

Department of Public Health's Health Facilities Inspection Division's management consider:

13. Obtaining and internally analyzing the results of all incidents and enforcement remedies issued to facilities residing within the County to

progressive enforcement (e.g., fines and denial of Medicare payment) until the nursing home either, (1) graduates from the SFF program or (2) is terminated from the Medicare and/or Medicaid program(s).

¹⁹ Targeted Infection Control Surveys are additional on-site inspections/visits, using the "COVID-19 Focused Survey for Nursing Homes" survey tool developed by CMS, to investigate compliance and determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections.

identify trends and areas for improvement to appropriately address reoccurring or systemic issues within the County.

14. **Conducting their own internal risk assessments of their health care facilities and the required activities they are required to complete under their State/County contract to help prioritize and reallocate resources and help ensure high risk facilities and critical responsibilities are appropriately and timely completed.**

IV. Benchmarking Analysis

The Board directed the AC to compare HFID's staffing level, in terms of number of employees and classifications, to other counties in the State in proportion to the number of SNFs and relative to the State-contracted scope of work. In addition, the A-C was instructed to work with the Chief Executive Officer, Director of the Department of Human Resources, County Counsel, and the Director of DPH to ensure there is the necessary staffing, expertise, training, enforcement protocols, and other functions required to support DPH's monitoring and enforcement effort.

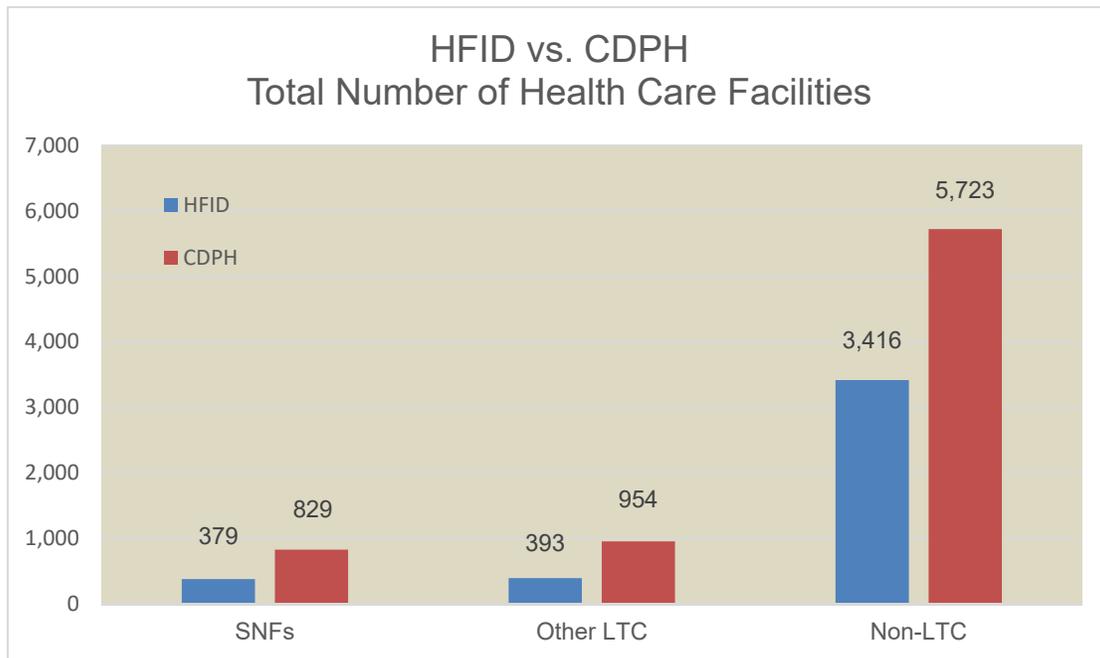
As previously mentioned, Los Angeles County is the only county in California with a State/County contract to perform the required activities as shown in Table 1, for all of the health care facilities in the County, including SNFs. In addition, in our discussions with CDPH, we were unable to identify any other comparable counties within the United States that had a similar State/County contract. Therefore, we attempted to benchmark against CDPH, where possible.

