



**LOS ANGELES COUNTY
OFFICE OF INSPECTOR GENERAL**

**IMPROVING OVERSIGHT AND ACCOUNTABILITY
WITHIN SKILLED NURSING FACILITIES:
SECOND INTERIM REPORT**

February 2021

TABLE OF CONTENTS

Introduction	1
COVID-19 Vaccine Rollout.....	2
Pasadena Skilled Nursing Facility Evacuations	5
Golden Cross Health Care.....	6
Foothill Heights Care Center	12
HFID’s Crisis Response at Golden Cross and Foothill Heights	17
Efficacy of HFID’s Oversight and Enforcement Actions	19
HFID’s Coordination and Communication with Partner Agencies	21
HFID Staff Concerns.....	22
Ownership Structures of Skilled Nursing Facilities	24
For-profit vs. Nonprofit Ownership.....	25
Chain Ownership.....	26
Complex Ownership Structures	27
Recommendations	28
Attachment I.....	31

INTRODUCTION

On May 26, 2020, in response to the devastating impact of the COVID-19 pandemic on skilled nursing facility (SNF)¹ residents and staff, the Los Angeles County (County) Board of Supervisors passed a motion directing the Executive Officer to facilitate the appointment of an inspector general to conduct an exhaustive review of the County's capacity to regulate SNFs.² The motion directs the inspector general to provide a report on the oversight and operations of SNFs with operational and regulatory recommendations aimed at improving conditions and care in these facilities, in consultation with the Auditor-Controller (A-C) and other appropriate department leaders.³ On June 26, 2020, the Executive Officer appointed the County's Inspector General as the inspector general called for in the motion. The Inspector General respectfully submits this second interim report pending the completion of the OIG's review.

The Board motion also directs the A-C to assess the Los Angeles County Department of Public Health (LACDPH), Health Facilities Inspection Division's (HFID) ability to accomplish all COVID-19-related mitigation activities and other critical oversight roles, analyze HFID's staffing levels and ensure necessary resources are available to support monitoring and enforcement efforts. Under contract with the California Department of Public Health (CDPH), HFID is responsible for the regulation and oversight of SNFs located in the County.⁴

On October 14, 2020, the OIG issued its first interim report, which focused largely on LACDPH's COVID-19 mitigation efforts in SNFs and provided an overview of the existing SNF regulatory and oversight structures.⁵ 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 addresses complaint and facility-reported incident (FRI)

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 on an extended basis. This 24-hour inpatient care includes, at a minimum, physician, skilled nursing, dietary, pharmaceutical services and an activity program. See 22 CCR § 72103.

² 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).

³ *Id.*

⁴ 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.

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 December 11, 2020).

investigations. The A-C's interim report also provides a status update on the development of a publicly available dashboard and other Board directives.

This OIG interim report provides an update on LACDPH's COVID-19 mitigation efforts and vaccine rollout. Despite the exceptional challenges LACDPH staff continue to face as they work around the clock to battle the pandemic's unrelenting grasp on the County's residents, they have nonetheless made themselves available for multiple conversations with OIG personnel and responded to email inquiries. LACDPH staff have met with the OIG's expert, Debra Saliba, M.D., M.P.H., (Dr. Saliba) and provided a thorough overview of the vaccine rollout plan and have been responsive to requests, questions and suggestions.

This report also provides the OIG's initial assessment of HFID operations by means of an analysis of two Pasadena SNF evacuations that took place in June and October 2020. The evacuations reveal serious SNF operational deficiencies that threatened the safety of SNF residents, and gaps in the current state and County mechanisms for triggering crisis response. The evacuations also highlight flaws in HFID's crisis identification and response and resident abuse and neglect investigations. In preparing this report, the OIG spoke with more than 40 HFID staff and supervisors regarding their perceptions of HFID's operations and practices. The OIG makes corresponding recommendations for improvement of LACDPH and HFID operations and SNF crisis response planning. Finally, this report provides an overview of the complex ownership and business structures that govern the majority of the County's for-profit SNFs, including the two Pasadena facilities that experienced care crises in 2020.

Attached hereto is the A-C's final report, titled *Improving Oversight and Accountability within Skilled Nursing Facilities (May 26, 2020, Board Agenda Item #23) – Auditor-Controller's Final Report*, on its assessment of HFID (Attachment I). The A-C has identified significant operational deficiencies that appear to impede HFID's ability to fulfill several of its oversight responsibilities and provides 18 corresponding recommendations for improvement.

COVID-19 VACCINE ROLLOUT

In December 2020, the first COVID-19 vaccines in the United States were authorized for emergency use by the Food and Drug Administration and by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on

Immunization Practices (ACIP).⁶ Demand for the COVID-19 vaccine, however, was expected to exceed supply in its first months of distribution. Therefore, the ACIP recommended, as interim guidance, that both health care personnel and residents of long-term care facilities be the first to receive the vaccine.⁷ In response, CDPH created a three-tiered allocation plan which prioritized SNF residents and staff in the highest tier.⁸

The Moderna vaccine and the Pfizer-BioNTech vaccine are currently the two COVID-19 vaccines authorized by the FDA for emergency use. Both vaccines require the administration of two doses. Initially, the CDC recommended that the Pfizer-BioNTech vaccine's doses be administered 21 days apart and that the Moderna vaccine's doses be administered 28 days apart.⁹ However, on January 21, 2021, the CDC revised its guidance to "allow for a second dose administration up to 6 weeks (42 days) after the first if it is not feasible to adhere to the recommended interval."¹⁰ The CDC added that it is "not advocating for people to delay getting their second dose, but [that] the data from clinical trials support this range."¹¹

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.¹² Select pharmacies have partnered

⁶ Dooling, K., et al., *The Advisory Committee on Immunization Practices' Updated Interim Recommendation for Allocation of COVID-19 Vaccine — United States, December 2020*, January 1, 2021, Centers for Disease Control and Prevention, at: https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm?s_cid=mm695152e2_w (accessed on February 5, 2021).

⁷ *Id.*

⁸ 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); See also California Department of Public Health, *CDPH COVID-19 Vaccination Planning*, at: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-19Vaccine.aspx> (accessed on December 8, 2020).

⁹ Centers for Disease Control and Prevention, *Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States*, January 21, 2021, at: <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html> (accessed on February 8, 2021).

¹⁰ *Id.*

¹¹ *Id.*

¹² 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).

with the CDC to administer the vaccine on-site to residents of long-term care facilities, including SNFs.¹³

LACDPH reports that it had initially enrolled all 340 SNFs in the FPP. However, in December 2020, when the first COVID-19 vaccines received Emergency Use Authorization, 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.

LACDPH reports that it began distributing the Moderna vaccine to SNFs on December 22, 2020. By January 15, 2021, the first doses of the vaccine had been made available to residents and staff in all 340 SNFs. In contrast, LACDPH reports that the FPP commenced in California around January 2, 2021, at which point it had 4 weeks to reach all assigned SNFs.

Initially, LACDPH's vaccine rollout saw some delays in onboarding all 340 SNFs, which required registering with the State and finalizing necessary agreements. For facilities that were pending state approval, LACDPH assigned strike teams from LACDPH or the Los Angeles City Fire Department to provide initial doses. By December 22, 2020, approximately 50-60 SNFs had not started the registration process and were assigned to a local third-party partner to provide end-to-end management of vaccine administration and reporting.

In order to determine how many residents and staff received the COVID-19 vaccine, LACDPH obtained vaccine distribution data from SNFs as part of weekly surveys. Facilities that lagged in resident and staff vaccine administration were targeted for outreach to assess barriers and offer assistance. LACDPH reports that administrators from 339 of 340 facilities responded to a survey conducted during the period of January 26 through 31, 2021. Self-reported data indicated that approximately three-quarters of eligible residents and staff had received initial doses of the COVID-19 vaccine.¹⁴ In comparison, as of January 17, 2021, the CDC reports that an estimated median of 77.8 percent of SNF residents and an

¹³ Centers for Disease Control and Prevention, *Understanding the Pharmacy Partnership for Long-Term Care Program*, January 7, 2021, at: <https://www.cdc.gov/vaccines/covid-19/long-term-care/pharmacy-partnerships.html> (accessed on February 8, 2021).

¹⁴ Information provided was self-reported by SNFs and has not been verified by LACDPH.

estimated median of 37.5 percent of SNF staff received at least one dose of the vaccine through the FPP.¹⁵

PASADENA SKILLED NURSING FACILITY EVACUATIONS

On June 11, 2020, more than 60 residents were evacuated from Golden Cross Health Care (Golden Cross) in Pasadena after the facility's license was suspended due to ongoing quality-of-care issues.¹⁶ Fewer than four months later, on October 1, 2020, the OIG responded to Foothill Heights Care Center (Foothill Heights) in Pasadena where more than 30 residents were evacuated due to excessive indoor temperatures. 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 (1) state and local mechanisms for triggering a crisis response, (2) efficacy of HFID's oversight and enforcement actions and (3) coordination and communication between HFID and partner agencies.

On October 29, 2020, the OIG submitted a request for information to LACDPH for documentation regarding both evacuations. The OIG received some of the requested documentation on December 16, 2020. The documentation HFID provided includes timelines for each facility that summarize conditions and HFID's efforts leading up to the evacuations. In conducting its review, OIG personnel met with 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. OIG personnel also met with representatives from the California Medical Assistance Team (CAL-MAT) Program and the WISE & Healthy Aging Long-Term Care Ombudsman (Ombuds),¹⁷ including the Vice President and the Regional and Special Projects Director. In addition, OIG personnel met with CDPH, LACDPH and HFID leadership.

¹⁵ Gharpure, R., et al., *Early COVID-19 First-Dose Vaccination Coverage Among Residents and Staff Members of Skilled Nursing Facilities Participating in the Pharmacy Partnership for Long-Term Care Program — United States, December 2020–January 2021*, Centers for Disease Control and Prevention, February 1, 2021, at:

https://www.cdc.gov/mmwr/volumes/70/wr/mm7005e2.htm?s_cid=mm7005e2_e&ACSTrackingID=USCDC_921-DM47945&ACSTrackingLabel=MMWR%20Early%20Release%20-%20Vol.%2070%2C%20February%201%2C%202021&deliveryName=USCDC_921-DM47945 (accessed on February 8, 2021).

