Investigative Report
97-2

STATE OF IOWA

IOWA OMBUDSMAN

Investigation of the Department of Inspections and Appeals' oversight of long-term care facilities (nursing homes)

TO: Kim Schmett, Director
Department of Inspections and Appeals

and

J.B. Bennett, Administrator
Division of Health Facilities

FROM: William P. Angrick II
Iowa Citizens' Aide/Ombudsman

RE: Case Files 93-34 and 95-14

ISSUED: October 2, 1997

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EXECUTIVE SUMMARY

Ombudsman: DIA was not adequately regulating nursing homes

Based on an investigation detailed in this report, the State Ombudsman concludes the Iowa Department of Inspections and Appeals (DIA) was not adequately enforcing state and federal laws governing nursing homes from 1988 to 1996.

DIA Director Kim Schmett told the Ombudsman he generally agrees with the Ombudsman's findings concerning the two nursing homes studied in the investigation. Mr. Schmett said DIA has been taking steps, since he was appointed agency director last year, to ensure it proactively enforces nursing home laws. Mr. Schmett also said he generally supports the Ombudsman's recommendations for improving DIA's enforcement of nursing home laws.

The Ombudsman is encouraged by Mr. Schmett's comments, particularly information which appears to indicate DIA has been taking positive steps since last year. However, without further study, the Ombudsman is unable to conclude that DIA is now adequately regulating nursing homes. The Ombudsman hopes to conduct a similar review in the future.

About this investigation

The Ombudsman's review was in response to two complaints. Both alleged DIA was failing to take appropriate enforcement actions when it found problems at nursing homes.

The first complaint, received in March 1993, involved DIA's oversight of a nursing home in western Iowa — Elmwood Care Centre in Onawa. The second complaint, received in February 1995, involved DIA's oversight of a nursing home in southeastern Iowa — Mahaska Manor in Oskaloosa (which closed on September 26, 1995).

The Ombudsman's office reviewed 45 DIA inspection reports detailing a total of 316 problems it found at these two facilities over eight years:

- Regarding Elmwood Care Centre, the Ombudsman's office reviewed 23 surveys which found a total of 99 "deficiencies" from 1988 to 1996.
- Regarding Mahaska Manor, the Ombudsman's office reviewed 22 surveys which found a total of 217 "deficiencies" from 1991 to 1995.

Staff also reviewed extensive amounts of other information. Included were state and federal nursing home statutes, which describe enforcement proactively, as a tool for protecting and promoting residents' health, safety and quality of life.

Relying on DIA's own inspection findings, the investigation focused on whether there were instances where DIA should have taken enforcement action but did not.

Basis for Ombudsman's conclusions

The investigation found 41 specific instances where the Ombudsman concludes DIA should have taken some kind of enforcement action but did not. Included were instances where residents sustained physical injuries — and two who died — in connection with the facility's failure to meet federal and state standards.

Other instances included:

- "Significant" errors in administering medications as ordered by a physician.
- Failing to prevent "avoidable and significant" weight losses in residents who needed help eating. One was observed to receive "minimal encouragement or assistance to eat," the findings said. "This resident is blind and was not always told the location of the food at the beginning of the meal."
- Thirteen instances where DIA was mandated or required to take action under statute or regulation.

Rather than revealing a proactive approach to enforcement, this investigation portrayed DIA as an agency often reluctant to use enforcement, *even when mandated.* Such a reactive view of enforcement — by the agency assigned to oversee facilities receiving millions of taxpayer dollars — has two troubling and significant implications:

- Residents may not have been getting the quality of care and quality of life they deserve and required by law.
- Taxpayers may not have been getting their money's worth for nursing home Medicaid expenditures.

At a minimum, the Ombudsman hopes this report reveals a compelling need for further study of this important "watchdog" role state government plays in the lives of Iowa's nursing home residents.

The Ombudsman also is making 12 recommendations. The primary goal of these recommendations is to improve the state regulatory system by enhancing the chances for proactive enforcement results, regardless of potential changes to the federal regulatory system.

Other issues

This investigation also revealed two other issues of concern.

First, the Ombudsman found that DIA's documentation is extremely confusing.

Few families would have the time and resources the Ombudsman's office expended in this review to understand the confusing documentation. This would be particularly true for families faced with the emotional difficulty of choosing a nursing home for a loved one.

As a result, the Ombudsman recommends DIA develop and implement a system designed to help consumers make informed decisions in selecting and monitoring a long-term care facility. The system should include report cards showing basic information about each facility's performance and any enforcement actions taken.

Second, the Ombudsman found three instances where DIA took lower-level enforcement actions after finding residents unnecessarily suffered physical harm — including five who died.

In response to each instance, DIA imposed fines of $500 (*two people had died*), $900 (*one person had died*) and $800 (*two more people had died*).

DIA had discretion to impose much stronger sanctions in each case. And the Ombudsman believes DIA should have exercised that discretion.

In addition, the Ombudsman will be recommending legislative action to give DIA authority to impose more severe fines for failing to correct a violation for which DIA had imposed a fine. (Current state law limits DIA to imposing a $50 per day fine in such instances until the facility corrects the problem, which often means the facility can pay a smaller penalty when it repeats a violation for which DIA imposed a fine).

Ombudsman's recommendations

In all, the Ombudsman is making 12 recommendations pursuant to Code section 2C.16(5).

These recommendations are detailed in subsequent sections of this report. They can be categorized as follows (*the page number of each recommendation and its basis is parenthetically noted*):

Enforcement philosophy

The Ombudsman recommends DIA:

1. Adopt and practice a proactive enforcement philosophy as agency policy. (*See page 42*)

Consumer protection

The Ombudsman recommends DIA:

2. Develop and implement a system designed to help consumers make informed decisions in selecting and monitoring a long-term care facility. (*See page 64*)
3. Publicize deficiencies and enforcement actions. (*See page 44*)

Regulatory action

The Ombudsman recommends DIA:

4. Rescind 481 IAC 56.9 and adopt a new rule based on the table attached as Appendix J. (*See page 42*)

5. Specify in the new rule that when DIA proposes a non-mandated fine pursuant to both state and federal regulations, DIA will rescind whichever would be greater *if* the facility corrects the deficiency within the specified time period (and that DIA will rescind whichever action would be the least severe if the facility fails to correct the deficiency within the specified time period.) (*See page 43*)

6. Amend 481 IAC 58 (chapter concerning state standards for nursing facilities) to remove the parenthetical notations indicating whether violations are considered Class I, Class II or Class III. (*See page 44*)

Policy action

The Ombudsman recommends DIA:

7. Pursuant to 42 CFR 488.303, "... establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to Medicaid residents...." (*See page 44*)

Legislative action

The Ombudsman will be recommending legislative action to amend:

8. Iowa Code section 135C.36. (*See page 44*)

9. Iowa Code section 135C.40(1). (*See page 45*)

10. Iowa Code section 135C.40(1). (*See page 61*)

11. Iowa Code section 135C.41. (*See page 46*)

12. Iowa Code section 135C.44. (*See page 46*)

OVERVIEW

The Office of Citizens' Aide/Ombudsman received a letter in March 1993 from an individual whose father was a resident at Elmwood Care Centre in Onawa. The letter-writer complained DIA had not taken any enforcement action against the facility despite finding numerous violations over several years.

The Ombudsman's office obtained copies of DIA's inspection reports about the facility dating back five years. Staff reviewed the reports but was unable to make significant progress, due to the complexity and volume of the documents.

Staff was still reviewing the complaint when the office received a similar complaint in February 1995. It came from a person who had friends and relatives living at Mahaska Manor in Oskaloosa. This individual raised many concerns, and alleged DIA "waters down" problems at the facility.

Citizens' Aide/Ombudsman William P. Angrick II combined the two complaints. He assigned them to Jeff Burnham, Assistant Citizens' Aide/Ombudsman, directing him to give greater priority to reviewing them. Mr. Burnham spent significant amounts of time reviewing several years' worth of DIA's inspection reports regarding these two facilities.

On February 6, 1996, Mr. Angrick mailed notice of the investigation to then-Acting DIA Director Kim Schmett.[1] The notice stated the allegations which the Ombudsman's office would investigate included, but may not be limited to, the following:

1. Whether DIA has been unreasonable in its enforcement of long-term care facility-related state laws and regulations involving Elmwood Care Centre by failing to take adverse action in response to significant and/or repeated deficiencies.

2. Whether DIA has been unreasonable in its enforcement of long-term care facility-related state laws and regulations involving Mahaska Manor by failing to take adverse action in response to significant and/or repeated deficiencies.

The Ombudsman has since revised the original allegations and added two allegations as follows:

1. Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Elmwood Care Centre by failing to take adverse action in response to significant and/or repeated deficiencies from 1988 to 1996.

2. Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Mahaska Manor by failing to take adverse action in response to significant and/or repeated deficiencies from 1991 to 1995, when the facility closed.

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[1] Mr. Schmett was appointed Acting Director in January 1996, following the retirement of long-time director Charles Sweeney. Mr. Schmett's appointment became permanent in June 1996.

3. Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Mahaska Manor by taking adverse actions whose severity was not commensurate with the severity of the violations from 1991 to 1995.

4. Whether DIA's system of documenting its oversight of long-term care facilities is objectionable in that it is not easily understood by the general public.

During the investigation, Mr. Burnham interviewed J.B. Bennett, Administrator of DIA's Health Facilities Division, and Quality Assurance Officer Vicki Clingan.[2] In the interview, Mr. Bennett indicated this was the first formal review of DIA's enforcement and oversight of long-term care facilities. [While the federal Health Care Financing Administration (HCFA) is required to conduct regular reviews of survey processes and techniques, it is not required to review the post-survey enforcement process. Mr. Burnham reviewed recent HCFA reports concerning DIA's survey processes and techniques and found those reports did not examine DIA's post-survey enforcement process.]

Mr. Burnham also reviewed:

- DIA documentation concerning its oversight of these two facilities, as well as other information about DIA's oversight activities in general.

- Relevant sections from the Code of Iowa and the Iowa Administrative Code, including Code Chapter 135C, "Health Care Facilities," [see Appendix A] and chapter 56 from DIA's rules in the Iowa Administrative Code (481 IAC 56). [see Appendix B]

- Extensive documentation concerning federal laws, regulations and policies concerning oversight of long-term care facilities, including the nursing home reform legislation contained within The Omnibus Budget Reconciliation Act of 1987 (See Appendix C)[3], as well as the "State Operations Manual."

- Materials submitted during two reviews of the long-term care system initiated by the Iowa General Assembly, including:

  — The Regulation of Long-Term Care in Iowa Health Care Facilities Study Committee, which met in November 1994.

  — a series of reports issued by the Auditor of State in response to a 1995 request by the Oversight, Audit and Government Reform

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[2] Mr. Bennett was appointed Division Administrator effective May 31, 1996. He was appointed interim division administrator in December 1995 following the retirement of Pearl Johnson. Before then, Mr. Bennett had served as chief of the Division's "Long-Term Care Bureau 1" since 1990. Ms. Clingan said she was appointed Quality Assurance Officer in 1995, before which she had been a facility surveyor since 1989.

[3] According to the federal Health Care Financing Administration, The Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Public Law 100-203, enacted on December 22, 1987, amended the Social Security Act to incorporate specific provisions for nursing home reform. Section 4212 of OBRA '87 added a new section, 1396(r), to the Act. The new section revised and expanded Medicaid provisions concerning State and Federal responsibilities. Appendix C of this report is a copy of section 1396(r).

Appropriations Subcommittee. The Subcommittee requested the auditor to conduct a study of issues relating to the provision of services to elderly persons by the State of Iowa. As a result of the study, the auditor in December 1995 released eight reports, including one titled "Health Care Facility Inspections."[4]

While that report focused on inspections, it included a section regarding DIA's enforcement process:

"Are fines being imposed according to the law? Are penalties improper? Is there a failure to enforce the law? Fines are being imposed according to law. The federal law just changed July 1, 1995, with the imposition of a federal penalties matrix. The state penalty structure has a significant gap between ranges which should be closed. State fines and penalties are assessed based on inspectors' judgment, while Federal fines and penalty assessments are determined by a team." [*page 6 of auditor's report, which is attached as Appendix D*]

- Information from other sources, including:

  — annual reports by the State Long-Term Care Residents' Advocate Program.

  — nursing home ratings systems established by Consumer Reports magazine and the Detroit Free Press Newspaper.

  — a 1996 report published jointly by the University of California and the National Citizens Coalition for Nursing Home Reform.

[4] The other seven reports were titled: Nursing Facility Issues; Long-Term Care Advocacy Programs; Medicaid Reimbursements; Certificate of Need; Case Management; Attribution of Resources; and Dependent Adult Abuse Investigations.

ALLEGATION #1

Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Elmwood Care Centre by failing to take adverse action in response to significant and/or repeated deficiencies from 1988 to 1996.

INTRODUCTION

For purposes of determining whether this allegation is substantiated, the Ombudsman will rely on the following definition of "*unreasonableness*":

> Unreasonableness was defined in *Churchill Truck Lines, Inc. v. Transportation Regulation Board*, 274 N.W.2d 295, 300 (Iowa 1979) to mean "action in the face of evidence as to which there is no room for difference of opinion among reasonable minds or not based on substantial evidence".... An abuse of discretion is synonymous with unreasonableness.... It is premised on lack of rationality, and focuses on whether the agency has made a decision clearly against reason and evidence....[5]

For a review of the State of Iowa's requirements and responsibilities regarding long-term care facilities, see Appendix E. The reader is advised, however, that Appendix E is relatively complicated and reviewing it is not necessary to understanding this section.

Most of the information in this section comes from DIA surveys involving Elmwood Care Centre. Information from other sources is noted.

The Ombudsman's office reviewed 23 surveys of Elmwood Care Centre covering eight years (July 1988 to August 1996). Those surveys found a total of 99 deficiencies (including repeats). The review did not examine the process by which DIA conducts inspections and determines whether deficiencies exist.

No adverse action resulted from those 99 deficiencies. While DIA issued a Class III citation concerning a repeat deficiency involving hot water temperatures following the August 14, 1989 survey, DIA rescinded the citation after the facility appealed.

The review focused on whether there was a reasonable basis supporting the lack of any adverse actions over the 23 surveys. The review relied upon and examined DIA's findings for each of the 99 deficiencies, as well as the facility's response.

Finally, the review considered the enforcement options available at the time, including those mandated to be applied under certain specific circumstances.

The review identified 20 specific instances where DIA clearly had sufficient basis to take adverse action, including three instances where DIA was required to take adverse action but did not.

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[5] This definition comes from *Frank v. Iowa Department of Transportation, Motor Vehicle Division*, 386 N.W.2d 86 (Iowa 1986).

FINDINGS OF FACT[6]

This section summarizes the key points of those 20 instances independently, categorizing them by issue. These summaries are based on:

- DIA's findings in surveys of Elmwood Care Centre.
- The facility's response to those findings.
- The federal "Guidance to Surveyors for Long Term Care Facilities."

For a complete version of the information these 20 summaries are based on, see Appendix H.

As stated previously, DIA took no adverse action in response to the deficiencies described in the following summaries.

Issue #1: FAILING TO TIMELY ASSESS A RESIDENT AND CONTACT HER PHYSICIAN AFTER AN ADVERSE CHANGE IN CONDITION.

- Instance #1: The May 23, 1996 survey reported staff found a resident's left ankle swollen and blue. The resident, totally dependent on staff for her "activities of daily living," would groan with any movement of the ankle. She could not verbalize pain. About 19 hours later, staff observed the ankle was turning inward and hot to touch. Ice was applied three times during the shift. The resident's physician was not notified until the next day, about 33 hours after staff found the ankle swollen and blue. The resident was transferred to the hospital, where she was treated for a fractured ankle.

Issue #2: ERRORS IN ADMINISTERING MEDICATIONS.

The federal "Guidance to Surveyors for Long Term Care Facilities" states an error rate of 5% or greater "indicates that the facility has systemic problems with its drug distribution system...." Errors include giving medications at times other than ordered by a physician, such as after a meal instead of before a meal as ordered.

- Instance #2: The October 26, 1989 survey reported a 9% error rate in administering medications. This was the third straight survey to cite this deficiency (previously cited April 6, 1989 and August 14, 1989. The facility had not corrected the deficiency following either.)
- Instance #3: The next annual survey (August 24, 1990) reported a 13% error rate in administering medications.
- Instance #4: The next annual survey (July 26, 1991) reported a 6% error rate.

[6] The findings of fact for Allegation #1 (Elmwood Care Centre) and Allegation #2 (Mahaska Manor) are specific to the respective facilities and are therefore presented separately. However, the analysis and conclusions concerning Allegations #1 and #2 are similar. As a result, the analysis and conclusions for both allegations are combined in one section that follows the findings of fact for Allegation #2 (*see page 17*).

- Instance #5: The next annual survey (August 7, 1992) reported a "significant medication error."[7] The facility had, for more than one month, failed to give a resident Feasol as ordered by a physician. The medication is used to replace iron stores for red blood cell development. The resident's hemoglobin and red blood cell count were still below normal when the error was discovered.

- Instance #6: The next survey (November 18, 1992) reported another significant medication error. The facility had, for 18 straight days, given a resident twice the dosage of a blood thinner, Coumadin, ordered by a physician.

Issue #3: USING PHYSICAL RESTRAINTS INAPPROPRIATELY.

The federal "Guidance to Surveyors for Long Term Care Facilities" requires facilities to have a physician's order before restraining residents. It also says residents have the right to accept or refuse restraints.

"For the resident to make an informed choice about the use of restraints," the guide states, "the facility should explain to the resident potential negative outcomes of restraint use. Potential negative outcomes might include incontinence, decreased range of motion, and decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact."

- Instance #7: The August 24, 1990 survey found the facility was using physical restraints on four residents without a physician's order, as required.

- Instance #8: The February 12, 1991 survey found the facility was using physical restraints on ten residents without consulting the residents or their legal representatives.

- Instance #9: The next survey (July 26, 1991) found the facility was using physical restraints on 11 residents without "a trial of less restrictive measures or consultation with other appropriate health professionals," as required. It found the facility had not consulted with two of these residents or their legal representatives. The findings indicated one resident had a significant potential for pressure sores through continued use of restraints.

  It also found restraint usage may have been associated with:

  -- one resident's decreased ability to walk and development of a pressure sore;[8]

  -- another resident had lost her ability to walk; and

  -- a third resident had lost the ability to stand.

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[7] The federal "Guidance to Surveyors for Long Term Care Facilities" states, "Significant medication error means one which causes the resident discomfort or jeopardizes his or her health and safety.... The relative significance of medication errors is a matter of professional judgment."

[8] Pressure sore, also referred to as a bedsore, is defined as "an ulceration of the tissue deprived of nutrition by prolonged pressure," according to Webster's Medical Desk Dictionary, 1986 edition.

- Instance #10: The next annual survey (August 7, 1992) found:

  -- two residents were restrained while under direct supervision during meal times;

  -- one resident was restrained while nursing staff were in close proximity during meal times;

  -- facility staff said a wrist restraint was used on one resident because they pulled at their feeding tube, but the resident "was not observed to pull at the feeding tube during the survey," the findings said. "It was observed that a padded mitt was used during part of the survey and the feeding tube was not pulled out by the resident when using this less restrictive type of restraint."

  -- facility staff said another resident was restrained because "the resident was combative with cares and that the wrist restraints were used when cares were being performed," the findings said. "At the time the resident was observed with the wrist restraints in place there were no staff members in the room and no cares were being performed."

- Instance #11: The April 20, 1994 survey found a variety of problems with how the facility was restraining ten residents. Restraints were being used on seven without "a trial of less restrictive measures or consultation with other appropriate health professionals," as required. Four were ordered to have "self-releasing restraints" but could not release their restraints. Three were observed to be restrained continuously throughout the survey. Two were restrained with the consent of family members, but there was no indication the families had been made aware of the risks or of the possibility of less restrictive devices.

  Also, one resident had a physician order for a restraint "as needed when the resident was agitated." The surveyor observed the resident restrained numerous times but "at none of these times did the resident appear to be agitated or combative with staff."

  Another resident had a restraint "up around their chest, which was not only inappropriate but can pose a risk for choking or making it difficult to breathe. This was especially risky because this resident wanders throughout the facility and is not within direct visual contact of facility staff at times."

Issue #4: FAILING TO ASSURE RESIDENTS MAINTAIN AN APPROPRIATE MINIMUM WEIGHT.

- Instance #12: The August 14, 1989 survey found the facility had not appropriately responded to weight losses. Seven residents had been losing weight (including a 14% weight loss in one month and a 17% weight loss over six months) but the facility's dietary assessments for these residents lacked protein and calorie needs and intake.

  The facility failed to contact the physician of the resident who had a 14% weight loss in one month. In addition, "Several alert residents stated that the food was bland, tasteless with no seasoning or of poor quality," the survey stated.

Issue #5: FAILING TO PREVENT PRESSURE SORES (UNLESS UNAVOIDABLE).

- Instance #13: The July 26, 1991 survey found a resident returned from a hospital on June 6, 1991 with no pressure sores. Six days later, staff started a "pressure sore documentation sheet" but noted nothing until a July 19, 1991 entry stating, "coccyx red."[9]

  "By 7/3/91 the coccyx had a Stage II pressure sore 2cm in diameter and by 7/19/91 it was a Stage III pressure sore 3cm x 2cm x1cm," the survey stated. "Staff had not followed up on this area when it was still at Stage II on 7/4/91 according to the Director of Nursing. During this same period the resident had experienced a 9% weight loss from 6/6/91 to 7/2/91."

  The survey concluded, "During the observations on 7/23/91 the coccyx area was red and the gluteal fold was excoriated."[10]

Issue #6: MOVING RESIDENTS TO A DIFFERENT ROOM WITHOUT PRIOR NOTICE.

- Instance #14: The December 30, 1991 survey found the facility moved three residents to different rooms without prior notice, as required.

  "Resident #31 with multiple coronary diagnosis and a recent hospitalization was found to have been moved on 11/25/91 without prior notification or consent, causing the resident distress and anxiety which lasted to the time of the investigation," the survey stated.

  There was no documentation of consent for the move of Resident #38," it added. "Documentation in the record indicated this resident was upset by the move."

  "There was documentation for consent of the move of Resident #57, however it was signed by a son of the resident who did not have P.O.A. [*power of attorney*] This was signed on the day of the move."

Issue #7: FAILING TO WEAN RESIDENTS FROM ANTIPSYCHOTIC DRUGS UNLESS CLINICALLY NECESSARY.

The federal "Guidance to Surveyors for Long Term Care Facilities" states, "Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual dose reduction should be under close supervision....

"... While the facility can refer to a physician's justification as a valid justification for use of a drug, it may not justify the use of a drug, its dose, its duration, etc. solely on the basis that 'the doctor ordered it.'"

The federal guide goes on to indicate that "clinically contraindicated" applies only under

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[9] Coccyx is defined as "the end of the spinal column beyond the sacrum," according to Webster's Medical Desk Dictionary, 1986 edition.

[10] Gluteal is defined as "of or relating to the buttocks or the gluteus muscles." Excoriation is defined as "a raw irritated lesion." (Both definitions are from Webster's Medical Desk Dictionary, 1986 edition.)

specific criteria to residents with any of 10 specific medical diagnoses, including schizophrenia, acute psychotic episodes and Huntington's disease.

- Instance #15: The July 26, 1991 survey found six residents were receiving antipsychotic drugs for extended periods without any attempts by the facility to gradually reduce the doses.

  Four of the six had their doses increased by their physicians, but the justifications (such as, "can become agitated at times" for a resident also documented as "friendly and cooperative") did not meet the federal criteria.

  One of the four had fallen six times in the four months since the dose was increased, but there was no indication of falls before then.

- Instance #16: The next annual survey, August 7, 1992, found four residents were receiving antipsychotic drugs without medically valid reasons. During the survey, the facility stopped giving the drugs to two of the residents.

Issue #8: FAILING TO CORRECT DEFICIENCIES WITHIN 90 DAYS.

Beginning October 1, 1990, both federal and state law required facilities to correct all deficiencies within 90 days or they would be denied payment for any new Medicaid admissions until the deficiencies were corrected.

- Instance #17: Eight deficiencies in the July 26, 1991 survey were not documented as corrected until February 28, 1992.

- Instance #18: Three deficiencies in the August 7, 1992 survey were not documented as corrected until February 22, 1993.

- Instance #19: One deficiency in the October 5, 1990 survey was not documented as corrected until February 12, 1991.

Issue #9: FAILING TO HELP RESIDENTS WHO NEED HELP WITH EATING AND HYGIENE.

- Instance #20: The April 19, 1996 survey reported the facility had assessed one resident as having a pressure sore, significant weight loss and needing help with eating.

  The resident ate only half of his breakfast one day, and staff did not encourage or help him to eat more. The next day, he ate none of his breakfast, and staff had not tried to help him.

  "The resident had sustained a significant weight loss of 11% in the past three months," the survey stated. "Failure to assist the resident in the area of eating resulted in weight loss and was a risk factor in the formation of a stage two pressure sore."

  Staff helped another resident eat her breakfast, but left when she had eaten less than half of the meal. In addition, the survey found problems with care given to three residents who were incontinent. For each one, the findings stated that failure to adequately cleanse residents after incontinence could result in excoriated skin and increases the chance for pressure sores to form.

ALLEGATION #2

Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Mahaska Manor by failing to take adverse action in response to significant and/or repeated deficiencies from 1991 to 1995, when the facility closed.

INTRODUCTION

For purposes of determining whether this allegation is substantiated, the Ombudsman will rely on the same definition of "unreasonableness" given on page 4.

For a review of the State of Iowa's requirements and responsibilities regarding long-term care facilities, see Appendix E. The reader is advised, however, that Appendix E is relatively complicated and reviewing it is not necessary to understanding this section.

Most of the information in this section comes from DIA surveys involving Mahaska Manor. Information from other sources is noted.

The Ombudsman's office reviewed 22 surveys of Mahaska Manor covering nearly four years (August 1991 to May 1995.) Mahaska Manor ceased operations on September 26, 1995, according to a memo DIA issued the following day to various state agencies.[11]

Those surveys found a total of 217 deficiencies (including repeats.) The review did not examine the process by which DIA conducts inspections and determines whether deficiencies exist.

DIA took 44 adverse actions in response to those deficiencies.

The review focused on whether there was a reasonable basis supporting the lack of any additional adverse actions over the 22 surveys. The review relied upon and examined DIA's findings for each of the 217 deficiencies, as well as the facility's response.

Finally, the review considered the enforcement options available at the time, including those mandated to be applied under certain specific circumstances.

The review identified 21 additional, specific instances where DIA clearly had sufficient basis to take adverse action, including 10 instances where DIA was required to take adverse action but did not.

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[11] The memo stated in part, "... The facility was only occupied by 19 private pay residents. Threatened with decertification from the Medicaid Program early in 1995, the facility voluntarily withdrew participation and discharged all Medicaid residents in May, 1995." The memo also said the owner had been negotiating sale of the facility to Mahaska County Hospital, but the hospital withdrew its offer.

FINDINGS OF FACT

This section summarizes the key points of those 24 instances independently, categorizing them by issue. These summaries are based on:

- DIA's findings in surveys of Mahaska Manor.
- The facility's response to those findings.
- The federal "Guidance to Surveyors for Long Term Care Facilities."

For a complete version of the information these 24 summaries are based on, see Appendix I.

As stated previously, DIA took no adverse action in response to the deficiencies described in the following summaries.

Issue #1: FAILING TO PROVIDE APPROPRIATE QUALITY OF CARE.

- Instance #1: The May 6, 1994 survey found the facility provided inappropriate quality of care to four residents. The findings indicated:

  -- Staff found a large amount of bleeding around a resident's catheter site at 1 a.m., May 3, 1994. Six and a half hours later, the resident was complaining of severe pain in the lower abdomen. "His abdomen was hard and distended and profuse bleeding continued from around the catheter site," the findings stated. "At 8:30 a.m. the resident continued to have profuse bleeding and severe pain." Staff did not call the physician's office until 9:15 a.m. The resident was later admitted to the local hospital with a diagnosis of hemorrhagic cystitis. "There had been no vital signs taken on this resident from the time the bleeding was first observed over ten hours before transfer," the findings stated. "There was no indication the staff had attempted to notify the physician of the bleeding and pain for eight hours. The failure of the facility to totally assess the resident and notify the physician timely resulted in delay in the provision of needed care and services and could have resulted in further complications for this resident."

  -- One resident had elevated blood sugars starting February 1, 1994. The physician ordered low doses of insulin. But the blood sugars continued to be elevated. The facility did not intervene further until February 15, 1994, when the resident was taken to the hospital. The resident died three days later.

  -- Another resident fell on February 12, 1994. She had abnormal vital signs. Her vital signs were still abnormal at 12:45 a.m. the next day. "Despite continued notation of abnormal vital signs, color pale, etc.," the findings stated, "there was no indication an attempt was made to contact the physician until 5 a.m. on 02/14/94." [28 hours later] The physician requested she be sent to the clinic the next day. But she didn't go because she didn't have a ride. She was taken to the clinic on February 16, 1994. At that time, she was having tachycardia, elevated temperature and elevated white blood count. She was admitted to the hospital a few hours later, where she died on March 7, 1994 "with the number one cause of death being renal failure," the findings stated. "The failure of the facility to totally assess the resident and notify the physician

timely resulted in delay in the provision of needed care and services which could have contributed to his death."

-- A fourth resident fell at 3:45 a.m., November 28, 1993. Staff noted a cut near her left eye; vital signs were in the normal range. At 8 a.m. the next day, staff noted she was complaining of pain to her left arm and wrist. Staff notified her doctor at 10:15 a.m. that day (30½ hours after she fell). The physician ordered they take her to the clinic for x-rays. At 4:35 p.m., staff tried calling the resident's family without success. At 6:40 p.m., staff reached a relative who said family members could not take her to the clinic. The next day (November 30, 1993) a staff member took her to the clinic, which found she had sprained her wrist and ordered a splint. "The failure of the facility to totally assess the resident, notify the physician timely and then get her to the clinic resulted in delay in the provision of needed care and services," the findings stated. "The delay in treatment of the injury to the wrist caused this resident to suffer needless pain."

Issue #2: MAKING SIGNIFICANT MEDICATION ERRORS.

- Instance #2: The December 18, 1992 survey was the second straight to include this deficiency, which was cited November 9, 1992. It had also been included in the November 21, 1991 survey. The December 18, 1992 survey reported a resident returned from the hospital at 7:30 p.m., November 27, 1992, after treatment for an injury from a human bite. "The physician ordered Augmentin [*an antibiotic*] 250 mg to be taken three times a day and a note to return to E.R. [*emergency room*] with any sign of infection," the findings stated. "The resident did not receive the first dose of the antibiotic until 12 noon on 11/28/92, seventeen hours after the medication was ordered...."

  Later that day, staff began to note inflammation, swelling and yellow drainage. Staff did not call the physician until November 30. The physician saw the resident and ordered a different antibiotic three times a day. But the medication was not started until 8 a.m. the next day, 16 hours later.

  Two days later, staff notified the physician that the left hand was swollen and there was a reddened area under the left forearm. The physician changed to yet a third antibiotic twice a day. On December 7, staff noted the left hand and fingers were swollen "with 1 plus edema and the arm was warm to touch and very tender." Four hours later, staff called the physician, who later admitted the resident to the hospital with cellulitis.

- Instance #3: The next survey, February 3, 1993, found two significant medication errors. One resident was given a dose of 250 milligrams of Keflex [*an antibiotic*] in error. "The medication had been prescribed for another resident with the same last name and had been placed in the wrong drawer," the findings stated.

  Another resident was ordered to receive 2.5 milligrams of Diabeta [*a blood-glucose lowering drug*] three times a day. "Due to a mix-up, the resident received 7.5 milligrams of the Diabeta at 8:00 am and noon on 01/22/93 prior to the recognition of the error," the findings stated.

Issue #3: FAILING TO PROVIDE SUFFICIENT NUMBERS OF LICENSED NURSES AND OTHER NURSING PERSONNEL.

- Instance #4: The September 17, 1992 survey was the fifth straight to include this deficiency. It was previously cited on surveys from October 3, 1991 to June 30, 1992, and was found to be corrected only once during that time, on March 24, 1992. The September 17 survey findings stated:

  -- residents said staff did not respond to call lights promptly. They sometimes had to wait for 1 to 1½ hours (an increase from the previous survey, when a maximum wait of 50 minutes was reported.)

  -- there was a prolonged waiting period after meals for residents needing help going to the bathroom.

  -- three residents did not have call light cords within reach, including one "who was calling out for help."

Issue #4: EMPLOYING NURSE AIDES WHO WERE NOT COMPETENT AND QUALIFIED.

- Instance #5: The September 17, 1992 survey found 11 incidents where residents sustained physical injury and/or fell while being helped by nurse aides. For example, a nurse aide was pushing a resident in a wheelchair "and the resident's feet were bent backwards under the wheelchair. The resident's feet were noted to be ran over with the wheelchair wheels."

Issue #5: FAILING TO ENSURE RESIDENTS MAINTAIN AN ACCEPTABLE BODY WEIGHT UNLESS UNAVOIDABLE.

- Instance #6: The May 20, 1993 survey found five residents had sustained severe weight losses. One had a severe weight loss of 7% in the past month and was hospitalized with a diagnosis of "malnutrition with significant recent weight loss."

  DIA cited the same deficiency on its March 5, 1992 and November 21, 1991 surveys.

- Instance #7: The next annual survey, June 20, 1994, found five residents sustained unplanned weight losses that were "avoidable and significant." Weight losses were:

  -- 10% over five months;

  -- 9% over four months;

  -- 12% over eight months;

  -- 10% over five months. "When observed at three of three meals, the resident received minimal encouragement or assistance to eat," the survey stated. "This resident is blind and was not always told the location of food at the beginning of the meal."

  -- 9% over five months.

Issue #6: FAILING TO TAKE APPROPRIATE STEPS TO PREVENT THE SPREAD OF INFECTIONS.

- Instance #8: The June 20, 1994 survey found three cases where staff members provided hands-on care to residents (two incontinency cares and one bed repositioning) without washing their hands before and/or after. "The practices described above can lead to spread of infections," the survey stated.

  The same survey also found five cases where staff handled dirty linens (i.e., soaked with urine and/or feces) in a manner that could lead to the spread of infections.

  The previous survey, May 6, 1994, had found staff failed to follow proper infection prevention techniques while changing pressure sore dressings on two residents.

Issue #7: FAILING TO CORRECT DEFICIENCIES WITHIN 90 DAYS.

Beginning October 1, 1990, both federal and state law required facilities to correct all deficiencies within 90 days or they would be denied payment for any new Medicaid admissions.

- Instance #9: One deficiency in the October 3, 1991 survey was not documented as corrected until March 24, 1993.

- Instance #10: Four deficiencies in the June 30, 1992 survey were not documented as corrected until December 18, 1992.

- Instance #11: Three deficiencies in the May 20, 1993 survey were not documented as corrected until December 20, 1993.

- Instance #12: Four deficiencies in the May 6, 1994 survey were not documented as corrected until October 14, 1994.

- Instance #13: One deficiency in the June 20, 1994 survey was not documented as corrected until November 30, 1994.

Issue #8: FAILING TO CORRECT A VIOLATION WITHIN THE TIME SPECIFIED BY DIA.

Iowa Code section 135C.40 states in part, "... Failure to correct a violation within the time specified, unless the licensee shows that the failure was due to circumstances beyond the licensee's control, ***shall*** subject the facility to a further penalty of fifty dollars for each day that the violation continues after the time specified for correction. (emphasis added)

- Instances #14 and #15: DIA issued Fining and Citation Report #969 (F&C 969) on October 5, 1992. It included two Class II citations for two deficiencies found in the September 17, 1992 survey. Both included a $300 fine with the correction date listed as "upon receipt."

  The following survey (November 9, 1992) included the same two deficiencies.

Issue #9: FAILING TO MAINTAIN FOOD AT PROPER TEMPERATURES.

- Instance #16: The August 19, 1994 survey found "the facility failed to provide food that was palatable, and maintained at proper temperatures.... Failure of the facility to maintain food at proper temperatures can lead to food borne illness. Food that is not of proper temperature makes the food less palatable for the residents, which can lead to decreased consumption and weight loss."

  DIA cited the identical deficiency on the previous survey (June 20, 1994) and July 2, 1993.

- Instance #17: The next survey, October 14, 1994, found the facility "failed to serve food at proper temperatures, hot foods at 140 degrees or above and cold foods at 45 degrees or below. Improper temperatures affect palatability and promotes the growth of bacteria which can lead to food borne illnesses."

Issue #10: FAILING TO CORRECT VIOLATIONS AS ORDERED BY DIA.

- Instance #18: DIA put Mahaska Manor's license on "conditional" status under a July 6, 1994 notice to the facility which stated: "The facility must substantially correct the attached violations by July 8, 1994. *Failure to correct the attached violations may result in the suspension or revocation of your license*." (emphasis added)

  While the notice did not state which particular violations it was referencing, Mr. Bennett of DIA told the Ombudsman's office that such notices are generally based on those violations that resulted in a citation or all violations referenced in the survey.

  This indicates the notice was based, at least in part, on the two deficiencies in "F&C 1069," which DIA issued at the same time. On its August 19, 1994 revisit, DIA found neither deficiency had been corrected and imposed a $50 daily fine pursuant to Code section 135C.40(1).

Issue #11: FAILURE TO APPLY FOR TEMPORARY MANAGER.

Former state rule 441 IAC 81.19(1)(b), rescinded July 1, 1995, stated: Grounds for appointing a temporary manager. A temporary manager ***shall*** be requested by the department of inspections and appeals when any of the following conditions exist: emergencies, immediate jeopardy, a pattern of violations, chronically substandard care, ***initiation of decertification or license revocation proceedings***, and acts such as foreclosure or seizure of the facility. (emphasis added)

- Instance #19: DIA issued a November 23, 1992 letter to the facility stating in part, "As a result of our most recent Federal findings ... the Department is recommending the Department of Human Services terminate your Medicaid (Title-19) contract effective February 7, 1993...."

  The revocation action was later rescinded, according to a December 23, 1992 letter from DIA to the facility.

- Instance #20: DIA issued a May 28, 1993 letter to Mahaska Manor stating in part, "As a result of our most recent Federal findings ... the Department is recommending that the Department of Human Services terminate your Medicaid (Title-19) contract effective August 18, 1993...."

  Also on May 28, 1993, DIA issued a "Notice of Revocation of Nursing Facility License," effective thirty days after receipt. DIA rescinded both actions on July 2, 1993.

- Instance #21: DIA issued a December 19, 1994 letter to Mahaska Manor stating in part, "As a result of our most recent Federal findings ... the Department is recommending that the Department of Human Services terminate your Medicaid (Title-19) contract effective February 28, 1995...."

  Also on December 19, 1994, DIA issued a "Notice of Revocation of Nursing Facility License," effective thirty days after receipt. DIA rescinded both actions on January 12, 1995.

ALLEGATIONS #1 AND #2: ANALYSIS AND CONCLUSIONS

During the past two decades, the number of people over age 65 has grown dramatically, more than 55 percent. While people are living longer, the number of people with chronic illnesses or disabilities that will require long-term care services is also increasing. By the year 2000, almost 9 million older Americans will need long-term care services, up from almost 7 million in 1988. Many of these people will require nursing home services.

—from "Guide to Choosing a Nursing Home," published by the federal Health Care Financing Administration

The fastest growing segment of the population is the very oldest, and the aging of the huge baby boomer population looms in the future. The number of 85-year-olds will explode from 3.6 million today to 17.6 million by 2050.

—from "Long-Term Care – Another Budget Buster?," March 1995 article in the magazine, State Legislatures

Expectations of enforcement

When it comes to nursing home enforcement, what is expected of DIA? The answer lies in the following statements from state and federal law:

- To promote and encourage adequate and safe care and housing (for residents of nursing facilities.) (*Iowa Code chapter 135C; see Appendix A*)
- Enforcement actions must be adequate to protect the health, safety, welfare and rights of nursing facility residents. (*OBRA 1987; see Appendix C*)
- Enforcement actions must promote the effective and efficient use of public moneys. (*OBRA 1987*)
- Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. (*OBRA 1987*)

These statements have one thing in common: Each describes enforcement in *proactive* terms, as a tool for protecting and promoting resident's health, safety and quality of life.

These expectations have not changed in the past decade.

Concerning facilities, the Ombudsman believes enforcement should strike an appropriate balance between two important yet competing goals:

- Working with facilities in a professional, and whenever possible, non-adversarial manner.
- Using enforcement proactively as a deterrent to prevent continued problems for residents.

DIA's performance in regulating Elmwood Care Centre

This review has revealed many specific instances where DIA was not meeting expectations under federal or state law concerning its oversight of Elmwood Care Centre from 1988 to 1996:

1. *ALLEGATION #1 — INSTANCE #1*

   Issue: Failing to timely assess a resident and contact her physician after an adverse change in condition

   Instance #1: DIA found the facility failed "to initially promptly assess" Resident #1 after discovering her ankle was swollen and blue. DIA also found the facility failed to notify her physician for 32 hours, which "resulted in pain for the resident." After the facility contacted her physician, she was treated for a fractured ankle.

   Applicable factors: 481 IAC 56.9(5) [*See Appendix B*]

   Given the 32 hours of pain that this resident — "who could not verbalize pain" — unnecessarily experienced, it was unreasonable for DIA not to take enforcement action to protect other residents from similar problems.

2. *ALLEGATION #1 — INSTANCES #2 through #6*

   Issue: Errors in administering medications

   Instance #2: DIA found a 9% error rate in administering medications. This was the third straight survey to cite this deficiency and the facility had failed to correct it following the other two.

   While DIA did not find any resulting harm to residents, the federal "Guidance to Surveyors for Long Term Care Facilities" states an error rate of 5% or greater "indicates the facility has *systemic problems* with its drug distribution system...." [emphasis added]

   Systemic problems with a facility's drug distribution system put all residents at risk, potentially.

   Applicable factors: 481 IAC 56.9(2)(3)(5)

   Given the significance of the deficiency, and the facility's prior history with it, it was unreasonable for DIA not to take enforcement action to protect residents from continued medication errors.