We compared HFID and CDPH's staffing structures and evaluated, for each staff level, the levels of expertise, training, and roles and responsibilities. We also compared the standard average hours it takes to complete the required activities for HFID and CDPH. However, CDPH was unable to provide the requested information on their total workload and management oversight responsibilities due to CDPH having to prioritize their workload to address COVID-19 responsibilities. Therefore, we were unable to determine if HFID has the appropriate staffing structure and levels, in comparison to the State, or whether the State's staffing structure and levels are the best model to emulate, since there are so many unknown factors. However, comparing the two organizations provided insights and highlighted areas for further review.

Number of Total Health Care Facilities – State vs. County

In the State of California, there are 11,694 health care facilities, of which CDPH is responsible for overseeing 7,506 (64%) and DPH's HFID is responsible for overseeing 4,188 (36%). The State currently has 1,208 SNFs, of which 379 (31%) are under HFID's purview and 829 (69%) are under CDPH's jurisdiction. Chart 3 illustrates the total number of SNFs, and other LTC and Non-LTC facilities for both HFID and CDPH:

Chart 3

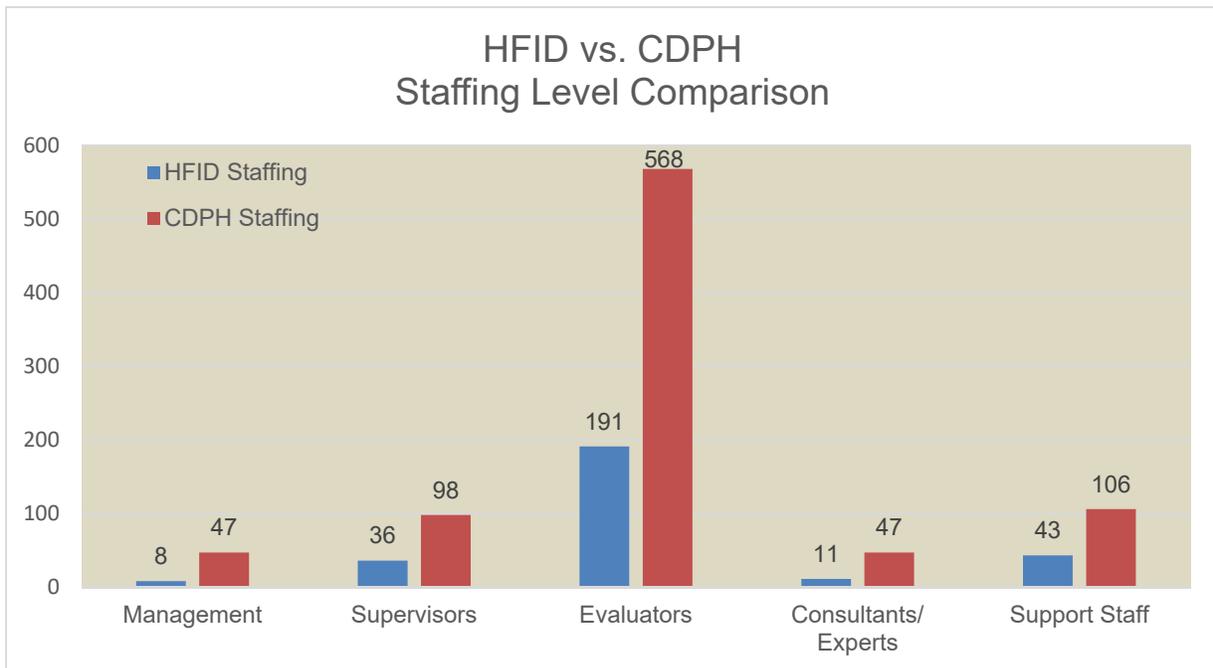


As shown in Chart 3, there are 2,555 total LTC health care facilities (SNFs and other LTC) in California, in which the State is responsible for 1,783 (70%) and HFID is responsible for 772 (30%). There are 9,139 Non-LTC health care facilities in California, in which the State is responsible for 5,723 (63%) and HFID is responsible for 3,416 (37%). In comparison, the total number of health care facilities the State is responsible for is approximately twice the number HFID is responsible for in each of the three categories.