¹⁶ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

¹⁷ 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 the county of Los Angeles. 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.

Golden Cross Health Care

On March 30, 2020, HFID conducted an on-site “COVID-19 Focused Infection Control Survey” pursuant to Centers for Medicare & Medicaid Services (CMS) Memorandum QSO-20-20-All¹⁸ to determine whether Golden Cross was in compliance with infection prevention and control requirements.¹⁹ According to HFID documentation, the surveyor reviewed the facility’s compliance with standard and transmission-based precautions, quality of resident care practices, infection screening and surveillance protocols and contingency plans to address staffing issues during emergencies.²⁰ HFID determined that the facility was in compliance with the requirements and no deficiencies were cited.²¹ On April 21, 2020, HFID conducted another “COVID-19 Focused Infection Control Survey” and determined that Golden Cross was “in compliance with 42 CFR §483.80 infection control regulations” and that the facility had “implemented the CMS and [CDC] recommended practices to prepare for COVID-19.”²²

HFID reports that the Pasadena Public Health Department (PPHD) was closely involved and supplemented HFID’s infection control guidance to Golden Cross.²³ PPHD reported that throughout March and April 2020, it monitored Golden Cross due to increasing COVID-19 infection rates.²⁴ PPHD conducted virtual and in-person site visits to assess compliance with COVID-19 mitigation requirements, provide technical assistance and training, implement testing strategies and assist in the procurement of personal protective equipment (PPE).²⁵

On May 4, 2020, a CDPH Healthcare-Associated Infections Program (HAI)²⁶ nurse conducted an on-site assessment of Golden Cross and provided technical assistance

¹⁸ 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/gso-20-20-allpdf.pdf-0> (accessed on January 10, 2021).

¹⁹ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

²⁰ COVID-19 Focused Survey for Nursing Homes, Golden Cross Health Care (on file with the OIG).

²¹ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: KWJ911, March 30, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=KWJ911 (accessed on January 10, 2021).

²² Form CDPH-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: 1H0G11, April 21, 2020 (on file with the OIG).

²³ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

²⁴ Conversation with Pasadena’s Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department regarding the evacuation of Golden Cross Health Care, October 16, 2020.

²⁵ *Id.*

²⁶ The CDPH Healthcare-Associated Infections (HAI) Program oversees the prevention, surveillance, and reporting of HAI and antimicrobial resistance in California’s hospitals and other healthcare facilities. See California Department of Public Health, *Healthcare-Associated Infections Program*, at: <https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HAIProgramHome.aspx> (accessed on January 10, 2021).

and guidance.²⁷ According to a PPHD representative who attended the assessment virtually, the CDPH HAI nurse provided extensive guidance to the facility on proper infection prevention and control protocols, including cohorting residents according to COVID-19 status.²⁸ The next day, the CDPH HAI nurse conducted a follow-up visit and noted that Golden Cross had not fully complied with the recommendation to cohort COVID-19-positive residents in a discrete location within the facility.²⁹

PPHD reported that in early-May 2020, it received reports of staffing shortages at Golden Cross due to a COVID-19 outbreak.³⁰ Documentation provided by the Ombuds indicates that by May 8, 2020, it had learned that a significant portion of the nursing staff were temporary workers obtained through nursing registries.³¹ The Ombuds reports that it immediately notified HFID of the staffing issues and began to closely monitor conditions at Golden Cross.³² HFID responded to the facility and requested assistance from the U.S. Navy to supplement staffing and assist with implementing COVID-19 mitigation protocols.³³ A U.S. Navy team was on-site at Golden Cross from May 8 through May 11, 2020.

From May 12 through May 14, 2020, HFID conducted additional site visits, completed on-site surveys, and documented ongoing concerns regarding infection prevention and control.³⁴ HFID reports that it also requested a National Guard team to provide assistance and assess Golden Cross conditions.³⁵ On May 14, 2020, 11 days after the HAI nurse provided instruction on infection control, the National Guard team assessed the facility but declined the mission the following day reportedly due to the facility's failure to adequately cohort residents by COVID-19 status.³⁶

²⁷ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

²⁸ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department regarding the evacuation of Golden Cross Health Care, October 16, 2020.

²⁹ CDPH Healthcare-Associated Infections Program, *Facility Assessment Tool for California Healthcare Facilities in Local Public Health Jurisdictions with Confirmed COVID-19 Cases*, Golden Cross Health Care, May 4 and 5, 2020.

³⁰ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department regarding the evacuation of Golden Cross Health Care, October 16, 2020.

³¹ Golden Cross Health Care timeline provided by the Ombuds (on file with the OIG).

³² *Id.*

³³ Conversation with HFID leadership regarding the evacuations of Golden Cross Health Care and Foothill Heights Care Center, December 22, 2020.

³⁴ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

³⁵ Conversation with HFID leadership regarding the evacuations of Golden Cross Health Care and Foothill Heights Care Center, December 22, 2020.

³⁶ *Id.*

On May 15, 2020, HFID identified several deficiencies that posed “immediate jeopardy” to residents’ health and safety.³⁷ Immediate jeopardy is defined as a situation in which a resident has suffered or is likely to suffer serious injury, harm, impairment or death as a result of a facility’s noncompliance with one or more health and safety requirements.³⁸ Specifically, HFID found that Golden Cross failed to: (1) ensure the facility’s Director of Nursing and Infection Preventionist were physically present in the facility to oversee infection prevention and control practices in resident care areas and investigate outbreaks of residents and staff, (2) designate units to separate residents based on COVID-19 status, (3) assign dedicated staff to care for suspected or confirmed COVID-19 residents, (4) ensure COVID-19-positive residents remained in their rooms, (5) designate separate donning and doffing areas for COVID-19 and non-COVID-19 areas and (6) instruct staff on proper donning and doffing of PPE.³⁹ HFID also documented that at least one staff member did not have complete PPE or a properly fitted N95 respirator. As a result, the mask was too small for the staff member’s face and was being worn below the nose inside a COVID-19 resident care area.⁴⁰

A team from the CAL-MAT arrived at Golden Cross on May 18, 2020.⁴¹ CAL-MATs are rapid deployment teams of health care and support professionals organized and coordinated by the State Emergency Medical Services Authority to respond to local emergency medical situations.⁴² The CAL-MAT that was on-site at Golden Cross from May 18 through June 8, 2020, identified several issues, including a lack of basic infection prevention and control protocols, inadequate staffing, poor quality of care, nursing process failures and a reluctance to heed recommendations.⁴³

The CAL-MAT supervisor explained that residents who were designated as persons under investigation because of potential or known exposure to COVID-19 were permitted to move about the facility and socialize with other residents, which is inconsistent with resident cohorting requirements.⁴⁴ The CAL-MAT reports that it witnessed several staff wearing improper PPE while working in the COVID-positive

³⁷ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: X3W711, May 27, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=X3W711 (accessed on January 10, 2021).

³⁸ 42 CFR § 488.1.

³⁹ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: X3W711, May 27, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=X3W711 (accessed on January 10, 2021).

⁴⁰ *Id.*

⁴¹ Conversation with CAL-MAT Senior Emergency Services Coordinator who served as the on-site supervisor at Golden Cross Health Care, October 30, 2020.

⁴² California Emergency Medical Services Authority, *Disaster Medical Services Division – CAL-MAT*, at: <https://emsa.ca.gov/cal-mat/> (accessed on January 10, 2021).

⁴³ Conversation with CAL-MAT Senior Emergency Services Coordinator who served as the on-site supervisor at Golden Cross Health Care, October 30, 2020.

⁴⁴ *Id.*

zones, reusing disposable PPE for several consecutive days and moving from COVID-positive zones to non-COVID zones without doffing PPE or performing adequate hand hygiene.⁴⁵ The CAL-MAT also reports it observed that several residents lost a significant amount of weight due to lack of adequate food and water.⁴⁶ In response to these issues, the Pasadena Fire Department reported that it provided food and water to residents, PPE to staff and installed fencing around the facility in order to control the movement of residents and staff.⁴⁷

The CAL-MAT supervisor indicated that the frequent turnover of temporary nurses from nursing registries made it difficult to implement and sustain recommendations and hold staff accountable.⁴⁸ The CAL-MAT also observed several nursing process failures, including inadequate medical documentation.⁴⁹ In one instance, a CAL-MAT wound care nurse found that a resident had an approximately six-inch gash that was infected and appeared to have been long-standing; however, the wound was not documented in the resident's medical file.⁵⁰ The CAL-MAT also identified instances of narcotic and controlled medication count discrepancies.⁵¹ CAL-MAT nurses documented their observations, evaluations and treatments on physical forms that were provided to the facility.⁵² According to the CAL-MAT supervisor, some of the documented findings indicated longstanding quality-of-care inadequacies.⁵³ The CAL-MAT supervisor later learned that the facility disposed of or did not retain most of the physical forms provided by the CAL-MAT.⁵⁴

As the CAL-MAT was assisting Golden Cross to remediate deficiencies, HFID surveyors continued to receive and investigate complaints and FRIs.⁵⁵ On May 20, 2020, two additional immediate jeopardy determinations were made regarding the facility's failure to administer medications in accordance with physicians' orders.⁵⁶ On May 26, 2020, a conference call was held between the CAL-MAT, HFID and CDPH leadership during which the CAL-MAT supervisor relayed several concerns.⁵⁷ On that same day, HFID management discussed the concerns with the facility's

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Conversation with Interim Chief of the Pasadena Fire Department, October 8, 2020.

⁴⁸ Conversation with CAL-MAT Senior Emergency Services Coordinator who served as the on-site supervisor at Golden Cross Health Care, October 30, 2020.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

⁵⁶ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: FGHK11, May 31, 2020, at:

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=FGHK11 (accessed on January 10, 2021).