Instance #3: On the next survey, DIA found a 13% error rate in administering medications as ordered. This was the fourth straight survey to cite this deficiency.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency, and the facility's prior history with it, it was unreasonable for DIA not to take enforcement action to protect residents from continued medication errors.

During the investigation, when asked why it took no enforcement action in this instance, DIA pointed to the absence of any actual harm to residents. But such a position is contradicted by statements DIA staff has made indicating DIA *does* consider the potential for harm.

For example, during an interview with Assistant Ombudsman Burnham, DIA Quality Assurance Officer Vicki Clingan said, "... DIA looks at potential harm. We take that into consideration in a very serious way."

The Ombudsman agrees that DIA should consider the potential for harm. If enforcement is to be proactive, it *must* include the possibility of adverse action in the face of a credible potential for harm to residents. Otherwise, enforcement becomes reactive, taken only after harm has occurred.

Also, had DIA taken enforcement action following Instance #2, perhaps the facility would not have been deficient in Instance #3.

Instance #4: The next annual survey reported a 6% error rate.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency, and the facility's prior history with it, it was unreasonable for DIA not to take enforcement action to protect residents from continued medication errors.

Instance #5: The next annual survey reported a "significant medication error" involving the drug Feasol — "used to replace iron stores for red blood cell development," the findings state.

A physician had ordered Feasol be given to Resident #10 with each meal. But DIA found that for about six weeks, the facility failed to give any Feasol to the resident. The findings indicate the resident's hemoglobin and red blood cell counts were still below normal.

Applicable factors: 481 IAC 56.9(3)(5)

Given the significance of the deficiency, the indication that it harmed the resident's health (delaying his or her recovery), and the facility's prior history with medication errors, it was unreasonable for DIA not to take enforcement action to protect residents from continued medication errors.

Instance #6: About three months later, DIA found another "significant medication error" involving the drug Coumadin, used as a blood thinner.

A physician had ordered 2.5 milligrams of Coumadin be given to Resident #27 daily. But DIA found the facility administered 5 milligrams daily — twice the prescribed dose — for 18 days.

Applicable factors: 481 IAC 56.9(3)(5)

DIA did not find any resulting harm to the resident. But given the significance of the deficiency and the facility's prior history with medication errors — this being the second "significant medication error" in three months — it was unreasonable for DIA not to take enforcement action to protect residents from continued medication errors.

During the investigation, when asked why it took no such action in this instance, DIA pointed to the absence of any actual harm to the resident. But such a position is contradicted by statements DIA staff has made indicating DIA *does* consider the potential for harm. (*See comment by Ms. Clingan referenced in Instance #3.*)

As stated previously, the Ombudsman agrees that DIA should consider the potential for harm. If enforcement is to be proactive, it *must* include the possibility of adverse action in the face of a credible potential for harm to residents. Otherwise, enforcement becomes reactive, taken only after harm has occurred.

Had DIA taken enforcement action following Instance #5, perhaps the facility would not have been deficient in Instance #6.

3. *ALLEGATION #1 — INSTANCES #7 through #11*

Issue: Inappropriate use of physical restraints

Instance #7: DIA found the facility was using physical restraints on four residents without a physician's order, as required.

Applicable factors: 481 IAC 56.9(2)(5)

Given the significance of the deficiency — physically restraining residents without a physician's order — it was unreasonable for DIA not to take enforcement action to protect residents from continued violations.

Instance #8: Six months later, DIA reviewed the records of ten residents the facility was using restraints on and found no documentation of asking the residents or their legal representatives before using the restraints. The findings indicate staff interviews revealed the facility did not always ask residents, or their legal representative, before using restraints.

The federal "Guidance to Surveyors for Long Term Care Facilities" states in part:

• "The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR 483.20(d) and 483.10(b), respectively, *and include the right to accept or refuse restraints.*" [emphasis added]

• "In the case of a resident who is incapable of making a decision, the surrogate or representative may exercise this right.... However, the surrogate or representative cannot give the facility permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms."

• "... [A] facility must have evidence of consultation with appropriate health professionals, such as occupational or physical therapists. *This consultation should consider the use of less restrictive therapeutic intervention prior to using restraints....*" [emphasis added]

• "... [I]f a resident is restrained, the assessment must show the presence of a specific medical symptom that would require the use of restraints, those symptoms that are being treated, and how the use of restraints will assist the resident in reaching his or her highest level of physical and psychosocial well-being...."

The federal guide also discusses potential negative outcomes associated with restraint use — including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency — particularly the potential negative outcomes of restraint use and the failure to consult residents first — as well as the number of residents affected (10) and the facility's prior history with the deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from inappropriate use of restraints.

Instance #9: In the next survey, five and a half months later, DIA found the identical deficiency at the facility. The findings discussed inappropriate use of restraints involving 11 residents and indicated:

• For all 11, there was no evidence an evaluation had been done to determine if a less restrictive device could be used or that the facility consulted with appropriate health professionals first.

• Three were having negative physical outcomes associated with restraint use — Resident #47 (decreased ability to ambulate and a pressure sore); Resident #3 (decreased ability to ambulate); and Resident #21 (unable to stand).

• Resident #31 had a history of pressure sores, "giving a potential for recurrent skin breakdown for someone restrained 24 hours a day."

• Resident #91 was observed on his back with a chest restraint throughout the survey in spite of a physician's order stating "keep resident off back." The same resident's documentation showed "near constant restraint night and day since admission."

• Resident #72 said the restraint was frequently too tight.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency — particularly the *actual* negative outcomes in the findings and potential negative outcomes of restraint use in general — as well as the number of residents affected (11) and the facility's prior history with the deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from inappropriate use of restraints.

Also, given the five and a half month interval between Instances #8 and #9, had DIA taken enforcement action following Instance #8, perhaps the facility would not have been deficient on the following survey.

Instance #10: At the next annual survey, DIA found:

-- two residents were restrained while under direct supervision during meal times;

-- one resident was restrained while nursing staff were in close proximity during meal times;

-- facility staff said a wrist restraint was used on one resident because they pulled at their feeding tube, but the resident "was not observed to pull at the feeding tube during the survey. It was observed that a padded mitt was used during part of the survey and the feeding tube was not pulled out by the resident when using this less restrictive type of restraint."

-- facility staff said another resident was restrained because "the resident was combative with cares and that the wrist restraints were used when cares were being performed. At the time the resident was observed with the wrist restraints in place there were no staff members in the room and no cares were being performed."

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency and the facility's prior history with it, it was unreasonable for DIA not to take enforcement action to protect residents from continued violations.

Instance #11: Nearly two years later, DIA found the identical deficiency at the facility. The findings discussed inappropriate use of restraints involving 10 residents and indicated:

• For seven, there was no evidence an evaluation had been done to determine if a less restrictive device could be used.

• Four had doctor's orders for "self releasing" restraints but were having problems, including: Resident #23 (could not release restraint because of a "decreased cognition"); Resident #16 (the restraint used was not self-releasing); Resident # 13 ("... when requested, the resident was unable to release the device or even comprehend simple commands or conversation...."); and Resident #20 (unable to release restraint).

• Resident #75's restraint was "up around their chest, which was not only inappropriate but can pose a risk for choking or making it difficult to breathe. This was especially risky because this resident wanders throughout the facility and is not within direct visual contact of staff at times...."

• Two were observed to be restrained throughout the survey (residents #16 and #14).

• Three were restrained after consulting with their legal representatives, but there was no evidence the facility explained the option of less restrictive devices (residents #16, #15 and #20).

• Resident #18 had a physician's order for a restraint "when agitated," but was observed several times to be restrained when she was not agitated.

• Resident #19 was restrained due to a family request even though the facility's records showed the resident cried and said they did not want to be "tied up." The

resident was restrained with a soft tie belt which the surveyor observed to be inappropriately tied on their upper abdomen.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of the deficiency — particularly the *actual* negative outcomes in the findings and potential negative outcomes of restraint use in general — as well as the number of residents affected (10) and the facility's prior history with the deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from inappropriate use of restraints.

4. *ALLEGATION #1 — INSTANCE #12*

Issue: Failing to assure residents maintain an appropriate minimum weight

DIA found the facility had not appropriately responded to weight losses. Seven residents had been losing weight (including a 14% weight loss in one month and a 17% weight loss over six months) but the facility's dietary assessments for these residents lacked protein and calorie needs and intake.

Also, the facility failed to contact the physician of a resident who had a 14% weight loss in one month. In addition, "Several alert residents stated that the food was bland, tasteless with no seasoning or of poor quality," the findings stated.

Applicable factors: 481 IAC 56.9(2)(5)

Given the significance of the facility's failure to adjust dietary assessments for seven residents who had been showing significant weight losses, it was unreasonable for DIA not to take enforcement action to protect residents from continued failures.

5. *ALLEGATION #1 — INSTANCE #13*

Issue: Failing to prevent pressure sores (unless unavoidable)

DIA found a resident returned from the hospital with no pressure sores. Thirteen days later, facility documentation stated the resident's coccyx[12] was red. Two weeks later, the coccyx had a Stage II pressure sore[13] two centimeters in diameter. At that point, "staff had not followed up on this area," the findings stated. During the same period, the resident had a 9% weight loss.

Two weeks later still, it had grown to a Stage III pressure sore measuring three centimeters by two centimeters by one centimeter. When the surveyor observed the area, it was "red and the gluteal fold was excoriated[14]," the findings stated.

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[12] Coccyx is defined as "the end of the spinal column beyond the sacrum," according to Webster's Medical Desk Dictionary, 1986 edition.

[13] Pressure sore, also referred to as a bedsore, is defined as "an ulceration of the tissue deprived of nutrition by prolonged pressure," according to Webster's Medical Desk Dictionary, 1986 edition.

[14] Gluteal is defined as "of or relating to the buttocks or the gluteus muscles." Excoriation is defined as "a raw irritated lesion." (Both definitions are from Webster's Medical Desk Dictionary, 1986 edition.)

Applicable factors: **481 IAC 56.9(5)**

Given the actual harm that could have been avoided had the facility intervened in a more timely fashion, it was unreasonable for DIA not to take enforcement action to protect residents from continued violations.

6. *ALLEGATION #1 — INSTANCE #14*

Issue: Moving residents to a different room without prior notice.

DIA found the facility had moved three residents to different rooms without prior notice, as required. One was still suffering "distress and anxiety" from being moved a month before the survey. This resident had recently been hospitalized and had "multiple coronary diagnosis."

Another was documented as being "upset" by the move. For a third, the consent documentation had been signed by the resident's son *the day of the move*. Further, the son did not have "power of attorney" to give such consent.

For many nursing home residents, their room is their final, permanent "home." Considered in this context, being moved without at least prior notice can have negative consequences, as illustrated above.

Applicable factors: **481 IAC 56.9(2)(5)**

Given the actual harm that DIA found, combined with the finding that this involved three residents, it was unreasonable for DIA not to take enforcement action to protect residents from continued violations.

7. *ALLEGATION #1 — INSTANCES #15 and #16*

Issue: Failing to wean residents from antipsychotic drugs unless clinically necessary.

The federal "Guidance to Surveyors for Long Term Care Facilities" states, "Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual dose reduction should be under close supervision.... ... While the facility can refer to a physician's justification as a valid justification for use of a drug, it may not justify the use of a drug, its dose, its duration, etc. solely on the basis that 'the doctor ordered it.'" The federal guide goes on to indicate that "clinically contraindicated" applies only under specific criteria to residents with any of 10 specific medical diagnoses, including schizophrenia, acute psychotic episodes and Huntington's disease.

Instance #15: DIA found six residents were receiving antipsychotic drugs for extended periods without any attempts by the facility to gradually reduce the doses. Four of the six had their doses increased by their physicians, but the justifications (such as, "can become agitated at times" for a resident also documented as "friendly and cooperative") did not meet the federal criteria. One of the four had fallen six times in the four months since the dose was increased, but there was no indication of falls before then.

Given the caretaker responsibility attached to facilities, this standard requires facilities to look out for situations where residents are given antipsychotic drugs without a medical necessity. In this instance, six residents were receiving these drugs for

extended periods without any evidence of a medical necessity, or of efforts to wean them from those drugs.

Applicable factors: 481 IAC 56.9(2)(5)

Given the significance of this deficiency, and the finding that it involved six residents, it was unreasonable for DIA not to take enforcement action to protect residents from being given antipsychotic drugs unless medically necessary.

Instance #16: The next annual survey found four residents were receiving antipsychotic drugs without medically valid reasons. During the survey, the facility stopped giving the drugs to two of the residents.

Applicable factors: 481 IAC 56.9(2)(3)(5)

Given the significance of this deficiency and the facility's prior history with it, it was unreasonable for DIA not to take enforcement action to protect residents from being given antipsychotic drugs unless medically necessary.

8. *ALLEGATION #1 — INSTANCES #17 through #19*

Issue: Failure to correct deficiencies within 90 days

There is no need to expound whether DIA should have taken enforcement action in these three instances. The facts clearly show that in all three, the facility failed to correct deficiencies within 90 days. Both federal law [42 USC 1396r(h)(2)(C)] and state rule [441 IAC 81.19(2)] required the "denial of payment" remedy when facilities failed to correct deficiencies within 90 days.

In these three instances, the approximate delays were six months, six and a half months, and four months. In each case, federal and state law mandated DIA to impose the "denial of payment" remedy until it documented that the facility had corrected the deficiency or deficiencies in question. DIA acted unreasonably, therefore, by failing to meet its mandate in these instances.

Also, given the relatively short intervals between these three instances (occurring October 1990, July 1991 and August 1992, respectively), had DIA recommended imposing the denial of payment remedy in the first instance, perhaps the facility would have more quickly corrected the deficiencies associated with the subsequent instances.

9. *ALLEGATION #1 — INSTANCE #20*

Issue: Failure to help residents maintain good nutrition and grooming

DIA found the facility's failure to help Resident #13 eat resulted in a significant weight loss of 11% over three months and "was a risk factor in the formation of a stage two pressure sore." The findings also state there was potential for harm to three other residents because of the deficiency.

Applicable factors: 481 IAC 56.9(1)(5)

Given the actual harm caused to Resident #13 and the potential for harm to other residents, it was unreasonable for DIA not to take enforcement action to protect other residents from similar problems.

Conclusion

Based on this information, the Ombudsman concludes DIA's failure to take adverse action in response to these instances was unreasonable in light of the evidence.

The Ombudsman therefore concludes Allegation #1 is *substantiated.*

DIA's performance in regulating Mahaska Manor

This review has revealed many specific instances where DIA was not meeting expectations under federal or state law concerning its oversight of Mahaska Manor from 1991 to 1995:

1. *ALLEGATION #2 — INSTANCE #1*

   Issue: Failing to respond timely to changes in residents' conditions

   DIA found problems with the facility's response to changes involving four residents:

   • Facility staff found a large amount of bleeding around Resident #60's catheter site. But the resident suffered through eight hours of bleeding and pain before staff contacted a physician. Staff also failed to take any vital signs. The staff's failures "resulted in delay in the provision of needed care and services and could have resulted in further complications," the findings state.

   • Facility staff found Resident #1 was having elevated blood sugar levels. Staff contacted a physician, who ordered low doses of insulin. But the insulin did not control the elevated blood sugars. Staff, however, failed to intervene further. Eventually, the resident was sent to the hospital and died there three days later of "sudden death with electro mechanical dissociation," the findings state.

   • Facility staff found Resident #3's vital signs were abnormal and his color was pale. But staff failed to contact a physician for 28 hours. When the patient was admitted to the hospital two days later, he was having tachycardia, elevated temperature and elevated white blood count. He died at the hospital about three weeks later "with the number one cause of death being renal failure," the findings state. "The failure of the facility to totally assess the resident and notify the physician timely resulted in delay in the provision of needed care and services which could have contributed to his death."

   • Facility staff found Resident #63 fell and sustained a small cut by her left eye. About 28 hours later, the medical record shows the resident complained of pain in her left arm and wrist. Staff called a physician, who ordered the resident be taken to the clinic for x-rays. Staff tried calling relatives and did not reach one until the evening, 6½ hours later. The relative said family members could not take her to the clinic. The next afternoon, a staff member took her to the clinic. She was diagnosed with a sprained wrist and ordered to wear a wrist splint. "The failure of the facility to totally assess the resident, notify the physician timely, and then get her to the clinic resulted in delay in the provision of needed care and services," the findings state. "The delay in treatment of the injury to the wrist caused this resident to suffer needless pain."

Applicable factors: **481 IAC 56.9(2)(5)**

Given the significance of these findings, particularly the two resident deaths related to staff's failure to respond timely, it was unreasonable for DIA not to take enforcement action to protect residents from continued failures to respond timely to condition changes.

2. *ALLEGATION #2 — INSTANCES #2 and #3*

Issue: Significant errors in administering medications

Instance #2: DIA found delays in starting antibiotics ordered for a resident whose left arm was bitten. The physician ordered the antibiotic be given three times a day and to return the resident to the emergency room "with any sign of infection," the findings stated.

The facility failed to administer the first dose until 17 hours after it was ordered. That same day, according to the findings, staff noted "inflammation, swelling and yellow drainage. There was no indication a physician was contacted until a call was made to the clinic" two days later.

After a follow-up appointment, the physician ordered a different antibiotic three times a day. But the facility failed to administer any for 16 hours.

A week later, according to the findings, staff noted "the left arm was three times larger than the right." The resident was admitted to the hospital with cellulitis.

These findings were cross-referenced to another deficiency which resulted in enforcement action. The Ombudsman, however, believes additional enforcement action was clearly warranted for several reasons:

• The enforcement action that DIA took resulted from the facility's failure to follow "professional standards of quality in assessment/intervention" involving four residents, including Resident #4.

• These findings involved a separate problem — a significant medication error involving Resident #4, indicating a nexus between the facility's failure to timely follow doctor's orders and the ensuing infection and physical suffering.

• The facility had a prior history with significant medication errors — the deficiency was cited the month before and the year prior.

• The enforcement action taken in connection with the other deficiency was a mandatory $50 per day fine (for failing to correct "upon receipt" of the initial fine) and lasted two days. The total fine for repeating the deficiency, $100, was only one-fifth of the original $500 fine.

• Federal law directs states to impose "incrementally more severe fines for repeated or uncorrected deficiencies." [42 USC §1396r(h)(2)(A)]

Applicable factors: **481 IAC 56.9(3)(5)**

For these reasons, it was unreasonable for DIA not to take enforcement action to protect residents from continued significant medication errors.

Instance #3: The next survey, two months later, included the same deficiency. The findings detail two significant medication errors:

• Staff gave 250 milligrams of Keflex to the wrong resident.

• Staff twice gave three times the ordered dosage of Diabeta to a resident. The physician ordered 2.5 milligrams three times a day. Staff gave the resident 7.5 milligrams at 8 a.m. and noon before realizing the error.

Applicable factors: 481 IAC 56.9(3)

Given that this was the third straight survey with this deficiency, and its potential significance to harm residents, it was unreasonable for DIA not to take enforcement action to protect residents from continued errors.

Also, given the two month interval between Instance #2 and Instance #3, had DIA taken enforcement action in the first instance, perhaps the facility would have not have been deficient on the following survey.

3. *ALLEGATION #2 — INSTANCE #4*

Issue: Insufficient numbers of licensed nurses and other nursing personnel

For the fifth straight survey, DIA included this as a deficiency on September 17, 1992. The findings included:

• Residents said staff did not respond promptly to call lights. Waits of 30 minutes were common. They sometimes waited up to one and a half hours. This was an *increase* from the previous survey findings, which reported a maximum wait of 50 minutes.

• Three residents did not have call light cords within reach, including one who was calling out for help.

While DIA fined the facility following this survey because of deficiencies involving incontinence and pressure sores, documentation from DIA shows surveyors identified the underlying problem was related to staff training and *turnover*.

Applicable factors: 481 IAC 56.9(3)

Given the significance of this deficiency — particularly the credible potential for harm due to the systemic and growing delays in responding to call lights — and the fact this was being cited for the fifth consecutive survey, it was unreasonable for DIA not to take enforcement action to protect residents.

4. *ALLEGATION #2 — INSTANCE #5*

Issue: Inadequately trained nurse aides

DIA found numerous residents sustained physical injury or harm while being assisted by inadequately trained nurse aides. Injuries included:

• Unidentified resident — "was observed being pushed in a wheelchair by staff member #10 and the resident's feet were bent backwards under the wheelchair. The resident's feet were noted to be ran over with the wheelchair wheels."

• Resident #64 — three centimeter skin tear at the elbow area

• Resident #82 — skin tear to right outer elbow area

• Resident #62 — swollen right eyelid, one-inch bruise encircling the right wrist

• Resident #49 — one centimeter skin tear on right elbow

• Resident #82 — possible hair-line fracture of shoulder

• Five additional incidents of falls and/or minor injury related to staff-assisted ambulation and/or transfer

• Four other residents received skin tears and bruises from unknown origin

Applicable factors: 481 IAC 56.9(2)(5)

Given the numerous, documented findings of residents sustaining physical injury and/or harm as a result of this deficiency, it was unreasonable for DIA not to take enforcement action to protect residents.

5. *ALLEGATION #2 — INSTANCES #6 and #7*

Issue: Failing to ensure residents maintain acceptable body weight (unless the resident's clinical condition makes this unavoidable)

Instance #6: DIA found five residents had sustained "severe weight loss" over a four-month period. Weight losses ranged from 7% to 18.2%.

Included was a resident who was hospitalized with a diagnosis of "malnutrition with significant recent weight loss and altered mental status." The same resident said "he could not feed himself because he shook so bad and staff did not assist him very often," the findings state.

In and of itself, the significance of these findings — particularly the showing of actual harm to multiple residents — should have been sufficient to cause DIA to take enforcement action.

But there was other relevant information — the same deficiency had been cited 14½ months prior and 3½ months before that.

Applicable factors: **481 IAC 56.9(2)(3)(5)**

Given the significance of the findings and the facility's prior history with this deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from continued weight loss problems.

Instance #7: The next annual survey found five residents sustained unplanned weight losses that were "avoidable and significant." Weight losses were: 10% over five months; 9% over four months; 12% over eight months; and 9% over five months.

A fifth resident sustained a 10% weight loss over five months. "When observed at three of three meals, the resident received minimal encouragement or assistance to eat," the findings stated. "This resident is blind and was not always told the location of the food at the beginning of the meal."

Applicable factors: **481 IAC 56.9(2)(3)(5)**

Given the significance of the findings and the facility's prior history with this deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from continued weight loss problems.

6. *ALLEGATION #2 — INSTANCE #8*

Issue: Failing to take appropriate steps to prevent the spread of infections.

DIA found three cases where staff did not wash their hands before and/or after providing hands-on care to residents. "The practices described above can lead to spread of infections," the findings stated.

The same survey also found five cases where staff handled dirty linens (i.e., soaked with urine and/or feces) in a manner that could lead to the spread of infections.

Applicable factors: **481 IAC 56.9(2)(3)**

Given the potential significance of improper infection control techniques, and the fact that the previous survey found a similar deficiency, it was unreasonable for DIA not to take enforcement action to protect residents.

7. *ALLEGATION #2 — INSTANCES #9 through #13*

Issue: Failure to correct deficiencies within 90 days

There is no need to expound whether DIA should have taken enforcement action in these five instances. The facts clearly show that in all five, the facility failed to correct deficiencies within 90 days. Both federal law [42 USC 1396r(h)(2)(C)] and state rule [441 IAC 81.19(2)] required the "denial of payment" remedy when facilities failed to correct deficiencies within 90 days.

In these five instances, the approximate delays ranged from four and a half to seven months. In each case, federal and state law mandated DIA to impose the "denial of payment" remedy until it documented that the facility had corrected the deficiency or deficiencies in question. DIA acted unreasonably, therefore, by failing to meet its mandate in these instances.

Also, had DIA recommended imposing the denial of payment remedy in the first instance, perhaps the facility would have more quickly corrected the deficiencies associated with the subsequent instances.

8. *ALLEGATION #2 — INSTANCES #14 and #15*

Issue: Failure to correct "cited" violation within the time specified

Iowa Code section 135C.40 clearly mandates that when DIA fines a facility for a violation, and the facility fails to correct it within the time specified, DIA **shall** impose an additional penalty of $50 for each day the violation continues.

In both of these instances, DIA issued a $300 fine on October 5, 1992 with the correction date listed as "upon receipt." But the next survey, November 9, 1992, included the same two deficiencies that had triggered the fines. In addition, the Post Certification Revisit Report (PCRR) dated November 2-9, 1992 does *not* list them as corrected.

However, other documentation from DIA states the deficiencies were "in compliance" on the November 9, 1992 revisit [this comes from the fining and citation log for Fining & Citation Report #969 (F&C 969).]

This factual conflict can be resolved as follows:

• There are three sources of information on this point — the November 9, 1992 survey; the PCRR; and the fining and citation log for F&C 969.

• The first two sources indicate the deficiencies were *not* corrected as required.

• The Ombudsman therefore concludes that a preponderance of the evidence indicates these deficiencies were not corrected as required. DIA was therefore mandated to impose the additional fine of $50 per day until they were corrected.

9. *ALLEGATION #2 — INSTANCES #16 and #17*

Issue: Failing to have food palatable, attractive and at proper temperature

Instance #16: The findings state the facility failed to maintain food at proper temperatures, which "can lead to food borne illness. Food that is not of proper temperature makes the food less palatable for the residents, which can lead to decreased consumption and weight loss."

The same deficiency had been cited in the previous survey two months prior, as well as a survey 13 months prior.

Applicable factors: 481 IAC 56.9(3)

Given the deficiency's potential for harming residents, and the facility's prior history with the deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from unsafe food.

Instance #17: The same deficiency was included in the next survey two months later. The findings stated the facility "failed to serve food at proper temperatures, hot foods at 140 degrees or above and cold foods at 45 degrees or below. Improper

temperatures affect palatability and promotes the growth of bacteria which can lead to food borne illness."

Applicable factors: 481 IAC 56.9(3)

Given the deficiency's potential for harming residents, and the facility's prior history with the deficiency, it was unreasonable for DIA not to take enforcement action to protect residents from unsafe food.

Also, had DIA taken enforcement action following Instance #19, perhaps the facility would not have been deficient again on the following survey.

10. *ALLEGATION #2 — INSTANCE #18*

Issue: Failure to correct violations as specified by a Notice of Conditional Nursing Facility License

On July 6, 1994, DIA took two enforcement actions against the facility:

• Issued a Class I citation with a $5,000 fine and correction date as "upon receipt."

• Issued a Notice of Conditional License which stated, "The facility must substantially correct the attached violations by July 8, 1994. Failure to correct the attached violations may result in the suspension or revocation of your license."

Six weeks later, DIA revisited the facility and found the deficiencies which triggered the Class I citation had not been corrected. While DIA imposed the mandatory $50 daily fine as required by Iowa Code section 135C.40(1), it did not take any further licensure action as a result of the August 19, 1994 revisit.[15]

Threatening to suspend or revoke a license unless the facility takes specific corrective action by a certain date, and then failing to carry out the threat when the facility fails to do so (especially considering two more residents died in connection with the continued violation), harms DIA's credibility as an enforcement agency. In this instance, more than a month had passed since DIA's deadline for action and the facility *still* had not corrected the deficiencies in question.

Given this, it was unreasonable for DIA not to initiate action to either suspend or revoke the facility's license under the circumstances. (It is worth noting that the facility would have had an opportunity to appeal the action, and DIA had previously rescinded similar actions upon finding the facility had corrected the violations in question.)

11. *ALLEGATION #2 — INSTANCES #19 through #21*

Issue: Failure to apply for temporary manager

Former rule 441 IAC 81.19(1)(b) *clearly* required DIA to request appointment of a temporary manager whenever it initiated decertification of license revocation

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[15] The August 19, 1994 revisit survey found two more residents had died in connection with these same deficiencies. These findings are further discussed and analyzed in a later section of this report. See page 53, "Allegation #3 — Instance #3."

proceedings.

In these three instances, DIA initiated decertification and/or license revocation proceedings. Because the rule was not rescinded until July 1, 1995, and these instances occurred well before that — the first approximately two and half years earlier — DIA was required to request appointment of a temporary manager. But it failed to do so.

Asked why not, Mr. Bennett of DIA did not argue about the rule's interpretation. Instead, he indicated DIA's enforcement philosophy included little or no consideration for pursuit of temporary managers.

However, this contradicts a previous statement made by former Health Facilities Division Administrator Pearl Johnson (who has since retired). In a written response to the State Long-Term Care Resident Advocate's 1994 report, Ms. Johnson defended DIA's practice of allowing poor-performing facilities to operate after they correct problems.

She then wrote, "The Department does not have any options, it is the law.... We cannot debate with him [the State Long-Term Care Resident Advocate] the rationale or reasoning for a law, our responsibility is to enforce the laws as written."

The Ombudsman agrees. While public officials may have philosophical differences with the statutes and rules empowering their agencies, such differences do not normally diminish their obligation to enforce those statutes and rules until they are rescinded or modified.

Also, had DIA appointed a temporary manager in the first instance, perhaps the subsequent instances would not have been necessary.

Conclusion

Based on this information, the Ombudsman concludes DIA's failure to take adverse action in response to these instances was unreasonable in light of the evidence.

The Ombudsman therefore concludes Allegation #2 is *substantiated.*

DIA was not meeting enforcement expectations

Rather than revealing a proactive approach to enforcement, these findings and conclusions portray an agency that was often reluctant to use enforcement, *even when mandated.* Such a reactive view of enforcement — by the agency assigned to oversee facilities receiving millions of taxpayer dollars — has two troubling and significant implications:

- Residents may not have been getting the quality of care they deserve and required by law.

- Taxpayers may not have been getting their money's worth for certain Medicaid expenditures.

Some may question whether these findings and conclusions are based on sufficient data. It is true that this investigation reviewed DIA's oversight of only two long-term care facilities, out of more than 900 in the state, over a four-year period and eight-year period, respectively.

However, this was one of the most complex and time-consuming investigations undertaken in the 27 year history of the Ombudsman's office. Consideration was given to expanding the review to examine DIA's oversight of other facilities, to provide additional data to analyze.

But this idea was rejected for several reasons:

- The Ombudsman has confidence in the basis for the conclusions in this report.
- Expanding the review would have prolonged, considerably, an investigation that ultimately took more than four years to conclude.
- The Ombudsman hopes to conduct similar reviews in the future.

At a minimum, the Ombudsman hopes the findings in this report reveal a compelling need for further study of this important "watchdog" role state government plays in the lives of Iowa's nursing home residents.

Further, the Ombudsman believes these findings form a basis for improving the state regulatory system to better ensure DIA engages in proactive enforcement.

Reasons for improving state regulatory system

Through this investigation, the Ombudsman has identified a number of reasons for improving the state regulatory system to better ensure DIA engages in proactive enforcement:

1. Protecting residents' health, safety and quality of life is the right thing to do.
2. It's the intent of the law. Previous sections noted where both state and federal lawmakers adopted language indicating a desire for a proactive approach to protect residents.
3. Concerning Medicaid-certified facilities, proactive enforcement ensures taxpayers get a proper return on their Medicaid "investment."
4. OBRA 1987 requires states to reimburse the Health Care Financing Administration (HCFA) for monies paid to facilities if they don't correct a deficiency in accordance with the plan of correction.

   If HCFA exercised its authority pursuant to OBRA 1987, the State of Iowa could be required to reimburse HCFA for significant amounts of money. This review indicates HCFA has not been enforcing this provision from OBRA 1987. But if HCFA did, states such as Iowa

would have additional incentive to use proactive enforcement to help and even compel facilities to timely correct their deficiencies.

5. In situations involving Medicaid-certified facilities, some of the federal policy directives — explained in the next sub-section, and which DIA is contractually obligated to follow — do not appear to reflect the proactive enforcement outcomes intended by federal lawmakers.

6. Both the state and federal regulatory systems heavily rely on discretionary-decision making for imposing enforcement actions. Discretionary decisions are perhaps the most difficult for government agencies, because they require a subjective determination based on all the available information. The difficulty is compounded because this involves whether to take adverse action against a private facility.

   This review, however, indicates DIA was setting too high a standard for when to take discretionary enforcement action. As a result, it many times failed to meet the expectations of state and federal law for protecting residents.

7. The federal regulatory system does not apply to approximately half of the long-term care facilities in the state — most of the state's 459 residential care facilities are not certified by Medicaid. This compares with the 475 nursing facilities in the state, all but 10 of which are certified by Medicaid.

   Residents who live in facilities that are not certified by Medicaid are protected only by the state's regulatory system. This makes it all the more important that the state's regulatory system proactively enforces state nursing home laws.

8. During the period of this review, Congress gave strong consideration to significantly revising OBRA 1987 and to shifting full responsibility for nursing homes to the states. While these proposals did not become law, there is ample reason to anticipate the federal regulatory system could be significantly altered over the next few years.

   As a result, it makes sense for the State of Iowa to design its regulatory system — based on the state's licensure authority in Iowa Code Chapter 135C, and therefore distinct from the federal regulatory system — to protect residents' health, safety and quality of life *regardless* of what happens at the federal level.

The following comment is relevant:

> Iowa is probably blessed with more than its share of nursing homes guided by concern and compassion, and staff members who willingly go the extra mile. But we cannot afford to let our attention flag. Nor can we assume that the quality of care in nursing homes won't be affected by a forced relaxation of federal regulation.
>
> *— from October 18, 1995 editorial in The Des Moines Register, "Less nursing-home oversight"*

While the Ombudsman believes Iowa's nursing homes, on the whole, provide better services than compared with the national average, this investigation clearly shows there is room for improvement. When it comes to our nursing home residents, our primary goal should be protecting residents' health, safety and quality of life, regardless of how we compare with other states.

Some may argue that the state and federal standards place too great a burden on facilities. But this argument was rebutted in the Institute of Medicine's 1986 report (requested by Congress and which preceded OBRA 1987):

> A lower standard of medical and nursing practice should not be accepted for nursing home residents than is accepted for the elderly in the community. Given the fragility of nursing home residents and their dependence on medical care for a satisfactory life, practice standards should even be higher. ("Improving the Quality of Care in Nursing Homes," page 4)

The point is best illustrated by the following passage:

> Wilbur. Marjorie. Michael. Ruth.
>
> All were residents of Quad-City nursing homes. All were subjected to abuse, neglect or injury....
>
> At one time, these people were our neighbors, our co-workers and our parents. They were our school teachers, our soldiers and our store clerks. They were as much a part of this community as all of us are today, and they deserved to live their last days free from abuse and neglect.
>
> *—from December 22, 1996 editorial in The Quad City Times*

State Operations Manual (SOM)

HCFA issued the SOM to give states further direction in regulating long-term care facilities which are certified by Medicaid.

DIA is obligated to follow the SOM, pursuant to DIA's contract with the state Department of Human Services for regulating long-term care facilities certified by Medicaid.

The SOM is:

- Several hundred pages long, with at least 23 appendices.
- Complicated, as compared with OBRA 1987 and the ensuing federal regulations.
- An evolving document. Some sections have not been updated since 1985. But many have been revised (or added) at various points since then. Most of the sections concerning enforcement were revised in

> June 1995, and several have been revised since then, including some as recently as January 1997.

Because of its length, complexity and status as an evolving document, the Ombudsman did not attempt to reconstruct the various versions of the SOM that were in effect during the period reviewed (1988 through 1996).

However, HCFA significantly revised the SOM section concerning enforcement[16] effective June 1995 and has made a number of additional, significant revisions since then.

As a result, and since DIA apparently is required to follow the SOM when it is wearing its federal enforcement "hat", the Ombudsman reviewed the SOM as updated through January 1997.

Some of these SOM revisions, when considered together, appear to confuse — and perhaps even to contradict — some of the provisions of OBRA 1987 and the 1995 federal regulations. As a result, the SOM as updated through January 1997 could actually reduce the potential for proactive enforcement outcomes state and federal lawmakers apparently were seeking.

[***NOTE:*** In order to better understand the rest of this sub-section, the reader is strongly urged to review Appendix E before continuing.]

The best example of this is the SOM's introduction of a concept called "date certain" in which the state survey agency:

> ... determines the date on which remedies will be imposed if the provider has not achieved substantial compliance. The provider is expected to correct deficiencies immediately or as soon as possible, but no later than the date specified by the SA. [*survey agency*] If substantial compliance is not achieved by this date, the SA will forward its recommendation to impose remedies. The date certain is derived by looking at what is in the best interest of residents in the facility. (*See SOM §7304*)

The SOM indicates states cannot offer the "date certain" concept if immediate jeopardy exists or the facility is found to be a "poor performer."[17]

On the other hand, "date certain" indicates facilities which would have faced a minimum of some type of mandatory enforcement remedy — from Category 1 remedies for deficiencies in grid boxes D and E; and from Category 2 remedies for deficiencies in grid boxes F through I (see Appendix G) — *can delay and even avoid the remedy by*

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[16] Chapter VII, "Survey and Enforcement Process for SNFs [*skilled nursing facilities*] and NFs [*nursing facilities*]."

[17] The 1995 regulations define "immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."
The SOM defines "poor performer" as "a facility with a history of 'in and out' compliance and/or a facility that has no system in place to monitor its own compliance." Remedies are imposed immediately on "poor performers."

correcting the deficiency (or deficiencies) at a later date.[18] This includes deficiencies where there was a finding of actual harm to residents.

This scenario is not affirmatively and directly authorized by OBRA 1987 and the 1995 federal regulations. Further, a similar system was criticized by the Institute of Medicine's 1986 report, "Improving the Quality of Care in Nursing Homes," which was requested by Congress and preceded OBRA 1987.

Page 148 of the Institute of Medicine's report stated in part:

> The current survey policies and procedures encourage states to consult and coerce facilities into compliance, not to punish them. The state agency does not have the authority under federal regulations to punish a violation immediately. The survey agency must issue a notice to the operator of a substandard nursing home, giving the facility a period of time (usually 30 to 60 days) in which to correct deficiencies. The survey agency is instructed to try to resolve cases before referring them to the formal administrative or law enforcement system. The agency may apply formal sanctions only if the facility remains in violation beyond the deadline set for compliance. Consequently, the facility is not punished for violations directly, but rather for failing to carry out an administrative order to correct violations by a certain date. Resort to formal sanctions by a compliance-oriented agency therefore becomes the last step in a long series of follow-up visits and plans of correction designed to induce conformity on the part of substandard facilities.

The "date certain" concept also appears to create confusion because the 1995 regulations, in a section discussing notification requirements when a state is taking enforcement action, state that "... in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent." [*See 42 CFR §488.402(f)(5)*] The SOM does not reference this section from the regulations and does not attach a maximum to how long "date certain" can be extended to a facility.

Neither the 1995 regulations nor the SOM appear to specify a maximum timeframe for a state survey agency to notify a facility that enforcement action is being taken. However, there are numerous statements in the regulations and in HCFA's preamble to the regulations indicating the goal was to send such notices as soon as practicably possible after the survey where the violations were found.

For example, 42 CFR §488.402(a) states, "The purpose of remedies is to ensure prompt compliance with program requirements."

And in HCFA's preamble to the 1995 regulations, it stated in part, "We ... are adopting procedures that allow for the swift imposition of remedies prior to a hearing. We believe that the intent of the Act was that remedies be imposed as soon as possible in order to protect the residents." [*See 59 Fed. Reg. 56,155*]

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[18] While the SOM and the 1995 regulations indicate facilities need to be in "substantial compliance" on a revisit (no deficiencies other than those causing no actual harm with potential for minimal harm), other information indicates revisits only need to focus on those practices where deficiencies were cited on the previous survey. For example, Section VI of Appendix P of the SOM states in part, "The purpose of the post-survey revisit (follow-up) is to re-evaluate the specific care and services that were cited as noncompliant during the original" survey.

Second, the SOM indicates states don't need to make a revisit to determine a facility has corrected a deficiency and achieved substantial compliance:

> Accept Written Documentation That Facility Is in Substantial Compliance in Lieu of Revisit An onsite revisit may not be necessary to determine if the facility is in substantial compliance with the requirements.... If a remedy has not been imposed, the SA will not recommend imposition of a remedy based on the evidence of substantial compliance. [*See SOM 7317(C)*]

HCFA clarified its position with an "Interim Revisit Policy" issued December 6, 1995 which stated in part:

> Revisits will no longer be required if the deficiency (-ies) are determined to fall into Boxes D, E, or F if there is no finding of substandard quality of care. [*See Appendix G*]

Combined, these items create a scenario where a facility can:

- Have deficiencies not involving substandard quality of care, and meeting the definition of widespread or pattern, showing "no actual harm with potential for more than minimal harm." For example, this could include making significant medication errors with most of the residents, meeting the definition of "pattern" but not "widespread." (Grid Box E on Appendix G)

- Avoid any enforcement action — as well as avoiding a revisit to ensure timely correction of the problem — by submitting an acceptable, written plan of correction.

Third, the SOM discourages states from imposing civil money penalties unless the deficiency involves "serious noncompliance," defined as:

> ... noncompliance in which the deficiencies fall in Boxes G, H, or I or noncompliance which constitutes a finding of substandard quality of care. [*See§7510 and Appendix G*]

Here's what the SOM says about when *not* to impose civil money penalties:

> A civil money penalty is a valuable enforcement tool because it can be imposed, under certain circumstances, for each day of noncompliance when a provider is out of compliance with the participation requirements and, therefore, if imposed, a provider cannot avoid the remedy. While a civil money penalty may be imposed immediately whenever a facility is not in substantial compliance, HCFA would expect it to occur when the facility is identified as a poor performing facility or a situation of immediate jeopardy exists. The civil money penalty may be imposed when a facility is given an opportunity to correct and a revisit finds that the facility is not in substantial compliance. However, a menu of remedies from which to choose exists, and a civil money penalty may not be the most appropriate choice of remedy in every situation of noncompliance. *It may be most appropriate to reserve the use of a civil money penalty remedy for a situation in which a facility is identified as a poor performer, a situation in which immediate jeopardy exists, or a situation of serious*

noncompliance which exists for a facility given an opportunity to correct. Serious noncompliance includes noncompliance in which the deficiencies fall in Boxes G, H, or I or noncompliance which constitutes a finding of substandard quality of care. While the State has the discretion to recommend the imposition of a CMP for any noncompliance, CMPs would generally not be considered when a facility has had a good compliance history and the current noncompliance may be less serious, i.e., the noncompliance falls in Boxes D, E, or F, without a finding of substandard quality of care. In cases of less serious noncompliance, other remedies may be more appropriate. (See §7400 for an explanation of deficiencies which fall in Boxes D, E, F, G, H, and I.) [*emphasis added; See§7510*]

Combining the impact of this section with the concept of "date certain," except in cases of "immediate jeopardy" or if a facility is identified as a "poor performer," civil money penalties would be discouraged even if a facility:

- Had multiple, repeated deficiencies indicating a pattern of potential for more than minimal harm (or widespread potential for more than minimal harm that does not involve "substandard quality of care"); and
- Failed to submit an acceptable plan of correction; and
- Failed to correct the deficiency by the time of the revisit *or* failed to provide written documentation that the deficiencies were corrected.