Staffing Structures and Levels – State vs. HFID

HFID consists of four district offices with 289 staff, including 191 Evaluators assigned to perform the required activities as shown in Table 1 for the 4,188 health care facilities in the County. In comparison, CDPH has 866 staff, including 568 Evaluators to perform similar required activities for 7,506 health care facilities. Both CDPH and HFID use the same reporting hierarchy, such that the Evaluators report to Supervisors, and Supervisors/Consultants report to Management. Chart 4 illustrates the staffing levels (as of August 7, 2020) of both HFID and CDPH:

Chart 4



In comparison, HFID has a similar percentage of Management personnel (3%) and Supervisors (12%) when compared to the State (5% and 11%, respectively). However, we noted the following variances that could have contributed to the significant delays and increases in investigation backlogs:

- HFID has a higher total staff-to-number of facilities ratio²⁰ (1:14) than the State (1:9).
- HFID has a higher Evaluator-to-number of investigations ratio²¹ (1:33) than the State (1:10).

It is unclear at this time whether HFID's higher ratios of total staff-to-number of facilities and Evaluator-to-number of investigations contributed to the 11,635 total outstanding investigations (as of June 30, 2020) and the significant delays in completing the older investigations as shown in Table 5. As such, HFID management should consider conducting or hiring a consultant to study the most appropriate staffing structure and staffing levels to ensure the ongoing health and safety of residents and staff within health care facilities in the County.

²⁰ Ratio is based on total number of facilities from Chart 3 to the total number of staff from Chart 4 for HFID and the State, respectively.

²¹ Ratio is based on total number of investigations from Table 6 to the total number of Evaluators from Chart 4 for HFID and the State, respectively.

Recommendation

Refer to Recommendation 18.

Roles and Responsibilities of Each Staffing Level – State vs. County

We obtained the Duty Statements and Job Descriptions for both CDPH's and HFID's Managers, Supervisors, Senior Evaluators, Evaluators, and Consultants/Experts. Attachment V is a summary of each staffing level's roles and responsibilities for both CDPH and HFID. Based on the Duty Statements and Job Descriptions obtained, we determined that the roles and responsibilities of each staffing level between CDPH and HFID are comparable.

Levels of Expertise – State vs. County

We obtained the Job Specifications for both CDPH's and HFID's Managers, Supervisors, Senior Evaluators, Evaluators, and Consultants. For both CDPH and HFID, at a minimum, a bachelor's degree from an accredited college, university, or educational institution approved by the CDPH in a recognized health field (e.g., nursing or other health related field) is required for each staffing level. In addition, below is a summary of the minimum experience requirements for each staffing level at both CDPH and HFID:

- Managers – Two years of experience as a Supervising Evaluator.
- Supervising Evaluators – One year of experience as a Senior Evaluator.
- Senior Evaluators – One year of experience as an Evaluator.
- Evaluators – One year of experience performing the duties of an Evaluator Trainee.
- Consultants – A license to practice in their area of expertise, issued by the State of California, is required, along with all educational requirements for the license and two years of experience in their field of expertise.

Based on the Job Specifications obtained, we determined the levels of expertise and minimum years of experience and licensure requirements between CDPH and HFID are comparable.

Training Requirements – State vs. County

Evaluators for both the State and HFID are required to complete the same basic federal and State training. On average, it takes approximately six months for a newly hired Evaluator to prepare, pass, and obtain their Surveyor Minimum Qualification Test (SMQT) certification. Specifically:

- It takes approximately eight weeks to complete all of the State licensing survey training courses, after which the Evaluator will be able to conduct State licensing surveys (e.g., COVID-19 Mitigation visits, complaint and FRI investigations, etc.).
- A new Evaluator, also referred to as a Surveyor, must also compete the four-week New Surveyor Academy, a one-week Basic LTC training, and pass and obtain the SMQT certification in order to meet federal requirements. The New Surveyor Academy prepares the new Evaluator to take the SMQT. During the New Surveyor Academy, the Evaluator will learn about their roles, and how to navigate the ASPEN software, investigate, document gathered evidence, and write a deficiency citation (narrative report). In addition, the Evaluators will learn about guidelines and duties related to oversight activities (e.g., the federal Recertification process, State Re-licensure Survey Process, Immediate Jeopardy investigations, etc.).