⁵⁷ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

Medical Director.⁵⁸ In response, the Medical Director suggested that HFID transfer residents in order to protect their health and safety.⁵⁹ As a result, HFID initiated a facility survey and identified 13 deficiencies, 6 of which were deemed to place residents in immediate jeopardy.⁶⁰ One deficiency included the failure to provide oxygen treatment and monitor oxygen saturation as ordered by the physician for eight residents who had COVID-19.⁶¹ The CAL-MAT supervisor reported that when HFID issued the six immediate jeopardy findings, it became clear that the facility could not adequately abate the deficiencies and that an evacuation of all residents was required.⁶²

On May 27, 2020, out of concern for the well-being of residents because of the six immediate jeopardy findings, the then-Interim Fire Chief (Chief) of the Pasadena Fire Department notified CDPH and HFID leadership that he had developed a transportation plan for an evacuation of all Golden Cross residents.⁶³ The same day, the Ombuds notified HFID that it had identified placement for the COVID-19-positive residents at a facility within 15 miles of Golden Cross.⁶⁴ HFID leadership indicated that they also shared concerns for patient safety but that they were waiting on further direction from CDPH.⁶⁵

On May 28, 2020, HFID notified Golden Cross management that it would recommend to CDPH that the facility be placed on a 23-day termination track pursuant to 42 CFR section 488.410. In part, this section provides that if there is immediate jeopardy to resident health or safety, the State must either terminate the facility's Medicare and/or Medicaid provider agreement within 23 calendar days of the last date of the survey, appoint a temporary manager to abate the immediate jeopardy, or both.⁶⁶ On the following day, the facility was notified that it was placed on a 23-day termination track.⁶⁷ On June 2, 2020, CDPH appointed a temporary manager to assess Golden Cross.⁶⁸ The temporary manager found that over half of the residents had developed stage 1 to stage 4 pressure ulcers.⁶⁹

⁵⁸ HFID, Golden Cross Health Care Correspondence, at 394, 407 (on file with the OIG).

⁵⁹ *Id.*

⁶⁰ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: 84UX11, May 28, 2020, at: https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=FGHK11 (accessed on January 10, 2021).

⁶¹ *Id.*

⁶² Conversation with CAL-MAT Senior Emergency Services Coordinator who served as the on-site supervisor at Golden Cross Health Care, October 30, 2020.

⁶³ HFID, Golden Cross Health Care Correspondence, at 267 (on file with the OIG).

⁶⁴ HFID, Golden Cross Health Care Correspondence, at 272 (on file with the OIG).

⁶⁵ HFID, Golden Cross Health Care Correspondence, at 267 (on file with the OIG).

⁶⁶ 42 CFR § 488.410.

⁶⁷ Continued Non-compliance with Federal Regulations Letter, Golden Cross Health Care, May 29, 2020 (on file with the OIG).

⁶⁸ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

⁶⁹ HFID, Golden Cross Health Care Correspondence, at 227 (on file with the OIG).

On June 6, 2020, HFID requested the facility's relocation plan after the facility was unable to abate the six immediate jeopardy findings.⁷⁰ On that same day, HFID issued an additional immediate jeopardy finding after concluding that the facility failed to investigate an allegation of physical abuse and failed to prevent further potential physical abuse.⁷¹

On June 10, 2020, a Temporary Suspension Order of the facility's license was issued by CDPH in response to the ongoing risk to the health and safety of residents.⁷² At the request of the temporary facility manager appointed by CDPH, the Ombuds contacted all of the residents' families to inform them of the situation at the facility and determine whether they wanted to voluntarily move their loved ones.⁷³ On the following day, the decision was made to evacuate all residents from Golden Cross on advice from the California Attorney General's office.⁷⁴ LACDPH reports that HFID staff were on-site to ensure that residents were evacuated in a safe and orderly manner in accordance with the facility's transfer plan and the evacuation was led by the Pasadena Fire Department.⁷⁵

By the time the decision was made to evacuate the facility, 71 residents and 32 staff had contracted COVID-19 and 16 residents had died.⁷⁶ Officials from PPHD, the Pasadena Fire Department, Ombuds and the CAL-MAT expressed the belief that Golden Cross should have been evacuated sooner.⁷⁷ In addition, officials from PPHD, the Pasadena Fire Department and the Ombuds reported that they were rarely included in conversations with HFID and CDPH about whether an evacuation was necessary, despite having first-hand knowledge about the conditions based on multiple site visits and close monitoring.⁷⁸ Officials from all three agencies

⁷⁰ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

⁷¹ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Golden Cross Health Care, Survey ID: O7EW11, June 7, 2020, at:

https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/Pages/ASPEN_FEDERAL_2567.aspx?EventID=O7EW11 (accessed on January 10, 2021).

⁷² Golden Cross Health Care timeline provided by HFID (on file with the OIG).

⁷³ Golden Cross Health Care timeline provided by the Ombuds (on file with the OIG).

⁷⁴ Golden Cross Health Care timeline provided by HFID (on file with the OIG).

⁷⁵ *Id.*

⁷⁶ Section 1424 Notice, Golden Cross Health Care, Citation Number: 950015964, August 7, 2020, at: https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/Pages/STATE_PENALTY_1424.aspx?citation_number=950015964 (accessed on January 10, 2021).

⁷⁷ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department regarding the evacuation of Golden Cross Health Care, October 16, 2020; Conversation with Interim Chief of the Pasadena Fire Department, October 8, 2020; Conversation with representatives of the Long-Term Care Ombudsman Program for Wise & Healthy Aging regarding the evacuation of Golden Cross Health Care, October 23, 2020; Conversation with CAL-MAT Senior Emergency Services Coordinator who served as the on-site supervisor at Golden Cross Health Care, October 30, 2020.

⁷⁸ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department regarding the evacuation of Golden Cross Health Care, October 16, 2020; Conversation with Interim Chief of the Pasadena Fire Department, October 8, 2020; Conversation with representatives of the Long-Term Care Ombudsman Program for Wise & Healthy Aging regarding the evacuation of Golden Cross Health Care, October 23, 2020.

contacted HFID leadership several times throughout late-May and early-June expressing concerns for the health and safety of residents and requesting updates, to which HFID leadership reportedly responded they were waiting on direction from CDPH.⁷⁹

The COVID-19 outbreak at Golden Cross was exacerbated by infection prevention and control and SNF management deficiencies and became a catalyst for a facility-wide crisis. On March 30, 2020, and on April 21, 2020, HFID determined that Golden Cross was in compliance with requirements for proper infection prevention and control practices to limit COVID-19 transmission. Weeks later, PPHD and CDPH documented the facility's noncompliance with cohorting and other infection prevention and control protocols. HFID conducted several site visits and investigations, identified deficiencies, made several immediate jeopardy findings, mobilized significant resources and appointed a temporary facility manager. However, quality of care did not improve and substandard conditions festered for more than one month before an evacuation was initiated. Although HFID recommended a 23-day termination track two weeks before the evacuation, questions remain about whether the recommendation should have been made sooner.

Foothill Heights Care Center

On August 19, 2020, HFID received a complaint alleging that Foothill Heights was exposing its residents to excessive temperatures inside the building and residents' rooms.⁸⁰ HFID responded to the facility and documented that residents' room temperatures ranged from 91.5°F to 95.4°F.⁸¹ On August 20, 2020, HFID conducted a follow-up inspection and found that residents' room temperatures were ranging from 84.4°F to 91.1°F.⁸² Title 22 of the California Code of Regulations requires that facilities keep all rooms at a comfortable range, between 78°F and 85°F, or in areas of extreme heat, 30°F lower than the outside temperature.⁸³ Foothill Heights' policies indicate that the acceptable range for air temperature is 71°F to 81°F.⁸⁴ HFID issued an immediate jeopardy finding the same day, citing the facility's failure to "maintain air conditioning and ventilating systems in normal

⁷⁹ *Id.*

⁸⁰ Foothill Heights Care Center timeline provided by HFID (on file with the OIG).

⁸¹ Section 1424 Notice, Foothill Heights Care Center, Citation Number: 950016044, October 9, 2020, at:

https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/Pages/STATE_PENALTY_1424.aspx?citation_number=950016044 (accessed on January 10, 2021).

⁸² *Id.*

⁸³ 22 CCR § 87303(b)(2).

⁸⁴ Section 1424 Notice, Foothill Heights Care Center, Citation Number: 950016044, October 9, 2020, at:

https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/Pages/STATE_PENALTY_1424.aspx?citation_number=950016044 (accessed on January 10, 2021).

operating conditions to provide a comfortable temperature” in accordance with regulatory requirements and failure to “follow its policy and procedures and keep the centralized air conditioning (A/C) units in working condition.”⁸⁵ As part of its investigation, HFID requested facility temperature logs. However, HFID documentation indicates that the facility’s Administrator did “not have the temperature logs” for July and August.⁸⁶ HFID documentation does not indicate whether temperatures were checked by facility staff but not logged; checked and logged but subsequently lost; or whether the completed logs existed, but were not available at the time requested.⁸⁷

For the next several days, HFID conducted site visits to measure the temperatures in each room. HFID recorded room temperatures ranging from 82°F to 96.8°F.⁸⁸ On August 27, 2020, HFID noted that all room temperatures were at or below 81°F while the outside temperature was 97°F.⁸⁹ The facility’s Plan of Correction⁹⁰ indicates that staff were providing cold drinks to residents and checking room temperatures hourly, and that an electrician had installed five electrical outlets in five residents’ rooms for five additional portable air conditioning units.⁹¹ As a result, HFID found that the immediate jeopardy concerns were abated and the immediate jeopardy determination was lifted.⁹²

HFID reports that on September 3, 2020, it received a request from PPHD for an on-site visit to Foothill Heights due to an anticipated heat wave.⁹³ As a result, HFID generated a complaint and conducted several site visits from September 3 through September 7, 2020, and found that the facility was unable to maintain room temperatures within the regulatory limits for at least two of those days.⁹⁴ HFID noted that the facility administrator acknowledged that the portable air conditioning units were inadequate to keep temperatures below 81°F but that additional units would overload the building’s electrical system.⁹⁵ The complaint was found to be “substantiated without deficiencies,” meaning that the allegation was substantiated,

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Plan of Correction is defined as a “plan developed by the facility and approved by CMS or the survey agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected.” 42 CFR § 488.401.