Combined, these sections from the SOM appear to contradict the report requested by Congress before it adopted OBRA 1987. The Institute of Medicine's 1986 report stated in relevant part:

> Fines are a valuable enforcement tool because they can be applied to *minor violations* early and often, thus deterring facilities from making more serious transgressions. They also can be used for serious but isolated incidents....
>
> For a fining system to be effective, it is essential that the administrative and legal delays be avoided by prompt, short hearings, that the fines be graduated according to seriousness, duration, and repetition of the violations, and that fines be used to deter further violations. All fines should be large enough to be more costly than the money saved by the violation. (Institute of Medicine, "Improving the Quality of Care in Nursing Homes," page 166)

The SOM includes one other section which appears to have significant relevance to Iowa. Concerning the "continuation of payments to facilities with deficiencies," the SOM states in part:

> There is no prohibition against the SMA [*state Medicaid agency*] securing an agreement to repay from a NF [*nursing facility*] when the State does not want to initiate a termination action, but does not want to be financially liable for the NF's continued noncompliance. *However, there is no authority for the SMA to require that a NF sign such an agreement.* [emphasis added; *see §7600(J)*]

The new rules adopted by DHS in 1995 include a requirement that facilities with deficiencies agree to repay the state for all payments received if the facility fails to resolve a deficiency in accordance with its plan of correction. This appears to be contrary to the preceding section from the SOM.

ALLEGATIONS #1 and #2: RECOMMENDATIONS

Based on the conclusion that the first two allegations are substantiated, the Ombudsman is making a number of recommendations pursuant to Code section 2C.16(5).

The primary objective of these recommendations is to improve the state regulatory system by enhancing the chances for proactive enforcement results, regardless of potential changes to the federal regulatory system.

The Ombudsman recommends that DIA's Health Facilities Division:

1. Adopt and practice a proactive enforcement philosophy as policy. The philosophy should stress the need to protect residents' health, safety and quality of life, as espoused in state and federal law.

2. Rescind 481 IAC 56.9 and adopt a new rule based on the table attached as Appendix J.

   Explanation: While the nine factors in the current rule appear to offer the only objective standards for determining whether to issue a state fine, the factors as written offer little or no direction in making that determination. As a result, the factors are open to interpretation and can lead to inconsistent results. For example, the first factor states, "The length of time during which the violation occurred." A person is left to wonder precisely how much time a violation would have to occur in order to warrant enforcement action under this factor.

   In addition, the nine factors offer no guidance concerning how many should be "met" to warrant issuance of a fine.

   The Institute of Medicine's 1986 report stated in part, "Guidelines on when to initiate sanctions are necessary for effective state enforcement.... Specified enforcement procedures would encourage states to be less tolerant of substandard providers, and to be more consistent in initiating enforcement activity and in setting precedents for future activities." (Institute of Medicine, "Improving the Quality of Care in Nursing Homes," page 154.)

   The proposed table makes it significantly easier for DIA to determine when to impose a state fine (and if so, to what degree) in connection with a deficiency. The table also ensures greater consistency concerning those determinations. Instead of having to assess nine factors, the determination relies on an assessment of four factors which this investigation indicates are the most crucial:

   • ***Harm.*** The degree of harm sustained by residents is the most significant of the factors. "Harm" should be defined to include any physical or psychological pain, suffering or impairment that is not insignificant. This would include any unnecessary delay in the provision of needed treatment or in the healing process for any physical injury, malady or condition. "Harm" can also be referred to as "outcomes."

   The table classifies the same four degrees of harm used in the new federal regulations implemented July 1, 1995. "Immediate jeopardy" should be defined identically to the definition in 441 IAC 81.31.

The new rule should also clarify that "immediate jeopardy" includes ***all*** situations in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury or death to a resident.

• ***Frequency.*** The frequency of the violation is the second most important factor. The table classifies three degrees of frequency in identical fashion to those used in the new federal regulations. These terms should be defined using the definitions in J. Bennett's July 2, 1996 memorandum to DIA staff. (*Attached as Appendix F.*)

• ***History.*** The facility's prior history of noncompliance concerning the deficiency is the third most important factor. Score this factor as follows:

-- *One point* is assessed if the same deficiency was cited on the last general survey or any survey in the past twelve months.

-- *Two points* are assessed if the same deficiency was cited on the two prior surveys or the two prior general (annual) surveys.

-- *Three points* are assessed if the same deficiency was cited on the four prior surveys or the four prior general (annual) surveys.

• ***Duration.*** The length of time during which the violation had been occurring is the fourth factor.

This factor is scored as follows:

-- *One point* is assessed if the deficiency has been occurring for at least three months but not more than six months.

-- *Two points* are assessed if the deficiency has been occurring for six months or longer.

Using the table to determine whether a particular deficiency warrants a state fine, first assess the factors of "harm" and "frequency" to locate the appropriate box on the grid.

Next, score the factors of "history" and "length," combine the scores and then follow the instructions in the appropriate box.

Two applications of the table are attached as Appendix K and Appendix L.

Implementation of the table would help DIA meet the requirement imposed by federal rule 42 CFR 488.312, which states, "HCFA does *and the survey agency must* implement programs to measure accuracy *and improve consistency* in the application of survey results and enforcement remedies." [emphasis added]

3. Specify in the new rule that when DIA proposes a non-mandated fine pursuant to both state and federal regulations, DIA will rescind whichever would be greater *if* the facility corrects the deficiency within the specified time period. Conversely, the new rule should specify that DIA will rescind whichever action would be the least severe if the facility fails to correct the deficiency within the specified time period.

Explanation: This recommendation is designed to encourage facilities to correct deficiencies.

4. Amend 481 IAC 58 (chapter concerning state standards for nursing facilities) to remove the parenthetical notations indicating whether violations are considered Class I, Class II or Class III.

   Explanation: The proposed state fining grid supercedes the parenthetical notations in 481 IAC 58.

5. Pursuant to 42 CFR 488.303, "... establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to Medicaid residents...."

6. Publicize deficiencies and enforcement actions.

   Explanation: The basis for this recommendation comes from the following statement on page C10 of DIA's response to the 1994 Annual Report of the State Long-Term Care Resident's Advocate/Ombudsman Program:

   "... It is not always the amount of the fine which corrects deficiencies and creates change in a facility. Rather, the pressure of poor publicity is often the single most important motivating factor in the correction of deficiencies, especially long-standing problems."

In addition, the Ombudsman will be recommending legislative action as follows:

7. Amend Code section 135C.36 as follows:

   Every violation by a health care facility of any provision of this chapter or of the rules adopted pursuant to it shall be classified by the department in accordance with this section. The department shall adopt and may from time to time modify, in accordance with chapter 17A rules setting forth so far as feasible the specific violations included in each classification and stating criteria for the classification of any violation not so listed.

   1. A Class I violation is one which presents an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility in which the violation occurs. A physical condition or one or more practices in a facility may constitute a Class I violation. A Class I violation shall be abated or eliminated immediately unless the department determines that a stated period of time, specified in the citation issued under section 135C.40, is required to correct the violation. A licensee is subject to a penalty of not less than ~~two~~ one thousand nor more than ten thousand dollars for each Class I violation for which the licensee's facility is cited.

   2. A Class II violation is one which has a direct or immediate relationship to the health, safety or security of residents of a health care facility, but which presents no imminent danger nor substantial probability of death or physical harm to them. A physical condition or one or more practices within a facility, including either physical abuse of any resident or failure to treat any resident with consideration, respect and full recognition of the resident's dignity and individuality, in violation of a specific rule adopted by the department, may constitute a Class II violation. A violation of section 135C.14, subsection 8, or section 135C.31 and rules adopted under those sections shall be at least a Class II violation and may be a Class I violation. A Class II violation shall be corrected within a stated period of time determined by the department and specified in the citation issued under section 135C.40. The stated period of time specified in the citation may subsequently be modified by the department for good

cause shown. A licensee is subject to a penalty of not less than ~~one hundred nor more than five hundred dollars~~ two hundred and fifty nor more than nine hundred and ninety nine dollars for each Class II violation for which the licensee's facility is cited, however the director may waive the penalty if the violation is corrected within the time specified in the citation.

3. A Class III violation is any violation of this chapter or of the rules adopted pursuant to it which violation is not classified in the department's rules nor classifiable under the criteria stated in those rules as a Class I or a Class II violation. A licensee ~~shall not be subject to a penalty for a~~ is subject to a penalty of not less than fifty nor more than two hundred and forty nine dollars for each Class III violation for which the licensee's facility is cited, however the director may waive the penalty if the violation is corrected within the time specified in the citation. ~~, except as provided by section 135C.40, subsection 1 for failure to correct the violation within a reasonable time specified by the department in the notice of the violation~~.

Explanation: This legislative proposal would accomplish several necessary objectives. First, it would establish fines of $50 to $249 for Class III violations, which currently include no fine. This investigation revealed that the absence of any fine for a Class III violation renders such a citation essentially meaningless, because its only enforcement directive — ordering the facility to correct the violation by a specified time period — is already addressed in federal law and regulations and is therefore redundant. The recommendation to have a minimum of a $50 fine for a Class III violation is envisioned as a tool to allow DIA to at least "send a message" to compel a facility to correct a violation without causing significant financial distress to the facility. DIA could in its discretion issue up to a maximum $249 fine for a Class III violation based on the circumstances.

The recommendation to amend the ranges for Class I and Class II violations is intended primarily to bridge the gap under current law (which limits Class II violations to a maximum of $500 but sets a minimum $2,000 fine for Class I violations.) The recommendation places the "bridge" between the two at $1,000 because the ombudsman believes it more reasonable to strike a compromise between the two rather than raising Class II's maximum range to $2,000 or lowering Class I's minimum to $500.

Upon adoption of this legislative proposal, DIA will need to amend 481 IAC 56.3 accordingly.

8. Amend Code section 135C.40(1) as follows:

If the director determines, based on the findings of an inspection or investigation of a health care facility, that the facility is in violation of this chapter or rules adopted under this chapter, the director within five working days after making the determination, may issue a written citation to the facility. The citation shall be served upon the facility personally or by certified mail~~, except that a citation for a Class III violation may be sent by ordinary mail~~. Each citation shall specifically describe the nature of the violation, identifying the Code section or subsection or the rule or standard violated, and the classification of the violation under section 135C.36

Explanation: This proposal would restore uniformity in the event the Legislature agrees to establish fines for Class III violations.

9. Amend Code section 135C.41 as follows:

Within twenty business days after service of a citation under section 135C.40, a facility shall either:

1. If it does not desire to contest the citation:

a. Remit to the department the amount specified by the department pursuant to section 135C.36 as a penalty for each Class I violation cited, and for each Class II and Class III violation unless the citation specifically waives the penalty, which funds shall be paid by the department into the state treasury and credited to the general fund; or

b. In the case of a Class II violation for which the penalty has been waived in accordance with the standards prescribed in section 135C.36, subsection 2, or a Class III violation for which the penalty has been waived in accordance with the standards prescribed in section 135C.36, subsection 3, send to the department a written response acknowledging that the citation has been received and stating that the violation will be corrected within the specific period of time allowed by the citation; or

2. Notify the director that the facility desires to contest the citation and, in the case of citations for Class II or Class III violations, request an informal conference with a representative of the department.

Explanation: This legislative proposal would restore uniformity in the event the Legislature adopts the previous recommendations. Upon adoption of this legislative proposal, DIA will need to amend 481 IAC 56.14(1) accordingly.

10. Amend Code section 135C.44 as follows:

The penalties authorized by section 135C.36 shall be trebled for a second or subsequent ~~Class I or Class II~~ violation occurring within any twelve-month period if a citation was issued for the same ~~Class I or Class II~~ violation occurring within that period and a penalty was assessed therefor.

Explanation: This legislative proposal would restore uniformity in the event the Legislature adopts the previous recommendations. Upon adoption of this legislative proposal, DIA will need to amend 481 IAC 56.5 accordingly.

ALLEGATION #3

Whether DIA was unreasonable in its enforcement of long-term care facility-related state and federal laws and regulations involving Mahaska Manor by taking adverse actions whose severity was not commensurate with the severity of the violations from 1991 to 1995.

INTRODUCTION

For purposes of determining whether this allegation is substantiated, the Ombudsman will rely on the same definition of "unreasonableness" given on page 4.

For a review of the State of Iowa's requirements and responsibilities regarding long-term care facilities, see Appendix E. The reader is advised, however, that Appendix E is relatively complicated and reviewing it is not necessary to understanding this section.

Most information in this section comes from DIA surveys involving Mahaska Manor. Information from other sources is noted.

The Ombudsman's office reviewed 22 surveys of Mahaska Manor covering a period of nearly four years (August 1991 to May 1995.) Mahaska Manor closed on September 26, 1995, according to a memo DIA issued the following day to various state agencies.[19]

Those surveys found a total of 217 deficiencies (including repeats.) The review did not examine the process by which DIA conducts inspections and determines whether deficiencies exist.

DIA took 44 adverse actions resulting from those deficiencies. Pursuant to this allegation, the Ombudsman reviewed whether the severity of those adverse actions was commensurate with the severity of the violation(s) on which the actions were based.

The review identified three adverse actions where DIA clearly had sufficient basis to take more severe action but did not.

FINDINGS OF FACT

This section will present:

- The findings on which the three adverse actions were based.
- The facility's response to the findings.
- The adverse actions DIA took.

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[19] The memo stated in part, "... The facility was only occupied by 19 private pay residents. Threatened with decertification from the Medicaid Program early in 1995, the facility voluntarily withdrew participation and discharged all Medicaid residents in May, 1995." The memo also said the owner had been negotiating sale of the facility to Mahaska County Hospital, but the hospital withdrew its offer.

ALLEGATION #3 — INSTANCE #1

Federal rule 42 CFR 483.20(d)(3)(i) states:

> The services provided or arranged by the facility must ... meet professional standards of quality.

The federal "Guidance to Surveyors for Long Term Care Facilities" states in part:

> "Professional standards of quality" means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting....

The November 9, 1992 survey included a deficiency under F299, referencing the above-mentioned federal rule. The findings stated:

> Based on observation, staff interviews and review of open and closed resident records it was determined that the facility failed to ensure professional standards of quality in assessment/intervention when resident conditions changed. Three of six closed records reviewed and two of sixteen open records reviewed revealed lack of assessment/intervention with condition change. Findings include:
>
> 1. The review of the closed record of Resident #82, with diagnoses of Parkinson's, dementia, and left hip pinning, revealed that the resident had a temperature of 103 degrees F rectally at 2:30 am on 10/03/92. The next entry on the nurses notes was 10/04/92 at 8:00 pm (41.5 hours later) noting a temperature of 104.4 degrees F rectally. The physician was notified and the resident was subsequently transferred to the local hospital at 10:20 pm that evening *where she expired on 10/06/92. There was no assessment of this resident other than the note of the elevated temperature. The only intervention by the facility was administration of Acetaminophen and lukewarm water rubdowns for the fever.* [emphasis added]
>
> 2. Nurses notes on the closed record of Resident #80, with a diagnosis of schizophrenia and stroke, indicated that the resident was observed to exhibit aggressive sexual behavior toward confused female residents since at least March of 1992. Although a staffing was held with the resident on 04/07/92, where he was told to stay out of female residents' rooms, an assessment of the behavior was not done nor did the care plan address the problem. By October 26, 1992, the facility had documented at least twelve incidents of fondling female residents or being verbally abusive to staff, again without assessment of the behaviors or care plan interventions. Finally on 10/19/92, the physician was contacted and the resident was transferred to a psychiatric unit for evaluation.

3. Resident #34 was observed at 7:25 a.m. on 11/03/92, to wretch and gag repeatedly after her nasogastric[20] tube was flushed with water, and prior to hanging a new bottle of Isosource EN. The resident vomited a moderate amount of cream colored liquid and continued to wretch with a heaving motion. At 8:40 a.m. the resident was observed to vomit a very large amount of dark brown liquid. The surveyor asked the charge nurse if the emesis had ever been tested for blood, to which she stated no, as this had been a chronic thing for months. A transfer sheet from the hospital dated 10/02/92, listed the admitting diagnoses as congestive heart failure and gastrointestinal bleeding. *Staff appeared to be unaware of this diagnosis. There was no further assessment of intervention for the gastrointestinal problem.* Although the physician was contacted at 3:45 p.m. concerning oxygen usage, *there was no documentation in the record to reflect a report was given regarding the two emesis* [*vomiting*] *which occurred that morning.* The resident had been using a nasogastric tube for feedings since 1988. [emphasis added]

   On 11/04/92, the resident was observed lying on her right side with the head of the bed elevated 45 degrees. Her respirations were rapid and shallow, and her face was ruddy and puffy. The surveyor questioned staff about the possibility of aspiration pneumonia due to the emesis the previous day. Two nurses confirmed the possibility as the resident had been treated for aspiration pneumonia earlier in the year. Nurses notes for the day documented unsuccessful attempts to reach the family and the physician and edema in the arms and legs with a "grayish looking left foot". However, there was no documented assessment of the resident's respiratory status.

   On 11/05/92, concerns relating to the nasogastric tube, gastrointestinal bleed, respiratory status, and lack of interventions by staff were addressed to the director of nursing. She then did a complete resident assessment and notified both the physician and the family.

4. Resident #41 had documentation on 10/23/92, at 9:30 p.m. of *a moderate amount of blood in the urine* and drainage noted at the urinary meatus.[21] *No further assessment was done and no interventions initiated.* On 11/03/92, the resident was observed to have dark urine with a reddish cast in the catheter bag. When the surveyor brought this to the attention of the facility the physician was notified and an order obtained for a urinalysis and antibiotics. [emphasis added]

5. Resident #83's closed record indicated that first of a series of bruises were noted on 09/15/92. The resident was receiving a blood thinner which was discontinued by the physician on 09/25/92 when more bleeding problems were noted. The resident was seen by the physician

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[20] "Nasogastric" is defined as "of, relating to, being, or performed by intubation [*introduction of a tube into a hollow organ to keep it open or restore its patency if obstructed*] of the stomach by way of the nasal passages," according to the Webster's Medical Desk Dictionary, 1986 edition.

[21] "Meatus" is defined as "a natural body passage; canal, duct," according to the Webster's Medical Desk Dictionary, 1986 edition.

on 09/26/92.

There was documentation at 7 a.m. on 09/27/92, that the normally alert but confused resident was confused, with a yellowish cast to the face and lower abdomen and the right side of her abdomen was swollen. Her blood pressure was recorded at 130/50. The med aide notified licensed practical nurse immediately.

At 11:55 am the med aide recorded the resident's blood pressure at 96/52. The resident's son was at bedside and voiced concern that his mother had not acknowledged him there at all. The med aide notified the licensed practical nurse "stat."

The resident expired at 2:50 pm with no assessment having been done and no interventions initiated. [emphasis added]

The facility's response stated:

Preparation and execution of these plans of correction should not be construed as an admission of the deficiencies cited.

Professional standards of quality will be met.

This requirement will be met by implementing the following:

[A] registered nurse, licensed #___, [*sic*] whose job description is attached to this report, has been hired as full time day shift supervisor, whose duties will include overall monitoring of notification to resident's legal representative or interested family member of instances listed above. This RN will be responsible for full physical assessments done on a regular basis, as well as monitoring documentation of all above listed situations. A mandatory inservice on assessments and proper documentation is scheduled to take place before 12/10/92. DON [*director of nursing*] assumes ultimate responsibility of all duties of the day shift. Supervisor, DON and scheduling/education coordinator will perform these duties in the absence of the day shift supervisor.

Nursing staff has been significantly increased. Listing of nursing new hires, name, job description, and RN license number is attached.

"24 Hour Report" sheets have been implemented, copy attached, to monitor needs and conditions of each resident. These report sheets will be a twenty four hour report on each resident's needs and conditions serving as free flowing information between all nurses. Monitoring and supervising this system will be the ultimate responsibility of the DON.

Tape recorders have been purchased (***copy receipt attached) to further implement free flowing information between nurses of different shifts. Monitoring and supervising this system will be the ultimate responsibility of the DON.

Additional certified nurse aides have been hired and trained in accordance with state regulations. New nurse aide hires are of a high quality, with full consideration to experience, professionalism and a responsible and caring

attitude towards elderly patients. A full list is attached of recent CAN [*sic*] hires.

Nurse aide notebooks have been implemented for purpose of CNA [*certified nurse aide*] documentation with regard to changes in residents condition, needs and requests. Charge nurses follow up with proper implementation of change and/or supervision as need is indicated by CAN [*sic*], supervising and initialing the action. DON then monitors all documentation and action, also initialing documentation.

Care planning nurse will work closely with DSS, SW, FSS, Activities Coordinator in a free flow of information and documentation, via "24 Hour Report," with regard to any and all changes of any and all residents.

Mandatory inservice is scheduled to take place before 12/10/92, subject to be NG tubes and GT tubes.

In connection with this deficiency, DIA issued a Class II citation with a $500 fine. The citation notice (Fining and Citation Report #977) referenced two state rules that had been violated: 481 IAC 58.20(2) and 58.20(3).

481 IAC 58.20 states in relevant part:

Duties of health service supervisor. Every intermediate care facility shall have a health service supervisor who shall:

... **58.20(2)** Plan for and direct the nursing care, services, treatments, procedures and other services in order that each resident's needs are met; (II,III)

58.20(3) Review the health care needs of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II,III)

ALLEGATION #3— INSTANCE #2

About six months later, the May 20, 1993 survey included the same federal deficiency, F299. The findings stated:

Based on record reviews, it was determined the facility failed to assess residents adequately to assure their health care needs were met. The findings are as follows:

1. Resident #70 with a diagnosis of chronic renal failure, diabetes mellitus and a history of congestive heart failure, was admitted to the facility from home on 03/08/93, and expired there 04/20/93.

   On 03/22/93, documentation in the record noted the resident was complaining of burning on urination. No followup to this complaint was found. On 03/30/93, the resident again complained of burning on urination, with the only documented assessment being that the urine was clear yellow and without odor. On 04/02/93, the resident was restless and again complained of burning on urination. Although the

physician was notified later that day of a skin tear, there was no indication of the urinary complaints being reported, nor of any follow-up by nursing staff. On 04/16/93, the resident was again complaining of burning on urination, and the physician was finally notified. A urine specimen was obtained on 04/17/93, and showed a packed field of white blood cells and 3 plus bacteria.

On 04/10/93, this same resident had documentation of "lungs sound rattley. Displays loose, non-productive cough." No further respiratory assessment was done and no follow-up to this condition was documented. On 04/12/93, at 5:30 a.m., documentation indicated the resident sounded congested and his color was dusky. At 9:30 a.m. the resident's temperature was recorded as 95.8 degrees F; however, the route was not documented nor was there any assessment or follow-up of this low reading. Although the physician was contacted at 1:00 p.m. regarding skin tears, there was no indication the respiratory problems were reported. On 04/13/93, at 11:50 p.m. the temperature was again documented as 95.9 F. On 04/14/93 and 04/17/93, respirations were documented at approximately 35 per minute, an increase from his usual rate of 20-24 per minute. At 4:10 a.m. on 04/19/93, nurses notes stated, "Resident continues to have rattley sounding respirations. Displays non-productive loose cough." At 11:30 p.m. on 04/19/93, documentation indicated he still sounded congested, with no interventions documented. At 2 a.m. on 04/20/93, the resident was found without a pulse, blood pressure or respirations.

2. Resident #58, with a history of chronic gastritis, was hospitalized in January, 1993, for a fracture of the left femur resulting from a fall from the wheelchair. From January through April the resident lost twelve pounds or a loss of 8% of her body weight. On 05/07/93, the resident developed an open area on the left knee as a result of a bone fragment from the fracture. The physician was also notified of a 9 ½ pound weight loss from April to May, for a loss of 24 ½ pounds since January. The resident was documented as having a poor appetite, nausea and vomiting and loose stools. The resident had been receiving pain medications for the leg fracture, and antibiotics since 04/19/93, for a urinary tract infection. The resident had not been assessed for the relation these medications could have to her nausea and vomiting in view of her history of gastritis. On 05/18/93, an order was obtained for Compazine for nausea.

The facility's response stated:

> Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited – and on all the following pages.
>
> This deficiency is in nursing assessments – will be addressed as outline in the Plan of Correction for Tag number F0287.

In connection with this deficiency, DIA imposed a Class II citation with a $900 treble fine, pursuant to Iowa Code section 135C.44. [*See Appendix A*] The citation notice (Fining and Citation Report #1006) referenced the same two state rules mentioned in Instance #1 above.

Following the same survey, DIA also imposed two other treble fines:

- A Class II citation and $1,500 fine for violating state rule 481 IAC 58.19(2)(b), involving pressure sores. The findings stated in part, "... it was determined the facility failed to provide care to prevent the development of pressure sores, and once present, failed to provide services to promote healing...."

- A Class II citation and $1,200 fine for violating state rule 481 IAC 58.19(1)j(3)(4), involving care for incontinent residents. The findings stated in part, "... it was determined the facility failed to provide adequate nursing services for incontinent residents."

ALLEGATION #3— INSTANCE #3

As a result of two deficiencies discovered at the June 20, 1994 survey, DIA issued a Class I citation with a $5,000 fine. The citation notice (Fining and Citation Report #1069) stated the correction date was to be "upon receipt." It indicated the citation was based on violations of two state rules:

- 481 IAC 58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition.

- 481 IAC 58.20(2) Every intermediate care facility shall have a health service supervisor who shall ... plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs are met.

The findings in F&C #1069 identically matched the survey findings under federal tag numbers F164 and F299..

The next survey was conducted August 19, 1994. Following that survey, DIA issued a September 6, 1994 letter to the facility stating it had again been found to be in violation of the two state rules [481 IAC 58.14(5) and 58.20(2)]. As a result, DIA imposed a $50 daily fine for failing to have corrected the violation "upon receipt" as previously ordered, pursuant to Iowa Code section 135C.40(1). [*see Appendix A*][22]

The September 6, 1994 letter stated the $50 per day fine was based on the following findings from the August 19, 1994 survey:

> Based on record reviews, it was determined the facility failed to thoroughly and promptly assess residents, notify the physician and provide appropriate interventions when an adverse condition change occurred. Problems were

[22] DIA's "fining and citation log" for this citation indicates the facility was ultimately fined an additional $800 for failing to correct the violation an additional 16 days — from September 7, 1994 (date facility received notice of additional fine) to September 16, 1994 (date DIA determined the violation had been corrected.)

noted in two of six closed records and two of four open records when condition changes occurred. The findings are as follows:

1. Closed record #2 was a 56-year old male with muscular dystrophy. Documentation in the nurses notes indicated that on 7/13/94 at 8:20 a.m. the resident was eating breakfast in the front dining room when he raised his arm to the nurse. When she asked him what he wanted, he was unable to speak, making gestures as though he was unable to breathe. An interviewable resident, present at the table at the time of the incident, told the surveyor the man choked on food. The nurse provided no emergency interventions at that time, instead rushed the resident to his room at the end of the hallway by the back nurses station. At 8:25 a.m., five minutes after the resident showed signs of distress, he was moved from the wheelchair to the floor. No pulse or respirations were noted and cardiopulmonary resuscitation (CPR) was begun. When the finger sweep was done, large amounts of undigested food were removed from the resident's mouth. At 8:30 a.m., 911 was called as an airway could not be established. At 8:35 a.m., emergency personnel arrived, took over CPR and transferred the resident to the hospital where he expired at 8:48 a.m.

   A late entry in the nurses notes indicated the Heimlich maneuver was attempted at 8:20 a.m. on 7/13/94; however, it was unsuccessful as the nurse was unable to reach around both the wheelchair and the resident. According to the American Red Cross and the American Heart Association guidelines, in this type of situation, the person should be immediately placed in a supine position [*lying on the back*] and with staff straddling the person's thighs, an inward and upward abdominal thrust should be given in an attempt to dislodge the foreign object or food.

   The failure of the facility to be knowledgeable of emergency procedures and to intervene immediately may have contributed to the unsuccessful resucitation of this resident. [emphasis added]

2. Closed Record #3 was admitted to the facility on 6/9/94 from the hospital following repair of a fractured hip. An indwelling catheter was in place due to urinary retention. On 7/8/94 at 4:30 a.m., nurses notes described thick, concentrated urine which was milky in color present in the catheter tubing. There was no indication further assessment was done, nor was the physician notified. At 9:45 p.m., another entry in the nurses notes described a large amount of sediment and largely concentrated foul-smelling urine in the catheter tubing and bag. A further entry stated, "will put on Dr. call list for UA. On 6/28/94 resident had urinalysis with trace of bacteria and no treatment was ordered at that time." Although the resident continued to have dark, concentrated foul-smelling urine, the physician was not notified until 9:00 a.m. on 7/11/94. At 11:30 a.m. on 7/11/94, the physician ordered a urinalysis; however, the specimen was not obtained until 3:15 a.m. on 7/12/94. The urinalysis results were abnormal and an antibiotic was started.

The failure of the facility to thoroughly assess the resident when he exhibited signs and symptoms of a urinary tract infection and promptly notify the physician of the assessed findings resulted in a delay in treatment, and placed the resident at risk for complications, such as urosepsis. [emphasis added]

3. On 07/25/94, at 6:55 p.m. Resident #80 was seen by the physician on call at the facility for hives. The physician ordered Benadryl 50 mg., one capsule every six hours as needed for hives and itch. He also ordered amoxicillin 500 mg. one capsule three times a day for ten days if okay with the attending physician. The attending physician was not contacted until 3 p.m. on 07/26/94, and the orders were not verified until 4:30 p.m. The initial dose of the amoxicillin was not given until 5 p.m. and the Benadryl was not started until 07/27/94, at 3 a.m. when the resident requested it due to itching.

   The failure of the facility to verify orders promptly resulted in a significant delay in the resident receiving needed medications. [emphasis added]

4. Resident #12 was admitted to the facility on 06/29/94, with diagnoses of possible TIA (transient ischemic attack), confusion due to Alzheimer's disease versus chronic use of Librium. On 07/07/94, at midnight, the nurses notes documented incontinence of foul-smelling urine. At 3:00 a.m. another entry identified foul-smelling urine with no further assessment completed. On 07/08/94 and 07/09/94 documentation continued to identify strong odorous urine with no further assessment and no physician notification. Finally on 07/11/94 at 9:45 a.m. the physician was contacted and a urinalysis ordered; however, the urine specimen was not obtained until 3:00 a.m. on 07/12/94. The urinalysis reports indicated an infection, and an antibiotic was ordered at 7:00 p.m. on 07/12/94. The first dose of this medication was not administered until 8:00 p.m. on 07/13/94.

   The failure of the facility to thoroughly assess signs and symptoms of a urinary tract infection and promptly notify the physician of the assessed findings resulted in a delay of treatment, and placed the resident at risk for complications, such as urosepsis. [emphasis added]

Those findings — referenced in the letter under state rules 481 IAC 58.14(5) and 58.20(2) — matched the survey's findings under federal tag number F309.

The letter did not list any other survey findings — even though deficiencies were included under the same two federal tag numbers (F164 and F299) which generated the original Class I citation following the June 20, 1994 survey.[23]

However, the August 19, 1994 findings from F164 and F299 *are* relevant in evaluating this particular allegation.

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[23] The Ombudsman suspects DIA did not include the findings from F164 and F299 in the September 6, 1994 letter to the facility because from a fining perspective, DIA still would have been limited to the $50 per day fine as mandated by Iowa Code section 135C.40(1), since it involved the same state rule violation.

This was the *sixth* straight survey to include a deficiency under F299. Because of some overlapping between the findings listed under F309, F164 and F299 on the survey, following is a list of those findings from F164 and F299 *not* already covered in F309 (listed above):

1. Nurses did not monitor and record color and consistency of bowel movements after residents received barium for x-ray procedures. Review of Closed Record #3 revealed that on 07/15/94, the resident had an Upper GI at the local hospital. On 07/16/94, at 2400 hours the resident was checked for an impaction and a large amount of bowel movement was felt. A Dulcolax Suppository was then given with large results according to the nurses notes. However, the color or consistency of the bowel movement was not noted. On 07/18/94, the resident was admitted to a hospital for a bronchoscopy and hospital records indicated due to barium being present they were unable to do an abdominal CAT scan.

   Staff indicated there was no procedure to follow up on residents passing barium after x-ray procedures.

2. Urine specimen were not always collected promptly and were not always fresh when sent to the laboratory. Review of Closed Record #3 revealed an order for an urinalysis was received at 11:30 a.m. on 07/11/94. The urine specimen was obtained from an indwelling catheter on 07/12/94, at 0315 hours and was placed in the refrigerator until 0800 hours when the lab picked it up.

   On 07/12/94, a urine specimen from Resident #12 was obtained at 3 a.m. to comply with an order received at 9 a.m. the previous day.

   Both residents had infected urine based on the laboratory reports. [emphasis added]

   Delay in the collection of the urine and then allowing the specimen to sit for this period of time is not good nursing practice and can lead to inaccurate findings and delay in treatment. [emphasis added]

3. Nurses did not accurately assess and stage pressure sores. Refer to tag F320 Items 1-3.[24]

4. Nurses did not always note route of temperatures taken and when axillary temperatures were taken, which are not accurate particularly on the elderly, they were not rechecked when results were abnormal. (Noted on closed record #1 regarding findings on 06/13 and 06/14/94.)

5. Nurses did not always monitor residents closely that were receiving blood thinners. Review of Closed Record #1 revealed that the resident was admitted to the facility in January 1994 and was hospitalized for a vascular bypass in May 1994. The resident had been receiving Coumadin (a blood thinner) by mouth daily with no prothrombin time taken to monitor for bleeding times. There was nothing on her care

[24] DIA issued a Class II citation with a $500 fine as a result of the deficiency involving pressure sores.

plan to monitor her for signs and symptoms of bleeding and/or clotting. *When the resident was admitted to the hospital 06/14/94, where she died 06/27/94, she was determined to have a severe overdose of Coumadin according to the hospital records.* [emphasis added]

The practices noted in the above examples are contrary to professional standards nursing practice.

The facility's response to the deficiency under F164 stated:

Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all following pages.

Notification of changes — DON will read nurses' notes daily and be knowledgeable of all change of conditions. Telephone orders from physicians will be checked throughout the day regarding all calls and orders. An extra nurse has been added daily to float thru facility to make all physician calls. This nurse supervisor will be responsible to call physician promptly to inform of any COC [*change of condition*]. Weekly nurses meetings have continued regarding proper assessments and timely calls to physicians. This area to be monitored daily by DON and/or ADM.

The facility's response to the deficiency under F299 stated:

Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all following pages.

RN consultant has held two lengthy inservices with all nurses regarding professional standards of nursing and proper assessing and caring for the residents at Mahaska Manor. DON will personally assess each pressure sore weekly and review the progress of treatments. An ET nurse has been contacted to establish a base line for all pressure sores. All lab orders will be reviewed by DON weekly and any order for urine specimen will be taken to lab promptly. RN consultant has instructed all nurses that axillary temperatures will no longer be taken. These areas will be monitored closely by DON and/or ADM.

ANALYSIS AND CONCLUSIONS

This review revealed three instances where DIA took enforcement action whose severity was not commensurate with the severity of the violation on which the action was based:

1. *ALLEGATION #3 — INSTANCE #1*

Deficiency: Failing to notify the physician immediately upon adverse change in resident's condition *and* failing to follow professional standards of quality

DIA found the facility violated this standard five times:

-- Staff found Resident #82 had a temperature of 103 degrees but failed to intervene or call her doctor for 42 hours. When the facility finally did call her doctor, she was transferred to the hospital, where she died two days later.

-- an unspecified number of female residents were fondled by Resident #80 over a six-month period *after* the facility found he had been exhibiting aggressive sexual behavior to confused female residents. The facility's response to the initial discovery was to tell the man (diagnosed with schizophrenia) to stay out of females' rooms. Ultimately, the facility contacted a physician and the man was transferred to a psychiatric unit for evaluation.

-- nursing staff were failing to assess why Resident #34 was continually, over at least a month, coughing up moderate-to-large amounts of liquid. They were apparently unaware she had a diagnosis (in the facility's medical record) of gastrointestinal bleeding and had not tested the liquid for blood. Though staff contacted the physician several hours after two such incidents, there was no documentation that staff told the physician about them.

-- staff found a moderate amount of blood in Resident #41's urine, but did not assess the problem or attempt to intervene. Eleven days later, when the surveyor noted the resident's urine had a "reddish cast," the facility contacted the physician.

-- eight hours before Resident #83 died at the facility, staff found she was confused "with a yellowish cast to the face and lower abdomen and the right side of her abdomen was swollen." Five hours after , staff found her blood pressure had significantly dropped and her son "voiced concern that his mother had not acknowledged him there at all." However, staff failed to assess the resident or intervene, and she died three hours later.

These findings show a number of residents unnecessarily suffered *actual harm* due to the facility's failure to meet this standard. Two residents died. Several were fondled. One had blood in his urine for eleven days — and his physician was contacted only after the surveyor noted the problem.

These multiple examples of significant harm to residents' health and safety clearly indicated there was "an imminent danger or a substantial probability of resultant or physical harm to the residents of the facility" — the definition of a state-authorized Class I citation, punishable by a fine ranging from $2,000 to $10,000.

But DIA only imposed a Class II citation, with a $500 fine (maximum allowed for a Class II violation.) In the notice to the facility, DIA cited two state rules: 481 IAC

58.20(2) and 58.20(3). Pursuant to 481 IAC 56.7 (*see Appendix B*) these two rules' parenthetical notations include the Roman numerals "II" and "III" — indicating neither rule *in and of itself* can lead to a Class I citation.

However, 481 IAC 56.12 authorizes DIA to issue a Class I citation when "... one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility."

Since the notice cited two rules that were in violation, DIA had authority to combine the two and issue a Class I citation. And, given the severity of the findings as described above, DIA should have exercised that authority in this instance.

2. *ALLEGATION #3 — INSTANCE #2*

Deficiency: Failing to notify the physician immediately upon adverse change in resident's condition *and* failing to follow professional standards of quality

Twenty-nine days before his death, Resident #70 complained of "burning on urination," but the facility didn't do anything.

Twenty-one days before his death, he complained again of "burning on urination," but staff did not intervene or contact his physician.

Eighteen days before his death, he complained yet again of burning on urination, but staff did nothing.

Ten days before his death, the resident was documented with "lungs sound rattley. Displays loose, non-productive cough." But the facility didn't do anything.

Eight days before his death, he was documented as sounding congested, his color was dusky, and his temperature was low (95.8 degrees Farenheit), but the facility didn't do anything.

Seven days before his death, his temperature was again recorded at 95.8 degrees Farenheit, but the facility didn't do anything.

Six days before his death, his respirations were documented at 35 per minute, up from his usual rate of 20-24 per minute, but the facility didn't do anything.

Four days before his death, he again complained of burning on urination. This time, the facility notified the physician. A urine specimen was obtained the next day, showing "a packed field of white blood cells and 3 plus bacteria."

Three days before his death, his respirations again were documented at 35 per minute, but the facility didn't do anything.

The day before his death, documentation stated he still sounded congested, but the facility didn't do anything.

The next day, "the resident was found without a pulse, blood pressure or respirations."

In all, the facility had nine "warning signs" that this resident was in trouble — nine chances over a month to intervene before the resident died.

These findings are particularly egregious. It is difficult to imagine how DIA could have issued anything other than a Class I citation in connection with this deficiency, *based solely on its findings concerning the facility's failure to intervene before Resident #70's death.*

But that wasn't all. The findings also describe how Resident #58 lost 24½ pounds (more than 16% weight loss) from January to May 1993. She was documented as having "a poor appetite, nausea and vomiting and loose stools."

In January 1993, she had been hospitalized with a broken leg. In the following five months, the resident — who had a history of chronic gastritis[25] — was receiving pain medications. And beginning April 19, 1993, she started receiving antibiotics for a urinary tract infection.

"The resident had not been assessed for the relation these medications could have to her nausea and vomiting in view of her history of gastritis," the findings stated. "On 05/18/93, an order was obtained for Compazine for nausea."

The findings don't indicate what prompted the order for Compazine. Nonetheless, it reveals the facility again failed to follow professional standards of quality to assess the resident at some earlier point.

Similar to Instance #1 above, DIA had authority to combine the two state rules it cited [481 IAC 58.20(2) and 58.20(3)] to issue a Class I citation, pursuant to 481 IAC 56.12. And, given the severity of the findings as described above, DIA should have exercised that authority in this instance.

It should also be noted that the $900 fine issued for the above-described findings was inconsistent when compared with the findings associated with violations involving:

-- failing to prevent and treat pressure sores ($1,500 fine); and

-- failing to properly care for incontinent residents ($1,200 fine).

This inconsistency further reinforces the case that DIA failed to take enforcement action concerning Instance #2 that was commensurate with the severity of the findings.

3. *ALLEGATION #3 — INSTANCE #3*

Deficiency: Failing to notify the physician immediately upon adverse change in resident's condition *and* failing to follow professional standards of quality

Since the findings of fact for this particular instance are relatively long and complex, here's a summary: Seven specific incidents were found where the facility violated these standards — *two of the incidents led to resident deaths* — and all DIA did was impose the mandatory $50 per day fine pursuant to Code section 135C.40(1).

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[25] "Gastritis" is defined as "inflammation, especially of the mucous membrane of the stomach," according to Webster's Medical Desk Dictionary, 1986 edition.