In addition, according to HFID management, all staff were provided with the “Immediate Jeopardy Process, and Severity and Scope Levels” training course, which provides a review of IJ components and how to determine if an IJ condition exists, including examples of past IJ cases. However, we were unable to obtain a listing of the additional trainings CDPH requires for their Managers, Supervisors, and Evaluators due to CDPH having to prioritize their workload to address their COVID-19 responsibilities.

Receiving the minimum amount of training required to perform their duties may not always be sufficient for staff to complete their job assignments in the most effective and efficient manner. Therefore, HFID management should consider, at minimum, ensuring HFID staff receive the same amount and types of training the State’s staff receive. In addition, HFID management should consider conducting an anonymous survey of all HFID staff to assess whether Managers, Supervisors, Evaluators, and their Consultants/Experts feel they have sufficient knowledge and expertise to appropriately perform their job duties, whether additional training should be provided, and if so, what types of training the staff believe are needed to perform their job functions in the most efficient and effective manner.

Recommendations

Department of Public Health’s Health Facilities Inspection Division’s management consider:

- 15. At minimum, ensuring HFID’s staff receive the same amount and types of training the State’s staff receive.**
- 16. Conducting an anonymous survey of all HFID staff to assess whether Managers, Supervisors, Evaluators, and their Consultants/Experts feel they have sufficient knowledge and expertise to appropriately perform their job duties, whether additional training should be provided, and if so,**

what types of training the staff believe are needed to perform their job functions in the most efficient and effective manner.

17. Providing additional training to all staff, specific to their levels, as identified through the anonymous survey.

Standard Average Hours Comparison – State vs. County

HFID’s staff reports the hours spent on their required activities into the State’s Time Entry and Activity Management System, and CDPH utilizes this data to calculate the standard average hours for HFID and their regional offices. CDPH calculated and provided the State’s and HFID’s standard average hours for each SNF oversight activity for FY 2018-19 as illustrated in Table 10:

Table 10

Standard Average Hours CDPH vs. HFID Skilled Nursing Facilities FY 2018-19			
Oversight Activities	Standard Average Hours		
	CDPH	HFID	Variance
Complaint (1)	19.75	17.02	2.73
Initial Certification	416.20	142.31	273.89
Life Safety Code (LSC) Initial Certification	18.82	15.38	3.43
Initial Licensure	104.73	47.69	57.04
Licensure Visit	73.39	12.31	61.09
Recertification	346.70	286.26	60.44
Recertification - Follow-up	80.56	46.96	33.60
LSC Recertification	26.70	34.19	(7.49)
LSC Recertification/Follow-up	7.74	4.71	3.03
Re-Licensure	87.78	90.38	(2.60)

(1) The State did not provide the standard average hours for FRIs. As such, we did not include this information on the Table.

According to Table 10, only four (40%) of the ten activities listed had comparable (within five hours) standard average hours between CDPH and HFID. Specifically, HFID’s Complaints, LSC Initial Certifications, LSC Recertifications/Follow-up, and Re-Licensures were within five hours to complete in comparison to CDPH. In general, it appears HFID required less hours to complete the activities than CDPH with two exceptions (LSC Recertifications and Re-Licensure). However, since assessing the quality of the required activities performed was not within our scope or area of expertise, we did not perform a review of the quality of the activities performed to determine whether HFID is performing more effectively and efficiently than CDPH. As a result, HFID management should

consider conducting a study, or hiring a consultant to conduct a study, to determine and resolve the cause(s) (i.e., different Quality Assessment reviews of staff's work, complexity of cases, etc.) for the significant variances in the standard average hours between the State and County, and to ensure HFID staff are performing their activities in the most efficient and effective manner.