⁹¹ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Foothill Heights Care Center, Survey ID: NQG011, August 27, 2020, at: https://www.cdph.ca.gov/Programs/CHCO/LCP/CalHealthFind/vti_bin/HFCISService.svc/DownloadDocumentByPenaltyNumber?param=950016044 (accessed on January 10, 2021).

⁹² *Id.*

⁹³ Foothill Heights Care Center timeline provided by HFID (on file with the OIG).

⁹⁴ *Id.*

⁹⁵ *Id.*

but that there was no regulatory violation at the time of inspection.⁹⁶ It is unclear why the facility was not cited for the deficiencies.

On October 1, 2020, officials from PPHD and HFID conducted an unannounced visit to Foothill Heights.⁹⁷ Upon arrival, they discovered that, contrary to the facility's own hourly temperature logs, which stated that no room was over 82°F, temperatures had reached 92°F in residents' rooms and 96°F in the hallway.⁹⁸ The city of Pasadena was experiencing a heatwave on that day with outdoor temperatures reaching as high as 107°F.⁹⁹ The Chief, who also coordinated the Golden Cross evacuation, responded to Foothill Heights and with PPHD determined that conditions warranted an evacuation.¹⁰⁰ The Chief reports that the on-site HFID surveyor was unable to provide adequate information about whether a determination would be made to evacuate the facility. As a result, the Chief escalated his concerns to the Deputy Director of CDPH's Center for Health Care Quality.¹⁰¹ Within four hours, all residents were relocated in a coordinated emergency response led by the Pasadena Fire Department.¹⁰² HFID and CDPH report that prior to the Chief's arrival, HFID had already notified CDPH of the facility's excessive indoor temperatures and recommended the evacuation. However, it appears that information about the evacuation was not communicated timely to the on-site surveyor, the Ombuds, PPHD or the Chief responsible for the emergency operation.¹⁰³

HFID cited the facility's efforts to remediate deficiencies, the risks associated with resident transfers and the notion that older residents like warmer temperatures in response to why it did not pursue more serious action sooner.¹⁰⁴ Excessive heat can place older adults at increased risk of heat-related illnesses that include heat

⁹⁶ California Department of Public Health, Cal Health Find Database, Foothill Heights Care Center, Intake ID CA00703814, September 3, 2020.

⁹⁷ Foothill Heights Care Center timeline provided by HFID (on file with the OIG).

⁹⁸ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department and the Interim Chief of the Pasadena Fire Department regarding the evacuation of Foothill Heights Care Center, November 12, 2020.

⁹⁹ AccuWeather, Pasadena, CA, October 2020, at:

<https://www.accuweather.com/en/us/pasadena/91101/october-weather/337195?year=2020> (accessed on January 10, 2021).

¹⁰⁰ Conversation with Pasadena's Director of Public Health and Health Officer and other representatives of the Pasadena Public Health Department and the Interim Chief of the Pasadena Fire Department regarding the evacuation of Foothill Heights Care Center, November 12, 2020.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ Conversation with CDPH leadership regarding the evacuation of Foothill Heights Care Center, February 7, 2021.

¹⁰⁴ Conversation with HFID leadership regarding the evacuations of Golden Cross Health Care and Foothill Heights Care Center, December 22, 2020.

stroke; heat edema; heat syncope; heat cramps; and heat exhaustion.¹⁰⁵ In addition, pre-existing medical conditions such as hypertension, neurological conditions, heart, lung or kidney diseases and associated medications increase the risk of heat-related illnesses.¹⁰⁶ HFID documentation reflects that multiple Foothill Heights residents were admitted to the facility with hypertension, and at least one resident had been diagnosed with Parkinson’s Disease and another with congestive heart failure.¹⁰⁷ Many SNF residents are of advanced age, have multiple medical conditions and are prescribed medications that in combination pose even greater risk with exposure to excessive heat. According to the facility’s Plan of Correction, in response to the August 27, 2020, citation, the installation of five temporary air conditioning units was not completed until October 6, 2020, several days after the evacuation.¹⁰⁸

HFID documentation provided does not indicate whether ventilation or air quality were considered in assessing risk to residents following the August excessive heat complaint. Both factors should have been weighed given that the air conditioning failures occurred in the midst of a high-impact respiratory pandemic and fluctuating air quality resulting from California’s destructive fire season. It is also unclear from the documentation whether HFID considered potential risk to Foothill Heights staff between August and October. Presumably, staff were required to don and retain PPE for the duration of their shifts, which in excessive temperatures, may have posed risks as well.

The Plan of Correction from August indicates that the facility was attentive to hydration in offering “cold drinks” to residents, but does not address the fact that proper hydration requires a balance of fluid and electrolytes and that different approaches might be indicated in consideration of underlying medical conditions or medication regimens.¹⁰⁹ A one-size-fits-all approach over several days may not have ensured that residents received appropriate fluid replacement and hydration. In addition to reporting discomfort from the heat, some residents reported loss of appetite, nausea or malaise, which are possible symptoms of heat exhaustion.

¹⁰⁵ National Institutes of Health, *Heat-related health dangers for older adults soar during the summer*, June 27, 2018, at: <https://www.nih.gov/news-events/news-releases/heat-related-health-dangers-older-adults-soar-during-summer#:~:text=Hyperthermia%20can%20include%20heat%20stroke,heat%20cramps%2C%20and%20heat%20exhaustion> (accessed on January 10, 2021).

¹⁰⁶ *Id.*

¹⁰⁷ Section 1424 Notice, Foothill Heights Care Center, Citation Number: 950016044, October 9, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/STATE_PENALTY_1424.aspx?citation_number=950016044 (accessed on January 10, 2021).

¹⁰⁸ *Id.*

¹⁰⁹ Form CMS-2567, Statement of Deficiencies and Plan of Correction, Foothill Heights Care Center, Survey ID: NQG011, August 27, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/vti_bin/HFCISService.svc/DownloadDocumentByPenaltyNumber?param=950016044 (accessed on January 10, 2021).

Residents were noted to have reported that temperatures were “acceptable.”¹¹⁰ However, SNF residents may be reluctant to voice concerns, especially to their own care providers, and their answers must be interpreted to account for residents’ cognitive and communication functions as well as the manner in which a question is posed. Furthermore, once HFID recorded temperatures that exceeded safe limits in contravention of the regulatory requirements, the actual room temperatures should have been the determining resident risk factor, not anecdotal information.

One of the fundamental principles of disaster response is planning based on likely or anticipated environmental challenges in a particular region.¹¹¹ Excessive environmental heat is common throughout Southern California and the failure of ventilation and air conditioning systems, particularly during summer heat waves, is an example of an environmental challenge that should have been anticipated at Foothill Heights and can be anticipated in other facilities in the County. This confluence of events is made more likely by aging buildings and equipment, as well as anticipated increases in global climate temperatures and the number of days a region can expect to experience extreme heat.

A facility’s disaster plan must anticipate not only equipment failure, but also power failure. For instance, at times, generator supplies are insufficient to cover air conditioning systems. Appropriate disaster plans should include clear emergency evacuation protocols, especially since most SNF residents require accommodations for transport and receiving facilities require preparation to meet medical and functional needs. In large or mass casualty disasters, ambulances may be overwhelmed, and detailed planning, including prearranged contractual agreements for resident transports and other needs may be necessary.

In order to remedy the excessive temperature deficiencies, Foothill Heights ultimately determined that it had to replace the building’s roof and electrical system in order to accommodate a new central air conditioning system.¹¹² On the night of the evacuation, the OIG was on scene and confirmed the facility administrator’s assertion that construction work had already begun, inside and outside of the building, with residents in place. HFID reports that it was aware of the extent of needed repairs and that Foothill Heights intended to complete the renovations without transferring residents. Documentation provided indicates that the Foothill Heights owners were aware that the air conditioning system needed to be repaired or replaced when they purchased the facility two years earlier.¹¹³ The facility

¹¹⁰ *Id.*

¹¹¹ Saliba, D., et al., *Function and Response of Nursing Facilities During Community Disaster*, *American Journal of Public Health*, 94(8), at 1436–1441, August 2004.

¹¹² Form CMS-2567, Statement of Deficiencies and Plan of Correction, Foothill Heights Care Center, Survey ID: NQG011, August 27, 2020, at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/vti_bin/HFCISService.svc/DownloadDocumentByPenaltyNumber?param=950016044 (accessed on January 10, 2021).

¹¹³ *Id.*

administrator also stated that Foothill Heights had purchased the portable air conditioning units and fans in preparation for the summer months.¹¹⁴ Facility owners clearly anticipated the environmental challenges posed by the summer heat wave but were ill-prepared for equipment failures and did not have an effective disaster plan.

Throughout the evacuation, OIG personnel observed Foothill Heights staff diligently attempting to prepare residents for transfer, helping them choose which basic necessities to carry, and lining them in gurneys and wheelchairs along facility hallways to wait on emergency personnel. Despite oppressive temperatures exacerbated by their PPE, concerned staff moved quickly and remained indoors until the last frightened resident was transferred to an ambulance. Foothill Heights owners failed to protect residents and staff by exposing them to excessive temperatures for more than six weeks. The safety risks and emotional trauma suffered by Foothill Heights residents is not mitigated by the owners' efforts to implement ineffective stop-gap measures after the equipment failed, particularly given that the crisis may have been averted altogether had they replaced the air conditioning system sooner.

HFID's Crisis Response at Golden Cross and Foothill Heights

The events leading up to the Golden Cross and Foothill Heights evacuations indicate inadequate mechanisms to trigger an effective, timely and coordinated crisis response. It is important to note that the evacuation of a SNF is a serious undertaking with inherent risks to frail, older residents, and research supports leaving residents in place whenever possible.¹¹⁵ Dr. Saliba confirms that care must be taken in deciding whether to evacuate, including among other considerations, whether necessary resources can be brought into a facility or can only be accessed elsewhere. However, when a facility fails to adequately remediate ongoing deficiencies that pose serious risk, swift action may be necessary to protect residents' health and safety.