The fine, which continued for 16 days and reached $800, paled in comparison to the $5,000 fine imposed just two months before in light of similarly grave findings.

Given the significance of the new findings, combined with the facility's failure to correct these violations as ordered just two months before, as well as the fact that this was the *sixth straight* survey over a 15-month period to include a deficiency under F299 (professional standards of quality), there was a compelling need for DIA to take additional enforcement action, such as:

-- initiation of license revocation proceedings; and/or

-- recommending DHS terminate the facility's Medicaid contract.

Based on this information, the Ombudsman concludes the adverse actions taken by DIA in these three instances were unreasonable in that the degree of the actions was not commensurate with the severity of the violations.

The Ombudsman therefore concludes Allegation #3 is *substantiated.*

RECOMMENDATION

The cure for these instances of failing to take enforcement action commensurate with the severity of the findings is for DIA to adopt and practice a proactive enforcement philosophy, as already discussed in a previous section.

In addition, the Ombudsman will be recommending legislative action to amend Code section 135C.40(1) as follows:

> ... Failure to correct a violation within the time specified; unless the licensee shows that the failure was due to circumstances beyond the licensee's control, shall subject the facility to a further penalty of fifty dollars for each day that the violation continues after the time specified for correction. <u>The director may increase the further penalty by an amount up to, but not exceeding, the amount of the original fine, if one was issued.</u>

Such a legislative amendment would give DIA flexibility to impose more severe fines in such circumstances, as warranted.

This recommendation is borne out of Instance #3 in this section, where state-authorized enforcement remedies limited DIA to issuing a $50 per day fine for failing to correct a violation that had drawn a $5,000 fine just two months prior. The $50 per day fine is discontinued when DIA finds the facility has corrected the violation.

In Instance #3, the $50 per day fine continued for 16 days. While that was the longest such fine found during the Ombudsman's review of DIA's oversight of these two facilities, the resulting $800 fine paled in comparison to the $5,000 fine imposed two months prior, considering they were issued for the identical problem.

ALLEGATION #4

Whether DIA's system of documenting its oversight of long-term care facilities is objectionable in that it is not easily understood by the general public.

Inspection reports are the only available objective measure of life in a nursing home. They are also one of the best-kept secrets in the U.S. health-care system....

—from Consumer Reports magazine's August 1995 article concerning nursing homes

The full inspection reports are often very difficult to read. Some of them are more than 100 pages long. They usually contain professional jargon, medical terminology, and references to nursing home standards.

—from "The Consumer Guide to Nursing Homes in Southeast Michigan," published in 1994 by Citizens for Better Care, a non-profit consumer organization

FINDINGS OF FACT

Iowa citizens make a significant investment in helping to pay for services offered by the state's nursing homes. That investment approached $100 million in the most recent year for which data was available [DHS figures show the state's Medicaid program contributed about $97.6 million for fiscal year 1996.] An additional $170.2 million was contributed by the federal Medicaid program, meaning more than a quarter of a billion dollars was paid by Medicaid to Iowa nursing homes in fiscal year 1996.

Each year, some of those citizens who help fund Medicaid are faced with the emotional difficulty of choosing the best nursing home for a family member. The decision can effect the quality of life for a loved one during the rest of his or her life. For the average consumer, the difficulty is made greater by the lack of any kind of an objective system to rate facilities.

Some contact DIA for guidance. Given its oversight role, DIA has a fairly significant amount of information concerning facilities' performance in meeting state and federal standards.

While DIA has myriad types of documentation, none summarize the essential elements of a facility's performance over a period of time and any adverse actions taken by DIA in connection with violations.

Instead, in order to get an objective understanding of a facility's performance over a period of time, a person would need to:

- Obtain copies of the following documents pertinent to the period under review:

  -- Statements of Deficiencies and Plan of Correction;

  -- Fining and Citation reports;

  -- other documents referencing non-fining adverse actions.

- Review the documents and try to understand them. Depending on the length of the period to be reviewed and the number of problems found by DIA, this could be an extremely time-consuming and complicated task.

If that person was trying to compare multiple facilities (i.e., someone shopping for the best nursing home for a family member), they would need to repeat the above-described process for each facility.

This may explain why DIA, instead of sending out boxes of documentation, offers to review its file on a facility (or facilities) and call people back with a summary of what has happened over the past year or so. Mr. Bennett stated in the June 6, 1996 interview with Mr. Burnham that DIA typically offers to summarize survey results from the past year and any adverse actions DIA took. Mr. Bennett said DIA also encourages people to visit a facility and, among other things, review the statement of deficiencies posted for public review.

Mr. Bennett indicated DIA does not track the number of such calls. He also said some callers ask for DIA's rating of a facility, but DIA does not rate facilities.

ANALYSIS AND CONCLUSIONS

This investigation demonstrated that DIA's documentation can be *extremely* confusing to anyone outside the regulatory system — and at least *somewhat* confusing to those within the system. This, along with the sheer volume of data reviewed and the number of issues identified, is the primary reason this investigation was not completed in a timely fashion.

Few families, if any, would have the time and resources the Ombudsman's office expended in this matter.

Based on this information, the Ombudsman concludes DIA's system of documenting its oversight of long-term care facilities is objectionable in that it is not easily understood by the general public.

The Ombudsman therefore concludes Allegation #5 is *substantiated.*

RECOMMENDATION

The Ombudsman recommends DIA develop and implement a system designed to help consumers make informed decisions in selecting and monitoring a long-term care facility. DIA should solicit and consider input from consumer groups and Iowa Partners for Resident Care.[26] The system should include the following features:

1. A **report card** will be created by DIA for every inspection of a long-term care facility. The report card will be created simultaneously with the Statement of Deficiencies and initiation of any enforcement actions.

2. All report cards will include a summary of all enforcement actions taken as a result of the inspection findings.[27]

3. For each general inspection, the report card will indicate the facility's compliance with a yet-to-be-determined number of "critical deficiencies." For example, if 45 requirements are identified as critical, the report card for each general survey would include a ratio [x/45] indicating the number of requirements the facility was found to be in compliance with. The ratio would be followed by a percentage [i.e., 45/45 would be 100 percent; 40/45 would be 88.9 percent; etc.]

4. The number and identity of "critical deficiencies" should be determined by DIA with input from consumer groups and Iowa Partners for Resident Care. Consideration should be given to those "critical deficiencies" identified by Consumer Reports magazine and the Detroit Free Press Newspaper.[28] Consideration should also be given to the September 1996 report, "Stakeholders Opinions Regarding Important Measures of Nursing Home Quality for Consumers."

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[26] Iowa Partners for Resident Care includes representatives from a variety of government and private agencies (DIA, DHS, the Department of Elder Affairs, Iowa Health Care Association, Iowa Association of Homes and Services for the Aging, Iowa Council for Health Care Center and consumer advocates.) According to literature from the group, "This partnership has been formed with the assistance of the Health Care Financing Administration. The purpose of the group is to enhance communication between providers and government agencies while completing joint projects which benefit Iowa's growing elderly population."

[27] Any enforcement actions authorized by state law should immediately be added to the facility's report card. However, DIA may not have authority to immediately include those actions authorized by federal law until after the appeals process is finalized [pursuant to 42 USC §1396r(g)(5) and 42 CFR 488.325].

[28] Consumer Reports magazine published a three-part series about nursing homes in August-October 1995. The series included a section rating national nursing home chains and groups, which was based on facilities' performance with 69 "critical deficiencies" identified by Consumer Reports. The Detroit Free Press published a series of articles about nursing homes in Michigan from October 7-11, 1996. The Free-Press series included a section rating Michigan's nursing homes. According to Alison Young, the reporter who worked on the series, the Free-Press ratings system was based on a modification of the 69 "critical deficiencies" identified by Consumer Reports. The modification was necessary, Young said, because HCFA had revised and consolidated the set of federal standards since the Consumer Reports series. Using federal "crosswalk" data to compare the old set with the new set, the Free-Press was able to come up with a modified set of 46 "critical deficiencies." That set is attached as Appendix M.

5. For each revisit inspection, the report card will indicate the ratio of deficiencies corrected as compared with the number of deficiencies identified on the prior survey, along with the percentage. For example, if a surveyor revisited a facility to determine the status of ten deficiencies found on the prior survey, and the surveyor found nine had been corrected, the report card would state: "9/10 deficiencies corrected (90 percent)."

6. For each complaint inspection, the report card will indicate the ratio of deficiencies identified as compared to the number of requirements reviewed. For example, if pursuant to a complaint, a surveyor reviewed a facility's performance concerning ten requirements, and the surveyor found the facility was in compliance with eight of the requirements, the report card would state: "8/10 complaints unsubstantiated (80 percent)."

   [*Examples of how report cards could be structured are attached as Appendix N.*]

7. When DIA implements this system, it should make every reasonable opportunity to notify the public about the system. This would include, but is not limited to, sending a press release about the system to all daily and weekly newspapers, as well as all television and radio stations. Other options could include newsletters and public service announcements.

8. Report cards should be revised only to correct errors or to revise summary information concerning enforcement actions pursuant to any modifications as a result of a facility's appeals. For example, if an enforcement action is modified or rescinded, that facility's report card would be revised to indicate the action initially proposed and the fact that it was modified or rescinded.

9. Report cards should be made available to the general public upon request.

10. Each report card should include basic information designed to help consumers get more information about long-term care facilities (such as HCFA's publication, "Guide to Choosing a Nursing Home"), and how to file complaints, including phone numbers and addresses of appropriate state and federal agencies.

DIA COMMENTS REGARDING OMBUDSMAN'S INVESTIGATION

Following the investigation, the Ombudsman met with DIA Director Kim Schmett and Health Facilities Division Administrator J. Bennett to consult about the Ombudsman's findings and conclusions.

Mr. Schmett indicated he does not generally dispute the Ombudsman's findings concerning DIA's oversight of the two nursing homes involved. However, he emphasized that since his appointment as agency director last year, DIA's Health Facilities Division has taken steps to ensure proactive enforcement of nursing home laws. These steps include:

1. A commitment to "Continuous Quality Improvement." Results to date have included:

   -- a mission statement saying, "To promote and protect the rights of persons who receive services from an entity inspected or regulated by the Division."

   -- a similarly focused "Vision Statement" and nine "Guiding Principles."

2. A new policy requiring that whenever a resident's death is mentioned in a deficiency statement, the deficiency must be considered at a "determination meeting" (formal consideration of possible enforcement action).

3. A new policy requiring surveyors to contact the chair of the local Care Review Committee on all surveys and complaint investigations.

4. A new policy requiring a facility's license be put on conditional status when a state-authorized Class I citation is issued, or when federal-authorized Category 2 or 3 remedies are imposed due to continued noncompliance.

Mr. Schmett also said he generally supports the Ombudsman's recommendations for improving DIA's enforcement of nursing home laws.

The Ombudsman is encouraged by Mr. Schmett's comments. However, without further study, the Ombudsman is unable to conclude that DIA is now adequately regulating nursing homes. The Ombudsman hopes to conduct a similar review in the future.

Appendix A

CHAPTER 135C
HEALTH CARE FACILITIES

Cost-related systems, § 249.12

135C.1 Definitions.
135C.2 Purpose—rules—special classifications—protection and advocacy agency.
135C.3 Nature of care.
135C.4 Residential care facilities.
135C.5 Limitations on use.
135C.6 License required.
135C.7 Application—fees.
135C.8 Scope of license.
135C.9 Inspection before issuance.
135C.10 Denial, suspension or revocation.
135C.11 Notice—hearings.
135C.12 Conditional operation.
135C.13 Judicial review.
135C.14 Rules.
135C.15 Time to comply.
135C.16 Inspections.
135C.17 Duties of other departments.
135C.18 Employees.
135C.19 Public disclosure of inspection findings—posting of citations.
135C.20 Information distributed.
135C.21 Penalties.
135C.22 Applicable to governmental units.
135C.23 Express requirements for admission or residence.
135C.24 Personal property or affairs of patients or residents.
135C.25 Care review committee appointments—duties—disclosure—liability.
135C.26 Director notified of casualties.
135C.27 Federal funds to implement program.
135C.28 Conflicting statutes.
135C.29 License list to county commissioner of elections.
135C.30 Operation of facility under receivership.
135C.31 Discharge of medicaid patients.
135C.32 Hospice services covered by medicare.
135C.33 Child or dependent adult abuse information and criminal records—evaluations.
135C.34 Medication aide—certification.
135C.35 Reserved.

VIOLATIONS

135C.36 Violations classified—penalties.
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135C.1 Definitions.

1. *"Adult day care services"* means an organized program of supportive care provided for sixteen hours or less in a twenty-four-hour period to persons who require support and assistance on a regular or intermittent basis in a licensed health care facility.

2. *"Department"* means the department of inspections and appeals.

3. *"Direction"* means authoritative policy or procedural guidance for the accomplishment of a function or activity.

4. *"Director"* means the director of the department of inspections and appeals, or the director's designee.

5. *"Governmental unit"* means the state, or any county, municipality, or other political subdivision or any department, division, board or other agency of any of the foregoing.

6. *"Health care facility"* or *"facility"* means a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with mental retardation.

7. *"House physician"* means a physician who has entered into a two-party contract with a health care facility to provide services in that facility.

8. *"Intermediate care facility for persons with mental illness"* means an institution, place, building, or agency designed to provide accommodation, board, and nursing care for a period exceeding twenty-four consecutive hours to three or more individuals, who primarily have mental illness and who are not related to the administrator or owner within the third degree of consanguinity.

9. *"Intermediate care facility for persons with mental retardation"* means an institution or distinct part of an institution with a primary purpose to provide health or rehabilitative services to three or more individuals, who primarily have mental retardation or a related condition and who are not related to the administrator or owner within the third degree of consanguinity, and which meets the requirements of this chapter and federal standards for intermediate care facilities for persons with mental retardation established pursuant to the federal Social Security Act, § 1905(c)(d), as codified in 42 U.S.C. § 1936d, which are contained in 42 C.F.R. pt. 483, subpt. D, § 410–480.

10. *"Licensee"* means the holder of a license issued for the operation of a facility, pursuant to this chapter.

11. *"Mental illness"* means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands of life.

12. *"Nursing care"* means those services which can be provided only under the direction of a registered nurse or a licensed practical nurse.

13. *"Nursing facility"* means an institution or a distinct part of an institution housing three or more individuals not related to the administrator or owner within the third degree of consanguinity, which is primarily engaged in providing health-related care and services, including rehabilitative services, but which is not engaged primarily in providing treatment or care for mental illness or mental retardation, for a period exceeding twenty-four consecutive hours for individuals who, because of a mental or physical condition, require nursing care and other services in addition to room and board.

14. *"Person"* means any individual, firm, partnership, corporation, company, association or joint stock association; and includes trustee, receiver, assignee or other similar representative thereof.

15. *"Physician"* has the meaning assigned that term by section 135.1, subsection 4.

16. *"Rehabilitative services"* means services to encourage and assist restoration of optimum mental and physical capabilities of the individual resident of a health care facility.

17. *"Residential care facility"* means any institution, place, building, or agency providing for a period exceeding twenty-four consecutive hours accommodation, board, personal assistance and other essential daily living activities to three or more individuals, not related to the administrator or owner thereof within the third degree of consanguinity, who by reason of illness, disease, or physical or mental infirmity are unable to sufficiently or properly care for themselves but who do not require the services of a registered or licensed practical nurse except on an emergency basis.

18. *"Resident"* means an individual admitted to a health care facility in the manner prescribed by section 135C.23.

19. *"Respite care services"* means an organized program of temporary supportive care provided for twenty-four hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person.

20. *"Social services"* means services relating to the psychological and social needs of the individual in adjusting to living in a health care facility, and minimizing stress arising from that circumstance.

21. *"Supervision"* means direct oversight and inspection of the act of accomplishing a function or activity.

[C50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.1]

87 Acts, ch 194, § 1; 90 Acts, ch 1039, § 2–5; 94 Acts, ch 1151, §1; 96 Acts, ch 1129, § 24

Subsections 6, 8, and 9 amended

135C.2 Purpose—rules—special classifications—protection and advocacy agency.

1. The purpose of this chapter is to promote and encourage adequate and safe care and housing for individuals who are aged or who, regardless of age, are infirm, convalescent, or mentally or physically dependent, by both public and private agencies by providing for the adoption and enforcement of rules and standards:

a. For the housing, care, and treatment of individuals in health care facilities, and

b. For the location, construction, maintenance, renovation, and sanitary operation of such

health care facilities which will promote safe and adequate care of individuals in such homes so as to further the health, welfare, and safety of such individuals.

2. Rules and standards prescribed, promulgated, and enforced under this chapter shall not be arbitrary, unreasonable, or confiscatory and the department or agency prescribing, promulgating, or enforcing such rules or standards shall have the burden of proof to establish that such rules or standards meet such requirements and are consistent with the economic problems and conditions involved in the care and housing of persons in health care facilities.

3. *a.* The department shall establish by administrative rule the following special classifications:

(1) Within the residential care facility category, a special license classification for residential facilities intended to serve persons with mental illness.

(2) Within the nursing facility category, a special license classification for nursing facilities which designate and dedicate the facility or a special unit within the facility to provide care for persons who suffer from chronic confusion or a dementing illness. A nursing facility which designates and dedicates the facility or a special unit within the facility for the care of persons who suffer from chronic confusion or a dementing illness shall be specially licensed. For the purposes of this subsection, *"designate"* means to identify by a distinctive title or label and *"dedicate"* means to set apart for a definite use or purpose and to promote that purpose.

b. The department may also establish by administrative rule special classifications within the residential care facility, intermediate care facility for persons with mental illness, intermediate care facility for persons with mental retardation, or nursing facility categories, for facilities intended to serve individuals who have special health care problems or conditions in common. Rules establishing a special classification shall define the problem or condition to which the special classification is relevant and establish requirements for an approved program of care commensurate with the problem or condition. The rules may grant special variances or considerations to facilities licensed within the special classification.

c. The rules adopted for intermediate care facilities for persons with mental retardation shall be consistent with, but no more restrictive than, the federal standards for intermediate care facilities for persons with mental retardation established pursuant to the federal Social Security Act, § 1905(c)(d), as codified in 42 U.S.C. § 1396d, in effect on January 1, 1989. However, in order to be licensed the state fire marshal must certify to the department an intermediate care facility for persons with mental retardation as meeting the applicable provisions of either the health care occupancies chapter or the residential board and care chapter of the life safety code of the national fire protection association, 1985 edition. The department shall adopt additional rules for intermediate care facilities for persons with mental retardation pursuant to section 135C.14, subsection 8.

d. Notwithstanding the limitations set out in this subsection regarding rules for intermediate care facilities for persons with mental retardation, the department shall consider the federal interpretive guidelines issued by the federal health care financing administration when interpreting the department's rules for intermediate care facilities for persons with mental retardation. This use of the guidelines is not subject to the rulemaking provisions of sections 17A.4 and 17A.5, but the guidelines shall be published in the Iowa administrative bulletin and the Iowa administrative code.

4. The protection and advocacy agency designated in the state, under Pub. L. No. 98-527, the Developmental Disabilities Act of 1984, Pub. L. No. 99-319, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and Pub. L. No. 100-146, the federal Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1987, is recognized as an agency

legally authorized and constituted to ensure the implementation of the purposes of this chapter for populations under its authority and in the manner designated by Pub. L. No. 98-527, Pub. L. No. 99-319, and Pub. L. No. 100-146 and in the assurances of the governor of the state.

5. The department shall establish a special classification within the residential care facility category in order to foster the development of residential care facilities which serve persons with mental retardation, chronic mental illness, a developmental disability, or brain injury, as described under section 225C.26, and which contain five or fewer residents. A facility within the special classification established pursuant to this subsection is exempt from the requirements of section 135.63. The department shall adopt rules which are consistent with rules previously developed for the waiver demonstration project pursuant to 1986 Iowa Acts, chapter 1246, section 206, and which include all of the following provisions:

a. A facility provider under the special classification must comply with rules adopted by the department for the special classification. However, a facility provider which has been accredited by the accreditation council for services to persons with mental retardation and other developmental disabilities shall be deemed to be in compliance with the rules adopted by the department.

b. A facility must be located in an area zoned for single or multiple-family housing or in an unincorporated area and must be constructed in compliance with applicable local requirements and the rules adopted for the special classification by the state fire marshal in accordance with the concept of the least restrictive environment for the facility residents. The rules adopted by the state fire marshal for the special classification shall be no more restrictive than the rules adopted by the state fire marshal for demonstration waiver project facilities pursuant to 1986 Iowa Acts, chapter 1246, section 206, subsection 2. Local requirements shall not be more restrictive than the rules adopted for the special classification by the state fire marshal and the state building code requirements for single or multiple-family housing.

c. Facility provider plans for the facility's accessibility to residents must be in place.

d. A written plan must be in place which documents that a facility meets the needs of the facility's residents pursuant to individual program plans developed according to age appropriate and least restrictive program requirements.

e. A written plan must be in place which documents that a facility's residents have reasonable access to employment or employment-related training, education, generic community resources, and integrated opportunities to promote interaction with the community.

f. A committee of not more than nine members must be established to provide monitoring of the special classification and the rules and procedures adopted regarding the special classification. The recommendations of the committee are subject to the approval of the director. The committee shall include but is not limited to representatives designated by each of the following:

(1) The association for retarded citizens of Iowa.
(2) The Iowa association of rehabilitation and residential facilities.
(3) The governor's planning council for developmental disabilities.
(4) The mental health and developmental disabilities commission created in section 225C.5.
(5) The alliance for the mentally ill of Iowa.
(6) The Iowa state association of counties.
(7) The state fire marshal.

g. The facilities licensed under this subsection shall be eligible for funding utilized by other licensed residential care facilities for persons with mental retardation, or licensed residential care

facilities for persons with mental illness, including but not limited to funding under or from the federal social services block grant, the state supplementary assistance program, state mental health and developmental disabilities services funds, and county funding provisions.

6. *a.* This chapter shall not apply to adult day care services provided in a health care facility. However, adult day care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

b. The level of care certification provisions pursuant to sections 135C.3 and 135C.4, the license application and fee provisions pursuant to section 135C.7, and the involuntary discharge provisions pursuant to section 135C.14, subsection 8, shall not apply to respite care services provided in a health care facility. However, respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

c. The department shall adopt rules to implement this subsection.

7. The rules adopted by the department regarding nursing facilities shall provide that a nursing facility may choose to be inspected either by the department or by the joint commission on accreditation of health care organizations. The rules regarding acceptance of inspection by the joint commission on accreditation of health care organizations shall include recognition, in lieu of inspection by the department, of comparable inspections and inspection findings of the joint commission on accreditation of health care organizations, if the department is provided with copies of all requested materials relating to the inspection process.

[C50, 54, § 135C.5; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.2]

85 Acts, ch 114, § 1; 87 Acts, ch 234, § 426; 88 Acts, ch 1249, § 3; 89 Acts, ch 115, § 1; 89 Acts, ch 269, § 1; 90 Acts, ch 1039, § 6; 90 Acts, ch 1267, § 27; 91 Acts, ch 267, § 139; 92 Acts, ch 1241, § 48; 94 Acts, ch 1151, § 2, 3; 94 Acts, ch 1170, §7, 22; 95 Acts, ch 67, § 11; 96 Acts, ch 1053, § 1; 96 Acts, ch 1129, § 25, 26, 113

Rules requiring special license classification for facility or unit designated and dedicated to caring for persons with chronic confusion or a dementing illness; applicability; existing facilities; 90 Acts, ch 1016, § 1

Subsection 7 is effective contingent upon passage of federal legislation; see 96 Acts, ch 1053, § 3

Subsection 3, paragraph b amended

Subsection 5, paragraph g amended

NEW subsection 7

Terminology change applied

135C.3 Nature of care.

1. A licensed nursing facility shall provide an organized twenty-four-hour program of services commensurate with the needs of its residents and under the immediate direction of a licensed nurse. Medical and nursing services must be provided under the direction of either a house physician or an individually selected physician. Surgery or obstetrical care shall not be provided within the facility. An admission to the nursing facility must be based on a physician's written order certifying that the individual being admitted requires no greater degree of nursing care than the facility to which the admission is made is licensed to provide and is capable of providing.

2. A licensed intermediate care facility for persons with mental illness shall provide an organized twenty-four-hour program of services commensurate with the needs of its residents and under the immediate direction of a licensed registered nurse, who has had at least two years of recent experience in a chronic or acute psychiatric setting. Medical and nursing service must be

provided under the direction of either a house physician or an individually selected physician. Surgery or obstetrical care shall not be provided within the facility. An admission to the intermediate care facility for persons with mental illness must be based on a physician's written order certifying that the individual being admitted requires no greater degree of nursing care than the facility to which the admission is made is licensed to provide and is capable of providing.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.3]

90 Acts, ch 1039, §7; 96 Acts, ch 1129, § 113

Terminology change applied

135C.4 Residential care facilities.

Each facility licensed as a residential care facility shall provide an organized continuous twenty-four-hour program of care commensurate with the needs of the residents of the home and under the immediate direction of a person approved and certified by the department whose combined training and supervised experience is such as to ensure adequate and competent care. All admissions to residential care facilities shall be based on an order written by a physician certifying that the individual being admitted does not require nursing services.

[C50, 54, § 135C.9; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.4]

135C.5 Limitations on use.

Another business or activity shall not be carried on in a health care facility, or in the same physical structure with a health care facility, unless such business or activity is under the control of and is directly related to and incidental to the operation of the health care facility or unless the business or activity is approved by the department and the state fire marshal. A business or activity which is operated within the limitations of this section shall not interfere in any manner with the use of the facility by the residents or the services provided to the residents, and shall not be disturbing to them. The department and the state fire marshal, in accordance with chapter 17A, shall adopt rules which establish criteria for approval of a business or activity to be carried on in a health care facility or in the same physical structure with a health care facility.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.5]

91 Acts, ch 241, §1

135C.6 License required.

1. A person or governmental unit acting severally or jointly with any other person or governmental unit shall not establish or operate a health care facility in this state without a license for the facility. A community, supervised apartment living arrangement, as defined in section 225C.21, is not required to be licensed under this chapter, but is subject to approval under section 225C.21 in order to receive public funding.

2. A health care facility suitable for separation and operation with distinct parts may, where otherwise qualified in all respects, be issued multiple licenses authorizing various parts of such facilities to be operated as health care facilities of different license categories.

3. No change in a health care facility, its operation, program, or services, of a degree or character affecting continuing licensability shall be made without prior approval thereof by the department. The department may by rule specify the types of changes which shall not be made without its prior approval.

4. No department, agency, or officer of this state or of any of its political subdivisions shall pay or approve for payment from public funds any amount or amounts to a health care facility under

any program of state aid in connection with services provided or to be provided an actual or prospective resident in a health care facility, unless the facility has a current license issued by the department and meets such other requirements as may be in effect pursuant to law.

5. No health care facility established and operated in compliance with law prior to January 1, 1976, shall be required to change its corporate or business name by reason of the definitions prescribed in section 135C.1, provided that no health care facility shall at any time represent or hold out to the public or to any individual that it is licensed as, or provides the services of, a health care facility of a type offering a higher grade of care than such health care facility is licensed to provide. Any health care facility which, by virtue of this section, operates under a name not accurately descriptive of the type of license which it holds shall clearly indicate in any printed advertisement, letterhead, or similar material, the type of license or licenses which it has in fact been issued. No health care facility established or renamed after January 1, 1976, shall use any name indicating that it holds a different type of license than it has been issued.

6. A health care facility operated by and for the exclusive use of members of a religious order, which does not admit more than two individuals to the facility from the general public, may be operated without obtaining a license under this chapter and shall not be deemed to be licensed by the state.

7. A freestanding hospice facility which operates a hospice program in accordance with 42 C.F.R. § 418 may be operated without obtaining a license under this chapter and shall not be deemed to be licensed by the state.

8. The following residential programs to which the department of human services applies accreditation, certification, or standards of review shall not be required to be licensed as a health care facility under this chapter:

a. A residential program which provides care to not more than three individuals and receives moneys appropriated to the department of human services under provisions of a federally approved home and community-based services waiver or other medical assistance program under chapter 249A.

b. A residential program which serves not more than four individuals and is operating under provisions of a federally approved home and community-based waiver for persons with mental retardation, if all individuals residing in the program receive on-site staff supervision during the entire time period the individuals are present in the program's living unit. The need for the on-site supervision shall be reflected in each individual's program plan developed pursuant to the department of human services' rules relating to case management for persons with mental retardation. In approving a residential program under this paragraph, the department of human services shall consider the geographic location of the program so as to avoid an overconcentration of such programs in an area.

9. Notwithstanding section 135C.9, nursing facilities which are accredited by the joint commission on accreditation of health care organizations shall be licensed without inspection by the department, if the nursing facility has chosen to be inspected by the joint commission on accreditation of health care organizations in lieu of inspection by the department.

[C50, 54, § 135C.2; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.6]

85 Acts, ch 141, §2; 86 Acts, ch 1245, § 1113; 90 Acts, ch 1107, § 2; 92 Acts, ch 1043, § 3; 96 Acts, ch 1053, § 2

Subsection 9 is effective contingent upon passage of federal legislation; see 96 Acts, ch 1053, § 3

NEW subsection 9

135C.7 Application—fees.

Licenses shall be obtained from the department. Applications shall be upon such forms and shall include such information as the department may reasonably require, which may include affirmative evidence of compliance with such other statutes and local ordinances as may be applicable. Each application for license shall be accompanied by the annual license fee prescribed by this section, subject to refund to the applicant if the license is denied, which fee shall be paid over into the state treasury and credited to the general fund if the license is issued. There shall be an annual license fee based upon the bed capacity of the health care facility, as follows:

1. Ten beds or less, twenty dollars.
2. More than ten and not more than twenty-five beds, forty dollars.
3. More than twenty-five and not more than seventy-five beds, sixty dollars.
4. More than seventy-five and not more than one hundred fifty beds, eighty dollars.
5. More than one hundred fifty beds, one hundred dollars.

[C50, 54, § 135C.3, 135C.4; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.7]

135C.8 Scope of license.

Licenses for health care facilities shall be issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable except with the written approval of the department, obtained prior to the purchase of the facility involved. Licenses shall be posted in a conspicuous place on the licensed premises as prescribed by regulation of the department. Such licenses, unless sooner suspended or revoked, shall expire one year after the date of issuance and shall be renewed annually upon an application by the licensee. Applications for such renewal shall be made in writing to the department, accompanied by the required fee, at least thirty days prior to the expiration of such license in accordance with regulations promulgated by the department. Health care facilities which have allowed their licenses to lapse through failure to make timely application for renewal of their licenses shall pay an additional fee of twenty-five percent of the annual license fee prescribed in section 135C.7.

[C50, 54, § 135C.5; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.8]

135C.9 Inspection before issuance.

1. The department shall not issue a health care facility license to any applicant until:

a. The department has ascertained that the staff and equipment of the facility is adequate to provide the care and services required of a health care facility of the category for which the license is sought. Prior to the review and approval of plans and specifications for any new facility and the initial licensing under a new licensee, a resume of the programs and services to be furnished and of the means available to the applicant for providing the same and for meeting requirements for staffing, equipment, and operation of the health care facility, with particular reference to the professional requirements for services to be rendered, shall be submitted in writing to the department for review and approval. The resume shall be reviewed by the department within ten working days and returned to the applicant. The resume shall, upon the department's request, be revised as appropriate by the facility from time to time after issuance of a license.

b. The facility has been inspected by the state fire marshal or a deputy appointed by the fire marshal for that purpose, who may be a member of a municipal fire department, and the department has received either a certificate of compliance or a provisional certificate of

compliance by the facility with the fire hazard and fire safety rules and standards of the department as promulgated by the fire marshal and, where applicable, the fire safety standards required for participation in programs authorized by either Title XVIII or Title XIX of the United States Social Security Act (42 U.S.C. § 1395 to 1395ll and 1396 to 1396g). The certificate or provisional certificate shall be signed by the fire marshal or the fire marshal's deputy who made the inspection.

2. The rules and standards promulgated by the fire marshal pursuant to subsection 1, paragraph *"b"* of this section shall be substantially in keeping with the latest generally recognized safety criteria for the facilities covered, of which the applicable criteria recommended and published from time to time by the national fire protection association shall be prima facie evidence.

3. The state fire marshal or the fire marshal's deputy may issue successive provisional certificates of compliance for periods of one year each to a facility which is in substantial compliance with the applicable fire hazard and fire safety rules and standards, upon satisfactory evidence of an intent, in good faith, by the owner or operator of the facility to correct the deficiencies noted upon inspection within a reasonable period of time as determined by the state fire marshal or the fire marshal's deputy. Renewal of a provisional certificate shall be based on a showing of substantial progress in eliminating deficiencies noted upon the last previous inspection of the facility without the appearance of additional deficiencies other than those arising from changes in the fire hazard and fire safety rules, regulations and standards which have occurred since the last previous inspection, except that substantial progress toward achievement of a good faith intent by the owner or operator to replace the entire facility within a reasonable period of time, as determined by the state fire marshal or the fire marshal's deputy, may be accepted as a showing of substantial progress in eliminating deficiencies, for the purposes of this section.

[C50, 54, § 135C.6; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.9]

135C.10 Denial, suspension or revocation.

The department shall have the authority to deny, suspend, or revoke a license in any case where the department finds that there has been repeated failure on the part of the facility to comply with the provisions of this chapter or the rules or minimum standards promulgated hereunder, or for any of the following reasons:

1. Cruelty or indifference to health care facility residents.
2. Appropriation or conversion of the property of a health care facility resident without the resident's written consent or the written consent of the resident's legal guardian.
3. Permitting, aiding, or abetting the commission of any illegal act in the health care facility.
4. Inability or failure to operate and conduct the health care facility in accordance with the requirements of this chapter and the minimum standards and rules issued pursuant thereto.
5. Obtaining or attempting to obtain or retain a license by fraudulent means, misrepresentation, or by submitting false information.
6. Habitual intoxication or addiction to the use of drugs by the applicant, manager or supervisor of the health care facility.
7. Securing the devise or bequest of the property of a resident of a health care facility by undue influence.
8. Willful failure or neglect to maintain a continuing in-service education and training program for all personnel employed in the facility.
9. In the case of an application by an existing licensee for a new or newly acquired facility,

continuing or repeated failure of the licensee to operate any previously licensed facility or facilities in compliance with the provisions of this chapter or of the rules adopted pursuant to it.

10. In the case of a license applicant or existing licensee which is an entity other than an individual, the department may deny, suspend, or revoke a license if any individual, who is in a position of control or is an officer of the entity, engages in any act or omission proscribed by this section.

[C50, 54, § 135C.6; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.10]
90 Acts, ch 1204, §13

135C.11 Notice—hearings.

1. The denial, suspension, or revocation of a license shall be effected by delivering to the applicant or licensee by certified mail or by personal service of a notice setting forth the particular reasons for such action. Such denial, suspension, or revocation shall become effective thirty days after the mailing or service of the notice, unless the applicant or licensee, within such thirty-day period, shall give written notice to the department requesting a hearing, in which case the notice shall be deemed to be suspended. If a hearing has been requested, the applicant or licensee shall be given an opportunity for a prompt and fair hearing before the department. At any time at or prior to the hearing the department may rescind the notice of the denial, suspension or revocation upon being satisfied that the reasons for the denial, suspension or revocation have been or will be removed. On the basis of any such hearing, or upon default of the applicant or licensee, the determination involved in the notice may be affirmed, modified, or set aside by the department. A copy of such decision shall be sent by certified mail, or served personally upon the applicant or licensee. The applicant or licensee may seek judicial review pursuant to section 135C.13.

2. The procedure governing hearings authorized by this section shall be in accordance with the rules promulgated by the department. A full and complete record shall be kept of all proceedings, and all testimony shall be reported but need not be transcribed unless judicial review is sought pursuant to section 135C.13. Copies of the transcript may be obtained by an interested party upon payment of the cost of preparing the copies. Witnesses may be subpoenaed by either party and shall be allowed fees at a rate prescribed by the department's rules. The director may, after advising the care review committee established pursuant to section 135C.25, either proceed in accordance with section 135C.30, or remove all residents and suspend the license or licenses of any health care facility, prior to a hearing, when the director finds that the health or safety of residents of the health care facility requires such action on an emergency basis. The fact that no care review committee has been appointed for a particular facility shall not bar the director from exercising the emergency powers granted by this subsection with respect to that facility.

[C50, 54, § 135C.6; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.11]

135C.12 Conditional operation.

If the department has the authority under section 135C.10 to deny, suspend or revoke a license, the department or director may, as an alternative to those actions:

1. Apply to the district court of the county in which the licensee's health care facility is located for appointment by the court of a receiver for the facility pursuant to section 135C.30.

2. Conditionally issue or continue a license dependent upon the performance by the licensee of reasonable conditions within a reasonable period of time as set by the department so as to permit the licensee to commence or continue the operation of the health care facility pending full

compliance with this chapter or the regulations or minimum standards promulgated under this chapter. If the licensee does not make diligent efforts to comply with the conditions prescribed, the department may, under the proceedings prescribed by this chapter, suspend or revoke the license. No health care facility shall be operated on a conditional license for more than one year.

3. The department, in evaluating corrections of deficiencies in a facility in receivership or operating on a conditional license, may determine what is satisfactory compliance, provided that in so doing it shall employ established criteria which shall be uniformly applied to all facilities of the same license category.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.12]

135C.13 Judicial review.

Judicial review of any action of the director may be sought in accordance with the terms of the Iowa administrative procedure Act. Notwithstanding the terms of said Act, petitions for judicial review may be filed in the district court of the county where the facility or proposed facility is located, and pending final disposition of the matter the status quo of the applicant or licensee shall be preserved except when the director, with the advice and consent of the care review committee established pursuant to section 135C.25, determines that the health, safety or welfare of the residents of the facility is in immediate danger, in which case the director may order the immediate removal of such residents. The fact that no care review committee has been appointed for a particular facility shall not bar the director from exercising the emergency powers granted by this subsection with respect to that facility.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.13]

135C.14 Rules.

The department shall, in accordance with chapter 17A, and with the approval of the state board of health adopt and enforce rules setting minimum standards for health care facilities. In so doing, the department, with the approval of the state board of health, may adopt by reference, with or without amendment, nationally recognized standards and rules, which shall be specified by title and edition, date of publication, or similar information. The rules and standards required by this section shall be formulated in consultation with the director of human services or the director's designee and with affected industry, professional, and consumer groups, and shall be designed to further the accomplishment of the purposes of this chapter and shall relate to:

1. Location and construction of the facility, including plumbing, heating, lighting, ventilation, and other housing conditions, which shall ensure the health, safety and comfort of residents and protection from fire hazards. The rules of the department relating to protection from fire hazards and fire safety shall be promulgated by the state fire marshal, and shall be in keeping with the latest generally recognized safety criteria for the facilities covered of which the applicable criteria recommended and published from time to time by the national fire protection association are prima facie evidence.

2. Number and qualifications of all personnel, including management and nursing personnel, having responsibility for any part of the care provided to residents.

3. All sanitary conditions within the facility and its surroundings including water supply, sewage disposal, food handling, and general hygiene, which shall ensure the health and comfort of residents.

4. Diet related to the needs of each resident and based on good nutritional practice and on

recommendations which may be made by the physician attending the resident.

5. Equipment essential to the health and welfare of the resident.

6. Requirements that a minimum number of registered or licensed practical nurses and nurses' aides, relative to the number of residents admitted, be employed by each licensed facility. Staff-to-resident ratios established under this subsection need not be the same for facilities holding different types of licenses, nor for facilities holding the same type of license if there are significant differences in the needs of residents which the respective facilities are serving or intend to serve.

7. Social services and rehabilitative services provided for the residents.

8. Facility policies and procedures regarding the treatment, care, and rights of residents. The rules shall apply the federal resident's rights contained in the federal Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, and the regulations adopted pursuant to the Act and contained in 42 C.F.R. § 483.10, 483.12, 483.13, and 483.15, as amended to February 2, 1989, to all health care facilities as defined in this chapter and shall include procedures for implementing and enforcing the federal rules. The department shall also adopt rules relating to the following:

a. The transfer of residents to other rooms within a facility.

b. The involuntary discharge or transfer of residents from a facility including provisions for notice and agency hearings and for the development of a patient discharge or transfer plan and for providing counseling services to a patient being discharged or transferred.

c. The required holding of a bed for a resident under designated circumstances upon payment of a prescribed charge for the bed.

d. The notification of care review committees by the department of all complaints relating to health care facilities and the involvement of the care review committees in resolution of the complaints.

e. For the recoupment of funds or property to residents when the resident's personal funds or property have been used without the resident's written consent or the written consent of the resident's guardian. .

[C50, 54, § 135C.5; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.14; 81 Acts, ch 60, § 1]

83 Acts, ch 96, § 157, 159; 83 Acts, ch 101, § 18; 89 Acts, ch 241, § 1, 2; 90 Acts, ch 1204, § 14

135C.15 Time to comply.

1. Any health care facility which is in operation at the time of adoption or promulgation of any applicable rules or minimum standards under this chapter shall be given reasonable time from the date of such promulgation to comply with such rules and minimum standards as provided for by the department. The director may grant successive thirty-day extensions of the time for compliance where evidence of a good faith attempt to achieve compliance is furnished, if the extensions will not place in undue jeopardy the residents of the facility to which the extensions are granted.

2. Renovation of an existing health care facility, not already in compliance with all applicable standards, shall be permitted only if the fixtures and equipment to be installed and the services to be provided in the renovated portion of the facility will conform substantially to current operational standards. Construction of an addition to an existing health care facility shall be permitted only if the design of the structure, the fixtures and equipment to be installed, and the services to be provided in the addition will conform substantially to current construction and

operational standards.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.15]

135C.16 Inspections.

1. In addition to the inspections required by sections 135C.9 and 135C.38, the department shall make or cause to be made such further unannounced inspections as it deems necessary to adequately enforce this chapter. At least one general unannounced inspection shall be conducted for each health care facility within a fifteen-month period. The inspector shall show identification to the person in charge of the facility and state that an inspection is to be made before beginning the inspection. An employee of the department who gives unauthorized advance notice of an inspection made or planned to be made under this subsection or section 135C.38 shall be disciplined as determined by the director, except that if the employee is employed pursuant to the merit system provisions of chapter 19A the discipline shall not exceed the discipline authorized pursuant to that chapter.