Recommendation

Refer to Recommendation 18

Total Oversight Responsibilities and Workload - State vs. HFID

CDPH was unable to provide the requested documentation/information on their total workload and management oversight responsibilities due to CDPH having to prioritize their workload to address COVID-19 responsibilities. Therefore, we were unable to complete our analysis on whether HFID has the appropriate staffing structure and levels, in comparison to the State, or whether the State's organizational structure and staffing levels are the best model to emulate since there are so many factors that are unknown. For example, we do not currently have the information on, or understanding of the State's:

- Total management oversight responsibilities and workload.
- Backlogs, if any, in the areas of investigations and other required activities.
- Processes for how they manage and track their work, whether by facility or staff, for all required activities.
- Enforcement protocols.
- Lower ratios of total staff-to-number of facilities and Evaluator-to-number of investigations, in comparison to HFID, and how these variances contributed to enhancing, or hindering, their efforts in effectively and efficiently completing their required workload.
- Practices, including timeframes, for performing quality assurance reviews of their staff's work.
- On-going efforts to provide additional training to their staff.
- Reason(s) for why their standard average hours to perform certain activities is higher compared to HFID.

HFID management should consider conducting their own study, or hire a consultant to conduct a study, to determine the most appropriate staffing structure and levels to ensure the ongoing health and safety of residents and staff within the health care facilities residing in Los Angeles County. This study should consider all issues/concerns identified in this report.

Recommendation

18. Department of Public Health's Health Facilities Inspection Division's management should consider conducting, or hiring a consultant to conduct, a comprehensive analysis/study, that takes into account all issues/concerns identified in this report, to:

- a) Determine the appropriate and necessary staffing structures and levels (i.e., Evaluators, Supervisors, Consultants/Experts, Managers and Support Staff), and types of positions (i.e., regular, part-time, seasonal, and contracted employees) HFID will need to best meet their current and future contractual needs to ensure the ongoing health and safety of residents and staff within the health care facilities in the County.**
- b) Identify the cause(s) and solution(s) for the significant delays in closing out investigations, and develop a plan, whether procedurally/operationally and/or modifying HFID's organizational structure and/or staffing levels, to ensure all investigations are closed within established timeframes as required.**
- c) Identify what improvements or changes in their processes are needed to ensure deficiencies and non-compliance issues are timely and effectively addressed and resolved.**
- d) Determine whether a systemic approach/solution would help reduce the number of similar complaints and non-compliance issues being reported.**
- e) Identify the cause(s) and solution(s) for the significant variances in the standard average hours between the State and County to ensure HFID staff are performing their activities in the most efficient and effective manner.**
- f) Develop corrective action plans for addressing and resolving any other areas of improvements identified during their comprehensive study.**

Glossary of Terms

For purposes of this report the following words as used herein shall be construed to have the following meaning, unless otherwise apparent from the context in which they are used.

“Backlog” is defined, for the purpose of this report, as any required activity (e.g., Long-Term Care (LTC) and Non-LTC complaint and Facility Reported Incidents (FRIs) investigations, etc.) that was opened/initiated in prior fiscal years but not yet closed/completed.

“Change of Service Survey” is an onsite facility survey following a facility’s submission of a Change of Service application to report changes that require an updated license, such as a change of name, change of location, or change of capacity. Facilities are required to submit a Change of Service application for any changes that require an updated license and the State conducts the onsite facility survey to ensure the facility complies with the requirements necessary to make those changes.

“Complaint” is an allegation of non-compliance by a health care provider with federal and/or State requirements made by a third party such as the resident, family member, friend, employee, members of the public, media, or other agencies (e.g., law enforcement, Fire Department, Department of Justice).