The current contract between CDPH and HFID provides that "CDPH retains the responsibility for establishment of program policies and standards, and enforcement actions relating to licensure, including denials, revocations and suspensions."¹¹⁶ As a result, HFID is required to conduct its oversight activities in accordance with the policies and procedures established by CDPH, and LACDPH does not have the discretion to modify or tailor such policies and procedures based on local needs.

¹¹⁴ *Id.*

¹¹⁵ Willoughby, M., et al., *Mortality in Nursing Homes Following Emergency Evacuation: A Systematic Review*, *Journal of the American Medical Directors Association*, 18(8), at 664-670, April 13, 2017.

¹¹⁶ Standard Agreement 19-10042, July 1, 2019, through June 30, 2022, Exhibit A, at 3.

The OIG requested from LACDPH all CDPH and HFID policies and procedures regarding the depopulation/evacuation of residents from SNFs, including any criteria for when depopulation/evacuation is appropriate. The OIG received the following two documents: California Health and Safety Code (HSC) section 1336.2 and CDPH Licensing and Certification Policy and Procedure Manual (CDPH Policy and Procedure Manual) section 527.20. Pursuant to HSC section 1336.2, CDPH has the authority to:

[P]rovide, or arrange for the provision of, necessary relocation services at a facility, including medical assessments, counseling, and placement of residents, if it determines that these services are needed promptly to prevent adverse health consequences to residents, and the facility refuses, or does not have adequate staffing, to provide the services.¹¹⁷

HSC section 1336.2 does not contain criteria for determining when necessary relocation services are to be provided or arranged nor does it contain protocols for how such relocation services are to be provided or arranged.

Section 527.20 of the CDPH Policy and Procedure Manual provides some additional guidance on the emergency transfer of residents. Under Section 527.20, CDPH is authorized to “take any necessary measures to protect and preserve the public health”; however, “[l]icensing staff should not obligate the Department financially in a transfer without clearance from headquarters.”¹¹⁸ Although HFID does not have the independent authority to initiate an evacuation in the event of a facility-wide crisis, it can recommend evacuations and other emergency responses to CDPH.

Section 527.20 provides the following three guidelines in determining the need to transfer residents:

- A. The facility is a danger to the health and safety of the [residents] if they were to remain.
- B. The facility staff is not available or indicates its refusal to provide the necessary service.
- C. If a facility is being enjoined from continuing its operations.¹¹⁹

No additional criteria, factors or considerations are provided for determining when the scope and severity of a danger to the health and safety of residents rises to the level of requiring a transfer. Lastly, the policy provides that “[o]nly in direct circumstances should licensing staff take over transfer arrangements.”¹²⁰ The policy does not define “direct circumstances” and the policies and procedures relied upon

¹¹⁷ CA HSC § 1336.2(f).

¹¹⁸ California Department of Public Health, Licensing and Certification Policy and Procedure Manual, Chapter 5, section 527.20.

¹¹⁹ *Id.*

¹²⁰ *Id.*

by HFID to determine when an evacuation is required do not appear to provide sufficient guidance.

Effective oversight during SNF crises requires thorough and critical risk assessment, continuous situation monitoring and swift emergency response where necessary. The events preceding the evacuations suggest that HFID recognized a danger to residents in both Pasadena facilities and attempted to intervene by conducting several surveys, identifying deficiencies and issuing citations. Nevertheless, both situations culminated in crises that posed greater risk to residents and required facility evacuations. It may be that HFID surveyors identified and considered all of the potential medical implications should residents have remained in place at Golden Cross and Foothill Heights, but documentation provided suggests otherwise. If HFID did not adequately identify or take appropriate action based on identified risks, it likely contributed to a delay in CDPH initiating the emergency response.

Efficacy of HFID's Oversight and Enforcement Actions

In addition to questions and issues detailed above regarding HFID's crisis response throughout the Foothill Heights and Golden Cross evacuations, the A-C's report details operational deficiencies that impact HFID's oversight and enforcement actions. The A-C identified a significant number of backlogged SNF complaint and FRI investigations, many of which have remained open for several years.¹²¹ As of June 30, 2020, 5,407 backlogged investigations remained open at various stages of the investigation process, almost half of which have remained open for more than 3 years. Of the 5,407 backlogged SNF investigations, 547 were categorized as immediate jeopardy. As part of the current contract, CDPH agreed to complete 989 of the 5,407 backlogged investigations. As a result, HFID is currently responsible for completing the remaining 4,418 backlogged SNF investigations. The A-C also noted that "HFID management did not demonstrate that they adequately manage or track the various phases/stages of all of their current and backlogged investigations" ¹²²

Complaint and FRI investigations serve as essential response mechanisms for addressing health and safety concerns and allow HFID to evaluate the quality of care provided by a SNF between periodic surveys and inspections. When allegations are substantiated through the investigation process, monetary and non-monetary (e.g., directed in-service training and directed Plan of Correction) enforcement remedies may be imposed to encourage SNFs to rectify deficiencies. In the event of suspected abuse and/or neglect, referrals may be made to law enforcement for criminal investigation. The failure to investigate complaints in a timely manner can

¹²¹ A-C Final Report (Attachment I) at 13.

¹²² A-C Final Report (Attachment I) at 15.

limit HFID's ability to collect sufficient evidence to substantiate allegations and prolong situations in which residents may be subjected to unsafe conditions, abuse and neglect.

The A-C also reports that HFID does not adequately track enforcement actions to ensure that deficiencies are resolved in a timely manner.¹²³ For example, the A-C found that HFID does not track monetary and non-monetary enforcement remedies against SNFs for violating federal-level requirements, or non-monetary enforcement remedies issued for violating state-level requirements. The A-C reports that HFID only tracks monetary enforcement remedies against SNFs for violating state-level requirements. However, as of October 27, 2020, 76 of the 249 (30 percent) state-level monetary enforcement remedies imposed from July 1, 2019, through June 30, 2020, remained unresolved. These 76 unresolved monetary enforcement remedies amount to a total of approximately \$1 million. The A-C notes HFID's position that HFID should not be required to track or ensure that enforcement remedies are resolved timely. Although HFID is only responsible for recommending remedies to CDPH or CMS, issued enforcement remedies directly impact the quality of care in SNFs.¹²⁴ As such, the A-C recommends that HFID 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."¹²⁵

The A-C conducted a comparative analysis of staffing levels and the average hours required to complete SNF oversight activities between HFID and CDPH and found that, despite comparable training requirements, levels of expertise and roles and responsibilities, HFID staff spent less time than their CDPH counterparts conducting most SNF oversight activities.¹²⁶ For example, HFID staff, on average, spent 17.02 hours conducting a complaint investigation while CDPH staff, on average, spent 19.75 hours. The A-C also found that HFID staff spent significantly less time conducting most state and federal licensing and certification activities than CDPH staff.

These deficiencies, in addition to others, identified by the A-C concern the core functions of HFID. The A-C recommends that HFID management initiate a comprehensive study to evaluate the problems identified in the A-C's report, including staffing needs and the causes for delays in completing investigations and addressing deficiencies.¹²⁷ The analysis the A-C recommends is an important step in ensuring that HFID can fulfill its mission to adequately protect the health and safety of residents and staff in the 4,188 health care facilities that it oversees.

¹²³ A-C Final Report (Attachment I) at 25.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ A-C Final Report (Attachment I) at 36.

¹²⁷ A-C Final Report (Attachment I) at 38.

HFID's Coordination and Communication with Partner Agencies

The evacuations reveal a lack of coordination and communication between HFID and partner agencies such as the Ombuds and local health and fire departments. Representatives from the city of Pasadena and the Ombuds reported little coordination and poor communication with HFID leading up to the evacuations. Partner agencies, particularly the Ombuds, have a pivotal role in advocating for residents and identifying deficiencies before they become facility-wide crises.

The Ombuds is authorized under federal and state law to receive, investigate and resolve complaints made by or on behalf of residents living in long-term care facilities, including SNFs. Ombuds work with regulatory agencies, including CDPH and HFID, to support resident-rights and improve quality of care and life. The Ombuds utilizes trained and certified staff and volunteers to respond to complaints and monitor long-term care facilities through unannounced visits and other monitoring. Communication failures between HFID and Ombuds thwarts the Ombuds' efforts to address complaints and monitor facilities. The Ombuds should be viewed as a valued partner whose expertise and access to residents supplements HFID's efforts. HFID and the Ombuds meet quarterly in order to maintain communication. The quarterly meetings are certainly important, but the Ombuds' efforts to address complaints and monitor facilities requires consistent, real-time communication, particularly during facility-wide crises.

The city of Pasadena is a comparatively affluent city with its own public health and fire departments, which provide an additional layer of oversight when SNF operations fail. An Assistant City Manager and other Pasadena officials were on-site before and during both evacuations to witness the conditions and aggressively advocate for the residents. Pasadena's efforts to protect the health and safety of SNF residents within its jurisdiction raises bigger questions about whether similar crises are occurring in some of the operating SNF's in other cities and unincorporated areas throughout the County that do not have local health or fire departments.

Lastly, as detailed in the OIG's first interim report, integration between HFID and other LACDPH divisions has improved as a result of COVID-19 mitigation efforts. However, the County's existing contract with CDPH, whereby CDPH retains much substantive and operational authority over HFID while LACDPH retains administrative control, appears to impede both communication between HFID, LACDPH, and CDPH and effective SNF oversight and regulation. For example, HFID reported that LACDPH leadership was not notified of the ongoing issues at Golden Cross until a few days prior to the evacuation.¹²⁸ This raises concerns about the

¹²⁸ Conversation with HFID leadership regarding the evacuations of Golden Cross Health Care and Foothill Heights Care Center, December 22, 2020.

extent to which HFID is integrated into LACDPH and whether LACDPH can provide the necessary support, direction and oversight to ensure the success of HFID's oversight mission pursuant to the County's contract with CDPH.