2. The department shall prescribe by rule that any licensee or applicant for license desiring to make specific types of physical or functional alterations or additions to its facility or to construct new facilities shall, before commencing the alteration or additions or new construction, submit plans and specifications to the department for preliminary inspection and approval or recommendations with respect to compliance with the department's rules and standards. When the plans and specifications have been properly approved by the department or other appropriate state agency, the facility or the portion of the facility constructed or altered in accord with the plans and specifications shall not for a period of at least five years from completion of the construction or alteration be considered deficient or ineligible for licensing by reason of failure to meet any rule or standard established subsequent to approval of the plans and specifications. When construction or alteration of a facility or portion of a facility has been completed in accord with plans and specifications submitted as required by this subsection and properly approved by the department or other appropriate state agency, and it is discovered that the facility or portion of a facility is not in compliance with a requirement of this chapter or of the rules or standards adopted pursuant to it and in effect at the time the plans and specifications were submitted, and the deficiency was apparent from the plans and specifications submitted but was not noted or objected to by the department or other appropriate state agency, the department or agency responsible for the oversight shall either waive the requirement or reimburse the licensee or applicant for any costs which are necessary to bring the new or reconstructed facility or portion of a facility into compliance with the requirement and which the licensee or applicant would not have incurred if the facility or portion of the facility had been constructed in compliance with the requirements of this chapter or of the rules or standards adopted pursuant to it and in effect at the time the plans and specifications were submitted. If within two years from the completion of the construction or alteration of the facility or portion thereof, a department or agency of the state orders that the new or reconstructed facility or portion thereof be brought into compliance with the requirements of this chapter or the rules or standards adopted pursuant to it and in effect at the time the plans and specifications were submitted, the state shall have a claim for damages to the extent of any reimbursement paid to the licensee or applicant against any person who designed the facility or portion thereof for negligence in the preparation of the plans and specifications therefor, subject to all defenses based upon the negligence of the state in reviewing and approving those plans and specifications, but not thereafter.

The provisions of this subsection shall not apply where the deficiency presents a clear and present danger to the safety of the residents of the facility.

3. An inspector of the department may enter any licensed health care facility without a warrant, and may examine all records pertaining to the care provided residents of the facility. An inspector of the department may contact or interview any resident, employee, or any other person who might have knowledge about the operation of a health care facility. An inspector of the department of human services shall have the same right with respect to any facility where one or more residents are cared for entirely or partially at public expense, and an investigator of the designated protection and advocacy agency shall have the same right with respect to any facility where one or more residents have developmental disabilities or mental illnesses, and the state fire marshal or a deputy appointed pursuant to section 135C.9, subsection 1, paragraph *"b"* shall have the same right of entry into any facility and the right to inspect any records pertinent to fire safety practices and conditions within that facility. If any such inspector has probable cause to believe that any institution, building, or agency not licensed as a health care facility is in fact a health care facility as defined by this chapter, and upon producing identification that the individual is an inspector is denied entry thereto for the purpose of making an inspection, the inspector may, with the assistance of the county attorney of the county in which the purported health care facility is located, apply to the district court for an order requiring the owner or occupant to permit entry and inspection of the premises to determine whether there have been any violations of this chapter.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.16; 82 Acts, ch 1065, § 1]

83 Acts, ch 96, § 157, 159; 84 Acts, ch 1227, § 1; 87 Acts, ch 234, § 427; 90 Acts, ch 1204, § 15; 92 Acts, ch 1242, § 26

135C.17 Duties of other departments.

It shall be the duty of the department of human services, state fire marshal, and the officers and agents of other state and local governmental units, and the designated protection and advocacy agency to assist the department in carrying out the provisions of this chapter, insofar as the functions of these respective offices and departments are concerned with the health, welfare, and safety of any resident of any health care facility. It shall be the duty of the department to cooperate with the protection and advocacy agency by responding to all reasonable requests for assistance and information as required by federal law and this chapter.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.17]

83 Acts, ch 96, § 157, 159; 87 Acts, ch 234, § 428

135C.18 Employees.

The department may employ, pursuant to chapter 19A, such assistants and inspectors as may be necessary to administer and enforce the provisions of this chapter.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.18]

135C.19 Public disclosure of inspection findings—posting of citations.

1. Following an inspection of a health care facility by the department pursuant to this chapter, the department's final findings with respect to compliance by the facility with requirements for licensing shall be made available to the public in a readily available form and place. Other information relating to a health care facility obtained by the department which does not constitute the department's findings from an inspection of the facility shall not be made available to the

public except in proceedings involving the citation of a facility for a violation under section 135C.40, or the denial, suspension, or revocation of a license under this chapter. The name of a person who files a complaint with the department shall be confidential.

2. A citation for a class I or class II violation which is issued to a health care facility and which has become final, or a copy of the citation, shall be prominently posted as prescribed in rules, until the violation is corrected to the department's satisfaction. The citation or copy shall be posted in a place in plain view of the residents of the facility cited, persons visiting the residents, and persons inquiring about placement in the facility.

A copy of each citation required to be posted by this subsection shall be sent by the department to the department of human services and to the designated protection and advocacy agency if the facility has one or more residents with developmental disabilities or mental illness.

3. If the facility cited subsequently advises the department of human services that the violation has been corrected to the satisfaction of the department of inspections and appeals, the department of human services shall maintain this advisory in the same file with the copy of the citation. The department of human services shall not disseminate to the public any information regarding citations issued by the department of inspections and appeals, but shall forward or refer inquiries to the department of inspections and appeals.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.19]

83 Acts, ch 96, § 157, 159; 84 Acts, ch 1227, § 2; 87 Acts, ch 234, § 429; 90 Acts, ch 1039, § 8; 90 Acts, ch 1204, § 16, 17

135C.20 Information distributed.

The department shall prepare, publish and send to licensed health care facilities an annual report of its activities and operations under this chapter and such other bulletins containing fundamental health principles and data as may be deemed essential to assure proper operation of health care facilities, and publish for public distribution copies of the laws, standards and rules pertaining to their operation.

[C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.20]

135C.21 Penalties.

1. Any person establishing, conducting, managing, or operating any health care facility without a license shall be guilty of a serious misdemeanor. Each day of continuing violation after conviction or notice from the department by certified mail of a violation shall be considered a separate offense or chargeable offense. Any such person establishing, conducting, managing or operating any health care facility without a license may be by any court of competent jurisdiction temporarily or permanently restrained therefrom in any action brought by the state.

2. Any person who prevents or interferes with or attempts to impede in any way any duly authorized representative of the department or of any of the agencies referred to in section 135C.17 in the lawful enforcement of this chapter or of the rules adopted pursuant to it is guilty of a simple misdemeanor. As used in this subsection, lawful enforcement includes but is not limited to:

a. Contacting or interviewing any resident of a health care facility in private at any reasonable hour and without advance notice.

b. Examining any relevant books or records of a health care facility.

c. Preserving evidence of any violation of this chapter or of the rules adopted pursuant to it.

[C50, 54, § 135C.7; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.21]

135C.22 Applicable to governmental units.

The provisions of this chapter shall be applicable to institutions operated by or under the control of the department of human services, the state board of regents, or any other governmental unit.

[C50, 54, § 135C.8; C58, 62, 66, 71, 73, 75, 77, 79, 81, § 135C.22]

83 Acts, ch 96, § 157, 159

135C.23 Express requirements for admission or residence.

No individual shall be admitted to or permitted to remain in a health care facility as a resident, except in accordance with the requirements of this section.

1. Each resident shall be covered by a contract executed at the time of admission or prior thereto by the resident, or the resident's legal representative, and the health care facility, except as otherwise provided by subsection 5 with respect to residents admitted at public expense to a county care facility operated under chapter 347B. Each party to the contract shall be entitled to a duplicate original thereof, and the health care facility shall keep on file all contracts which it has with residents and shall not destroy or otherwise dispose of any such contract for at least one year after its expiration. Each such contract shall expressly set forth:

a. The terms of the contract.

b. The services and accommodations to be provided by the health care facility and the rates or charges therefor.

c. Specific descriptions of any duties and obligations of the parties in addition to those required by operation of law.

d. Any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter, nor contain any disclaimer of responsibility for injury to the resident, or to relatives or other persons visiting the resident, which occurs on the premises of the facility or, with respect to injury to the resident, which occurs while the resident is under the supervision of any employee of the facility whether on or off the premises of the facility.

2. A health care facility shall not knowingly admit or retain a resident:

a. Who is dangerous to the resident or other residents.

b. Who is in an acute stage of alcoholism, drug addiction, or mental illness.

c. Whose condition or conduct is such that the resident would be unduly disturbing to other residents.

d. Who is in need of medical procedures, as determined by a physician, or services which cannot be or are not being carried out in the facility.

This section does not prohibit the admission of a patient with a history of dangerous or disturbing behavior to an intermediate care facility for persons with mental illness, intermediate care facility for persons with mental retardation, nursing facility, or county care facility when the intermediate care facility for persons with mental illness, intermediate care facility for persons with mental retardation, nursing facility, or county care facility has a program which has received prior approval from the department to properly care for and manage the patient. An intermediate care facility for persons with mental illness, intermediate care facility for persons with mental retardation, nursing facility, or county care facility is required to transfer or discharge a resident

with dangerous or disturbing behavior when the intermediate care facility for persons with mental illness, intermediate care facility for persons with mental retardation, nursing facility, or county care facility cannot control the resident's dangerous or disturbing behavior. The department, in coordination with the state mental health and developmental disabilities commission created in section 225C.5, shall adopt rules pursuant to chapter 17A for programs to be required in intermediate care facilities for persons with mental illness, intermediate care facilities for persons with mental retardation, nursing facilities, and county care facilities that admit patients or have residents with histories of dangerous or disturbing behavior.

The denial of admission of a person to a health care facility shall not be based upon the patient's condition, which is the existence of a specific disease in the patient, but the decision to accept or deny admission of a patient with a specific disease shall be based solely upon the ability of the health care facility to provide the level of care required by the patient.

3. Except in emergencies, a resident who is not essentially capable of managing the resident's own affairs shall not be transferred out of a health care facility or discharged for any reason without prior notification to the next of kin, legal representative, or agency acting on the resident's behalf. When such next of kin, legal representative, or agency cannot be reached or refuses to cooperate, proper arrangements shall be made by the facility for the welfare of the resident before the resident's transfer or discharge.

4. No owner, administrator, employee, or representative of a health care facility shall pay any commission, bonus, or gratuity in any form whatsoever, directly or indirectly, to any person for residents referred to such facility, nor accept any commission, bonus, or gratuity in any form whatsoever, directly or indirectly, for professional or other services or supplies purchased by the facility or by any resident, or by any third party on behalf of any resident, of the facility.

5. Each county which maintains a county care facility under chapter 347B shall develop a statement in lieu of, and setting forth substantially the same items as, the contracts required of other health care facilities by subsection 1. The statement must be approved by the county board of supervisors and by the department. When so approved, the statement shall be considered in force with respect to each resident of the county care facility.

[C71, 73, 75, 77, 79, 81, § 135C.23]

83 Acts, ch 76, § 1; 87 Acts, ch 190, §1; 88 Acts, ch 1234, §9; 90 Acts, ch 1039, § 9; 94 Acts, ch 1170, §23; 96 Acts, ch 1129, § 113

Terminology changes applied

135C.24 Personal property or affairs of patients or residents.

The admission of a resident to a health care facility and the resident's presence therein shall not in and of itself confer on such facility, its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident, nor any authority or responsibility for the personal affairs of the resident, except as may be necessary for the safety and orderly management of the facility and as required by this section.

1. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee or conservator for any resident of such facility, or any of such resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

2. A health care facility shall provide for the safekeeping of personal effects, funds and other property of its residents, provided that whenever necessary for the protection of valuables or in

order to avoid unreasonable responsibility therefor, the facility may require that they be excluded or removed from the premises of the facility and kept at some place not subject to the control of the facility.

3. A health care facility shall keep complete and accurate records of all funds and other effects and property of its residents received by it for safekeeping.

4. Any funds or other property belonging to or due a resident, or expendable for the resident's account, which are received by a health care facility shall be trust funds, shall be kept separate from the funds and property of the facility and of its other residents, or specifically credited to such resident, and shall be used or otherwise expended only for the account of the resident. Upon request the facility shall furnish the resident, the guardian, trustee or conservator, if any, for any resident, or any governmental unit or private charitable agency contributing funds or other property on account of any resident, a complete and certified statement of all funds or other property to which this subsection applies detailing the amounts and items received, together with their sources and disposition.

5. The provisions of this section notwithstanding, upon the verified petition of the county board of supervisors the district court may appoint the administrator of a county care facility as conservator or guardian, or both, of a resident of such county care facility, in accordance with the provisions of chapter 633. Such administrator shall serve as conservator or guardian, or both, without fee. The county attorney shall serve as attorney for the administrator in such conservatorship or guardianship, or both, without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards.

[C71, 73, 75, 77, 79, 81, § 135C.24]

135C.25 Care review committee appointments—duties—disclosure—liability.

1. Each health care facility shall have a care review committee whose members shall be appointed by the director of the department of elder affairs or the director's designee. A person shall not be appointed a member of a care review committee for a health care facility unless the person is a resident of the service area where the facility is located. The care review committee for any facility caring primarily for persons with mental illness, mental retardation, or a developmental disability shall only be appointed after consultation with the administrator of the division of mental health and developmental disabilities of the department of human services on the proposed appointments. Recommendations to the director or the director's designee for membership on care review committees are encouraged from any agency, organization, or individual. The administrator of the facility shall not be appointed to the care review committee and shall not be present at committee meetings except upon request of the committee.

2. Each care review committee shall periodically review the needs of each individual resident of the facility and shall perform the functions pursuant to sections 135C.38 and 231.44.

3. A health care facility shall disclose the names, addresses, and phone numbers of a resident's family members, if requested, to a care review committee member, unless permission for this disclosure is refused in writing by the family member. The facility shall provide a form on which a family member may indicate a refusal to grant this permission.

4. Neither the state nor any care review committee member is liable for an action by a care review committee member in the performance of duty, if the action is undertaken and carried out in good faith.

[C71, 73, 75, 77, 79, 81, § 135C.25]

83 Acts, ch 73, § 6; 86 Acts, ch 1245, § 1027; 87 Acts, ch 70, § 1; 88 Acts, ch 1068, §2; 94 Acts, ch 1170, §24

135C.26 Director notified of casualties.

The director shall be notified within twenty-four hours, by the most expeditious means available, of any accident causing major injury or death, and any fire or natural or other disaster occurring in a health care facility.

[C71, 73, 75, 77, 79, 81, § 135C.26]

135C.27 Federal funds to implement program.

If the department's services are necessary in order to assist another governmental unit to implement a federal program, the department may accept in compensation for such services federal funds initially available from the federal government to such other governmental unit for such purpose. Any governmental unit is authorized to transfer to the department for such services any federal funds available to such governmental unit, in accordance with applicable federal laws and regulations.

[C71, 73, 75, 77, 79, 81, § 135C.27]

135C.28 Conflicting statutes.

Provisions of this chapter in conflict with the state building code shall not apply where the state building code has been adopted or when the state building code applies throughout the state.

[C73, 75, 77, 79, 81, § 135C.28]

135C.29 License list to county commissioner of elections.

To facilitate the implementation of section 53.8, subsection 3 and section 53.22, the director shall provide to each county commissioner of elections at least annually a list of each licensed health care facility in that county. The list shall include the street address or location, and the mailing address if it is other than the street address or location, of each facility.

[C77, 79, 81, § 135C.29]

135C.30 Operation of facility under receivership.

When so authorized by section 135C.11, subsection 2, or section 135C.12, subsection 1, the director may file a verified application in the district court of the county where a health care facility licensed under this chapter is located, requesting that an individual nominated by the director be appointed as receiver for the facility with responsibility to bring the operation and condition of the facility into conformity with this chapter and the rules or minimum standards promulgated under this chapter.

1. The court shall expeditiously hold a hearing on the application, at which the director shall present evidence in support of the application. The licensee against whose facility the petition is filed may also present evidence, and both parties may subpoena witnesses. The court may appoint a receiver for the health care facility in advance of the hearing if the director's verified application states that an emergency exists which presents an imminent danger of resultant death or physical harm to the residents of the facility. If the licensee against whose facility the receivership petition is filed informs the court at or before the time set for the hearing that the licensee does not object to the application, the court shall waive the hearing and at once appoint a receiver for the facility.

2. The court, on the basis of the verified application and evidence presented at the hearing, may

order the facility placed under receivership, and if so ordered, the court shall direct either that the receiver assume the duties of administrator of the health care facility or that the receiver supervise the facility's administrator in conducting the day-to-day business of the facility. The receiver shall be empowered to control the facility's financial resources and to apply its revenues as the receiver deems necessary to the operation of the facility in compliance with this chapter and the rules or minimum standards promulgated under this chapter, but shall be accountable to the court for management of the facility's financial resources.

3. A receivership established under this section may be terminated by the district court which established it, after a hearing upon an application for termination. The application may be filed:

a. Jointly by the receiver and the current licensee of the health care facility which is in receivership, stating that the deficiencies in the operation, maintenance or other circumstances which were the grounds for establishment of the receivership have been corrected and that there are reasonable grounds to believe that the facility will be operated in compliance with this chapter and the rules or minimum standards promulgated under this chapter.

b. By the current licensee of the facility, alleging that termination of the receivership is merited for the reasons set forth in paragraph *"a"* of this subsection, but that the receiver has declined to join in the petition for termination of the receivership.

c. By the receiver, stating that all residents of the facility have been relocated elsewhere and that there are reasonable grounds to believe it will not be feasible to again operate the facility on a sound financial basis and in compliance with this chapter and the rules or minimum standards promulgated under this chapter, and asking that the court approve surrender of the facility's license to the department and subsequent return of control of the facility's premises to the owners of the premises.

4. Payment of the expenses of a receivership established under this section is the responsibility of the facility for which the receiver is appointed, unless the court directs otherwise. The expenses include, but are not limited to:

a. Salary of the receiver.

b. Expenses incurred by the facility for the continuing care of the residents of the facility.

c. Expenses incurred by the facility for the maintenance of buildings and grounds of the facility.

d. Expenses incurred by the facility in the ordinary course of business, such as employees' salaries and accounts payable.

The receiver is not personally liable for the expenses of the facility during the receivership. The receiver is an employee of the state as defined in section 669.2, subsection 3, only for the purpose of defending a claim filed against the receiver. Chapter 669 applies to all suits filed against the receiver.

5. This section does not:

a. Preclude the sale or lease of a health care facility, and the transfer or assignment of the facility's license in the manner prescribed by section 135C.8, while the facility is in receivership, provided these actions are not taken without approval of the receiver.

b. Affect the civil or criminal liability of the licensee of the facility placed in receivership, for any acts or omissions of the licensee which occurred before the receiver was appointed.

[C81, § 135C.30]

84 Acts, ch 1136, § 1; 91 Acts, ch 107, §3

135C.31 Discharge of medicaid patients.

A resident of a health care facility shall not be discharged solely because the cost of the resident's care is being paid under chapter 249A or because the resident's source of payment is changing from private support to payment under chapter 249A.

[81 Acts, ch 60, § 2]

135C.32 Hospice services covered by medicare.

The requirement that the care of a resident of a health care facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

1. The resident is terminally ill.
2. The resident has elected to receive hospice services under the federal Medicare program from a medicare certified hospice program.
3. The health care facility and the medicare certified hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

88 Acts, ch 1037, §1

135C.33 Child or dependent adult abuse information and criminal records—evaluations.

1. On or after July 1, 1994, with regard to new applicants for licensure or employment, if a person is being considered for licensure under this chapter, or for employment involving direct responsibility for a resident or with access to a resident when the resident is alone, or if the person considered for licensure or employment under this chapter will reside in a facility, the facility may request that the department of human services conduct criminal and child and dependent adult abuse record checks in this state and in other states, on a random basis. Beginning July 1, 1994, a facility shall inform all new applicants for employment of the possibility of the performance of a record check and shall obtain, from the applicant, a signed acknowledgment of the receipt of the information. Additionally, on or after July 1, 1994, a facility shall include the following inquiry in an application for employment: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" If the person has been convicted of a crime under a law of any state or has a record of founded child or dependent adult abuse, the department of human services shall perform an evaluation to determine whether the crime or founded child or dependent adult abuse warrants prohibition of licensure, employment, or residence in the facility. The evaluation shall be performed in accordance with procedures adopted for this purpose by the department of human services.
2. If the department of human services determines that a person has committed a crime or has a record of founded child or dependent adult abuse and is licensed, employed by a facility licensed under this chapter, or resides in a licensed facility, the department shall notify the licensee that an evaluation will be conducted to determine whether prohibition of the person's licensure, employment, or residence is warranted.
3. In an evaluation, the department of human services shall consider the nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded child or dependent adult abuse, the circumstances under which the crime or founded child or dependent adult abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded child

or dependent adult abuse again, and the number of crimes or founded child or dependent adult abuses committed by the person involved. The department of human services has final authority in determining whether prohibition of the person's licensure, employment, or residence is warranted.

4. If the department of human services determines that the person has committed a crime or has a record of founded child or dependent adult abuse which warrants prohibition of licensure, employment, or residence, the person shall not be licensed under this chapter and shall not be employed by a facility or reside in a facility licensed under this chapter.

94 Acts, ch 1130, §12

135C.34 Medication aide—certification.

The department of inspections and appeals, in cooperation with other appropriate agencies, shall establish a procedure to allow a person who is certified as a medication aide in another state to become certified in this state upon completion and passage of both the certified nurse aide and certified medication aide challenge examinations, without additional requirements for certification, including but not limited to, required employment in this state prior to certification. The department shall adopt rules pursuant to chapter 17A to administer this section.

94 Acts, ch 1036, §1

135C.35 Reserved.

VIOLATIONS

135C.36 Violations classified—penalties.

Every violation by a health care facility of any provision of this chapter or of the rules adopted pursuant to it shall be classified by the department in accordance with this section. The department shall adopt and may from time to time modify, in accordance with chapter 17A rules setting forth so far as feasible the specific violations included in each classification and stating criteria for the classification of any violation not so listed.

1. A Class I violation is one which presents an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility in which the violation occurs. A physical condition or one or more practices in a facility may constitute a Class I violation. A Class I violation shall be abated or eliminated immediately unless the department determines that a stated period of time, specified in the citation issued under section 135C.40, is required to correct the violation. A licensee is subject to a penalty of not less than two thousand nor more than ten thousand dollars for each Class I violation for which the licensee's facility is cited.

2. A Class II violation is one which has a direct or immediate relationship to the health, safety or security of residents of a health care facility, but which presents no imminent danger nor substantial probability of death or physical harm to them. A physical condition or one or more practices within a facility, including either physical abuse of any resident or failure to treat any resident with consideration, respect and full recognition of the resident's dignity and individuality, in violation of a specific rule adopted by the department, may constitute a Class II violation. A violation of section 135C.14, subsection 8, or section 135C.31 and rules adopted under those sections shall be at least a Class II violation and may be a Class I violation. A Class II violation shall be corrected within a stated period of time determined by the department and specified in the

citation issued under section 135C.40. The stated period of time specified in the citation may subsequently be modified by the department for good cause shown. A licensee is subject to a penalty of not less than one hundred nor more than five hundred dollars for each Class II violation for which the licensee's facility is cited, however the director may waive the penalty if the violation is corrected within the time specified in the citation.

3. A Class III violation is any violation of this chapter or of the rules adopted pursuant to it which violation is not classified in the department's rules nor classifiable under the criteria stated in those rules as a Class I or a Class II violation. A licensee shall not be subject to a penalty for a Class III violation, except as provided by section 135C.40, subsection 1 for failure to correct the violation within a reasonable time specified by the department in the notice of the violation.

[C77, 79, 81, § 135C.36; 81 Acts, ch 60, § 3]
86 Acts, ch 1168, § 1

135C.37 Complaints alleging violations—confidentiality.

A person may request an inspection of a health care facility by filing with the department, care review committee of the facility, or the long-term care resident's advocate as defined in section 231.4, subsection 16, a complaint of an alleged violation of applicable requirements of this chapter or the rules adopted pursuant to this chapter. A person alleging abuse or neglect of a resident with a developmental disability or with mental illness may also file a complaint with the protection and advocacy agency designated pursuant to section 135B.9 or section 135C.2. A copy of a complaint filed with the care review committee or the long-term care resident's advocate shall be forwarded to the department. The complaint shall state in a reasonably specific manner the basis of the complaint, and a statement of the nature of the complaint shall be delivered to the facility involved at the time of the inspection. The name of the person who files a complaint with the department, care review committee, or the long-term care resident's advocate shall be kept confidential and shall not be subject to discovery, subpoena, or other means of legal compulsion for its release to a person other than department employees involved in the investigation of the complaint.

[C77, 79, 81, § 135C.37]
84 Acts, ch 1227, § 3; 85 Acts, ch 186, § 2; 89 Acts, ch 241, § 3; 89 Acts, ch 321, § 28; 91 Acts, ch 107, §4

135C.38 Inspections upon complaints.

1. *a.* Upon receipt of a complaint made in accordance with section 135C.37, the department or care review committee shall make a preliminary review of the complaint. Unless the department or committee concludes that the complaint is intended to harass a facility or a licensee or is without reasonable basis, it shall within twenty working days of receipt of the complaint make or cause to be made an on-site inspection of the health care facility which is the subject of the complaint.

b. The complaint investigation shall include, at a minimum, an interview with the complainant, the alleged perpetrator, and the victim of the alleged violation, if the victim is able to communicate, if the complainant, alleged perpetrator, or victim is identifiable, and if the complainant, alleged perpetrator, or victim is available. Additionally, witnesses who have knowledge of facts related to the complaint shall be interviewed, if identifiable and available. The names of witnesses may be obtained from the complainant or the victim. The files of the facility

may be reviewed to ascertain the names of staff persons on duty at the time relevant to the complaint. The department shall apply a preponderance of the evidence standard in determining whether or not a complaint is substantiated. For the purposes of this subsection, *"a preponderance of the evidence standard"* means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true. *"A preponderance of the evidence standard"* does not require that the investigator personally witnessed the alleged violation.

c. The department may refer to the care review committee of a facility any complaint received by the department regarding that facility, for initial evaluation and appropriate action by the committee.

2. *a.* The complainant shall be promptly informed of the result of any action taken by the department or committee in the matter. The complainant shall also be notified of the name, address, and telephone number of the designated protection and advocacy agency if the alleged violation involves a facility with one or more residents with developmental disabilities or mental illness.

b. Upon conclusion of the investigation, the department shall notify the complainant of the results. The notification shall include a statement of the factual findings as determined by the investigator, the statutory or regulatory provisions alleged to have been violated, and a summary of the reasons for which the complaint was or was not substantiated.

c. The department shall mail the notification to the complainant without charge. Upon the request of the complainant, the department shall mail to the complainant, without charge, a copy of the most recent final findings regarding compliance with licensing requirements by the facility against which the complaint was filed.

d. A person who is dissatisfied with any aspect of the department's handling of the complaint may contact the long-term care resident's advocate, established pursuant to section 231.42, or may contact the protection and advocacy agency designated pursuant to section 135C.2 if the complaint relates to a resident with a developmental disability or a mental illness.

3. An inspection made pursuant to a complaint filed under section 135C.37 need not be limited to the matter or matters complained of; however, the inspection shall not be a general inspection unless the complaint inspection coincides with a scheduled general inspection. Upon arrival at the facility to be inspected, the inspector shall show identification to the person in charge of the facility and state that an inspection is to be made, before beginning the inspection. Upon request of either the complainant or the department or committee, the complainant or the complainant's representative or both may be allowed the privilege of accompanying the inspector during any on-site inspection made pursuant to this section. The inspector may cancel the privilege at any time if the inspector determines that the privacy of any resident of the facility to be inspected would otherwise be violated. The dignity of the resident shall be given first priority by the inspector and others.

4. If upon an inspection of a facility by its care review committee, pursuant to this section, the committee advises the department of any circumstance believed to constitute a violation of this chapter or of any rule adopted pursuant to it, the committee shall similarly advise the facility at the same time. If the facility's licensee or administrator disagrees with the conclusion of the committee regarding the supposed violation, an informal conference may be requested and if requested shall be arranged by the department as provided in section 135C.42 before a citation is issued. If the department thereafter issues a citation pursuant to the committee's finding, the facility shall not be

entitled to a second informal conference on the same violation and the citation shall be considered affirmed. The facility cited may proceed under section 135C.43 if it so desires.

[C77, 79, 81, § 135C.38]

87 Acts, ch 234, § 430; 89 Acts, ch 241, § 4; 91 Acts, ch 107, § 5, 6

135C.39 No advance notice of inspection—exception.

No advance notice of an on-site inspection made pursuant to section 135C.38 shall be given the health care facility or the licensee thereof unless previously and specifically authorized in writing by the director or required by federal law. The person in charge of the facility shall be informed of the substance of the complaint at the commencement of the on-site inspection.

[C77, 79, 81, § 135C.39]

89 Acts, ch 241, § 5; 90 Acts, ch 1039, § 10

Administrative penalty; see § 135C.45A

135C.40 Citations when violations found—penalties—exception.

1. If the director determines, based on the findings of an inspection or investigation of a health care facility, that the facility is in violation of this chapter or rules adopted under this chapter, the director within five working days after making the determination, may issue a written citation to the facility. The citation shall be served upon the facility personally or by certified mail, except that a citation for a Class III violation may be sent by ordinary mail. Each citation shall specifically describe the nature of the violation, identifying the Code section or subsection or the rule or standard violated, and the classification of the violation under section 135C.36. Where appropriate, the citation shall also state the period of time allowed for correction of the violation, which shall in each case be the shortest period of time the department deems feasible. Failure to correct a violation within the time specified, unless the licensee shows that the failure was due to circumstances beyond the licensee's control, shall subject the facility to a further penalty of fifty dollars for each day that the violation continues after the time specified for correction.

2. When a citation is served upon or mailed to a health care facility under subsection 1 and the licensee of the facility is not actually involved in the daily operation of the facility, a copy of the citation shall be mailed to the licensee. If the licensee is a corporation, a copy of the citation shall be sent to the corporation's office of record. If the citation was issued pursuant to an inspection resulting from a complaint filed under section 135C.37, a copy of the citation shall be sent to the complainant at the earliest time permitted by section 135C.19, subsection 1.

3. No health care facility shall be cited for any violation caused by any practitioner licensed pursuant to chapter 148, 150 or 150A if that practitioner is not the licensee of and is not otherwise financially interested in the facility, and the licensee or the facility presents evidence that reasonable care and diligence have been exercised in notifying the practitioner of the practitioner's duty to the patients in the facility.

[C77, 79, 81, § 135C.40; 81 Acts, ch 61, § 1]

84 Acts, ch 1227, § 4

135C.41 Licensee's response to citation.

Within twenty business days after service of a citation under section 135C.40, a facility shall either:

1. If it does not desire to contest the citation:

a. Remit to the department the amount specified by the department pursuant to section

135C.36 as a penalty for each Class I violation cited, and for each Class II violation unless the citation specifically waives the penalty, which funds shall be paid by the department into the state treasury and credited to the general fund; or

b. In the case of a Class II violation for which the penalty has been waived in accordance with the standards prescribed in section 135C.36, subsection 2, or a Class III violation, send to the department a written response acknowledging that the citation has been received and stating that the violation will be corrected within the specific period of time allowed by the citation; or

2. Notify the director that the facility desires to contest the citation and, in the case of citations for Class II or Class III violations, request an informal conference with a representative of the department.

[C77, 79, 81, § 135C.41]

135C.42 Informal conference on contested citation.

The director shall assign a representative of the department, other than the inspector upon whose inspection the contested citation is based, to hold an informal conference with the facility within ten working days after receipt of a request made under section 135C.41, subsection 2. At the conclusion of the conference the representative may affirm or may modify or dismiss the citation. In the latter case, the representative shall state in writing the specific reasons for the modification or dismissal and immediately transmit copies of the statement to the director, and to the facility. If the facility does not desire to further contest an affirmed or modified citation, it shall within five working days after the informal conference, or after receipt of the written explanation of the representative, as the case may be, comply with section 135C.41, subsection 1.

[C77, 79, 81, § 135C.42]

135C.43 Formal contest—judicial review.

1. A facility which desires to contest a citation for a Class I violation, or to further contest an affirmed or modified citation for a Class II or Class III violation, may do so in the manner provided by chapter 17A for contested cases. Notice of intent to formally contest a citation shall be given the department in writing within five days after service of a citation for a Class I violation, or within five days after the informal conference or after receipt of the written explanation of the representative delegated to hold the informal conference, whichever is applicable, in the case of an affirmed or modified citation for a Class II or Class III violation. A facility which has exhausted all adequate administrative remedies and is aggrieved by the final action of the department may petition for judicial review in the manner provided by chapter 17A.

2. Hearings on petitions for judicial review brought under this section shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. The times for pleadings and for hearings in such actions shall be set by the judge of the court with the object of securing a decision in the matter at the earliest possible time.

[C77, 79, 81, § 135C.43]

135C.44 Treble fines for repeated violations.

The penalties authorized by section 135C.36 shall be trebled for a second or subsequent Class I or Class II violation occurring within any twelve-month period if a citation was issued for the same Class I or Class II violation occurring within that period and a penalty was assessed therefor.

[C77, 79, 81, § 135C.44]

135C.45 Refund of penalty.

If at any time a contest or appeal of any citation issued a health care facility under this chapter results in an order or determination that a penalty previously paid to or collected by the department must be refunded to the facility, the refund shall be made from any money in the state general fund not otherwise appropriated.

[C77, 79, 81, § 135C.45]

135C.45A Notification penalty.

A person who notifies, or causes to be notified, a health care facility, of the time and date on which a survey or on-site inspection of the facility is scheduled, is subject to an administrative penalty of not less than one thousand dollars and not more than two thousand dollars.

90 Acts, ch 1039, §11

135C.46 Retaliation by facility prohibited.

1. A facility shall not discriminate or retaliate in any way against a resident or an employee of the facility who has initiated or participated in any proceeding authorized by this chapter. A facility which violates this section is subject to a penalty of not less than two hundred fifty nor more than five thousand dollars, to be assessed and collected by the director in substantially the manner prescribed by sections 135C.40 to 135C.43 and paid into the state treasury to be credited to the general fund, or to immediate revocation of the facility's license.

2. Any attempt to expel from a health care facility a resident by whom or upon whose behalf a complaint has been submitted to the department under section 135C.37, within ninety days after the filing of the complaint or the conclusion of any proceeding resulting from the complaint, shall raise a rebuttable presumption that the action was taken by the licensee in retaliation for the filing of the complaint.

[C77, 79, 81, § 135C.46]

135C.47 Report listing licensees and citations.

The department shall annually prepare and make available in its office at the seat of government a report listing all licensees by name and address, indicating:

1. The number of citations and the nature of each citation issued to each licensee during the previous twelve-month period and the status of any action taken pursuant to each citation, including penalties assessed; and

2. The nature and status of action taken with respect to each uncorrected violation for which a citation is outstanding.

[C77, 79, 81, § 135C.47]

135C.48 Information about complaint procedure.

The department shall make a continuing effort to inform the general public of the appropriate procedure to be followed by any person who believes that a complaint against a health care facility is justified and should be made under section 135C.37.

[C77, 79, 81, § 135C.48]

Appendix B

CHAPTER 56
FINING AND CITATIONS

[Prior to 7/15/87, Health Department[470] Ch 56]

481—56.1(135C) Authority for citations. Pursuant to the authority vested in the director of the department of inspections and appeals to issue citations and assess penalties for violations of the statutes or departmental rules relating to the health care facilities, the following rules indicate the method by which citations may be issued when a particular statute or departmental rule is violated by a facility.

481—56.2(135C) Classification of violations—classes. There are three classifications for violations of statutes or departmental rules which may result in the issuance of a citation by the director of inspections and appeals and the assessment of a penalty therefor.

56.2(1)*Class I.* A class I violation is one which presents an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility in which the violation occurs. A physical condition or one or more practices in a facility may constitute a class I violation;

56.2(2)*Class II.* A class II violation is one that has a direct or immediate relationship to the health, safety, or security of residents of a health care facility, but which presents no imminent danger nor substantial probability of death or physical harm to them. A physical condition or one or more practices within a facility, including either physical abuse of any resident or failure to treat any resident with consideration, respect, and full recognition of the resident's dignity and individuality, in violation of a specific rule adopted by the department, may constitute a class II violation;

56.2(3)*Class III.* A class III violation is one which is not classifiable in the department's rules nor classifiable under the criteria stated in those rules as a class I or class II violation.

481—56.3(135C) Fines. Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules relating to health care facilities will subject the facility to the following penalties:

56.3(1)*Citation for a class I violation:* Not less than $2,000 nor more than $10,000;

56.3(2)*Citation for a class II violation:* Not less than $100 nor more than $500. (The director of the department of inspections and appeals may waive the penalty if the violation is corrected within the time specified in the citation);

56.3(3)*Citation for a class III violation:* No penalty, except as provided in 56.5(135C).

481—56.4(135C) Time for compliance. Citations which are issued by the director of the department of inspections and appeals for violations of the statutes or rules related to health care facilities shall specify the length of time permitted for the violation to be abated or eliminated, as follows:

56.4(1)*Citation for a class I violation:* The violation shall be abated or eliminated immediately, unless the department determines that a stated period of time, specified in the citation, is required to correct the violation;

56.4(2)*Citation for a class II violation:* The violation shall be corrected within a stated period of time determined by the department and specified in the citation. The stated period of time specified in the citation may subsequently be modified by the department for good cause shown;

56.4(3)*Citation for a class III violation:* The violation shall be corrected within a reasonable time specified by the department in the citation.

481—56.5(135C) Failure to correct a violation within the time specified—penalty. Failure to correct any class of violation within the time specified in the citation, unless the licensee shows that the failure was due to circumstances beyond the licensee's control, shall subject the facility to a further penalty of $50 for

each day that the violation continues after the time specified for correction.

481—56.6(135C) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in 56.3(135C) for any second or subsequent class I or class II violation occurring within any 12–month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.

481—56.7(135C) Notation of classes of violations. All rules relating to health care facilities, other than those which are informational in character, shall be followed by a notation at the end of each rule, or pertinent part thereof. This notation shall consist of a Roman numeral or numerals in parentheses. These Roman numerals refer to the class (either Class I, Class II, or Class III) of violation which may be cited by the commissioner when that rule, or part of a rule carrying the notation is violated by the facility.

481—56.8(135C) Notation for more than one class of violation. In those instances where a particular rule, or part of a rule is followed by a notation consisting of more than one Roman numeral in parentheses, at the discretion of the director of the department of inspections and appeals, the director may issue a citation for a violation of that rule, or part thereof designating any one of the multiple classes of violations specified in the notation.

481—56.9(135C) Factors determining selection of class of violation. In determining which class of violation will be designated in the citation, where more than one class is specified in the notation following the rule, the director of the department of inspections and appeals may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

56.9(1) The length of time during which the violation occurred;

56.9(2) The frequency of the violation, i.e., whether the violation was an isolated or a widespread occurrence, practice, or condition;

56.9(3) The past history of the facility, as it relates to the nature of the violation, i.e., whether the violation was a first–time occurrence or one which has occurred in the past at that facility;

56.9(4) The intent of the facility, as it relates to the reasons the violation occurred;

56.9(5) The extent of any harm to the residents or the effect on the health, safety, or security of the residents which resulted from the violation;

56.9(6) The relationship of the violation to any other types of violations which have occurred in the facility, i.e., whether other violations in combination with the violation in question, caused increased harm or adverse effects to the residents of the facility;

56.9(7) The actions of the facility after the occurrence of the violation, including when corrective measures, if any, were implemented;

56.9(8) The accuracy and extent of records kept by the facility which relates to the violation, and the availability of such records to the department;

56.9(9) The number of other types of related violations occurring simultaneously or within a short period of time of the violation in question.

481—56.10(135C) Factors determining imposition of citation and fine. The director of the department of inspections and appeals may consider evidence of the circumstances surrounding the violation including, but not limited to, those factors set out in rule 56.9(135C) when:

1. Determining whether a violation will be subject to a fine or citation; and
2. Determining the monetary amount of the penalty to be specified in the citation, when such a fine is authorized to be levied for a particular class of violation.

481—56.11(135C) Class I violation not specified in the rules. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exists in a facility which are not in violation of a specific statute or rule, but which constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

481—56.12(135C) Class I violation as a result of multiple lesser violations. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.

481—56.13(135C) Form of citations. Each citation issued by the director of the department of inspections and appeals shall contain the following information:

56.13(1) A description of the nature of the violation;

56.13(2) A statement of the Code section or subsection or the rule or standard violated. (In the case of class I violations as described in **56.11**(135C), a statement of the specific physical condition or one or more practices may be made in lieu of this statement.);

56.13(3) A statement of the classification of the violation, as specified in section **56.2**(135C);

56.13(4) When appropriate, a statement of the period of time allowed for correction of the violation, which shall in each case be the shortest period of time the department deems feasible.

481—56.14(135C) Licensee's response to a citation. Within 20 business days after service of a citation, the facility shall respond in the following manner, according to the type of citation issued.

56.14(1) If the facility does not desire to contest the citation:

a. For each class I violation, the facility shall remit to the department of inspections and appeals the amount specified by the department of inspections and appeals in the citation;

b. For each class II violation for which the penalty has not been waived, the facility shall remit to the department of inspections and appeals the amount specified by the department of inspections and appeals in the citation;

c. For each class II violation for which the penalty has been waived or for each class III violation, the facility shall send a written response to the department of inspections and appeals, acknowledging that the citation has been received and stating that the violation will be corrected within the specified period of time allowed by the citation.

56.14(2) If the facility desires to contest a citation for a class I violation, the facility shall follow the procedure as set out in **56.16**(135C).

56.14(3) If the facility desires to contest a citation for a class II or class III violation, the facility shall notify the director of the department of inspections and appeals in writing that it desires to contest such citation and request in writing an informal conference with a representative of the department of inspections and appeals.