“Current” is defined as any required activity (e.g., LTC and Non-LTC complaint and FRI investigations, etc.) that was opened/initiated in the current fiscal year but not yet closed/completed, and limited to HFID’s proportionate share based on the annual contract percentage of the projected full caseload amounts as outlined in Exhibit A-1 in the State/County contract (also shown in Table 1).

“Deficiency” means a health care provider failed to meet participation requirements with federal regulatory requirements.

“Enforcement Action” means the process of imposing one or more remedies, such as termination of a provider agreement, denial of payment for new admissions, or civil monetary penalties, for health care facilities found not to be in substantial compliance.

“Facility Reported Incidents” (FRIs) are reported by a self-reporting facility or health care provider (i.e., the administrator or authorized official for the provider) that alleges non-compliance with federal and/or State laws and regulations. Facilities are required to report unusual occurrences such as epidemics, outbreaks, disruption of services, major accidents or unusual occurrences that threaten the health and safety of patients, residents, clients, staff or visitors. FRIs and complaints are investigated in the same manner.

“Federal Certification and Recertification” surveys are conducted to ensure whether health care providers meet federal Centers for Medicare & Medicaid Services (CMS) regulations. Health care providers must undergo an initial Certification survey to certify whether the provider complies with standards required by federal regulations. State

Survey Agencies are also required to perform periodic Recertification surveys to certify whether the health care provider meets the applicable federal health and safety requirements for continued participation in the federal program.

“Initial Licensing Survey” is an onsite initial facility survey following an approved application evaluating compliance with Health and Safety Codes and California Code of Regulations Title 22 regulations for a facility seeking initial licensure. Licensure is a state process establishing approval to conduct business as a health care facility.

“Investigation” is the process of conducting fact finding surveys to determine and report whether a complaint or FRI is substantiated or unsubstantiated. The investigation process includes intake, triage and prioritization, and follow-up. State Survey Agencies investigate nursing home complaints and FRIs on behalf of CMS.

“Required Activity” is defined in Exhibit A-1 of the State/County contract (also shown in Table 1) as LTC and Non-LTC complaint and FRI investigations, federal Recertifications, State Re-Licensure Surveys, State Initial and Change of Service Surveys, and Miscellaneous work.

“Skilled Nursing Facilities” (SNFs) provide 24-hour nursing and support services for the elderly and disabled requiring skilled inpatient care on an extended basis. SNFs are required by federal law to undergo an annual survey and certification process by its State’s health department to ensure compliance with federal requirements, as well as State law.

“Standard Average Hours” (SAH) is the average hours each activity type takes to complete. The SAH are developed from the State’s actual timekeeping data from the prior three years. The State uses SAH as a metric for quantifying workload.

“State Licensing and Re-Licensing” surveys are conducted to ensure health care providers are in compliance with all State laws and regulations. Initial Licensing surveys are conducted for facilities that have applied for licensure with the State. State Survey Agencies are required to conduct periodic Re-Licensing surveys to ensure the provider continues to meet the applicable State regulatory requirements.

“State Survey Agency” is the entity responsible for conducting most surveys, on behalf of CMS, to certify health care providers’ compliance with the federal CMS participation requirements. They also investigate and validate complaints and FRIs.

“Statement of Deficiencies Notice” is an official notice, provided to the facility, that lists the deficiencies cited by an Evaluator during an investigation or survey that require correction.

“Surveys” are periodic inspections (i.e., federal Recertifications, State Re-licensure, and State Initial and Change of Services Surveys) conducted at the health care facility site that gather information about the quality of service to determine compliance with applicable State and federal regulations.