The current contract allows for CDPH to withhold a certain percentage of budgeted funds if HFID does not meet its contractual obligations.¹²⁹ In addition, any federal fiscal sanctions that are assessed against CDPH that are attributable to HFID's non-compliance with the terms of the current contract may be levied in full against the County via a reduction of the fiscal year end invoice.¹³⁰ These and other terms in the existing contract may undermine some of the soundly reasoned goals of local versus state oversight. If jurisdictional and other bureaucratic complexities of the current contract limit effective oversight of SNFs and meaningful advocacy for vulnerable SNF residents, these costs must be weighed against any benefits of local integration and budgetary efficiency.

HFID STAFF CONCERNS

Since the Inspector General's appointment in May 2020, the OIG has received numerous complaints about HFID operations from advocates, stakeholders and HFID staff. As part of the OIG's review, OIG personnel spoke with more than 40 HFID staff, including Health Facilities Evaluator Nurses (HFEN), Health Facilities Evaluators, support staff and supervisors from each region and the Acute Care Hospitals section to gather information regarding HFID's practices and staff perceptions. HFID staff made themselves available and appeared to speak candidly with OIG personnel about the challenges they face. The majority of HFID staff who spoke with OIG personnel expressed passion for their work and a determination to enforce regulatory requirements.

Several HFID staff who conduct complaint and FRI investigations expressed feeling pressure to close investigations quickly in order to meet deadlines, reduce the number of backlogged investigations and remain current on new complaints and FRIs. Most staff reported that they are expected to submit four completed investigations per week if they are working from the office or six completed investigations per week if they are working remotely. Others reported that they are expected to submit three completed investigations per week. Complaint investigations involve varying levels of complexity depending on the nature, scope and severity of the allegation(s). Several staff stated that they believe these expectations are rigid, unrealistic and ultimately compromise the quality of complaint investigations, sometimes at the expense of residents' health and safety. These beliefs were also communicated by some HFID supervisors.

¹²⁹ Standard Agreement 19-10042, July 1, 2019, through June 30, 2022, Exhibit B, at 4.

¹³⁰ Standard Agreement 19-10042, July 1, 2019, through June 30, 2022, Exhibit A, at 9.

Numerous staff expressed feeling pressure to rush immediate jeopardy investigations and, at times, close them prematurely. Other staff expressed that they were given too many immediate jeopardy cases to investigate at one time. Some staff reported that they have been instructed by their supervisors to leave a facility without pursuing a further investigation into a suspected immediate jeopardy situation that they had identified. Some staff reported that they have expressed their concerns about closing investigations prematurely to their supervisors to no avail. In addition, several staff stated that, at times, supervisors have downgraded their deficiency findings against their own recommendations. Numerous staff communicated the belief that HFID leadership appears to prioritize closing investigations, at times, over the wellbeing and safety of SNF residents.

Several staff also expressed feeling inadequately trained, particularly in conducting comprehensive and thorough complaint and FRI investigations. Staff reported feeling pressure to begin field work on their own despite being ill-prepared. OIG personnel were also informed that some new HFENs are beginning field work prior to completing training and passing the Surveyor Minimum Qualifications Test (SMQT).

Staff and supervisors routinely expressed a strong desire for a robust on-the-job training and mentoring program. New staff are assigned to work with an experienced staff member who serves as a "mentor" for a brief period after completing initial training, however, it is not uncommon for mentors to be assigned additional/collateral responsibilities that limit their ability to dedicate sufficient time to training. In addition, some supervisors stated that mentors lack formal training to provide adequate coaching, recognition and real-time feedback.

Supervisors explained that once new surveyors are assigned to their units, they are generally required to work at the same capacity as other surveyors due to the significant workload. Supervisors recognized that this likely contributes to new staff feeling overwhelmed, as well as low morale and staff turnover. In addition, supervisors expressed the belief that webinars alone are not enough to teach the application of new skills, especially when staff are required to multi-task during webinars so that they do not fall behind.

As detailed in the OIG's first interim report, CDPH required all SNFs to submit COVID-19 mitigation plans with specific elements and an attestation by June 1, 2020, for review and approval. Upon approval, CDPH requires that each SNF receive an on-site infection control survey at least once every six to eight weeks to verify implementation of approved COVID-19 mitigation plans. Staff assigned to COVID-19 mitigation activities such as the infection control surveys reported receiving approximately one hour of initial COVID-19 mitigation training prior to being required to conduct such surveys on their own. Some staff reported feeling ill-prepared to assess COVID-19-related infection control and prevention protocols.

In July 2020, approximately four months into the pandemic, CDPH reportedly offered over 20 hours of infection control training. Some staff stated that they found the CDPH training helpful and wished they had received it earlier.

Lastly, the majority of staff and supervisors reported feeling overworked and exhausted, which appears to have impacted staff morale. They report that it has become increasingly difficult for staff to thoroughly investigate high priority and urgent complaints and FRIs without falling behind. Staff and supervisors stressed the need for additional staffing, including higher supervisor-to-staff ratios. Finally, the OIG also received some complaints regarding possible hostile work environment issues that were referred to the County Equity Oversight Panel.

These accounts, consistently reported to the OIG by HFID staff, require the prompt attention of LACDPH leadership to ensure that staff are not cutting corners. If true, the issues alleged may impact the County's ability to oversee SNFs, protect the health and safety of residents and fulfill its contractual obligations with CDPH. If reported accounts are untrue, the common perception of multiple HFID staff and supervisors is itself concerning and calls for further evaluation and appropriate intervention.

OWNERSHIP STRUCTURES OF SKILLED NURSING FACILITIES

The Golden Cross and Foothill Heights crises highlight serious operational deficiencies in both SNFs. HFID, the Ombuds, advocacy groups, and more recently the OIG, regularly receive similar complaints about other SNFs throughout the County. Sustained allegations involving resident abuse and neglect are often linked to commonly identified issues such as high staff-to-patient ratios, inadequate staffing and training and physical plant and other infrastructure problems.¹³¹ These and other deficiencies are often linked to cost containment efforts commonly associated with for-profit SNFs, such as Golden Cross and Foothill Heights.¹³² This section offers an introduction to complex SNF ownership structures.

There are three general types of SNF ownership structures: for-profit, nonprofit, and government-owned facilities. For-profit SNFs have largely dominated SNF ownership in California. From 2003 through 2017, 78 to 84 percent of California SNFs were registered as for-profit entities, with a decrease to 69 percent in

¹³¹ Bos, A., et al., *Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review*, *Health Care Management Review*, October 12, 2017, 42(4), at 352-368.

¹³² *Id.*

2019.¹³³ The County exceeds the state-wide totals with approximately 89 percent of the county's 379 operating SNFs registered as for-profit entities.¹³⁴

For-profit vs. Nonprofit Ownership

Researchers have found that a greater percentage of poorly performing SNFs are operated by for-profit entities.¹³⁵ For-profit SNFs usually operate under the leadership of a board of directors that is required to maximize shareholder profits. In order to maximize profits, research has shown that for-profit facilities generally operate with lower staffing levels and experience more deficiencies¹³⁶ than nonprofit facilities.¹³⁷

CDPH has identified adequate staffing as a point of emphasis in the control of COVID-19.¹³⁸ In 2020, researchers from the University of California, San Francisco examined the relationship between staffing levels in California SNFs and resident infections and found that SNFs with registered nurse staffing levels under the recommended minimum standard (0.75 hours per resident per day) were twice as likely to have COVID-19 resident infections.¹³⁹ As such, SNFs with insufficient staffing appear to leave residents more vulnerable to COVID-19 infections.

¹³³ Kaiser Family Foundation, *Distribution of Certified Nursing Facilities by Ownership Type*, 2019, at: <https://www.kff.org/other/state-indicator/nursing-facilities-by-ownership-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed on January 10, 2021).

¹³⁴ Percentage calculated based on the remaining 338 of the 379 total skilled nursing facilities that are not registered as nonprofit facilities based on their first-level owner.

¹³⁵ See 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*, GAO-09-68, August 2009, at: <https://www.gao.gov/new.items/d09689.pdf> (accessed on January 10, 2021); see also Bos, A., et al., *Financial performance, employee well-being, and client well-being in for-profit and not-for-profit nursing homes: A systematic review*, *Health Care Management Review*, October 12, 2017, 42(4), at 352-368.

¹³⁶ "Deficiency" is defined as a skilled nursing facility's failure to meet Medicare/Medicaid participation requirements. 42 CFR § 488.301.

¹³⁷ 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-09-68, <https://www.gao.gov/new.items/d09689.pdf> (accessed on January 10, 2021).

¹³⁸ On May 11, 2020, CDPH issued AFL 20-52 requiring all SNFs to submit mitigation plans for review and approval to HFID by June 1, 2020, which address the following six elements: (1) testing of residents and staff, including how test results will be used to inform cohorting, (2) infection prevention and control, (3) personal protective equipment, (4) staffing shortages, (5) designation of space to separate infected residents and limit transmission, and (6) communication with staff, residents and their families regarding the status and impact of COVID-19 in the facility. See 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, at: <https://www.cdph.ca.gov/Programs/CHCO/LCP/Pages/AFL-20-52.aspx> (accessed on January 10, 2021).

¹³⁹ 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.

This study also found that California SNFs with lower CMS five-star quality ratings in total nurse staffing had more infection control deficiencies, more total health deficiencies and a higher probability of having COVID-19 positive residents.¹⁴⁰ Conversely, SNFs with higher CMS five-star quality ratings in total nurse staffing had fewer infection control deficiencies, fewer total health deficiencies and a lower probability of having COVID-19 positive residents.¹⁴¹ Analyses of data from SNFs across the country also 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.¹⁴²

Researchers from University of California, San Francisco's Institute for Health and Aging found that for-profit facilities generally received significantly lower CMS rating¹⁴³ scores for overall quality and staffing than nonprofit facilities. For example, the staffing rating of for-profit facilities was found to be just below average, whereas, the staffing rating for nonprofit facilities was almost at the above average level. Staffing turnover rates were also found to be greater in for-profit facilities.¹⁴⁴ In addition, this study found that for-profit facilities received significantly higher frequency of deficiencies, citations and complaints than nonprofit facilities.¹⁴⁵

Chain Ownership

In California, corporate chains that own or manage two or more facilities have emerged as the dominant SNF ownership structure. By 2015, over 74 percent of California facilities were owned by corporate chains.¹⁴⁶ A 2017 study presented a cross-country comparison of trends in for-profit SNF chains in Canada, Norway, Sweden, the United Kingdom and the United States.¹⁴⁷ This study found that large, for-profit SNF chains have complex organizational structures and increasingly dominate their markets utilizing such corporate strategies as the separation of

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² 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.