481—56.15(135C) Procedure for facility after informal conference. After the conclusion of an informal conference requested by the licensee and provided pursuant to **56.14**(3):

56.15(1) If the facility does not desire to further contest an affirmed or modified citation for a class II or class III violation, the facility shall, within five working days after the informal conference, or within five working days after receipt of the written decision and explanation of the department of inspections and appeals' representative at the informal conference, as the case may be, comply with the provisions of

56.14(1)*"b"* or 56.14(1)*"c."*

56.15(2) If the facility does desire to further contest an affirmed or modified citation for a class II or class III violation, the facility shall, within five working days after the informal conference, or within five working days after receipt of the written decision and explanation of the department of inspections and appeals' representative at the informal conference, as the case may be, notify the department of inspections and appeals in writing of the facility's intent to formally contest the citation.

481—56.16(135C) Contesting a citation for a class I violation. If a facility desires to contest a citation for a class I violation, the facility shall, within five working days after service of such citation, notify the department of inspections and appeals in writing of the facility's intent to formally contest the citation.

481—56.17(135C) Formal contest. The procedures for contested cases, as set out in Iowa Code chapter 17A, and the rules adopted by the department of inspections and appeals shall be followed in all cases where proper notice has been made to the department of inspections and appeals of the intent to formally contest any citation.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.14(8), 135C.25 and 135C.36.

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[Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]**

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[Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]

[Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91]

*Effective date of Ch 56 delayed by the Administrative Rules Review Committee until 12/6/76, pursuant to Iowa Code section 17A.4 as amended by 66 GA, SF 1288, section 2, to allow further time to study and examine the rules.

legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature."

Section 13612(d) of Pub. L. 103-66 provided that:

"(1)(A) Except as provided in subparagraph (B), the amendments made by this section [amending this section] shall apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

"(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements imposed by such amendments solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act [Aug. 10, 1993]. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(2) The amendments made by this section shall not apply to individuals who died before October 1, 1993."

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by Pub. L. 101-239 applicable to transfers occurring after Dec. 19, 1989, see section 6411(e)(4) of Pub. L. 101-239, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 303(b) of Pub. L. 100-360 applicable to payments under this subchapter for calendar quarters beginning on or after July 1, 1988 (except in certain situations requiring State legislative action), without regard to whether or not final regulations to carry out such amendment have been promulgated by such date, and subsection (c) of this section, as amended by section 303(b) of Pub. L. 100-360, applicable to resources disposed of on or after July 1, 1988, but not applicable with respect to inter-spousal transfers occurring before Oct. 1, 1989, see section 303(g)(2), (5) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(l)(3)(I) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA: Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENT

Amendment by Pub. L. 100-203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100-203, as amended, set out as an Effective Date note under section 1396r of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97-448 effective as if originally included as a part of this section as this section was added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, see section 309(c)(2) of Pub. L. 97-448, set out as a note under section 428-1 of this title.

EFFECTIVE DATE

Section 132(d) of Pub. L. 97-248 provided that: "The amendments made by this section [enacting this section and amending section 1396a of this title] shall become effective on the date of the enactment of this Act [Sept. 3, 1982], but the provisions of section 1917(c)(2)(B) of the Social Security Act [subsec. (c)(2)(B) of this section] shall not apply with respect to a transfer of assets which took place prior to such date of enactment."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 1382, 1382b, 1396a, 1396r-5 of this title.

§ 1396q. Application of provisions of subchapter II relating to subpoenas

The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in so applying such subsections, and in applying section 405(*l*) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(Aug. 14, 1935, ch. 531, title XIX, § 1918, as added July 18, 1984, Pub. L. 98-369, div. B, title III, § 2370(a), 98 Stat. 1110; amended Aug. 15, 1994, Pub. L. 103-296, title I, § 108(d)(5), 108 Stat. 1486.)

AMENDMENTS

1994—Pub. L. 103-296 inserted before period at end ", except that, in so applying such subsections, and in applying section 405(*l*) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively".

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by Pub. L. 103-296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103-296, set out as a note under section 401 of this title.

EFFECTIVE DATE

Section 2370(b) of Pub. L. 98-369 provided that: "The amendment made by this section [enacting this section] shall become effective on the date of the enactment of this Act [July 18, 1984]."

§ 1396r. Requirements for nursing facilities

(a) "Nursing facility" defined

In this subchapter, the term "nursing facility" means an institution (or a distinct part of an institution) which—

(1) is primarily engaged in providing to residents—

(A) skilled nursing care and related services for residents who require medical or nursing care,

(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

(2) has in effect a transfer agreement (meeting the requirements of section 1395x(l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and

(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d) of this section.

(b) Requirements relating to provision of services

(1) Quality of life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(B) Quality assessment and assurance

A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

(2) Scope of services and activities under plan of care

A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(3) Residents' assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification

(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

(III) The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted—

(I) promptly upon (but no later than [1] not later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

(E) Coordination

Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(F) Requirements relating to preadmission screening for mentally ill and mentally retarded individuals

Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A) of this section, a nursing facility must not admit, on or after January 1, 1989, any new resident who—

(i) is mentally ill (as defined in subsection (e)(7)(G)(i) of this section) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental illness, or

(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii) of this section) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires specialized services for mental retardation.

A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(4) Provision of services and activities

(A) In general

To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and

(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

(B) Qualified persons providing services

Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required nursing care; facility waivers

(i) General requirements

With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

(II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week.

[1] So in original. The words "no later than" probably should not appear.

(ii) Waiver by State

To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if—

(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility,

(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the facility,

(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965 [42 U.S.C. 3027(a)(12)]) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (iii) shall be accepted by the Secretary for purposes of this subchapter to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to use other qualified, licensed personnel.

(iii) Assumption of waiver authority by Secretary

If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the State to grant waivers.

(5) Required training of nurse aides

(A) In general

(i) Except as provided in clause (ii), a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual—

(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A) of this section, and

(II) is competent to provide nursing or nursing-related services.

(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

(B) Offering competency evaluation programs for current employees

A nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) of this section and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

(C) Competency

The nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information concerning the individual.

(D) Re-training required

For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(E) Regular in-service education

The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

(F) "Nurse aide" defined

In this paragraph, the term "nurse aide" means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

(ii) who volunteers to provide such services without monetary compensation.

(G) Licensed health professional defined

In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner,

physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

(6) Physician supervision and clinical records

A nursing facility must—

(A) require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician);

(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any preadmission screening conducted under subsection (e)(7) of this section.

(7) Required social services

In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(c) Requirements relating to residents' rights

(1) General rights

(A) Specified rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right—

(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of subchapter XVIII of this chapter) to a portion of the facility that is such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident.

(B) Notice of rights

A nursing facility must—

(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r-5(c)(1)(B) of this title;

(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under subsection (e)(6) of this section;

(iii) inform each resident who is entitled to medical assistance under this subchapter—

(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1396a(a)(28)(B) of this title) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1396o of this title), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under subchapter XVIII of this chapter or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

(C) Rights of incompetent residents

In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

(2) Transfer and discharge rights

(A) In general

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII of this chapter on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (iv), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this subchapter after admission to the facility, only charges which may be imposed under this subchapter shall be considered to be allowable.

(B) Pre-transfer and pre-discharge notice

(i) In general

Before effecting a transfer or discharge of a resident, a nursing facility must—

(I) notify the resident (and, if known, an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

(III) include in the notice the items described in clause (iii).

(ii) Timing of notice

The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

(I) in a case described in clause (iii) or (iv) of subparagraph (A);

(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(iii) Items included in notice

Each notice under clause (i) must include—

(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3) of this section;

(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]);

(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act [42 U.S.C. 6041 et seq.]; and

(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i) of this section), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act [42 U.S.C. 10801 et seq.].

(C) Orientation

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(D) Notice on bed-hold policy and readmission

(i) Notice before transfer

Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning—

(I) the provisions of the State plan under this subchapter regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

(ii) Notice upon transfer

At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in clause (i).

(iii) Permitting resident to return

A nursing facility must establish and follow a written policy under which a resident—

(I) who is eligible for medical assistance for nursing facility services under a State plan,

(II) who is transferred from the facility for hospitalization or therapeutic leave, and

(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(E) Information respecting advance directives

A nursing facility must comply with the requirement of section 1396a(w) of this title (relating to maintaining written policies and procedures respecting advance directives).

(3) Access and visitation rights

A nursing facility must—

(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw con-

sent at any time, by others who are visiting with the consent of the resident;

(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(B) Construction

(i) Nothing prohibiting any charges for non-medicaid patients

Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

(ii) No additional services required

Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

(5) Admissions policy

(A) Admissions

With respect to admissions practices, a nursing facility must—

(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII of this chapter, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII of this chapter, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

(ii) Contracts with legal representatives

Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(iii) Charges for additional services requested

Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term "nursing facility services".

(iv) Bona fide contributions

Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.

(6) Protection of resident funds

(A) In general

The nursing facility—

(i) may not require residents to deposit their personal funds with the facility, and

(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

(B) Management of personal funds

Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

(i) Deposit

The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate

from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

(ii) Accounting and records

The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

(iii) Notice of certain balances

The facility must notify each resident receiving medical assistance under the State plan under this subchapter when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1382(a)(3)(B) of this title and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under subchapter XVI of this chapter.

(iv) Conveyance upon death

Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

(C) Assurance of financial security

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

(D) Limitation on charges to personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this subchapter or subchapter XVIII of this chapter.

(7) Limitation on charges in case of medicaid-eligible individuals

(A) In general

A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this subchapter, that exceed the payment amounts established by the State for such services under this subchapter.

(B) "Certain medicaid-eligible individual" defined

In subparagraph (A), the term "certain medicaid-eligible individual" means an individual who is entitled to medical assistance for nursing facility services in the facility under this subchapter but with respect to whom such benefits are not being paid because, in determining the amount of the individual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this subchapter.

(8) Posting of survey results

A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g) of this section.

(d) Requirements relating to administration and other matters

(1) Administration

(A) In general

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5) of this section).

(B) Required notices

If a change occurs in—

(i) the persons with an ownership or control interest (as defined in section 1320a-3(a)(3) of this title) in the facility,

(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1320a-5(b) of this title) of the facility,

(iii) the corporation, association, or other company responsible for the management of the facility, or

(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

(C) Nursing facility administrator

The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4) of this section.

(2) Licensing and Life Safety Code

(A) Licensing

A nursing facility must be licensed under applicable State and local law.

(B) Life Safety Code

A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

(i) the Secretary may waive, for such periods as he deems appropriate, specific

provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

(3) Sanitary and infection control and physical environment

A nursing facility must—

(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

(4) Miscellaneous

(A) Compliance with Federal, State, and local laws and professional standards

A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a-3 of this title [2] and with accepted professional standards and principles which apply to professionals providing services in such a facility.

(B) Other

A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.

(e) State requirements relating to nursing facility requirements

As a condition of approval of its plan under this subchapter, a State must provide for the following:

(1) Specification and review of nurse aide training and competency evaluation programs and of nurse aide competency evaluation programs

The State must—

(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) of this section and that meet the requirements established under subsection (f)(2) of this section, and

(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii) of this section.

The failure of the Secretary to establish requirements under subsection (f)(2) of this section shall not relieve any State of its responsibility under this paragraph.

(2) Nurse aide registry

(A) In general

By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

(B) Information in registry

The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of this section of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

(C) Prohibition against charges

A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

(3) State appeals process for transfers and discharges

The State, for transfers and discharges from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3) of this section, for hearing appeals on transfers and discharges of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

(4) Nursing facility administrator standards

By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) of this section respecting the qualification of administrators of nursing facilities.

(5) Specification of resident assessment instrument

Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the re-

[2] So in original. Probably should be followed by a closing parenthesis.

quirement of subsection (b)(3)(A)(iii) of this section. Such instrument shall be—

(A) one of the instruments designated under subsection (f)(6)(B) of this section, or

(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A) of this section.

(6) Notice of medicaid rights

Each State, as a condition of approval of its plan under this subchapter, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this subchapter.

(7) State requirements for preadmission screening and resident review

(A) Preadmission screening

(i) In general

Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8) of this section) described in subsection (b)(3)(F) of this section for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) of this section shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

(ii) Clarification with respect to certain readmissions

The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(iii) Exception for certain hospital discharges

The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(B) State requirement for annual resident review

(i) For mentally ill residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) of this section and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1396d(h) of this title) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

(II) whether or not the resident requires specialized services for mental illness.

(ii) For mentally retarded residents

As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8) of this section)—

(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1396d(d) of this title; and

(II) whether or not the resident requires specialized services for mental retardation.

(iii) Frequency of reviews

(I) Annual

Except as provided in subclauses (II) and (III), the reviews and determinations under clauses (i) and (ii) must be conducted with respect to each mentally ill or mentally retarded resident not less often than annually.

(II) Preadmission review cases

In the case of a resident subject to a preadmission review under subsection (b)(3)(F) of this section, the review and determination under clause (i) or (ii) need not be done until the resident has resided in the nursing facility for 1 year.

(III) Initial review

The reviews and determinations under clauses (i) and (ii) must first be conducted (for each resident not subject to preadmission review under subsection (b)(3)(F) of this section) by not later than April 1, 1990.

(iv) Prohibition of delegation

A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise)

their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).

(C) Response to preadmission screening and resident review

As of April 1, 1990, the State must meet the following requirements:

(i) Long-term residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

A State shall not be denied payment under this subchapter for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

(ii) Other residents not requiring nursing facility services, but requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require specialized services for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section,

(II) prepare and orient the resident for such discharge, and

(III) provide for (or arrange for the provision of) such specialized services for the mental illness or mental retardation.

(iii) Residents not requiring nursing facility services and not requiring specialized services

In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require specialized services for mental illness or mental retardation, the State must—

(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2) of this section, and

(II) prepare and orient the resident for such discharge.

(iv) Annual report

Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).

(D) Denial of payment

(i) For failure to conduct preadmission screening or annual review

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual for whom a determination is required under subsection (b)(3)(F) of this section or subparagraph (B) but for whom the determination is not made.

(ii) For certain residents not requiring nursing facility level of services

No payment may be made under section 1396b(a) of this title with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility.

(E) Permitting alternative disposition plans

With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require specialized services for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirements of subparagraphs (A) through (C) of this paragraph if, before April 1, 1989, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C). The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facili-

ty are discharged from the facility by not later than April 1, 1994.

(F) Appeals procedures

Each State, as a condition of approval of its plan under this subchapter, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

(G) Definitions

In this paragraph and in subsection (b)(3)(F) of this section:

(i) An individual is considered to be "mentally ill" if the individual has a serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness.

(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition (as described in section 1396d(d) of this title).

(iii) The term "specialized services" has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4) of this section.

(f) Responsibilities of Secretary relating to nursing facility requirements

(1) General responsibility

It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

(2) Requirements for nurse aide training and competency evaluation programs and for nurse aide competency evaluation programs

(A) In general

For purposes of subsections (b)(5) and (e)(1)(A) of this section, the Secretary shall establish, by not later than September 1, 1988—

(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights, and procedures for determination of competency;

(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

(iv) requirements, under both such programs, that—

(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

(B) Approval of certain programs

Such requirements—

(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on December 22, 1987;

(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) of this section if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

(iii) shall prohibit approval of such a program—

(I) offered by or in a nursing facility which, within the previous 2 years—

(a) has operated under a waiver under subsection (b)(4)(C)(ii) of this section that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) of this section for a period in excess of 48 hours during a week;

(b) has been subject to an extended (or partial extended) survey under section 1395i-3(g)(2)(B)(i) of this title or subsection (g)(2)(B)(i) of this section; or

(c) has been assessed a civil money penalty described in section 1395i-3(h)(2)(B)(ii) of this title or subsection (h)(2)(A)(ii) of this section of not less than $5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i) of this section, clauses [3] (i), (iii), or (iv) of subsection (h)(2)(A) of this section, clauses [3] (i) or (iii) of section 1395i-3(h)(2)(B) of this title, or section 1395i-3(h)(4) of this title, or

(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the nursing facility.

(3) Federal guidelines for State appeals process for transfers and discharges

For purposes of subsections (c)(2)(B)(iii) and (e)(3) of this section, by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) of this section must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from nursing facilities.

(4) Secretarial standards qualification of administrators

For purposes of subsections (d)(1)(C) and (e)(4) of this section, the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

(5) Criteria for administration

The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) of this section with respect to—

(A) its governing body and management,

(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

(C) disaster preparedness,

(D) direction of medical care by a physician,

(E) laboratory and radiological services,

(F) clinical records, and

(G) resident and advocate participation.

(6) Specification of resident assessment data set and instruments

The Secretary shall—

(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3) of this section, and establish guidelines for utilization of the data set; and

(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) of this section for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii) of this section.

(7) List of items and services furnished in nursing facilities not chargeable to the personal funds of a resident

(A) Regulations required

Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after December 22, 1987, that define those costs which may be charged to the personal funds of residents in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this subchapter and those costs which are to be included in the payment amount under this subchapter for nursing facility services.

(B) Rule if failure to publish regulations

If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this subchapter, for purposes of section 1396a(a)(23)(B) of this title, the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this subchapter) include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(8) Federal minimum criteria and monitoring for preadmission screening and resident review

(A) Minimum criteria

The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations

[3] So in original. Probably should be "clause".

under subsections (b)(3)(F) and (e)(7)(B) of this section and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

(B) Monitoring compliance

The Secretary shall review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) of this section (relating to discharge and placement for active treatment of certain residents).

(9) Criteria for monitoring State waivers

The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii) of this section.

(g) Survey and certification process

(1) State and Federal responsibility

(A) In general

Under each State plan under this subchapter, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d) of this section. The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

(B) Educational program

Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

(C) Investigation of allegations of resident neglect and abuse and misappropriation of resident property

The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

(D) Construction

The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

(2) Surveys

(A) Annual standard survey

(i) In general

Each nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

(ii) Contents

Each standard survey shall include, for a case-mix stratified sample of residents—

(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

(II) written plans of care provided under subsection (b)(2) of this section and an audit of the residents' assessments under subsection (b)(3) of this section to determine the accuracy of such assessments and the adequacy of such plans of care, and

(III) a review of compliance with residents' rights under subsection (c) of this section.

(iii) Frequency

(I) In general

Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

(II) Special surveys

If not otherwise conducted under subclause (I), a standard survey (or an ab-

breviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

(B) Extended surveys

(i) In general

Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

(ii) Timing

The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

(iii) Contents

In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d) of this section. Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

(iv) Construction

Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) of this section on the basis of findings in a standard survey.

(C) Survey protocol

Standard and extended surveys shall be conducted—

(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

(D) Consistency of surveys

Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

(E) Survey teams

(i) In general

Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

(ii) Prohibition of conflicts of interest

A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

(iii) Training

The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(3) Validation surveys

(A) In general

The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

(B) Scope

With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

(C) Reduction in administrative costs for substandard performance

If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1396b(a)(2)(D) of this title with respect to a

quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d) of this section. A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1316 of this title in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1316(a)(1) of this title.

(D) Special surveys of compliance

Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d) of this section, the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

(4) Investigation of complaints and monitoring nursing facility compliance

Each State shall maintain procedures and adequate staff to—

(A) investigate complaints of violations of requirements by nursing facilities, and

(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d) of this section, if—

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

(5) Disclosure of results of inspections and activities

(A) Public information

Each State, and the Secretary, shall make available to the public—

(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans of correction,

(ii) copies of cost reports of such facilities filed under this subchapter or under subchapter XVIII of this chapter,

(iii) copies of statements of ownership under section 1320a-3 of this title, and

(iv) information disclosed under section 1320a-5 of this title.

(B) Notice to ombudsman

Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 [42 U.S.C. 3021 et seq., 3058 et seq.] in accordance with section 712 of the Act [42 U.S.C. 3058g]) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d) of this section, or of any adverse action taken against a nursing facility under paragraphs[4] (1), (2), or (3) of subsection (h) of this section, with respect to a nursing facility in the State.

(C) Notice to physicians and nursing facility administrator licensing board

If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

(i) the attending physician of each resident with respect to which such finding is made, and

(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

(D) Access to fraud control units

Each State shall provide its State medicaid fraud and abuse control unit (established under section 1396b(q) of this title) with access to all information of the State agency responsible for surveys and certifications under this subsection.

(h) Enforcement process

(1) In general

If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) of this section or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d) of this section, and further finds that the facility's deficiencies—

(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

(B) do not immediately jeopardize the health or safety of its residents, the State may—

(i) terminate the facility's participation under the State plan,

(ii) provide for one or more of the remedies described in paragraph (2), or

(iii) do both.

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[4] So in original. Probably should be "paragraph".

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d) of this section, but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

(2) Specified remedies

(A) Listing

Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d) of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i) of this section) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the State may provide for other specified remedies, such as directed plans of correction.

(B) Deadline and guidance

(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

(C) Assuring prompt compliance

If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) of this section, within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

(D) Repeated noncompliance

In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2) of this section, has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

(i) impose the remedy described in subparagraph (A)(i), and

(ii) monitor the facility under subsection (g)(4)(B) of this section,

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d) of this section, and that it will remain in compliance with such requirements.

(E) Funding

The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1396b(a)(7) of this title, to be necessary for the proper

and efficient administration of the State plan.

(F) Incentives for high quality care

In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this subchapter. For purposes of section 1396b(a)(7) of this title, proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this subchapter.

(3) Secretarial authority

(A) For State nursing facilities

With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

(B) Other nursing facilities

With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e) of this section, and further finds that the facility's deficiencies—

(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

(C) Specified remedies

The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

(i) Denial of payment

The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

(ii) Authority with respect to civil money penalties

The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Appointment of temporary management

In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

(I) there is an orderly closure of the facility, or

(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d) of this section.

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d) of this section.

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

(D) Continuation of payments pending remediation

The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this subchapter with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d) of this section, if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective

action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

(4) Effective period of denial of payment

A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d) of this section.

(5) Immediate termination of participation for facility where State or Secretary finds noncompliance and immediate jeopardy

If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d) of this section, and finds that the failure immediately jeopardizes the health or safety of its residents, the State or the Secretary, respectively [1] shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2) of this section.

(6) Special rules where State and Secretary do not agree on finding of noncompliance

(A) State finding of noncompliance and no Secretarial finding of noncompliance

If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d) of this section, but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

(B) Secretarial finding of noncompliance and no State finding of noncompliance

If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

(7) Special rules for timing of termination of participation where remedies overlap

If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d) of this section, and neither finds that the failure immediately jeopardizes the health or safety of its residents—

(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

(8) Construction

The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing. The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII of this chapter.

(9) Sharing of information

Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this subchapter and subchapter XVIII of this chapter, including investigations by State medicaid fraud control units.

[1] So in original. Probably should be followed by a comma.

(i) Construction

Where requirements or obligations under this section are identical to those provided under section 1395l–3 of this title, the fulfillment of those requirements or obligations under section 1395l–3 of this title shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.

(Aug. 14, 1935, ch. 531, title XIX, § 1919, as added and amended Dec. 22, 1987, Pub. L. 100–203, title IV, §§ 4211(a)(3), (c), 4212(a), (b), 4213(a), 4216, 101 Stat. 1330–182, 1330–196, 1330–207, 1330–213, 1330–220, as amended July 1, 1988, Pub. L. 100–360, title IV, § 411(*l*)(3)(C)(ii), (6)(B), (8)(A), 102 Stat. 803–805; July 1, 1988, Pub. L. 100–360, title III, § 303(a)(2), title IV, § 411(*l*)(2)(A)–(D), (F)–(K), (L)(ii), (3)(A), (B), (C)(iii), (D), (5), (6)(A), (7), (8)(B), 102 Stat. 760, 801–805, as amended Oct. 13, 1988, Pub. L. 100–485, title VI, § 608(d)(27)(C)–(E), (I), 102 Stat. 2423; Dec. 19, 1989, Pub. L. 101–239, title VI, § 6901(b)(1), (3), (4)(A), (d)(1), (4), 103 Stat. 2298–2301; Nov. 5, 1990, Pub. L. 101–508, title IV, §§ 4751(b)(2), 4801(a)(2)–(6)(A), (7), (b)(2)–(5)(A), (6)–(8), (d)(1), (e)(2)–(7)(A), (8)–(10), (12)–(15), (18), 104 Stat. 1388–205, 1388–211 to 1388–219; Sept. 30, 1992, Pub. L. 102–375, title VII, § 708(a)(1)(B), 106 Stat. 1292.)

REFERENCES IN TEXT

The Older Americans Act of 1965, referred to in subsecs. (c)(2)(B)(iii)(II) and (g)(5)(B), is Pub. L. 89–73, July 14, 1965, 79 Stat. 218, as amended. Titles III and VII of the Act are classified generally to subchapters III (§ 3021 et seq.) and XI (§ 3058 et seq.), respectively, of chapter 35 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title and Tables.

The Developmental Disabilities Assistance and Bill of Rights Act, referred to in subsec. (c)(2)(B)(iii)(III), is title I of Pub. L. 88–164, as added by Pub. L. 98–527, § 2, Oct. 19, 1984, 98 Stat. 2662, as amended. Part C of the Developmental Disabilities Assistance and Bill of Rights Act is classified generally to subchapter III (§ 6041 et seq.) of chapter 75 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 6000 of this title and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act, referred to in subsec. (c)(2)(B)(iii)(IV), probably means the Protection and Advocacy for Mentally Ill Individuals Act of 1986, Pub. L. 99–319, May 23, 1986, 100 Stat. 478, as amended, which is classified generally to chapter 114 (§ 10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

Section 6901(b)(4)(B)–(D) of the Omnibus Budget Reconciliation Act of 1989, referred to in subsec. (e)(2)(A), is section 6901(b)(4)(B)–(D) of Pub. L. 101–239, which is set out as a note under section 1395l–3 of this title.

Section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, referred to in subsec. (f)(7)(A), probably means section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. 95–142, which is set out as a note under section 1395x of this title.

PRIOR PROVISIONS

A prior section 1919 of act Aug. 14, 1935, was renumbered section 1922 and is classified to section 1396r–3 of this title.

AMENDMENTS

1992—Subsecs. (c)(2)(B)(iii)(II), (g)(5)(B). Pub. L. 102–375 substituted "title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act" for "section 307(a)(12) of the Older Americans Act of 1965".

1990—Subsec. (b)(1)(B). Pub. L. 101–508, § 4801(e)(2), inserted at end "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."

Subsec. (b)(3)(C)(i)(I). Pub. L. 101–508, § 4801(e)(3), substituted "not later than 14 days" for "4 days".

Subsec. (b)(3)(F). Pub. L. 101–508, § 4801(b)(8), substituted "specialized services" for "active treatment" in cls. (i) and (ii).

Pub. L. 101–508, § 4801(b)(4)(A), inserted at end "A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility)."

Pub. L. 101–508, § 4801(b)(2)(A), substituted "Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A) of this section, a nursing facility" for "A nursing facility" in introductory provisions.

Subsec. (b)(4)(A)(vii). Pub. L. 101–508, § 4801(e)(4), added cl. (vii).

Subsec. (b)(4)(C)(ii). Pub. L. 101–508, § 4801(e)(5)(A), substituted "To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if" for "A State may waive the requirement of subclause (I) or (II) of clause (i) with respect to a facility if" in introductory provisions.

Subsec. (b)(4)(C)(ii)(IV), (V). Pub. L. 101–508, § 4801(e)(5)(B)–(D), which directed amendment of cl. (ii) by adding subcls. (IV) and (V) at the end, was executed by adding subcls. (IV) and (V) after subcl. (III) and before concluding provisions to reflect the probable intent of Congress.

Subsec. (b)(5)(A). Pub. L. 101–508, § 4801(a)(2), designated existing provision as cl. (i), substituted "Except as provided in clause (ii), a nursing facility" for "A nursing facility" and "on a full-time basis" for "(on a full-time, temporary, per diem, or other basis)", redesignated former cls. (i) and (ii) as subcls. (I) and (II), respectively, and added cl. (ii).

Subsec. (b)(5)(C). Pub. L. 101–508, § 4801(a)(3), substituted "any State registry established under subsection (e)(2)(A) of this section that the facility believes will include information" for "the State registry established under subsection (e)(2)(A) of this section as to information in the registry".

Subsec. (b)(5)(D). Pub. L. 101–508, § 4801(a)(4), inserted before period at end ", or a new competency evaluation program".

Subsec. (b)(5)(F)(i). Pub. L. 101–508, § 4801(e)(6), substituted "(G)) or a registered dietician" for "(G))".

Subsec. (b)(6)(A). Pub. L. 101–508, § 4801(d)(1), inserted before semicolon at end "(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)".

Subsec. (c)(1)(A). Pub. L. 101–508, § 4801(e)(8)(B), inserted at end "A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this subchapter or a State's entitlement to Federal medical assistance under this subchapter with respect to services furnished to such a resident."

Subsec. (c)(1)(A)(iv). Pub. L. 101–508, § 4801(e)(9), inserted before period at end "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within

24 hours (excluding hours occurring during a weekend or holiday) after making such a request".

Subsec. (e)(1)(A)(x), (xi). Pub. L. 101-508, § 4801(e)(8)(A), added cl. (x) and redesignated former cl. (x) as (xi).

Subsec. (e)(1)(B)(ii). Pub. L. 101-508, § 4801(e)(10), inserted "including the notice (if any) of the State developed under subsection (e)(6) of this section" after "in such rights)".

Subsec. (e)(2)(E). Pub. L. 101-508, § 4751(b)(2), added subpar. (E).

Subsec. (e)(7), (8). Pub. L. 101-508, § 4801(e)(7)(A), added par. (7) and redesignated former par. (7) as (8).

Subsec. (e)(1)(A). Pub. L. 101-508, § 4801(e)(18), substituted "under subsection (f)(2) of this section" for "under clause (i) or (ii) of subsection (f)(2)(A) of this section".

Subsec. (e)(2)(A). Pub. L. 101-508, § 4801(e)(12)(A), inserted ", or any individual described in subsection (f)(2)(B)(ii) of this section or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989" after "in the State".

Subsec. (e)(2)(C). Pub. L. 101-508, § 4801(e)(12)(B), added subpar. (C).

Subsec. (e)(7)(A). Pub. L. 101-508, § 4801(b)(2)(B), designated existing provision as cl. (i), inserted cl. (i) heading, and added cls. (ii) and (iii).

Subsec. (e)(7)(B)(i)(II), (ii)(II). Pub. L. 101-508, § 4801(b)(3), substituted "specialized services" for "active treatment".

Subsec. (e)(7)(B)(iv). Pub. L. 101-508, § 4801(b)(4)(B), added cl. (iv).

Subsec. (e)(7)(C)(i) to (iii). Pub. L. 101-508, § 4801(b)(3), substituted "specialized services" for "active treatment" wherever appearing.

Subsec. (e)(7)(C)(iv). Pub. L. 101-508, § 4801(b)(5)(A), added cl. (iv).

Subsec. (e)(7)(D). Pub. L. 101-508, § 4801(b)(3)(A), struck out "where failure to conduct preadmission screening" after "Denial of payment" in heading, designated existing provisions as cl. (i), inserted cl. (i) heading, and added cl. (ii).

Subsec. (e)(7)(E). Pub. L. 101-508, § 4801(b)(3), substituted "specialized services" for "active treatment".

Pub. L. 101-508, § 4801(b)(6), inserted at end "The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994."

Pub. L. 101-508, § 4801(b)(3)(B), substituted "the requirements of subparagraphs (A) through (C) of this paragraph" for "the requirement of this paragraph".

Subsec. (e)(7)(G)(i). Pub. L. 101-508, § 4801(b)(7), substituted "serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)" for "primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition)" and inserted before period at end "or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness".

Subsec. (e)(7)(G)(iii). Pub. L. 101-508, § 4801(b)(3), substituted "specialized services" for "active treatment".

Subsec. (f)(2)(A)(iv)(II). Pub. L. 101-508, § 4801(a)(5)(B), inserted "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program" after "nurse aide".

Subsec. (f)(2)(A)(iv)(III). Pub. L. 101-508, § 4801(a)(5)(A), (C), (D), added subcl. (III).

Subsec. (f)(2)(B). Pub. L. 101-508, § 4801(a)(7), inserted "(through subcontract or otherwise)" after "may not delegate" in last sentence.

Subsec. (f)(2)(B)(ii)(I). Pub. L. 101-508, § 4801(a)(6)(A), amended subcl. (I) generally. Prior to amendment, subcl. (I) read as follows: "offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d) of this section, within the previous 2 years, or".

Subsec. (g)(1)(C). Pub. L. 101-508, § 4801(e)(13), inserted at end "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

Subsec. (g)(5)(A)(i). Pub. L. 101-508, § 4801(e)(14), substituted "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans" for "deficiencies and plans".

Subsec. (g)(5)(B). Pub. L. 101-508, § 4801(e)(15), substituted "or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h) of this section, with respect" for "with respect".

1989—Subsec. (b)(5)(A). Pub. L. 101-239, § 6901(b)(1)(A), substituted "October 1, 1990" for "January 1, 1990" in introductory provisions.

Subsec. (b)(5)(B). Pub. L. 101-239, § 6901(b)(1)(B), substituted "January 1, 1990" and "October 1, 1990" for "July 1, 1989" and "January 1, 1990", respectively.

Subsec. (e)(1)(A)(ii)(II). Pub. L. 101-239, § 6901(d)(4)(A), substituted "Secretary until such an order could reasonably be obtained)" for "Secretary) until such an order could reasonably be obtained".

Subsec. (e)(1)(A)(v)(I). Pub. L. 101-239, § 6901(d)(4)(B), substituted "accommodation" for "accommodations".

Subsec. (f)(2)(A)(i)(I). Pub. L. 101-239, § 6901(d)(4)(C), substituted "and content of the curriculum" for ", content of the curriculum".

Pub. L. 101-239, § 6901(b)(3)(A), inserted "care of cognitively impaired residents," after "social service needs,".

Subsec. (f)(2)(A)(ii). Pub. L. 101-239, § 6901(b)(3)(B), substituted "recognition of mental health and social service needs, care of cognitively impaired residents" for "cognitive, behavioral and social care".

Subsec. (f)(2)(A)(iv). Pub. L. 101-239, § 6901(b)(3)(C), (D), added cl. (iv).

Subsec. (f)(2)(B)(ii). Pub. L. 101-239, § 6901(b)(4)(A), substituted "July 1, 1989" for "January 1, 1989".

Subsec. (h)(3)(D). Pub. L. 101-239, § 6901(d)(4)(D), substituted "not longer than 6 months after the effective date of the findings" for "not longer than 6 months".

Subsec. (h)(8). Pub. L. 101-239, § 6901(d)(1), inserted at end "The provisions of this subsection shall apply to a nursing facility (or portion thereof) notwithstanding that the facility (or portion thereof) also is a skilled nursing facility for purposes of subchapter XVIII of this chapter."

1988—Subsec. (b)(3)(A)(ii). Pub. L. 100-360, § 411(f)(2)(B), struck out "in the case of a resident eligible for benefits under this subchapter," before "uses an instrument".

Subsec. (b)(3)(A)(iv). Pub. L. 100-360, § 411(f)(2)(A), as amended by Pub. L. 100-485, § 608(d)(27)(C), struck out "in the case of a resident eligible for benefits under part A of subchapter XVIII of this chapter," before "includes the identification of medical problems".

Subsec. (b)(3)(B)(i)(III). Pub. L. 100-360, § 411(f)(2)(C), amended subcl. (III) generally. Prior to amendment, subcl. (III) read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a-7a of this title."

Subsec. (b)(4)(C)(i)(II). Pub. L. 100-360, § 411(f)(3)(A)(i), inserted "professional" after "registered".

Subsec. (b)(4)(C)(ii). Pub. L. 100-360, § 411(f)(3)(A)(i)-(iv), in heading, substituted "(ii) Waiver" for "(ii) Facility waivers.—(I) Waiver", in subcl. (III), inserted "professional" after "registered".

and in concluding provisions, substituted "clause (iii)" for "clause (ii)" and "use" for "employ".

Subsec. (b)(4)(C)(iii). Pub. L. 100-360, § 411(f)(3)(A)(v), (vi), substituted "(iii) Assumption" for "(ii) Assumption" in heading and "exercise" for "excercise" in text.

Subsec. (b)(5)(A). Pub. L. 100-360, § 411(f)(3)(B), which directed amendment of subpar. (A) by striking "subparagraph (E)" and inserting "subparagraph (F)", could not be executed because of prior amendment by Pub. L. 100-360, § 411(f)(2)(D)(i), see Amendment note below.

Pub. L. 100-360, § 411(f)(2)(D)(i), as amended by Pub. L. 100-485, § 608(d)(27)(D), struck out ", who is not a licensed health professional (as defined in subparagraph (E))," after "any individual" in introductory provisions.

Subsec. (b)(5)(A)(ii). Pub. L. 100-360, § 411(f)(2)(D)(ii), substituted "nursing or nursing-related services" for "such services".

Subsec. (b)(5)(G). Pub. L. 100-360, § 411(f)(2)(D)(iii), inserted "physical or occupational therapy assistant," after "occupational therapist,".

Subsec. (c)(1)(B)(i). Pub. L. 100-360, § 303(a)(2), inserted before semicolon at end "and of the requirements and procedures for establishing eligibility for medical assistance under this subchapter, including the right to request an assessment under section 1396r-5(c)(1)(B) of this title".

Subsec. (c)(2)(A)(v). Pub. L. 100-360, § 411(f)(2)(F), substituted "for a stay at the facility" for "an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this subchapter and subchapter XVIII of this chapter".

Subsec. (c)(2)(B)(iii)(III). Pub. L. 100-360, § 411(f)(3)(C)(iii), as added by Pub. L. 100-485, § 608(d)(27)(E), substituted "responsible" for "responsibile".

Subsec. (c)(6). Pub. L. 100-360, § 411(f)(2)(G), substituted "upon the written" for "once the facility accepts the written" in subpar. (A)(ii) and "Upon written" for "Upon a facility's acceptance of written" in subpar. (B).

Subsec. (c)(7). Pub. L. 100-360, § 411(f)(6)(B), amended Pub. L. 100-203, § 4212(b), see 1987 Amendment note below.

Subsec. (e). Pub. L. 100-360, § 411(f)(3)(C)(ii), as added by Pub. L. 100-485, § 608(d)(27)(E), amended Pub. L. 100-203, § 4211, see 1987 Amendment note below.

Subsec. (e)(1). Pub. L. 100-360, § 411(f)(3)(D)(i), (ii), substituted "January 1, 1989" for "September 1, 1988" in subpar. (A) and "January" for "September" in subpar. (B).

Subsec. (e)(2)(B). Pub. L. 100-360, § 411(f)(2)(H), inserted after first sentence "The State shall make available to the public information in the registry."

Subsec. (e)(3). Pub. L. 100-360, § 411(f)(2)(I), inserted "and discharges" after "transfers" in heading and two places in text.

Subsec. (e)(7)(E). Pub. L. 100-360, § 411(f)(3)(D)(iii), substituted "April 1, 1989" for "October 1, 1988".

Subsec. (f). Pub. L. 100-360, § 411(f)(3)(C)(ii), as added by Pub. L. 100-485, § 608(d)(27)(E), amended Pub. L. 100-203, § 4211, see 1987 Amendment note below.

Subsec. (f)(2)(A). Pub. L. 100-360, § 411(f)(3)(D)(iv), substituted "September" for "July" in introductory provisions.

Subsec. (f)(2)(A)(i)(I). Pub. L. 100-360, § 411(f)(2)(J), substituted "recognition of mental health and social service needs" for "cognitive, behavioral and social care".

Subsec. (f)(3). Pub. L. 100-360, § 411(f)(2)(I), inserted "and discharges" after "transfers" in heading and in text.

Subsec. (f)(7)(A). Pub. L. 100-360, § 411(f)(2)(K), substituted "residents" for "patients".

Subsec. (f)(7)(B). Pub. L. 100-360, § 411(f)(2)(L)(ii), substituted "include" for "do not include".

Subsec. (g)(1)(C). Pub. L. 100-360, § 411(f)(5)(A)-(C), substituted "and timely review" for ", review,", inserted "or by another individual used by the facility in providing services to such a resident" after "a nursing facility", and substituted "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority" for "If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding".

Subsec. (g)(1)(D). Pub. L. 100-360, § 411(f)(5)(D), substituted "to issue regulations to carry out this subsection" for "to establish standards under subsection (f) of this section".

Subsec. (g)(2)(A)(i). Pub. L. 100-360, § 411(f)(5)(E), amended third sentence generally. Prior to amendment, third sentence read as follows: "The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1320a-7a of this title."

Subsec. (g)(2)(B)(ii). Pub. L. 100-360, § 411(f)(5)(F), as added by Pub. L. 100-485, § 608(d)(27)(I), substituted "practicable" for "practical".

Subsec. (g)(3)(C). Pub. L. 100-360, § 411(f)(6)(A), redesignated subpar. (C), relating to special surveys of compliance, as (D).

Subsec. (g)(3)(D). Pub. L. 100-360, § 411(f)(5)(G), formerly § 411(f)(5)(F), as redesignated by Pub. L. 100-485, § 608(d)(27)(I), substituted "on the basis of that survey" for "on that basis".

Subsec. (g)(4). Pub. L. 100-360, § 411(f)(5)(H), formerly § 411(f)(5)(G), as redesignated by Pub. L. 100-485, § 608(d)(27)(I), struck out "chronically" after "enforcement actions against" in last sentence.

Subsec. (h). Pub. L. 100-360, § 411(f)(8)(A), made technical correction to directory language of Pub. L. 100-203, § 4213(a), see 1987 Amendment note below.

Subsec. (h)(1). Pub. L. 100-360, § 411(f)(8)(B)(i), substituted "paragraph (2)(A)(ii)" for "paragraph (2)(A)(i)" in last sentence.

Subsec. (h)(2)(B)(i). Pub. L. 100-360, § 411(f)(8)(B)(ii), struck out "or otherwise" after "regulations".

Subsec. (h)(3)(C)(ii). Pub. L. 100-360, § 411(f)(7)(A), substituted ". The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title" for "and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1320a-7a of this title".