**Department of Public Health
Health Facilities Inspection Division (HFID)
HFID vs. California Department of Public Health (CDPH)
Total Number of Health Care Facilities by Type**

Facility Breakdown (1)					
Facility Type	Agency				TOTAL
	Department of Public Health - Health Facilities Inspection Division (HFID)	HFID Total	California Department of Public Health - Licensing and Certification	CDPH Total	
Long Term Care	Skilled Nursing Facility	379	772	829	1,783
	Intermediate Care Facility - DD/H/N/CH/IID	249		859	
	Congregate Living Health Facility	144		95	
Non-Long Term Care	Primary Care Clinic	-	3,416	1,976	5,723
	Home Health Agency	1,367		976	
	Hospice	934		729	
	Community Clinic	525		-	
	Chronic Dialysis Clinic	198		524	
	Ambulatory Surgical Center	178		-	
	General Acute Care Hospital	88		333	
	Adult Day Health Care	-		138	
	Acute Psychiatric Hospital	41		82	
	Outpatient/Speech Pathologist	30		-	
	End Stage Renal Disease	12		-	
	Psychology Clinic	8		15	
	Free Clinic	7		-	
	Federally Qualified Health Center	6		-	
	Chemical Dependency Recovery Hospital	4		5	
	Other	-		222	
	Rehabilitation Clinic	4		98	
	Surgical Clinic	1		556	
	Correctional Treatment Center	-		19	
	Pediatric Day Health & Respite Care Facility	2		16	
	Hospice Facility	-		13	
	Transplant Center	2		-	
	Alternative Birthing Center	1		10	
	Community Mental Health Center	1		-	
	Intermediate Care Facility	1		10	
	Prospective Payment System - Rehab Unit	1		-	
	Psychiatric Health Facility	1		-	
	Referral Agency	2		1	
Rural Health Clinic	1	-			
Unlicensed Facility	1	-			
TOTAL	4,188	4,188	7,506	7,506	11,694
	36%		64%		

(1) Facility Information obtained from CDPH's Open Data Portal.

Complaint and Facility Reported Incidents Investigations

Priority Ranking Descriptions (1)		
Priority Ranking (High to Low)	Ranking Criteria	Timeframes to Initiate Investigations
Immediate Jeopardy	Alleged non-compliance indicates there was serious injury, harm, impairment or death of a patient or resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment or death of a patient or resident unless immediate corrective action is taken.	Initiate an onsite survey within 2 business days of receipt.
Non-Immediate Jeopardy, High	Alleged non-compliance with one or more requirements may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well-being that a rapid response by the State Agency is indicated.	Initiate an onsite survey within 10 business days of receipt.
Non-Immediate Jeopardy, Medium	Alleged non-compliance with one or more requirements caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status or function.	No timeframe specified, but an onsite survey must be scheduled.
Non-Immediate Jeopardy, Low	Alleged non-compliance with one or more requirements may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage.	Must investigate during the next onsite visit.
Administrative Review/Offsite Investigation	Assigned if an onsite investigation is not necessary. However, the Survey Agency or Regional Office conducts and documents in the provider's file an offsite administrative review was conducted to determine if further action is necessary.	Must investigate during the next onsite visit.
Referral - Immediate	Assigned if the nature and seriousness of a complaint/incident or State procedures require the referral or reporting of the information for investigation to another agency or board (e.g., Department of Justice, Ombudsman) without delay.	Timeframes vary by investigation.
Referral - Other	Assigned if the complaint/incident is referred to another agency or board for investigation or for informational purposes.	Timeframes vary by investigation.
No Action Necessary	Assigned if the Survey Agency or Regional Office determines with certainty that no further investigation, analysis, or action is necessary.	Not Applicable.
(1) As defined in Chapter 5 of the Centers for Medicare & Medicaid Services' State Operations Manual.		

**Department of Public Health's
Health Facilities Inspection Division and California Department of Public Health
Roles and Responsibilities of Each Staff Level**