¹⁴³ CMS employs a quality rating system that gives each SNF a rating of between one and five stars. SNFs with five stars are considered to have much above average quality and SNFs with one star are considered to have quality much below average. There is one Overall five-star rating for each SNF, and a separate five-star rating for health inspections, staffing and quality measures.

¹⁴⁴ Ross, L., et al., *California Nursing Home Chains By Ownership Type Facility and Resident Characteristics, Staffing, and Quality Outcomes in 2015*, August 2016, at:

https://theconsumervoice.org/uploads/files/general/CA-Chains-Report_20AUG2016.pdf (accessed on January 10, 2021).

¹⁴⁵ *Id.*

¹⁴⁶ 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 January 10, 2021).

¹⁴⁷ Harrington, C., et al., *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains*, *Health Services Insights*, 2017, Vol. 10, at 1-23.

property from operational companies, diversification and location of services and the use of tax havens. This study further found that the lack of adequate public information about the ownership, costs and quality of services provided by SNF chains was problematic in all the countries that were analyzed.¹⁴⁸

Complex Ownership Structures

Large SNF chains have developed specific strategies to increase their profitability, including creating complex ownership structures to reduce liability by establishing multiple layers of related companies which separately own, manage and operate their component facilities.¹⁴⁹ Some SNF chains implement complicated ownership structures which utilize separate management companies and service providers owned by the same ownership group via a series of limited liability corporations (LLCs).¹⁵⁰ This can result in a complex and interlocking structure of related individual and corporate owners, management companies and service providers that obscures the ownership and the financial relationships between the various LLCs and lead to higher administrative costs.¹⁵¹ A study of one of California's largest SNF chains found that corporate profits were hidden in management fees, lease agreements and various payments for ancillary support services that were made to companies related to the chain.¹⁵²

In 2014, the Sacramento Bee effectively captured the issues inherent to "extraordinarily elaborate" ownership structures.¹⁵³ One owner had created a network of nearly eighty separate business entities which managed or provided services to fifty-four nursing homes throughout California. The Sacramento Bee noted that a corporate ownership pattern emerges wherein:

[A] nursing home owned by a limited liability company, which is owned by another limited liability company, which is owned by another one after that, with the primary owner at the top of the pile. Some chains

¹⁴⁸ *Id.*

¹⁴⁹ Harrington, C., et al., *Organization, financing and management strategies of the ten largest for-profit nursing home chains in the US*, *International Journal of Health Services*, 2011, 41(4), at 725-746.

¹⁵⁰ *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, at 30-47.

¹⁵¹ 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.

¹⁵² *Id.*; 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 February 11, 2021).

¹⁵³ 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 January 10, 2021).

structure the various entities as general partnerships, others as corporations.

Picture a giant, elaborate wheel, with the owners at the center, then dozens of spokes splaying out toward subsidiaries that in turn connect to other wheels, with more spokes connecting to individual homes.¹⁵⁴

The article notes that advocates for for-profit SNF operators argue that such business structures are necessary. For example, when all facilities within a chain of facilities are held 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 risks losing government funding.¹⁵⁵ However, resident advocates argue that some SNF operators intentionally strive to obscure facility ownership such that consumers are unable to determine who really owns a SNF. As such, a consumer could unwittingly transfer a family member from one poor quality facility to another facility owned by the same chain. The article identified a corporation that had created a different corporation for each of its thirty-two SNFs with dissimilar names like “Tzippy Care Inc.” and “SGV Healthcare Inc.,” making it difficult for consumers to identify when SNFs are related to one another.

Larger ownership groups may use complex and overlapping systems of dissimilarly named companies to create confusing corporate structures that complicate accountability efforts. Inadequate oversight and accountability mechanisms and allowances that exist in the current regulatory framework may also inadvertently aide those who are inclined to engage in corporate conflicts of interest, self-dealing or other financial crimes or abuses. The OIG will further analyze the complex issues involving ownership structures, and make corresponding recommendations, in its final report.

RECOMMENDATIONS

Recommendation #1: In addition to implementing the A-C’s recommendations, 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

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

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.

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
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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**

TABLE OF CONTENTS

	<u>Page</u>
I. Background	1
Department of Public Health’s (DPH) Health Facilities Inspection Division (HFID)	1
State/County Contract Requirements	2
II. Meeting COVID-19 Requirements	5
COVID-19 Mitigation Plans and On-Site Survey Visits	6
Resources Required to Meet New COVID-19 Mitigation Plan Requirements	7
Total Hours Required to Meet Both <u>Original</u> State/County Contract and COVID-19 Requirements	10
III. Assessment of DPH’s HFID	11
A. Actual Backlogged Investigations as of June 30, 2020	12
Tracking All Current and Backlogged Investigations	15
Completing Investigations within Required Timeframes	17
Enforcement Protocols	22
Enforcement Tracking	24
Continuous Increases in Complaints and FRIs	25
Understanding Contractual Responsibility of All Current and Backlogged Investigations	27
B. HFID's Other Required Activities	27
Tracking HFID’s Overall Workload	28
Other Oversight Activities – Analysis and Risk Assessments	29
IV. Benchmarking Analysis	31
Number of Total Health Care Facilities – State vs. County	31
Staffing Structures and Levels – State vs. HFID	32
Roles and Responsibilities of Each Staffing Level – State vs. County	34
Levels of Expertise – State vs. County	34
Training Requirements – State vs. County	34
Standard Average Hours Comparison – State vs. County	36
Total Oversight Responsibilities and Workload – State vs. HFID	37

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

I. Background

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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 amended⁸ 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	SNF Facility Reported Incidents	SNF Totals	Other LTC/Non-LTC Complaints	Other LTC/Non-LTC FRIs	Grand Totals
	A	B	A+B=C	D	E	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

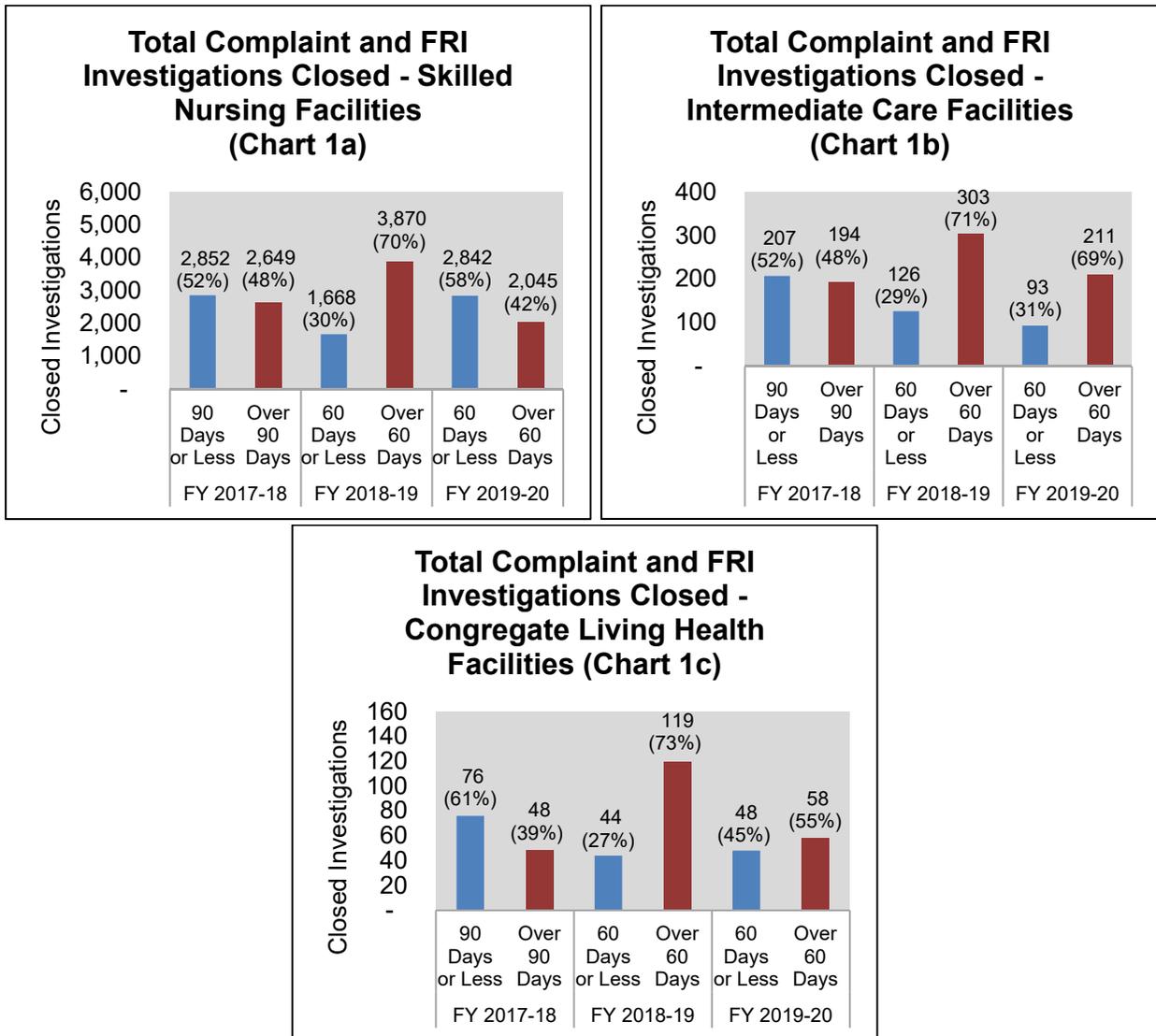
Required Timeframes for Investigations Starting July 1, 2018		
Investigation Process	Type of Investigation	
	Immediate Jeopardy (IJ)	Non-IJ
Initiate Investigation (upon receipt)	24 Hours	10 Business days
Exit Conference with facility	(1)	(1)
Statement of Deficiencies Notice issued to facility	Two days 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