Subsec. (h)(5). Pub. L. 100-360, § 411(f)(8)(B)(iii), substituted "State or the Secretary, respectively" for "State and the Secretary".

Subsec. (h)(9). Pub. L. 100-360, § 411(f)(7)(B), inserted "by such facilities" after "be made available".

1987—Subsec. (c)(7). Pub. L. 100-203, § 4212(b), as amended by Pub. L. 100-360, § 411(f)(6)(B), added par. (7).

Subsecs. (e), (f). Pub. L. 100-203, § 4211, which contained two subsecs. (c), the first of which amended this section and the second of which enacted provisions set out as a note below, was amended by Pub. L.

100-360, § 411(*l*)(3)(C)(ii), to delete the designation, heading, and directory language of the first subsec. (c), resulting in subsecs. (e) and (f) being added by section 4211(a)(3) of Pub. L. 100-203, which enacted subsecs. (a) to (d) of this section.

Subsec. (g). Pub. L. 100-203, § 4212(a), added subsec. (g).

Subsec. (h). Pub. L. 100-203, § 4213(a), as amended by Pub. L. 100-360, § 411(*l*)(8)(A), added subsec. (h).

Subsec. (i). Pub. L. 100-203, § 4216, added subsec. (i).

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102-375 inapplicable with respect to fiscal year 1993, see section 4(b) of Pub. L. 103-171, set out as a note under section 3001 of this title.

Amendment by Pub. L. 102-375 inapplicable with respect to fiscal year 1992, see section 905(b)(6) of Pub. L. 102-375, set out as a note under section 3001 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by section 4751(b)(2) of Pub. L. 101-508 applicable with respect to services furnished on or after the first day of the first month beginning more than 1 year after Nov. 5, 1990, see section 4751(c) of Pub. L. 101-508, set out as a note under section 1396a of this title.

Section 4801(a)(6)(B) of Pub. L. 101-508 provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203], except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

"(i) had its participation terminated under title XVIII of the Social Security Act [subchapter XVIII of this chapter] or under the State plan under title XIX of such Act [this subchapter];

"(ii) was subject to a denial of payment under either such title;

"(iii) was assessed a civil money penalty not less than $5,000 for deficiencies in nursing facility standards;

"(iv) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

"(v) pursuant to State action, was closed or had its residents transferred."

Amendment by section 4801(a)(2)-(5), (7) of Pub. L. 101-508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, see section 4801(a)(9) of Pub. L. 101-508, set out as a note under section 1396b of this title.

Section 4801(b)(9) of Pub. L. 101-508 provided that:

"(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this subsection [amending this section] shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100-203].

"(B) EXCEPTION.—The amendments made by paragraphs (4), (6), and (8) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated."

Section 4801(d)(2) of Pub. L. 101-508 provided that: "The amendment made by paragraph (1) [amending this section] applies with respect to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date."

Section 4801(e)(7)(B) of Pub. L. 101-508 provided that: "The amendments made by subparagraph (A) [amending this section] shall take effect on the date of the enactment of this Act [Nov. 5, 1990], without regard to whether or not regulations to implement such amendments have been promulgated."

Amendment by section 4801(e)(2)-(6), (8)-(10), (12)-(15), and (18) of Pub. L. 101-508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, see section 4801(e)(19) of Pub. L. 101-508, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Amendment by section 6901(b)(1), (4)(A) of Pub. L. 101-239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, and amendment by section 6901(b)(3) of Pub. L. 101-239 applicable to nurse aide training and competency evaluation programs, and nurse aide competency evaluation programs, offered on or after end of 90-day period beginning on Dec. 19, 1989, but not to affect competency evaluations conducted under programs offered before end of that period, see section 6901(b)(6) of Pub. L. 101-239, set out as a note under section 1395i-3 of this title.

Amendment by section 6901(d)(1) of Pub. L. 101-239 effective Dec. 19, 1989, and amendment by section 6901(d)(4) of Pub. L. 101-239 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, see section 6901(d)(6) of Pub. L. 101-239, set out as a note under section 1395i-3 of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Amendment by Pub. L. 100-485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100-360, see section 608(g)(1) of Pub. L. 100-485, set out as a note under section 704 of this title.

Amendment by section 303(a)(2) of Pub. L. 100-360 applicable, except as otherwise provided, to payments under this subchapter for calendar quarters beginning on or after Sept. 30, 1989, without regard to whether or not final regulations to carry out such amendment has been promulgated by such date, see section 303(g)(1)(A), (5) of Pub. L. 100-360, set out as an Effective Date note under section 1396r-5 of this title.

Except as specifically provided in section 411 of Pub. L. 100-360, amendment by section 411(*l*)(2)(A)-(D), (F)-(K), (L)(ii), (3)(A), (B), (C)(ii), (iii), (D), (5), (6)(A), (B), (7), and (8)(A), (B) of Pub. L. 100-360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, effective as if included in the enactment of that provision in Pub. L. 100-203, see section 411(a) of Pub. L. 100-360, set out as a Reference to OBRA: Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE

Section 4214 of title IV of Pub. L. 100-203, as amended by Pub. L. 100-360, title IV, § 411(*l*)(10), July 1, 1988, 102 Stat. 806, provided that:

"(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1919 of the Social Security Act [this section], the amendments made by sections 4211 [enacting this section, amending sections 1320a-7b, 1396a, 1396b, 1396d, 1396j, 1396l, 1396n, 1396o, 1396p, 1396r, and 1396s of this title, redesignating section 1396r of this title as section 1396r-8 of this title, and amending provisions set out as a note under section 1396r-3 of this title] and 4212 [amending sections 1395cc, 1396a, 1396b, 1396i, and 1396r of this title] (relating to nursing facility requirements and survey and certification requirements) shall apply to nursing facility services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date; except that section 1902(a)(28)(B) of the Social Security Act [section

1396a(a)(28)(B) of this title] (as amended by section 4211(b) of this Act), relating to requiring State medical assistance plans to specify the services included in nursing facility services, shall apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such section are promulgated by such date.

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1919 of the Social Security Act [this section], the amendments made by section 4213 of this Act [amending this section and sections 1396a and 1396b of this title] apply to payments under title XIX of the Social Security Act [this subchapter] for calendar quarters beginning on or after the date of the enactment of this Act [Dec. 22, 1987], without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In applying the amendments made by this part [part 2 of subtitle C (§§ 4211–4218) of title IV of Pub. L. 100–203, see Tables for classification] for services furnished before October 1, 1990—

"(A) any reference to a nursing facility is deemed a reference to a skilled nursing facility or intermediate care facility (other than an intermediate care facility for the mentally retarded), and

"(B) with respect to such a skilled nursing facility or intermediate care facility, any reference to a requirement of subsection (b), (c), or (d) of section 1919 of the Social Security Act [subsec. (b), (c), or (d) of this section], is deemed a reference to the provisions of section 1861(j) or section 1905(c), respectively, of the Social Security Act [section 1395x(j) or 1396d(c) of this title].

"(c) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part and implementing the amendments made by this part."

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; COMPLIANCE ACTIONS

Section 4801(a)(1) of Pub. L. 101–508 provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [section 1396c of this title] on the basis of the State's failure to meet the requirement of section 1919(e)(1)(A) of such Act [subsec. (e)(1)(A) of this section] before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1919(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date."

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW; COMPLIANCE ACTIONS

Section 4801(b)(1) of Pub. L. 101–508 provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 or section 1919(e)(7)(D) of the Social Security Act [section 1396c of this title and subsec. (e)(7)(D) of this section] on the basis of the State's failure to meet the requirement of section 1919(e)(7)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing minimum criteria under section 1919(f)(8)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date."

RESTRICTION ON ENFORCEMENT PROCESS

Section 4801(c) of Pub. L. 101–508 provided that: "The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act [section 1396c of this title] on the basis of the State's failure to meet the requirements of section 1919(h)(2) of such Act [subsec. (h)(2) of this section] before the effective date of guidelines, issued by the Secretary, regarding the establishment of remedies by the State under such section, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirements before such effective date."

STAFFING REQUIREMENTS

Section 4801(e)(17) of Pub. L. 101–508 provided that:

"(A) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 [Dec. 22, 1987] with respect to services described in clauses (ii), (iv), and (v) of section 1919(b)(4)(A) of the Social Security Act [subsec. (b)(4)(A)(ii), (iv), (v) of this section] shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

"(B) STUDY ON STAFFING REQUIREMENTS IN NURSING FACILITIES.—The Secretary shall conduct a study and report to Congress no later than January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for skilled nursing facilities serving as providers of services under title XVIII of the Social Security Act [subchapter XVIII of this chapter] and nursing facilities receiving payments under a State plan under title XIX of the Social Security Act [this subchapter], and shall include in such study recommendations regarding appropriate minimum ratios."

NURSE AIDE TRAINING AND COMPETENCY EVALUATION; SATISFACTION OF REQUIREMENTS; WAIVER

For satisfaction of training and competency evaluation requirements of subsec. (b)(5)(A) of this section and section 1395i-3(b)(5)(A) of this title and authorization for a State to waive such competency evaluation requirements, see section 6901(b)(4)(B)–(D) of Pub. L. 101–239, set out as a note under section 1395i-3 of this title.

PUBLICATION OF PROPOSED REGULATIONS RESPECTING PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

Section 6901(c) of Pub. L. 101–239 provided that: "The Secretary of Health and Human Services shall issue proposed regulations to establish the criteria described in section 1919(f)(8)(A) of the Social Security Act [subsec. (f)(8)(A) of this section] by not later than 90 days after the date of the enactment of this Act [Dec. 19, 1989]."

EVALUATION AND REPORT ON IMPLEMENTATION OF RESIDENT ASSESSMENT PROCESS

Section 4211(c) of Pub. L. 100–203 directed Secretary of Health and Human Services to evaluate and report to Congress by not later than Jan. 1, 1993, on implementation of resident assessment process for residents of nursing facilities under amendments made by section 4211(c).

REPORT ON STAFFING REQUIREMENTS

Section 4211(k) of Pub. L. 100–203 directed Secretary of Health and Human Services to report to Congress, by not later than Jan. 1, 1993, on progress made in implementing the nursing facility staffing requirements of 42 U.S.C. 1396r(b)(4)(C), including the number and types of waivers approved under subparagraph (C)(ii) of such section and the number of facilities which received waivers.

Appendix D

HEALTH CARE FACILITY INSPECTIONS
IN THE STATE OF IOWA

PART OF THE ELDER CARE SERVICES STUDY
REQUESTED BY THE
OVERSIGHT, AUDIT, AND GOVERNMENT REFORM
APPROPRIATIONS SUBCOMMITTEE

DECEMBER 1995

Richard D. Johnson, CPA
AUDITOR OF STATE

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To the Members of the Oversight, Audit,
and Government Reform Appropriations Subcommittee:

In accordance with Chapter 11 of the Code of Iowa, we have conducted a study of issues relating to the provision of services to elderly persons by the State of Iowa. Our study, based on the Subcommittee's identified issues, emphasized the state's compliance with laws, regulations, and guidelines, especially the monitoring of nursing homes, and opportunities for the state to improve its organization of functions providing services to the elderly.

We performed the following procedures:

1. Reviewed laws, regulations, guidelines, policies and procedures and identified critical areas of concentration.
2. Identified elder care services provided by the state, state plans and programs to provide those services and identified the funding allocated to provide certain services.
3. Gathered and reviewed numerous reports and publications relating to the identified issues.
4. Interviewed numerous individuals involved in providing or monitoring services.
5. Attended various meetings and seminars to obtain direct information being provided.
6. Tested compliance with laws, regulations, guidelines, policies, and procedures for the identified critical areas of concentration.

Based on these procedures, we developed certain recommendations and other relevant information which we believe the Subcommittee should be aware of. Because of the number of issues identified and the resulting volume of information developed for Subcommittee consideration, the results of our study are being presented in various individual reports. This report on Health Care Facility Inspections is one of eight reports to be issued.

We extend our appreciation to the management and staff at the Iowa Departments and at the various organizations we visited for the courtesy, cooperation, and assistance provided to us during this study.

RICHARD D. JOHNSON, CPA
Auditor of State

January 10, 1996

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ISSUES IDENTIFIED BY SUBCOMMITTEE

In addition to answering questions posed by the Oversight, Audit, and Government Reform Appropriations Subcommittee, we obtained a full understanding of the background related to each issue, tested compliance with laws and regulations, and noted related issues and recommendations for the Subcommittee's consideration. Each of the Subcommittee's questions relating to Health Care Facility Inspections are followed by brief answers. The report contains more details related to each of these issues.

1. Are annual inspections of nursing facilities sufficient?
   - Annual inspections of nursing facilities are required by federal law and must be performed for the 98% of nursing facilities in Iowa receiving Medicare and/or Medicaid funding. For state-regulated facilities, such as residential care facilities, regular inspections (which had not been performed as required by state law) may be more than adequate for some facilities but are not enough for problem facilities -- therefore a focus toward risk-based inspections is recommended. This approach would target those facilities with a high level of deficiencies, spending more inspection time where there is more risk.
   - Federal funds pay for the majority of the nursing home inspections. If the state performs regular inspections of state-regulated facilities as required by present state law, the state must fund the cost of those inspections.
2. Should every nursing home receive the same number of inspections?
   - No. Risk-based inspections would be most effective.
3. Should there be regular inspections or spot checks?
   - Both. Currently, both are being performed. When a complaint is investigated, an abbreviated inspection is performed. In addition, the inspections are to be unannounced visits.
4. Is the inspection process being carried out with due process for both sides and in accordance with laws and adopted rules and regulations?
   - Yes. The regulations are being complied with for the most part. Only minor issues of noncompliance were noted in regard to inspection procedures. Due process is spelled out in the law and the Department of Inspections and Appeals (DIA) is complying with the process.

5. Are care facilities borrowing extra staff from other facilities when inspections are conducted?
   - This is not a standard area addressed during an inspection unless some of the inspection deficiencies are believed to be caused by staffing problems. If so, the matter is referred to DIA's investigation and audit divisions to determine if any irregularities have taken place. No documented instances were noted in 1995. However, DIA staff suspect some level of this activity does occur.
6. Does the conflict resolution process need to be modified?
   - No. The process was just changed on July 1, 1995, with the implementation of new federal regulations. The written process requires specific timelines, is to be fully documented, and appears adequate.
7. Are fines being imposed according to law? Are penalties improper? Is there a failure to enforce the law?
   - Fines are being imposed according to law. The federal law just changed July 1, 1995, with the imposition of a federal penalties matrix. The state penalty structure has a significant gap between ranges which should be closed. State fines and penalties are assessed based on inspectors' judgment, while Federal fines and penalty assessments are determined by a team.
8. How can we better address complaints which are "unresolved?"
   - We did not note any unresolved complaints, only unsubstantiated cases. The process, as spelled out in the administrative code, relies on the preponderance of evidence standard which requires substantiation of complaints. DIA is following this standard and outlined procedures.
9. Do the inspectors check for misappropriation of funds?
   - No. If misappropriations of funds are suspected during an inspection, the inspectors inform DIA's investigation and audit divisions and work jointly to resolve the matter. Additionally, the Audits Division of DIA periodically conducts Medicaid program audits of nursing facilities and residential care facilities to ensure that services paid by Medicaid are allowable and consistent with Medicaid requirements. As part of their process, DIA looks at Medicaid reimbursement records, patient trust accounts, and other financial records as deemed necessary.
10. Are funds for inspections and appeals inadequate?
    - Yes. DIA cannot perform inspections required by state law.

HEALTH CARE FACILITY INSPECTIONS

KEY ISSUES

To enable a better understanding of the issues regarding inspections of health care facilities by the Department of Inspections and Appeals (DIA), this report details background information, the department's processes related to the questions of the legislative subcommittee, recommendations and further observations concerning inspections of health care facilities. The following briefly summarizes the main focus of health care facility inspections.

New federal enforcement regulations governing the inspections of nursing facilities (NF) were implemented July 1, 1995. These regulations redirect the efforts of state nursing facility inspections, require faster state action to resolve deficient practices, advocate long-lasting remedies, and emphasize self-monitoring by nursing facilities to improve the quality of care for the elderly to the highest practicable level.

DIA anticipates a staff shortage during the implementation of the new federal enforcement regulations. By DIA continuing to perform other mandated duties, full compliance with the new enforcement regulations may not be possible without additional staff. Further, uncertainty about the fate of federal programs complicates the planning of the future inspection process of long-term care facilities.

For the last several years, inspections of residential care facilities (RCF) have not been performed because of insufficient staffing levels. Only one of 459 RCFs was inspected during fiscal year 1995 with the majority of inspectors' time devoted to investigating complaints. For fiscal year 1996, four inspectors have been designated to perform RCF inspections and complaint investigations. Currently, RCF inspections are being performed in conjunction with complaint investigations as much as possible. To comply with state requirements for RCF inspections and

complaint investigations, DIA indicated two additional full-time inspectors are needed at an estimated cost of $178,200 which includes salary, benefits, travel, support, and related vehicle and computer costs. Once DIA completes a series of RCF inspections identifying facilities with a high incidence of deficiencies, the state should then concentrate on a risk-based inspection approach for RCFs, which would necessitate a change in the law.

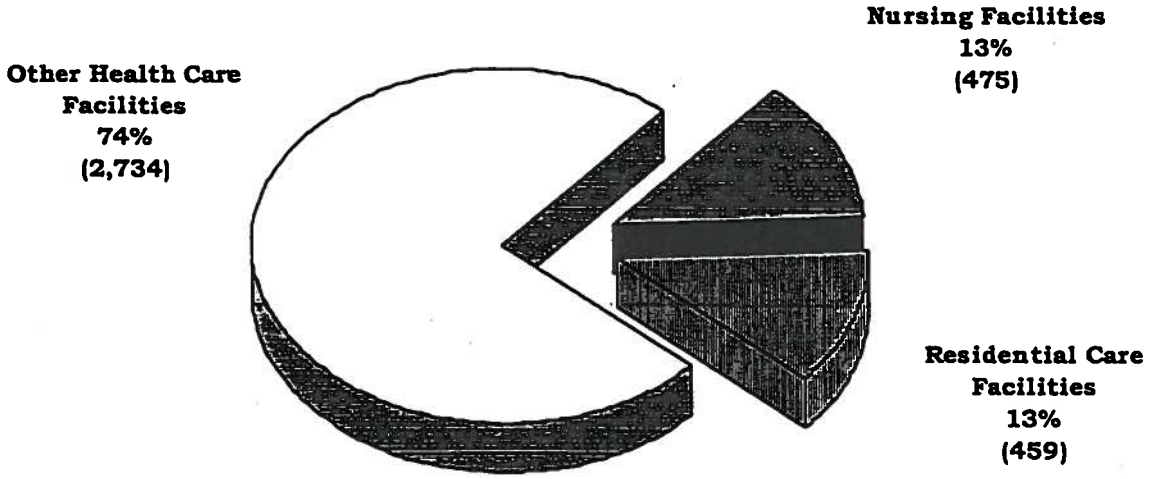
DIA can assess state fines for deficiencies identified during the inspection process which are Class I or Class II violations. Class I fines range from $2,000 to $10,000 and are assessed for violations which place a resident in imminent danger of death or physical harm. Class II violations have a direct or immediate relationship to the health, safety, or security of a resident and carry fines ranging from $100 to $500. Many times, distinguishing between Class I and Class II violations is a matter of inspector judgment.

Payments of assessed fines were not always remitted by nursing facilities within twenty business days, as required by state law. For those fines, the fining and citation log did not indicate that collection had been pursued.

BACKGROUND

Health care facilities in Iowa are listed in a publication prepared by the Department of Inspection and Appeals (DIA). The 1995 listing categorizes the health care facilities. For older Iowans, nursing facilities (NF), residential care facilities (RCF) and hospital-based facilities represent the predominant long-term care (LTC) facilities for the elderly; therefore, those facilities are the focus of this report. **Exhibit 1** on page 29 details the facility definitions, the numbers of facilities, and the number of beds for each type of LTC facility. As the chart below indicates, the long-term care facilities represent about 25% of the health care facilities in Iowa.

Iowa Health Care Facilities
(3,668 Total Facilities)



DIA, the agency responsible for inspections of health care facilities, employs 33 health professionals to perform on-site inspections and complaint investigations of NFs. DIA currently has four staff to perform on-site inspections and complaint investigations of RCFs.

The Code of Iowa section 135C.16 requires at least one general unannounced inspection be conducted on each NF and RCF within a 15-month period. NFs and RCFs are required to be licensed in accordance with Code of Iowa section 135C.6. This necessitates a determination of whether a facility has adequate staff, equipment, and safety factors in place to provide the appropriate level of care and services as required by Code of Iowa section 135C.9. DIA performs both of these functions.

Of the 475 NFs in Iowa, about 98% of the facilities receive federal Medicaid and/or Medicare funding. RCFs, on the other hand, do not generally receive federal funding. For those facilities receiving Medicaid and/or Medicare, federal guidelines require specific federal inspections.

The Department of Human Services (DHS), the state agency responsible for Medicaid in Iowa, contracts with DIA to inspect facilities receiving Medicaid funding. The federal agency responsible for Medicare, the Health Care Financing Administration (HCFA), also contracts with DIA to conduct inspections of facilities receiving Medicare funding.

The standard federal inspection for NFs receiving Medicaid and Medicare funding must be conducted within 15 months of the previous standard inspection for each facility. The average statewide interval between the federally-mandated inspections must be twelve months or less. The timing of the state-mandated inspections is similar to the federal requirements.

Another similarity between the state and federal inspections is their purpose -- to determine whether facilities are providing the required level of care and services to residents. Compliance with both federal and state inspection requirements can be assessed during the same inspection. However, for facilities receiving Medicaid and/or Medicare, the federal regulations normally take precedence over state requirements.

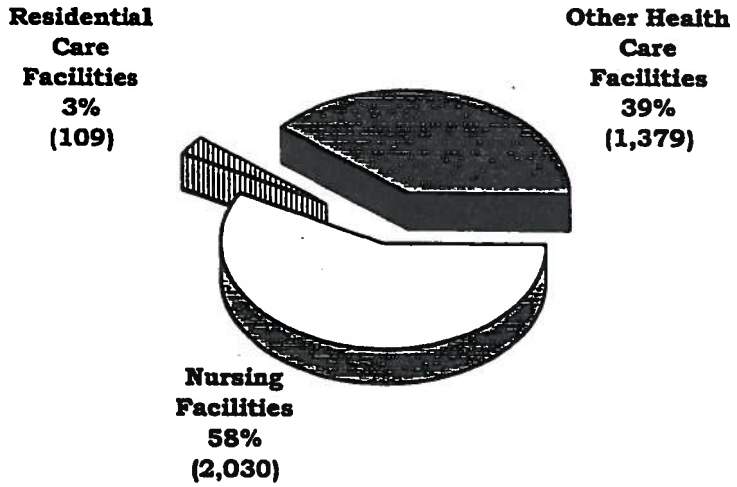
On July 1, 1995, new federal LTC enforcement regulations, under HCFA, became effective. These inspections are to be more resident-centered for gathering information about the quality of service furnished in a nursing facility to ascertain compliance. The regulations emphasize the need for continued, rather than cyclical, compliance and mandate policies and procedures to remedy deficient practices promptly and to ensure that correction of deficiencies is long-lasting. Facilities are encouraged to take the initiative for monitoring their own performance in maintaining compliance with established regulations. The new inspection process should help ensure that residents receive the care and services they need to attain their highest practicable level of functioning.

The new federal enforcement regulations require numerous tasks for conducting standard inspections. Initially, inspectors review facility files off-site. Once on site, they hold an entrance conference, perform preparatory activities, and tour the facility. They select a sample of residents, review the files and interview residents and staff to assess quality of life. They also make general observations of the facility and observe food service and medication distribution. Inspectors perform a quality assessment and assurance review of facility procedures, prepare an analysis for deficiency determination, and hold an exit conference with the facility.

Based on the results of each inspection, DIA professionals prepare statements of deficiencies regarding the level of compliance by the nursing facility, noting noncompliance and/or substandard care. The deficiencies are then categorized by scope and severity using the federal grid matrix included on page 20. The DIA program coordinator reviews results and a committee meets to determine the fines, if any, to be assessed. Although the enforcement regulations were effective July 1, 1995, the associated federal fine structure did not become effective until later in the year. Prior to this time period, only state fines were imposed.

In addition to the required state and federal inspections, DIA inspectors must conduct revisits as necessary to verify that corrective actions have been implemented for the deficiencies noted during inspections. Inspectors are also required to investigate complaints received against licensed health care facilities within pre-established guidelines. **Exhibit 2** includes detailed statistics related to the number of contacts made for health care inspections during fiscal year 1995 and highlights contacts of NFs and RCFs. The following chart compares total fiscal year 1995 contacts for NFs, RCFs, and other health care facilities.

Department of Inspection and Appeals
Contacts with Health Care Facilities



INSPECTION PROCESS

STAFFING

Although new federal enforcement regulations for nursing facility inspections just became effective July 1, 1995, Congress is presently debating issues that could drastically change both the Medicaid and Medicare programs. The impact on the inspection and regulatory process of those facilities from potential modifications to the federal programs is unknown at this time.

DIA has been implementing the new long-term care (LTC) enforcement regulations. Although there are procedural changes in the implementation of many new regulations, with a temporary learning curve, the new process should ultimately result in some efficiencies for the inspectors. However, the new process is likely to increase administrative costs because of the required processing of enforcement actions, notification requirements, and involvement of inspection personnel in the new dispute resolution process. Once implemented, HCFA, the federal agency administering the enforcement regulations, anticipates an offset between the cost savings from inspection efficiencies and the additional processing requirements.

The DIA division responsible for the inspection of nursing facilities (NF) and residential care facilities (RCF), as well as other health care facilities, has a state-imposed budgetary limitation of 101 full-time equivalent positions. Of these positions, 88.6 full-time equivalent positions are available for Medicaid and Medicare inspections of all health care facilities and four positions are designated for RCF inspections. Based on historical workload data and expected process changes, DIA projects a shortage of approximately 13 full-time equivalent positions for inspections of all facilities receiving Medicaid and Medicare funding because of the new regulations.

For the past several years, the Office of Auditor of State has reported DIA noncompliance with the Code of Iowa section 135C.16 requirement for one general unannounced inspection, within a 15-month period, for every licensed LTC facility in Iowa. RCF inspections had not been performed for the last several years due to insufficient DIA staffing levels. RCF inspections were generally performed when facilities were newly licensed and when complaints were filed against the facility.

During the budget process for fiscal year 1995, DIA requested funding for four full-time equivalent (FTE) positions and support staff to perform required RCF inspections. The Governor's recommendation included two FTEs, however, the legislature did not fund any additional positions. During the fiscal year 1996 budget process, DIA requested two positions, which the Governor recommended but the legislature appropriated funding for four RCF inspectors. DIA has filled the four positions with experienced staff from other units, completing the transfer of the final two individuals during November of 1995.

With the visibility of inspectors in RCFs, DIA personnel experienced an increase in the number of complaints received. The number of inspections performed have been limited because of the volume of complaints, which increased from eight complaints per month during fiscal year 1995 to ten per month already in fiscal year 1996. When possible, DIA performs inspections concurrently with complaint investigations. Based on current inspection and complaint information, more inspectors are needed to meet the state law requirements. DIA has indicated that two additional full-time inspectors are needed at an estimated cost of $178,200 which includes salary, benefits, travel, support, and related vehicle and computer costs and has included this in their 1997 budget request.

To ensure compliance with federal and state requirements, DIA must have an adequate number of professional staff to perform facility inspections and complaint

investigations. With more potential changes imminent in federal enforcement regulations, the future inspection process of long-term care facilities may become more complicated. The state should remain flexible when planning for staffing needs. We recommend DIA develop short- and long-term strategies to adequately maintain staffing levels for compliance with the current federal regulations while continuing to anticipate future needs.

DIA Response: The division now conducts weekly meetings with management staff and program coordinators to develop a strategic plan. This plan will include long and short-term goals to accomplish our workload with fewer resources. The Health Care Financing Administration is also making efforts to change the survey process, so less time will be required to conduct inspections and retain aspects to assure the quality of life and care for residents in nursing facilities. We anticipate additional reductions of federal funds in future budgeting periods.

We also recommend DIA obtain sufficient staff to complete all required RCF inspections and investigations to comply with state requirements. Once DIA completes a series of RCF inspections, the information base could be analyzed to determine the types, causes, and extent of deficiencies. DIA could use the results to develop a risk-based inspection approach for state-regulated facilities. The risk-based approach could focus available state resources toward the smaller percentage of facilities with severe deficiencies.

DIA Response: DIA will attempt to obtain sufficient staff to complete all required RCF inspections and investigations. Staff resources needed cannot be determined until all RCF facilities have been surveyed and numbers of substandard facilities have been identified. It will take more than one fiscal year to make this assessment.

DISPUTE RESOLUTION

Prior to July 1, 1995, federal regulations did not require an informal resolution process for a nursing facility to dispute inspection findings of deficiencies. The new LTC enforcement regulations define the opportunity for facilities to refute inspection findings through an informal dispute resolution process. The state process must offer facilities an informal opportunity, at the facility's request, to dispute inspection findings. DIA implemented the new informal dispute resolution policy on July 26, 1995, and the process has only been used in a few instances.

If a nursing facility cannot resolve the findings through the informal process, it may proceed through the formal appeal process. The first level is a conference with the deputy director. The second level involves a hearing before a DIA administrative law judge. Next, the facility may request the Director of DIA to review the administrative law judge's decision. Finally, if all other avenues are unacceptable, the facility may appeal to the Iowa District Court.

INSPECTION PROCESS INEFFICIENCIES

Of the numerous facilities inspected by DIA, many facilities offer multi-level services (such as a combination of nursing care and residential care services). Because of the organizational structure of DIA, different bureaus perform different facility inspections. The processes can overlap for many of the tasks performed in multi-level service facilities. If a multi-level service facility uses the same dietary or medicine distribution personnel in both the nursing care section and the residential care areas, the DIA team is likely to inspect the same personnel during each type of inspection. Inspection teams may also avoid observing facility personnel while performing functions unrelated to the specific facility-type being inspected.

We recommend DIA explore options to avoid the duplication of efforts when performing inspections of multi-level facilities. Certain efficiencies may be realized by performing inspections of all facets of multi-level facilities simultaneously.

DIA Response: DIA policy in the past has been the inspections of all levels of care in a facility at the same time. This policy will be reinforced, and scheduling of surveys will be in accord with this policy to the extent resources are available.

One concern expressed by several nursing facility personnel dealt with the inconsistent interpretation of regulations among inspectors. It was reported that different groups of inspectors noted deficiencies in areas that had previously passed numerous inspections. These areas were not subject to new laws, nor had the specific areas been changed by the nursing facility. These deficiencies sometimes arose because of different interpretations of the regulations as provided by HCFA.

We recommend DIA better define internal policies to emphasize consistency among inspectors. Inspector training could focus on interpretation of regulations and components of deficiencies.

DIA Response: DIA agrees training on interpretation of regulations and components of deficiencies is the means to develop consistency. We will continue to provide training to inspectors on areas identified in our quality assurance program as needing a more consistent approach.

Another concern involves restrictions limiting inspector assistance. Even though inspectors may be the best resource for offering suggestions and recommendations to facilities for improving and correcting noted deficiencies, inspectors are not allowed to offer suggestions for improvement. Facilities might misinterpret an inspector's suggestion and use it as a defense in trying to resolve a deficiency.

We recommend DIA coordinate with industry groups to offer training courses to highlight common deficiencies in facility inspections. The training would not be specific to a certain facility, but could give general guidance to assist and encourage

improvement in the quality of life for residents in LTC facilities. DIA may also be able to identify situations in which inspectors can offer suggestions and methods for improvements to long-term care facilities.

DIA Response: The division and provider groups have cooperated in the past on selecting and implementing training on subjects when a need was identified. In addition, the Iowa Foundation for Medical Care, under contract with the Department of Human Services, conducts provider training programs on an ongoing basis. We will continue to collaborate with the industry and other groups to identify needs and provide training.

FEDERAL NONCOMPLIANCE

The standard inspection process required by HCFA long-term care enforcement regulations identifies procedures for the performance of nursing facility inspections. Accordingly, we selected nursing facility inspection files and tested for compliance with specific criteria. We also interviewed HCFA staff responsible for monitoring various states' compliance with federal regulations. HCFA staff, who review inspection procedures of states within a larger geographic region, were complimentary of Iowa DIA inspections and rate of successful inspections.

Although DIA substantially complied with the standard inspection process requirements, we did note some instances in which the nursing facility inspection files did not contain documentation that the inspectors performed certain required inspection tasks. We recommend DIA maintain the required inspection task documentation in appropriate files.

DIA Response: DIA will reinforce the need to document all aspects of the inspections process. Some tasks we are required to perform do not require documentation in the survey work forms.

FINING AND CITATIONS

At the conclusion of an inspection, DIA inspectors prepare statements of deficiencies to identify the facility's areas of noncompliance, if any. When deficiencies are identified for a nursing facility, federal guidelines, as applicable prior to July 1, 1995, allowed the state to assess fines for the noted deficiencies, but did not specify amounts. The new long-term care (LTC) enforcement regulations, effective July 1, 1995, delineate stringent fines for certain deficiencies noted during inspections. HCFA, the federal agency responsible for administering the new LTC enforcement regulations, has not fully implemented the imposition of those new fines.

In accordance with the federal regulations, DIA developed a federal fine policy. DIA decided that since the pre-established federal fines may be very significant, as illustrated on the chart on the following page, the assessment is to be determined by a group consisting of the DIA compliance officer, an assistant attorney general assigned to DIA, the program coordinator for the area, the bureau chief, and appropriate inspection personnel.

Scope and Severity Matrix
Federal Fine Ranges

Immediate jeopardy to resident health or safety	**Remedy:** Required: Cat. 3 Optional: Cat. 1& 2 **Fine Range:** $3,050 to $5,000	**Remedy:** Required: Cat. 3 Optional: Cat. 1& 2 **Fine Range:** $5,000 to $7,500	**Remedy:** Required: Cat. 3 Optional: Cat. 1& 2 **Fine Range:** $7,500 to $10,000
Actual harm that is not immediate jeopardy	**Remedy:** Required: Cat. 2 Optional: Cat. 1 **Fine Range:** Not substandard $300 to $600	**Remedy:** Required: Cat. 2 Optional: Cat. 1 **Fine Range:** Substandard $500 to $2,000 Not substandard $400 to $800	**Remedy:** Required: Cat. 2 Optional: Cat. 1 or Temporary Mgmt. **Fine Range:** Substandard $750 to $3,000 Not substandard $500 to $1,000
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**Remedy:** Required: Cat. 1 Optional: Cat. 2 **Fine Range:** Not substandard $50 to $100	**Remedy:** Required: Cat. 1 Optional: Cat. 2 **Fine Range:** Not substandard $150 to $300	**Remedy:** Required: Cat. 2 Optional: Cat. 1 **Fine Range:** Substandard $250 to $1,000 Not substandard $200 to $500
No actual harm with potential for minimum harm	No Plan of Correction Commitment to correct No fine	No Plan of Correction Commitment to correct No fine	No Plan of Correction Commitment to correct No fine
	Isolated	**Pattern**	**Widespread**

Substandard quality of care is any deficiency in resident behavior and facility practices, quality of life, or quality of care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Category 1: Directed Plan of Correction, State Monitor; and/or Directed In-Service Training

Category 2: Denial of Payment for New Admissions and/or all individuals; and/or daily fines ranging from $50 to $3,000

Category 3: Temporary Management or Termination; optional daily fines ranging from $3,050 to $10,000

The ranges included above are to be used as a general guideline and may be increased over the amount in the grid if individuals involved in the determination deem the increase to be appropriate. Penalties will also be increased if the maximum penalty in a grid or Category 2 has been imposed previously and the facility receives a repeat deficiency in the same regulatory grouping.

State fines for deficiencies noted during inspections of LTC facilities are outlined in Iowa laws and administrative rules. The Code of Iowa section 135C.36 categorizes violations as Class I, II, or III. Class I fines are assessed for deficiencies that present an imminent danger or a substantial probability of resultant death or physical harm to residents in a facility. Class I fines range from $2,000 to not more than $10,000. Class II violations, generally, are deficiencies with a direct or immediate relationship to the health, safety, or security of residents in a facility. These fines range from not less than $100 to not more than $500. Class III violations are noted deficiencies that cannot be classified as Class I or Class II. These violations do not result in a fine. The following table charts the state violation classes.

State Violations and Fines

Violation Classes	Description of Violation	Fines
Class I:	**Imminent danger** or a substantial probability of resultant death or physical harm to residents in a facility	**Fine Range:** $2,000 to $10,000
Class II:	**Direct or immediate** relationship to the health, safety, or security of residents in a facility	**Fine Range:** $100 to $500
Class III:	Violations that cannot be classified as a Class I or Class II	**No fine**
Failure to correct any class of violation shall subject the facility to further daily fine		**Daily fine:** $50 Until corrected

Section 249A.19 of the Code of Iowa prohibits the impositions of both federal and state fines or penalties for the same violation.

To track violations for each nursing facility, DIA maintains a fining and citation log in which dates are recorded, violations are described, classified, and referenced to the specific law and/or rule violated, fine amounts are noted, date facility corrected the

violation is recorded, and history of appeals and other related activity is noted. The DIA recorded the following statistics relating to NF and RCF violations and related fines for fiscal year 1995.

LTC Facility Type	State Law Violation Class	Number of Violations Cited	Number of Facilities Cited	Total Dollars Initially Assessed
Nursing Facilities	Class I	13	13	$77,000
	Class II	90	34	$43,500
	Class III	25	19	$0
Residential Care Facilities	Class I	0	0	$0
	Class II	7	5	$3,300
	Class III	0	0	$0

Distinguishing between Class I and Class II violations is a judgment made by DIA inspectors based on nine factors described in section [481]-56.9 of the Iowa Administrative Code (IAC). For the fine line between the two types of violations, a large disparity exists between the allowable amounts for assessment of these fines. Since Class II fines range from $100 to $500 and Class I fines range from $2,000 to $10,000, there is a $1,500 gap between the two ranges. The federal penalty ranges are consecutive dollar amounts, giving flexibility for judgment.

Monetary penalties are not the only allowable federal remedies to address the noted violations. Although monetary penalties are not allowable costs for Medicaid and Medicare reimbursements, facilities must divert resources to pay the assessed fines. Federal enforcement guidelines identify actions that may be taken by the enforcement agency in lieu of or in addition to the monetary fines. The enforcing agency may require specific in-service training for facility staff, may place sanctions on federal reimbursement payments to the facility, or may determine a plan of correction for the facility to pursue.

We also noted penalty payments which had not been remitted to the state within twenty business days as required by section [481]-56.14 of the IAC. Many times, there was no indication in the fining and citation log of an appeal, DIA's pursuit of collection, or reason for nonpayment. However, appeal information was contained in inspection files.

We recommend DIA develop a more complete system for collection of fines to ensure that all assessed fines are received by the Department. The system should record all activity from the statements of deficiencies and official notice of fine to the facilities until fines are received and/or the fining and citation process is resolved. DIA should explore the possibility of implementing a database to record all activity related to the fining and citation process. We further recommend DIA implement written procedures for defining allowable payment delays when a stay of payment is to be granted. The process should also identify situations where DIA should use the state's income/payment offset process through the Department of Revenue and Finance to collect the fines.

We recommend the large disparity between the fine categories be lessened to make the structure more flexible for assessing appropriate fines and more comparable to the federal fine structure. The Code of Iowa section 135C.36 Class II fines could range from $100 to $2,000 or the state could adopt the federal guidelines to eliminate confusion and the disparity. We further recommend DIA take full advantage of alternate deficiency remedies to ensure and promote facilities' compliance with laws and regulations.

DIA Response: DIA will develop a more complete system for monitoring the payment of assessed fines and taking legal steps available to the Department to collect fines. DIA will develop written policies for allowable payment delays. DIA agrees Class II state fines should be increased to remove the gap between the current maximum for a Class II [$500] and the minimum for a Class I [$2,000]. With approval of the state legislature, the federal fine structure could be utilized in the state.

MISCELLANEOUS

COMPLAINT INVESTIGATIONS

In addition to the standard inspections performed, DIA investigates complaints made against licensed facilities. The same group of inspectors perform both the complaint investigations and the standard inspections. The on-site complaint investigation is generally an abbreviated version of the standard inspection. Based on the "preponderance of evidence standard" outlined in section 135C.38 of the Iowa Code, complaints are resolved and classified as either substantiated or unsubstantiated. We did not note any unresolved complaints.

The federal guidelines state that professional judgment must be used to determine the timing, scope, and duration of the complaint investigation. The Code of Iowa section 135C.38 requires DIA to perform an on-site investigation of the complaint within 20 working days of receipt, unless DIA concludes that a complaint is intended to harass a facility or a licensee or is without reasonable basis. We noted noncompliance with the established time requirement for three of the ten nursing facility complaint investigations tested.

Further, when DIA receives complaints about nursing facilities, DIA is required by the federal regulations effective July 1, 1995, to contact the State Long-Term Care (LTC) Ombudsman within the Department of Elder Affairs to discuss the nature of the complaint and determine whether there have been any similar complaints reported to and substantiated by the LTC Ombudsman.

We tested compliance and noted DIA compliance with the HCFA requirements, except for eight instances where documentation was lacking for the required communication with the LTC Ombudsman. Additionally, the LTC Ombudsman

program personnel at the Department of Elder Affairs could not locate notification documentation pertaining to those complaints.

We recommend DIA strive to comply with all established laws and regulations.

DIA Response: DIA will make notifications to the Long-Term Care Ombudsman's Office and document these contacts.

DIA REVIEW OF NURSING FACILITY STAFFING

Current HCFA regulations state that nursing facilities must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The inspections are outcome-based to determine whether a facility is providing the quality of life, quality of environment, and quality of care that residents need.

DIA inspectors assess the appropriateness of staffing but do not delve into whether a facility is temporarily borrowing staff from other facilities to pass an inspection. If the inspectors have reason to believe a health care deficiency was related to staffing problems, staffing patterns are reviewed.