- **Managers** – Assign, direct, and review the work of subordinate Supervisors and other personnel, including Consultants/Experts that exercise professional expertise in fields such as medicine, nursing, pharmacy, etc. Managers are also responsible for assisting in planning and implementing operational policies and procedures, and for monitoring and evaluating program operations for compliance with licensure and regulatory standards. In addition, Managers coordinate all enforcement actions for the Division, including processing license revocations, Medicare and Medi-Cal de-certifications, and criminal complaints.
- **Supervising Evaluators** – Supervise the activities of Evaluators assigned to a District Office by planning, assigning and reviewing work, both administratively and in the field. Supervisors are responsible for evaluating performance by determining effectiveness in enforcing applicable medical care standards and regulations, counseling evaluators for purposes of improving performance and productivity, adjusting grievances, and recommending disciplinary actions. In addition, Supervisors are responsible for evaluating facility records and other evidence and recommending enforcement proceedings.
- **Senior Evaluators** – Supervise and evaluate the activities of the survey teams, and provide technical and administrative reviews pertaining to areas affecting total patient care, such as nursing, physician, pharmacy, etc. Senior Evaluators are also responsible for preparing written submissions related to enforcement actions and recommending improved procedures to appropriate supervisory personnel.
- **Evaluators** – Conduct surveys of hospitals, Skilled Nursing Facilities, clinics, and other providers in accordance with State, federal and local laws, regulations and departmental guidelines by visiting the facility, interviewing patients, evaluating the adequacy of patient care through direct observation, and inspecting the physical premises. Evaluators are also responsible for conducting investigations of health care facilities based on complaints or on suspected violations of public health laws.
- **Consultants/Experts** – Conduct surveys as a specialist surveyor to evaluate the quality of services provided by facilities in fields such as medicine, nursing, pharmacy, etc. Consultants/Experts also serve as consultants to District Office Evaluators by providing guidance and making recommendations on all aspects of services provided by facilities under their area of expertise.

**Department of Public Health
Health Facilities Inspection Division
Other COVID-19 Related Activities Performed**

On January 8, 2021, the Department of Public Health (DPH) management indicated their Health Facilities Inspection Division (HFID) currently performs the following additional COVID-19 related activities as referenced under the “Resources Required to Meet New COVID-19 Mitigation Plan Requirements” section of our report (Attachment I):

- Monitoring and responding to California Department of Public Health’s (CDPH or State) Predictive Analytics Dashboard related to COVID-19 risk, which requires an on-site visit depending on the findings;
- Responding to CDPH’s Urgent Needs Dashboard, which monitors critical situations related to staffing, personal protective equipment (PPE) and other vital resources, which may require follow-up with a facility and an on-site visit;
- Conducting virtual tours for outbreak management, infection prevention, and technical support with DPH’s Acute and Communicable Disease Control Program (ACDC) staff;
- Performing outbreak monitoring on-site visits with ACDC staff to investigate the source/cause of an incident;
- Conducting Focused Infection Control (FIC) surveys, a streamlined inspection process to ensure providers are implementing actions to protect the health and safety of residents specific to infection control;
- Communicating daily with facilities that have an active outbreak or urgent needs (e.g., staffing shortage or insufficient PPE), to determine if further action is required, including coordination of deploying external staffing resources;
- Reviewing requests from General Acute Care Hospitals (GACH), Long-Term Care (LTC), and non-LTC facilities for lowering staffing to patient ratio, allowing areas not approved for patient use when facility is above capacity, use of tents for expansion of patient areas, etc.;
- Analyzing and validating Skilled Nursing Facilities (SNF) Weekly COVID-19 Testing surveys for both CDPH and ACDC to monitor cases among SNF residents and staff;
- Monitoring numerous State/local dashboards (e.g., CDPH’s Data Hub which includes urgent needs tools for SNFs and Intermediate Care Facilities, and COVID-19 SNF Survey validation) and surveys (e.g., Daily Capacity Surveys, Smart Surveys for Congregate Living Health Facilities);
- Validating SNF reported data when there are notable changes (e.g., increase in COVID-19 cases, urgent needs, change of administrator, etc.) to confirm actual needs, correct any potential errors in the data, and determine next steps such as, on-site visit, request staffing resources from the State, monitoring, etc.;
- Ensuring implementation of Health Officer Orders;
- Assisting SNFs with COVID-19 vaccine suppliers and distribution preparation; and,
- Providing various trainings such as FIC Survey processes and requirements, how to complete the Centers for Medicare and Medicaid Services form 20054, COVID-19 updates for SNFs standard practices, inter-facility rules for GACH, hospital transfer and SNF readmission protocols, and other logistical requirements.