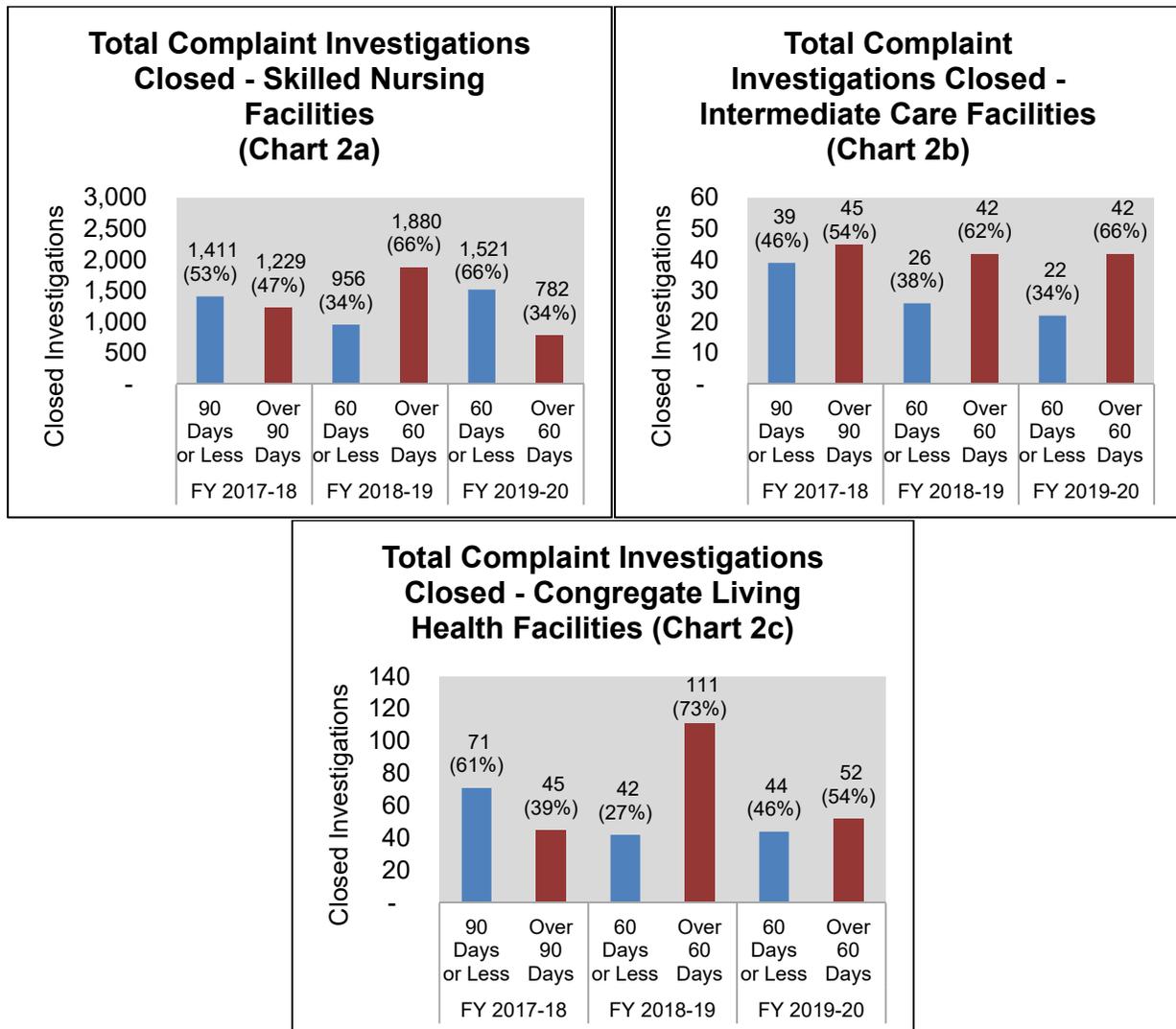


According to the State/County contract, a specific percentage of HFID’s LTC and Non-LTC investigations have to be completed within 60 days. For example, in Year 1, FY 2019-20, 75% of all LTC complaint investigations are required to be completed within 60 days. In Years 2 and 3, 90% and 95%, respectively,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

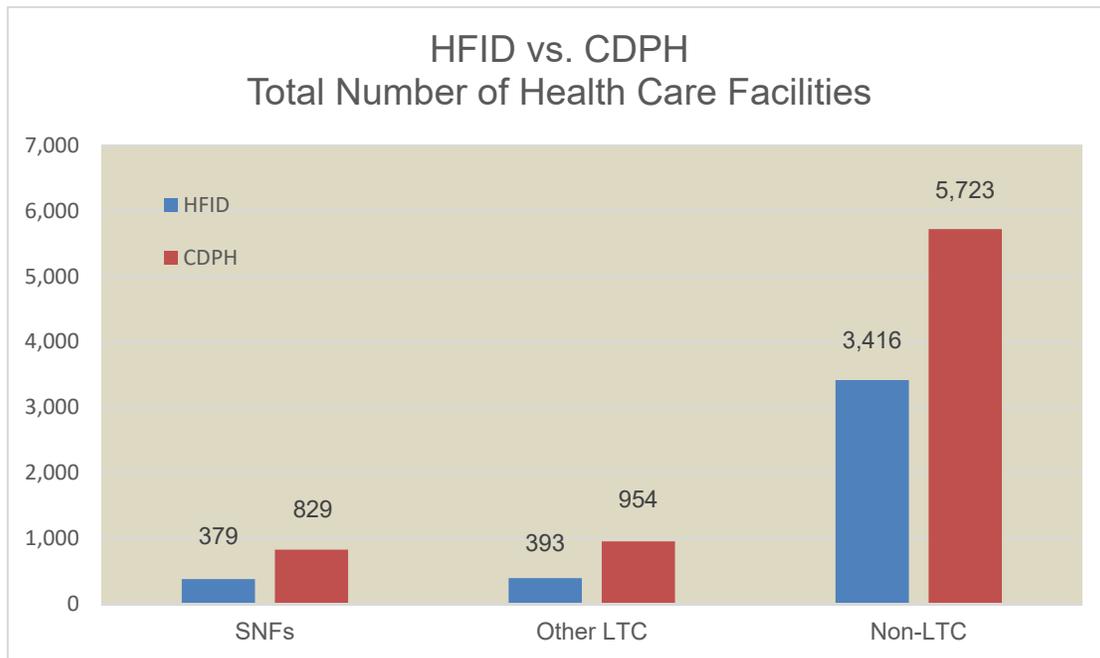
As previously mentioned, Los Angeles County is the only county in California with a State/County contract to perform the required activities as shown in Table 1, for all of the health care facilities in the County, including SNFs. In addition, in our discussions with CDPH, we were unable to identify 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

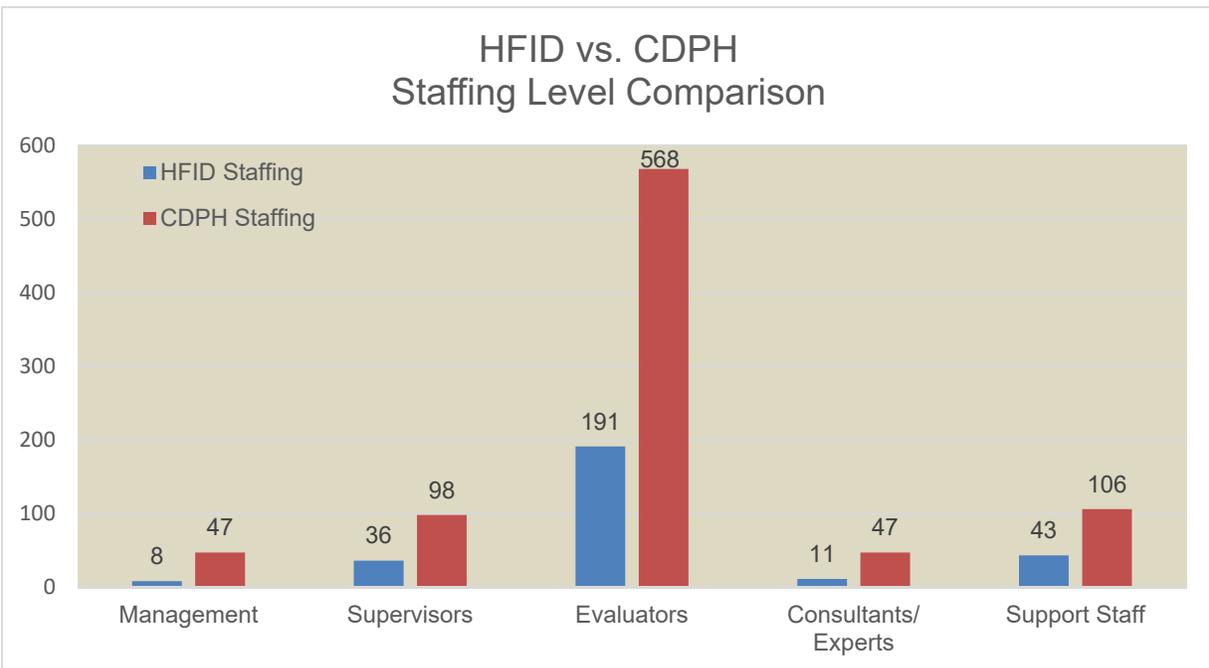


As shown in Chart 3, there are 2,555 total LTC health care facilities (SNFs and other LTC) in California, in which the State is responsible for 1,783 (70%) and HFID is responsible for 772 (30%). There are 9,139 Non-LTC health care facilities in California, in which the State is responsible for 5,723 (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	2,555
	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	9,139
	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.