DIA REVIEW OF MISAPPROPRIATION OF FUNDS

If inspectors suspect any kind of misappropriation of funds by an LTC facility, they inform the DIA Audits Division or the Medicaid Fraud Control Unit within the Investigation Division. The two divisions work together to resolve the matter. Additionally, the DIA Audits Division periodically conducts Medicaid program audits of NFs and RCFs to ensure that services paid by Medicaid are allowable and consistent with Medicaid requirements. As a part of their process, DIA looks at Medicaid reimbursement records, patient trust accounts, and other financial records as deemed necessary.

Auditors and investigators in the Medicaid Fraud Control Unit investigate allegations of Medicaid fraud by health care providers. They also investigate allegations of abuse and neglect of residents of LTC facilities that receive Medicaid reimbursement and allegations that residents have been defrauded of personal funds or possessions. When there is sufficient evidence, investigators refer the cases for criminal prosecution. In cases where medical providers received overpayments from the Medicaid program, but intent to defraud cannot be established, the Unit refers the case for administrative recoupment or civil remedies.

PAPERWORK

When interviewing nursing facility administrators, excessive paperwork was a major area of their concern. The most significant problem stemmed from the federally-required resident assessments and care plans. These resident care plans must be prepared by a registered nurse for each nursing facility resident at least quarterly. If a resident's condition permanently changes, the care plan must be updated.

The resident care plan is a single document used to record the resident's problems, the nursing facility's goals for the resident, the facility's approach and activities for the resident, the resident's responses to each identified approach, and any additional comments. If a goal is not met for the resident, the care plan must explain why the goal was not met. Much of the information recorded on the care plan may also be documented elsewhere in the resident's charts because of required nursing documentation or corporate procedures, resulting in duplication of information. Even if the information is charted elsewhere in the resident's charts, inspectors can not accept the other documentation as part of the resident care plan document because of federal regulations.

Many of the nursing facility administrators interviewed have hired full-time registered nurses whose sole responsibility is to prepare resident care plans. Occasionally, the registered nurses may simply transfer the resident's information from other charts maintained for the resident on to the care plans. These care plans may average 29 pages or more per resident each quarter, well over 100 pages annually. Excessive paperwork can be very burdensome for nursing facilities and costly when considering the Medicaid reimbursement rates since the time spent on care plan paperwork by nurses is to provide compliance with the law and not direct care of residents.

These care plans, if used appropriately, can be an invaluable tool for facility care givers, such as nurse aides and dietitians, to become familiar with a resident's needs and activities. However, many nursing facilities have just added the documentation required by the care plans to the files instead of integrating the paperwork into their daily operational records. This causes repetitive recording of information which is time consuming and unnecessary.

The paperwork process could be streamlined. The care plan, instead of duplicating work, could become the central resident document to relieve the burden of regulation. DIA staff, personnel from other state departments and nursing facility personnel could work jointly to incorporate nursing documentation and other requirements into the required care plan to streamline resident care paperwork to the fullest extent possible. The state should work with the providers to develop an educational process for the coordination and effective utilization of paperwork for LTC facilities.

DIA Response: DIA will work with other agencies, HCFA, and provider associations to assess the need for and means of decreasing facility documentation requirements.

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The following represent the definitions for the health care facilities included in the scope of this study.

NURSING FACILITIES

Free-Standing - Institutions or distinct parts of institutions housing three or more individuals for a period exceeding 24 consecutive hours, whose primary purpose is to provide health-related care and services, including rehabilitation for individuals who, because of mental or physical condition, require nursing care and other services in addition to room and board. Nursing facilities do not engage primarily in providing treatment or care for mental illness or mental retardation. There are 427 licensed nursing facilities in Iowa (only 10 of which are not Medicaid/Medicare certified) with a total of 33,803 beds. Of the 427 facilities, 315 are nursing facilities (Medicaid certified) and 102 are nursing/skilled nursing facilities (Medicaid/Medicare certified).

Hospital-Based (Distinct Part) Nursing Facilities - The term "distinct part" denotes the unit is organized and operated to give a distinct type of care within a larger organization that renders other types or levels of care. "Distinct" denotes both organizational and physical separateness. A distinct-part facility must be physically identifiable and be operated distinguishably from the rest of the institution. It must consist of all the beds within that unit, such as a separate building, floor, wing, or ward. Several rooms at one end of a hall or one side of a corridor may be accepted as a distinct part of a nursing facility. (This definition includes nursing facilities, skilled nursing facilities, and skilled nursing facilities/nursing facilities.) There are 48 facilities of this type in Iowa with a total of 1,992 beds.

RESIDENTIAL CARE FACILITIES

Residential Care Facilities are institutions, places, buildings, or agencies providing accommodation, board, personal assistance and other essential daily living activities for a period exceeding 24 consecutive hours. Individuals living in a residential care facility are unable to sufficiently or properly care for themselves because of illness, disease, or physical or mental infirmity, but do not require the services of a registered or licensed practical nurse, except for emergencies. There are 182 residential care facilities in Iowa with a total of 6,866 beds.

Residential Care Facilities for the Mentally Retarded provide accommodation, board, personal assistance, essential activities of daily living and habilitation services to three or more individuals with mental retardation. Residents of a residential care facility for the mentally retarded are unable to sufficiently or properly care for themselves, but do not require the services of a registered or licensed practical nurse. There are 260 residential care facilities for the mentally retarded in Iowa with a total of 2,210 beds.

Residential Care Facilities for Persons with Mental Illness provide accommodation, board, personal assistance and other essential daily living activities to three or more individuals for a period exceeding 24 consecutive hours. Clients must be able to sufficiently or properly care for themselves, but do not require the services of a registered or licensed practical nurse. These facilities emphasize individualized program planning in an aggressive effort to assist clients to a more independent way of life. There are 17 residential care facilities for persons with mental illness in Iowa with a total of 372 beds.

The following lists some of the other types of health care facilities not included in the scope of this study.

OTHER HEALTH CARE FACILITIES

Psychiatric medical institutions for children, intermediate care facilities for the mentally retarded and for persons with mental illness, ambulatory surgical centers, community mental health centers, comprehensive outpatient rehabilitation facilities, home health agencies, hospices, hospitals, laboratories, occupational and physical therapists in independent practice, and rural health clinics.

Source: DIA 1995 Health Care Facilities in Iowa publication.

Department of Inspections and Appeals
Facility Contact Statistics
Fiscal Year 1995

Type of Long-Term Care Facility	# of Facilities	# of Insp.	Insp. Revisits	Complaints Recd.	Complaints Invest.	Cmplt. Revisits	Total Contacts
Nursing Facilities (NF)							
Hosp. Based NFs	19	22	20	4	3	0	45
Hosp. Based SNFs	9	11	4	2	2	0	17
Hosp. Based SNF/NFs	20	19	14	5	3	0	36
NFs - licensed only	10	3	0	3	8	0	11
NFs	315	284	256	619	587	136	1,263
SNF/NFs	102	97	91	375	365	105	658
Totals	475	436	385	1,008	968	241	2,030
Residential Care Facilities (RCF)							
RCFs	182	1	0	64	69	1	71
RCF/MR	260	0	0	20	17	0	17
RCF/PMI	17	0	0	11	20	1	21
Totals	459	1	0	95	106	2	109
NF & RCF Subtotals	934	437	385	1,103	1,074	243	2,139
Other Health Care Facilities Totals	2,734	779	499	123	87	14	1,379
Health Care Facilities Totals	3,668	1,216	884	1,226	1,161	257	3,518

Abbreviations

Cmplt. - Complaint
Hosp. - Hospital
Insp. - Inspections
Invest. - Investigations
MR - Mentally Retarded
PMI - Persons with Mental Illness
Recd. - Received
SNFs - Skilled Nursing Facilities

Source: DIA Gold Book Statistics

Appendix E

LONG-TERM CARE FACILITY INSPECTIONS AND ENFORCEMENT

Introduction

This section reviews the State of Iowa's requirements and responsibilities regarding long-term care facilities.

In general, the state's requirements and responsibilities can be understood as follows:

- *The state **requires** all facilities to obtain and maintain a license.*

  Iowa Code chapter 135C authorizes DIA to make licensing decisions based on inspections of facilities' performance in meeting state standards (in the Iowa Administrative Code at 481 IAC 57, 481 IAC 58 and 481 IAC 61.) Iowa Code chapter 135C also authorizes DIA to issue fines and apply to district court for appointment of a receiver when a facility fails to meet the standards.

- *The state is **responsible** to the federal government to oversee facilities wanting reimbursement for serving people who qualify for Medicaid.*

  The federal government pays about 63 percent of the cost of services provided to Medicaid residents and the state pays the rest.[1] In return, the state is responsible to inspect facilities' performance in meeting federal standards (in the Code of Federal Regulations at 42 CFR 483) and to take appropriate enforcement actions pursuant to:

  • *Federal law* — "Requirements for nursing facilities," in the United States Code at 42 USC §1396r [adopted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)]

  • *Federal regulations* — 42 CFR 488

  • *Federal policy* — particularly the "State Operations Manual"

[1] The federal Medicaid program also reimburses the state for a significant portion of its oversight costs. The percentage varies depending on various factors, such as:

- If the facility is also certified under the federal Medicare program, the total federal share is at least (approximately) 82 percent of the oversight costs.
- If the particular inspection was required only by federal law, the federal share is 100 percent.

The long-term care regulatory system is not easy to understand. Seven key points will help the reader better understand the rest of this section:

1. The state wears its two "hats" simultaneously. In other words, DIA at the same time regulates nursing facilities' compliance with the state licensure requirements, and also is responsible to regulate the facilities' compliance with the federal Medicaid requirements.

2. The state standards and the federal standards are similar but separate. Both sets are lengthy and complex. Some involve nursing practices not easily understood by people outside the profession.

3. When DIA finds a facility isn't meeting the standards, it has an array of enforcement options available. There are two sets of enforcement options — those authorized by federal law and those authorized by state law. Both sets are significantly different in scope and severity.

4. Many of the *state* enforcement options are discretionary and require a subjective determination that adverse action against a facility is appropriate. (Some state enforcement actions are mandated to be imposed under certain circumstances.) Iowa Code chapter 135C and the ensuing administrative rules do not specify when the discretionary, state-authorized enforcement actions are appropriate.

5. After OBRA 1987 but before July 1, 1995, many of the *federal* enforcement options were discretionary and required a subjective determination that adverse action against a facility was appropriate. (Some federal enforcement actions before July 1, 1995, were mandated to be imposed under certain circumstances.) OBRA 1987 and the pre-July 1, 1995 federal regulations did not specify when the discretionary, federal-authorized enforcement actions were appropriate.[2]

6. Effective July 1, 1995, new federal regulations established minimum thresholds when certain federal enforcement actions are required. The new regulations give states discretion to apply more severe actions than those required for a given situation.

7. The federal policy document "State Operations Manual," as updated through January 1997, is long and complex. Compared with the 1995 federal regulations, the manual introduces new concepts and directives that effectively raise the minimum thresholds when enforcement actions can or should be taken.

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[2] However, OBRA 1987 required states to develop criteria for when enforcement actions were appropriate. The law added, "Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies...." [*See USC §1396r(h)(2)(A)*]

There are two types of long-term care facilities:

- *Nursing facilities* There are 475 nursing facilities in Iowa with 35,795 beds, according to the December 1995 report, "Health Care Facility Inspections," by the State Auditor's Office. All but 10 facilities are certified by Medicaid. For a Medicaid-eligible resident, the costs are split by the federal Medicaid program (which pays about 63 percent) and the state Medicaid program (which pays the remaining 37 percent.)

  Nursing facilities that are Medicaid-certified are responsible to meet the federal standards, as well as the state standards for nursing facilities (481 IAC 58.) *Both of the facilities involved in this review were functioning as Medicaid-certified nursing facilities.*

- *Residential care facilities* There are 459 residential care facilities in Iowa with 9,448 beds, according to the State Auditor's report. These facilities generally are not certified by Medicaid. Residential care facilities are responsible to meet the state standards for such facilities (481 IAC 57.)

State requirements for long-term care facilities

The state's requirements for long-term care facilities are based on Iowa Code chapter 135C. Among other things, chapter 135C:

- Authorizes DIA to set minimum state standards for nursing facilities [see 481 IAC 58 and 481 IAC 61.]
- Requires DIA to inspect facilities before issuing a license.
- Requires DIA to conduct a general inspection of licensed facilities at least once every fifteen months.
- Requires DIA to inspect facilities upon receipt of complaints alleging violation of standards.

When DIA finds facilities in violation of the state standards, chapter 135C authorizes DIA to issue one or more of the following enforcement options:

1. *Monetary penalty* Code section 135C.36 authorizes DIA to issue one of the following citations to a facility failing to comply with state standards:

   • *Class I violation*: Presents an imminent danger or a substantial probability of resultant death or physical harm. Includes a penalty between $2,000 and $10,000.

   • *Class II violation*: Has a direct or immediate relationship to the health, safety or security of residents, but which presents no imminent danger nor substantial probability of death or physical harm. Includes a penalty between $100 and $500.

• *Class III violation*: Any violation not classifiable as a Class I or Class II violation. Involves no monetary penalty.

The decision of whether to impose a citation, and if so, the amount of the fine, is to be based on the circumstances surrounding the violation, including nine factors set out in DIA's administrative rules (see 481 IAC 56.9 and 56.10, in Appendix B.)

When DIA issues a citation, it notifies the facility through a written report specifying the time by which the violation must be corrected. Failure to correct a deficiency by that time is mandated to result in a further penalty of $50 for each day it continues, under section 135C.40 (unless the facility shows the failure was beyond its control.)

If DIA issues a subsequent Class I or Class II citation to the same facility within 12 months of issuing a monetary penalty for the same Class I or Class II citation, DIA is mandated to triple the fine, under section 135C.44.

2. *Licensure action* DIA can deny, suspend or revoke a facility's state license for a number of reasons, including failure to meet the minimum standards under section 135C.10(4). DIA can also place a license in "conditional" status, under section 135C.12(2).

3. *Receivership (temporary manager)* DIA can apply to district court for appointment of a receiver to temporarily manage the facility in order to correct violations, under section 135C.12(1).

Iowa Code section 135C.2 establishes the purpose of Chapter 135C and states in part:

The purpose of this chapter is to promote and encourage adequate and safe care and housing for individuals who are aged or who, regardless of age, are infirm, convalescent, or mentally or physically dependent, by both public and private agencies by providing for the adoption and enforcement of rule and standards:

a. For the housing, care and treatment of individuals in health care facilities, and

b. For the location, construction, maintenance, renovation and sanitary operation of such health care facilities which will promote safe and adequate care of individuals in such homes as to further the health, welfare and safety of such individuals.

State responsibilities (to implement federal Medicaid requirements) under federal statute

The following two passages provide background information about the emergence of Medicaid in helping to pay for long-term care services and in raising standards for facilities:

> Long-term care never used to be the political issue it is today. In the first half of the century, elderly people either lived with their families or in boarding houses where landlords provided the occasional assistance, some more humanely than others. Then, in 1950, Congress passed an amendment that forbade Social Security payments for residents of institutions if those institutions did not provide health care. Boarding houses did not; nursing homes did.
>
> Out of such small bureaucratic change is a new world born. Boarding houses just about disappeared; new nursing homes were built and flourished. In 1965, nursing homes got another boost when Medicare and Medicaid were signed into law. Medicare helped nursing home fortunes only peripherally; it paid nursing home bills only if care followed a hospital stay and was brief in duration. But Medicaid, the federal-state partnership for the poor, had the mandate to become the great provider. It could pay for chronic care at nursing homes for as long as such care was needed — and that could be the rest of an elderly person's life. With public money to pay the tab, modern nursing homes hit pay dirt and became the dominant force in long-term care.
>
> *— from "Nursing Homes and Common Sense," July 1994 article in Governing magazine (pages 45-46)*

> Because of the concern about nursing home quality in the early 1980s, Congress requested a study by the Institute of Medicine (IOM).[3] The IOM's Study on Nursing Home Regulation (1986) and other studies reported widespread quality of care problems and recommended the strengthening of federal regulations for nursing homes (USGAO, 1987; US Senate, 1986; Zimmerman et al., 1985). The IOM Committee recommendations and the active efforts of many consumer advocacy groups resulted in Congress passing Nursing Home Reform Legislation as a part of the Omnibus Budget Reconciliation Act of 1987 (OBRA, 1987).
>
> OBRA 1987, implemented by the Health Care Financing Administration (HCFA) in a series of regulations since 1989, mandated a number of changes. Nursing homes were required to conduct comprehensive

[3] A preface to the IOM report, "Improving the Quality of Care in Nursing Homes," states, "The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an advisor to the federal government, and its own initiative in identifying issues of medical care, research, and education." The report was published by National Academy Press (which can be reached at 2101 Constitution Avenue, NW, Washington, D.C. 20418) and is referenced as Library of Congress Catalog Card Number 86-70879.

assessments of all nursing home residents including their functional, cognitive, and affective levels of residents which must be used in the care planning process. More specific requirements for nursing, medical and psychosocial services were designed to attain and maintain the highest possible mental and physical functional status by focusing on outcomes (such as incontinence, mobility, and decubitus ulcers). Regulations detailing and protecting residents' rights were added and a greater focus on the quality of life was mandated. Finally, the regulations strengthened the enforcement procedures for violations and allowed to [*sic*] fines and other sanctions.

— from "Stakeholders Opinions Regarding Important Measures of Nursing Home Quality for Consumers," (pages 4-5)[4]

HCFA requires each state to assign an agency to administer Medicaid. That agency in turn can delegate its sanctioning authority over long-term care facilities.

The "state Medicaid agency" in Iowa is the Department of Human Services (DHS). DHS in turn has contracted with DIA to inspect and regulate long-term care facilities participating in the Medicaid program.[5]

Besides raising standards, OBRA 1987 sets out an "enforcement process" if a state finds a facility isn't meeting one (or more) of the standards:

- *If residents' health or safety is immediately jeopardized* — the state must either:

  — appoint a temporary manager over the facility to remove the jeopardy; *or*

  — terminate the facility's Medicaid contract.

  The state can also impose any combination of the following actions:

  — deny payment for new Medicaid admissions until the deficiency is corrected;

  — assess a fine ("civil money penalty") for each day the facility did not comply with the standard(s);[6]

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[4] This report was published September 1996 by the Department of Social & Behavioral Sciences, University of California, and the National Citizens Coalition for Nursing Home Reform. Copies of this report can be obtained by contacting the Department of Social & Behavioral Sciences, University of California, San Francisco, California 94143; or by contacting the National Citizens Coalition For Nursing Home Reform, 1424 16th Street, NW, Suite 202, Washington, D.C. 20036.

[5] The contract between DHS and DIA does not reference the need for DIA to follow federal statute and regulations concerning ongoing oversight of long-term care facilities. It states in relevant part, "DIA will follow the State Operations Manual (SOM) in all respects and state plan requirements unless directed in writing by DHS to disregard portions of the SOM." The contract officially expires June 30, 1997.

[6] While OBRA 87 did not specify when fines should be imposed, the Institute of Medicine's 1986 report included the following comments: "Fines are a valuable enforcement tool because they can be applied to minor violations early and often, thus deterring facilities from making more serious transgressions. They

-- close the facility, transfer residents to another facility, or do both. [*See 42 USC §1396r(h)(1)(A)*]

- *If there is no immediate jeopardy* — the state may:

  -- terminate the facility's Medicaid contract; *and/or any of the following*

  -- deny payment for new Medicaid admissions until the deficiency is corrected;

  -- assess a civil money penalty for each day the facility did not comply with the standard(s);

  -- appoint a temporary manager;

  -- close the facility, transfer residents to another facility, or do both (in case of an emergency). [*See 42 USC §1396r(h)(1)(B)*]

- *Regardless of whether immediate jeopardy is present* — HCFA can continue payments to the facility no longer than six months only if the state:

  -- finds it is more appropriate to take alternative action than to terminate the facility's Medicaid contract; and

  -- submits a plan and timetable for corrective action and HCFA approves; and

  -- agrees to repay HCFA for payments made to the facility if the facility fails to take corrective action pursuant to the approved plan and timetable. [*See 42 USC §1396r(h)(3)(D)*]

- *Mandatory denial of payment for new Medicaid admissions* — if a facility fails to correct deficiencies within three months or if a facility has "substandard quality of care" (not defined) on three consecutive standard surveys.[7] [*See 42 USC §1396r(h)(2)(C) and (D)*]

  Also, once denial of payment is imposed for any reason, it continues until the state finds the facility "is in substantial compliance with all" of the standards. [*See 42 USC §1396r(h)(4)*]

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according to seriousness, duration, and repetition of the violations, and that fines be used to deter further violations. All fines should be large enough to be more costly than the money saved by the violation." (page 166)

[7] OBRA 1987 requires states to conduct five types of inspections to survey nursing facilities' compliance with the new standards:

Initial survey to certify if the facility is in compliance.

Standard survey (general inspection) at least every 15 months, with the statewide average not to exceed 12 months.

Extended survey for any facility found to have provided "substandard quality of care" (not defined in OBRA 87.)

Complaint survey to investigate complaints.

Revisit survey to assess whether the facility has corrected violations found at a prior survey.

Other key points of OBRA 1987 include:

- States were required to establish four remedies — denial of payment, civil money penalties, temporary managers and closure — by October 1, 1989. While OBRA 1987 mandated HCFA, by October 1, 1988, to promulgate regulations helping states establish such remedies, HCFA's failure "to provide such guidance shall not relieve a State of the responsibility for establishing such remedies." [*See 42 USC §1396r(2)(B)(i)*][8]

- States must "specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. *Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.* In addition, the State may provide for other specified remedies, such as directed plans of correction." [emphasis added] [*See USC §1396r(h)(2)(A)*]

- States will be reimbursed for "reasonable expenditures" incurred when implementing any of the federal remedies. [*See 42 USC §1396r(h)(2)(E)*]

- States must implement programs "to measure and reduce inconsistency in the application of survey results among surveyors." [*See 42 USC §1396r(g)(2)(D)*]

- States can "establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care...." It also authorizes states to be reimbursed for "proper expenses incurred" in carrying out such a program. [*See 42 USC §1396r(h)(2)(F)*]

Concerning the purpose of enforcement, Congress included the following language in OBRA 1987:

> **(1) General responsibility**
>
> It is the duty and responsibility of the Secretary [of the U.S. Department of Health and Human Services] to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, *and the enforcement of such requirements*, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys. [emphasis added; *see 42 USC § 1396r(f)*]

[8] DHS promulgated administrative rules establishing denial of payment and temporary managers effective August 8, 1990. Those rules did not establish remedies concerning civil money penalties and closure. Given the passage of time, the Ombudsman did not ask DHS why those rules did not establish those two remedies.

This indicates Congress' intent regarding enforcement was two-fold:

- Enforcement must be adequate to protect the health, safety, welfare and rights of nursing facility residents.
- Enforcement must promote the effective and efficient use of public moneys.

State responsibilities (to implement federal Medicaid requirements) under federal regulation

HCFA did not complete promulgating its regulations as mandated by OBRA 1987 until July 1, 1995. The preamble to the final rules included several comments concerning the purpose of enforcement:

- ... Violations must be recognized and remedied appropriately if resident interests are to be protected and integrity is to remain in the enforcement system. [*See 59 Fed. Reg. 56,134*]
- We ... are adopting procedures that allow for the swift imposition of remedies prior to a hearing. We believe that the intent of the Act was that remedies be imposed as soon as possible in order to protect the residents. [*See 59 Fed. Reg. 56,155*]
- We are not accepting suggestions that would require pre-sanction hearings because we continue to believe that residents are best served if remedies are imposed promptly. The residents are the beneficiaries of the Medicare and Medicaid programs, and their best interests are the motivating force behind OBRA '87 and these regulations. [*See 59 Fed. Reg. 56,157*]

Compared with OBRA 1987, the new set of regulations significantly clarifies when enforcement action is appropriate, and if so, to what degree. It also defines, for the first time, a number of terms used in OBRA 1987.

First, the new regulations require states to determine the seriousness of deficiencies using two factors[9] [*see 42 CFR 488.404*]:

- *Degree of harm* Four levels:

  1) Immediate jeopardy[10] to resident health or safety;

  2) Actual harm that is not immediate jeopardy;

  3) No actual harm with potential for more than minimal harm;

  4) No actual harm with potential for minimal harm.

- *Frequency* Three levels:

  1) Widespread;

  2) Pattern;

  3) Isolated.[11]

To better understand the next steps, it is easier to first see how HCFA uses these two factors — degree of harm and frequency — to create a grid with 12 boxes, and lettered "A" through "L," as follows:

Immediate jeopardy	J	K	L
Actual harm	G	H	I
No actual harm with potential for more than minimal harm	D	E	F
No actual harm with potential for minimal harm	A	B	C
	Isolated	Pattern	Widespread

A state's primary responsibility is to certify whether a facility is in compliance with the federal Medicaid standards. The new regulations define "substantial compliance" as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." [*See 42 CFR 488.301*]

[9] States can consider other factors, including but not limited to: (1) The relationship of the one deficiency to other deficiencies resulting in noncompliance.
(2) The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. [*See 42 CFR 488.404(c)*]

[10] The new regulations define immediate jeopardy as a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

[11] These terms were defined in a July 2, 1996 memorandum by J. Bennett to DIA staff. See Appendix F.

This means that to be in compliance, a facility cannot have any deficiency in boxes D through L on the grid.

Next, the new regulations set out three "remedy categories":

- *Category 1* (least severe):

  -- directed plan of correction
  -- state monitor
  -- directed in-service training

- *Category 2*:

  -- denial of payment for new admissions
  -- denial of payment for all individuals
  -- civil money penalties ranging from $50 to $3,000 per day

- *Category 3* (most severe):

  -- temporary management
  -- terminate facility's Medicaid contract
  -- (optional) civil money penalties ranging from $3,050 to $10,000 per day

The preceding categories, and when they are to be applied, are illustrated in the federal "Scope and Severity Grid" (see Appendix G.) As the grid indicates, if the state finds a facility is not in substantial compliance, and determines that terminating the facility's Medicaid contract is not necessary, the state is *required* to impose at least one remedy from the appropriate category *and has discretion to impose multiple remedies, including more severe remedies*:

- At least one Category 1 remedy is required for deficiencies in grid boxes D and E.

- At least one Category 2 remedy is required for deficiencies in grid boxes F through I.

- At least one Category 3 remedy is required for deficiencies in grid boxes J through L (immediate jeopardy).

Under the new regulations, a successful appeal of the finding of noncompliance which led to the enforcement action is the only opportunity for a facility to avoid receiving at least a required minimum remedy.

As the grid indicates, the new regulations require facilities to submit an acceptable "plan of correction" for all deficiencies except those in grid box A (isolated with no actual harm with potential for minimal harm.)

The new regulations also define the term "substandard quality of care" as:

> ... one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and facility practices, 42 CFR 483.15, quality of life, or 42 CFR 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

OBRA 1987 had mandated denial of payment for new Medicaid admissions if a facility has "substandard quality of care" on three consecutive standard surveys.

Finally, the new regulations contain one comment about the purpose of enforcement:

> *Purpose of remedies.* The purpose of remedies is to ensure prompt compliance with program requirements. [*See 42 CFR 488.402*]

The state DHS, as a requirement for continued participation in the federal Medicaid program, adopted the new federal rules effective July 1, 1995 at 441 IAC 81, "Division II, Enforcement of Compliance."[12]

Also on July 1, 1995, HCFA implemented the latest significant revision of the federal standards (found at 42 CFR 483). The revision consolidated what had been 325 requirements into 165 requirements under 17 categories.[13]

State responsibilities (to implement federal Medicaid requirements) under "State Operations Manual"

As mentioned previously, the contract between DHS and DIA does not mention OBRA 1987 or the ensuing federal regulations implemented in 1995. Instead, it says DIA "... will follow the State Operations Manual (SOM) in all respects and state plan requirements unless directed in writing by DHS to disregard portions of the SOM."

The SOM is a policy directive HCFA issued to give states further direction in regulating long-term care facilities. The Ombudsman reviewed relevant sections of the SOM as updated through January 1997.

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[12] There is at least one significant difference between the federal rules and the state rules as adopted by DHS. Under the heading, "Continuation of payments to a facility with deficiencies," the federal rules provide that HCFA may continue such payments only if several criteria are met. Among the criteria is a requirement that the state, in the case of Medicaid facilities, agrees to repay the federal government if corrective action is not taken in accordance with the corrective action plan. [See 42 CFR §488.450] The state rules, however, require the facility to agree to repay the state for such payments. [See 441 IAC 81.54(1)(a)(3)]

[13] This is according to pages 5-6 the report, "Stakeholders Opinions Regarding Important Measures of Nursing Home Quality for Consumers" (published September 1996 by the Department of Social & Behavioral Sciences, University of California, and the National Citizens Coalition for Nursing Home Reform.)

Compared with OBRA 1987 and the 1995 federal regulations, the SOM as updated through January 1997 provides significant guidance regarding when enforcement action is appropriate, and if so, to what degree. The SOM also is:

- Several hundred pages long, with at least 23 appendices.
- Complicated, as compared with OBRA 1987 and the ensuing federal regulations.
- An evolving document. Some sections had not been updated since 1985. But many have been revised (or added) at various points since then. Most of the sections concerning enforcement were revised in June 1995, and several have been revised since then, including some as recently as January 1997.

The Ombudsman did not attempt to review versions that were in effect during the period reviewed in this investigation (1988 through 1996). Based on the review of the SOM as updated through January 1997, the Ombudsman believes that reconstructing (and then reviewing) previous versions of the document from 1988 through 1996 would be an extremely time-consuming project.

More importantly, such a project is not necessary to the Ombudsman's evaluation of the first two allegations, regarding whether DIA was unreasonable in its enforcement of federal and state *statutes and regulations* involving two long-term care facilities.

Blending the state's responsibilities and requirements

Instead of making two visits to inspect facilities, DIA conducts one survey to accomplish both the state and federal oversight functions. In doing so, DIA uses the survey process established by OBRA 1987.

When DIA finds a facility has failed to meet any of the federal and/or state standards, it documents its findings on a "Statement of Deficiencies and Plan of Correction" form (sometimes called a survey.) DIA then mails the survey to the facility, which is required to describe its "plan of correction" for each deficiency, unless it disputes DIA's findings. Even well-run facilities usually are found to have at least a few deficiencies.

After completing the "Statement of Deficiencies," surveyors are to recommend whether DIA should take any enforcement action against the facility. Ultimately, that decision is made by a "determination team," usually comprised of (at least) the surveyor, their supervisor, a compliance officer and an assistant attorney general.

An important limitation DIA has in choosing from the various enforcement options is in Iowa Code section 249A.19, which states in relevant part:

> ... If a health care facility is assessed a [*federal*] civil penalty under this section, the health care facility shall not be assessed a penalty under section 135C.36 [*state-authorized monetary penalty*] for the same violation.

When DIA proposes to take enforcement action, facilities have the right to challenge it through an administrative review process that ultimately can be appealed to district court.

According to DIA, it assessed administrative fines against long-term care facilities in recent years in the following amounts:

- *Fiscal year ending June 30, 1994:* $61,300.
- *Fiscal year ending June 30, 1995:* $143,350.
- *Fiscal year ending June 30, 1996:* $61,200.

Given that there are approximately 934 long-term care facilities in the state, this indicates DIA fined facilities an average of $65.52 for the most recent fiscal year — the first in which the new federal regulations were effective.

These figures also show DIA collected a smaller amount in fines that year than compared with the two previous fiscal years.

DIA's views on oversight and enforcement

DIA has provided additional clarification regarding its opinion about the purpose of enforcement in responses to recent annual reports of the State Long-Term Care Resident Advocate:

- ... The role of the Division [*of Health Facilities*] is to assure the residents in Iowa's nursing facilities that they are receiving appropriate care, regardless of payment status, through careful and thorough regulation of health facilities. [*The Division's purpose is also to*] protect the rights and dignity of the residents while seeing to it that they receive quality care for the duration of their residency....

  — from February 10, 1995 response to the 1994 Annual Report, signed by then-Division Administrator Pearl Johnson

- ... A facility whose license has been threatened by revocation or decertification action must be allowed to operate if it corrects the deficiencies and maintains substantial compliance with the federally-defined minimum standards. The Department does not have any options, it is the law.... We cannot debate with him [*the State Long-Term Care Resident Advocate*] the rationale or reasoning for a law, our responsibility is to enforce the laws as written.

  — from February 10, 1995 response by Ms. Johnson

- ... The Department shall apply a preponderance of the evidence standard in determining whether or not a complaint is substantiated. A preponderance of the evidence standard means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true. A preponderance of the evidence standard does not require that the investigator personally witness the alleged violation.

—from unsigned attachment to January 5, 1996 letter signed by then-Director Charles Sweeney in response to the 1995 Annual Report

- In conclusion, to label the Department of Inspections and Appeals as grossly inadequate or insensitive in the enforcement of laws and regulations regarding the health, safety and well-being of nursing facility residents is not only repugnant but outright false. Since the DIA was established by the Iowa General Assembly in 1986, it has been the Department's purpose to protect the rights of Iowa's elderly and infirmed residents. Anything said to the contrary is without merit.

—from unsigned attachment to January 5, 1996 response

Further insight has been given in other comments by DIA staff:

- It [*harm to residents, both potentially and actually*] is one of the nine factors and certainly we do look at harm very closely, whether it is harm that has actually happened, such as pressure sores, holes in the body kind of thing, or whether it is incontinence, laying in wet beds, with the potential for harm later down the road to create pressure sores, we still take that into consideration along with the other nine factors. If you're asking me, 'Do we really focus in on it,' yes we do, it's a serious aspect.

  ... DIA looks at potential harm. We take that into consideration in a very serious way.

— DIA Quality Assurance Office Vicki Clingan during June 6, 1996 interview with Mr. Burnham of the Ombudsman's office

- I think DIA's approach to enforcement has always been, we aren't out to do an 'I got you' with facilities and we aren't out to arbitrarily close facilities. Our goal has been to try and make sure facilities stay in compliance, and if they demonstrate they can't do that, then to use the tools we have to promote it, help it, foster it, depending on your perspective.

— DIA Health Facilities Division Administrator J. Bennett during June 6, 1996 interview with Mr. Burnham of the Ombudsman's office

STATE OF IOWA

Appendix F

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF INSPECTIONS AND APPEALS
CHARLES H. SWEENEY, DIRECTOR

MEMORANDUM

DATE: July 2, 1996

TO: Long-Term Care Surveyors, Program Coordinators, and Bureau Chiefs

FROM: J. Bennett

RE: Clarification of the August 17, 1995 Memorandum on Scope/Severity Determination and 2567A

This Memorandum serves as clarification for the August 17, 1995 Memorandum based on information from HCFA.

1. When writing deficiencies on the 2567A form, the principles of documentation are to be used.

2. For each deficiency, surveyors are to determine the highest level of severity and then the scope rating.

   Widespread: Widespread, a facility-wide system failure, is a deficient practice that has the potential to affect or is pervasive in its affect on residents or the facility. This scope rating would not be used when a deficiency existed in a particular care population or geographic area of the facility; i.e., Alzheimer's unit, pressure sores, tube feedings. Although you may consider this a system failure, it does not have the potential or ability to be pervasive and affect all residents in the facility.

   Pattern: Pattern can include multiple observations or incidents with one resident, when there are several different residents involved, when the deficient practice occurs in several different geographic locations, or a number of staff are involved in the deficient practice.

   Isolated: Isolated means one, or a very limited number of residents or incidents (clarified by HCFA to mean 2 but no more than 3) and a minimal amount of staff or an isolated geographic location.

3. **Severity** is based on current findings, not on resident or facility history. As an example, a resident's past history of urinary tract infections (UTI) would not increase the severity rating from a level 2, potential for harm, to a level 3, actual harm, when they received inappropriate catheter care and did not have a UTI.

4. There are three types of regulations:

   A. Those that specify **"each resident."**
   B. Those that specify **"the facility must."**
   C. Those that specify **"the facility must. . . "and "each resident shall."**

   Based on HCFA clarification, the statements, "The exception to this is Resident Rights when a pattern of rights violations is needed before it is considered deficient practice. . ." and " 'Facility shall' or 'Facility must' regulations go back to the principle of patterns and trends," are in error. Deficient practice is identified and applied to the matrix for scope/severity.

HEALTH FACILITIES DIVISION / LUCAS STATE OFFICE BUILDING / DES MOINES, IOWA 50319-0083 / 515-281-411
FAX# 515-242-5022 / TDD# 515-242-6515

Appendix G

	Isolated	Pattern	Widespread
Immediate jeopardy to to resident health or safety	J [redacted] PoC [redacted] Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K [redacted] PoC [redacted] Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L [redacted] PoC [redacted] Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1
Actual harm that is not immediate jeopardy	G PoC Required* Cat. 2 Optional: Cat. 1	H [redacted] PoC [redacted] Required* Cat. 2 Optional: Cat. 1	I [redacted] PoC [redacted] Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F [redacted] PoC [redacted] Required* Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A [redacted] No PoC No Remedies Commitment to Correct Not on HCFA-2567	B [redacted] PoC	C [redacted] PoC

[redacted] Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

[redacted] Substantial compliance

REMEDY CATEGORIES

Category 1 (Cat.1)

Directed Plan of Correction
State Monitor; and/or
Directed In-Service Training

Category 2 (Cat.2)

Denial of Payment for New Admissions
Denial of Payment for All Individuals imposed by HCFA; and/or
CMPs:
$50 - $3,000/day

Category 3 (Cat.3)

Temporary Management
Termination

Optional:

CMPs
$3,050 - $10,000/day

Denial of payment for new admissions must be imposed when a facility is not in substantial compliance within 3 months after being found out of compliance.

Denial of payment and State monitoring must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

NOTE: Termination may be imposed by the State or HCFA at any time when appropriate.

Following a determination of scope and severity, the SA enters on Form HCFA-2567L the letter corresponding to the box of the grid for at least any deficiency which constitutes substandard quality of care and any deficiency which drives the choice of a required remedy category. The SA enters this letter in ID prefix tag column immediately below the tag number of the Form HCFA-2567L. Deficiencies falling in box A are recorded on Form A.

* This is required only when a decision is made to impose alternative remedies instead of or in addition to termination.

Appendix H

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ALLEGATION #1— INSTANCE #1

The May 23, 1996 survey included a deficiency under F309, referencing federal rule 42 CFR 483.25:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The findings stated:

> Based on record review and staff interviews, the facility failed to assure that each resident received the necessary care and services to attain the highest practicable physical well being. Incident reports for April and May were reviewed (63 total incidents) for prompt assessment and treatment of acute condition changes. Problems were found with one of these residents. Findings include:
>
> 1. Resident #1 was assessed on 1/18/96 as being totally dependent on staff for her activities of daily living and had limited function of her legs and arms. The record indicated that on 4/26/96 at 12:45 A.M., staff observed that the resident's left ankle was swollen and blue and the resident would groan with any movement of the ankle. (The resident could not verbalize pain). There was no indication that the physician was notified of this change of condition. The next entry at 1:45 P.M. indicated the ankle remained swollen and purple. At 8:00 P.M., the nurse documented that there was increased swelling and bruising present. At that time, the ankle was observed to be turning inward and was hot to touch. Ice was applied three times during this shift. The documentation indicated the physician was not notified at any time on this day.
>
> Documentation on 4/27/96 at 5:00 A.M. stated that the left ankle remained swollen and bruised. The staff continued to apply ice and elevate the foot on a pillow. Further documentation at 9:00 A.M. indicated the ankle continued to be red, hot to touch, swollen and bruised. The foot turned inward and the resident grimaced when the foot was moved slightly. The physician was notified for the first time at 9:30 A.M. and came to the facility to examine the resident. *The resident was transferred to the hospital where a fractured ankle was treated.* [emphasis added]
>
> The nurse who was working on the day shift on 4/26/96 was interviewed and stated that there was a "mix-up" as to which one of the two nurses was responsible for notifying the physician of the condition change. *Because each nurse thought the other was responsible, the physician was not called.* [emphasis added]
>
> *The facility staff failed to initially promptly assess the resident for signs and symptoms of a fractured ankle which resulted in failure to provide prompt treatment. The delay of over thirty two hours resulted in pain for the resident and failure of the resident to reach her highest level of physical well being.* [emphasis added]

The facility's response stated:

> Preparation and execution of a plan of correction does not constitute an admission or agreement on the part of Elmwood Care Centre of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies.
>
> The circumstances surrounding the incident which prompted complaint letter #ILT96-347 were thoroughly investigated by Elmwood administration prior to the Surveyor's arrival. The finding of that investigation were communicated to the family. Since that time, the Administrator has been in contact with the daughter on at least 9 occasions spanning a total of 5 hours.
>
> This was an unfortunate incident which was caused by an assumption on the part of two nurses that their counter part was going to make the notification call. This occurrence, by State affirmation, has happened only once. The policy (unwritten) had been that the nurse in charge of Wing 5 would make the family and doctor calls. The new policy (in process of being promulgated) will be for the nurse who is serving as Charge Nurse for the resident in question will make the notification calls. This policy will be issue by 6/23/96. The policy will include a requirement to communicate from shift to shift when the notifications have occurred via the communication log. This policy was inserviced on 5/9/96. Our monitoring system will remain the same as the one which identified the initial occurrence. The QARN will monitor the communication logs daily in conjunction with the OPC input monitoring for closure of the notification process.

ALLEGATION #1— INSTANCES #2 through #6

The federal document, "Guidance to Surveyors for Long Term Care Facilities," states in part:

> A medication error rate of 5% or greater ... indicates that the facility has systemic problems with its drug distribution system and a deficiency should be written.

The October 26, 1989 survey included a deficiency under F191/F192. It was the third straight survey to include this deficiency. It had not been corrected following the other two surveys — April 6, 1989; August 14, 1989; and October 26, 1989 — according to Post-Certification Revisit Reports (PCRRs, used by DIA to document correction of a deficiency) provided by DIA.

It should be noted that the federal enforcement remedies (such as mandatory denial of payment for failure to correct a deficiency within 90 days) did not become effective until October 1, 1990, and therefore were not applied.

The October 26, 1989 findings stated:

> The facility did not always have an effective system that was established or adequately maintained to assure that medications were administered in accordance with written orders of the physician as evidenced by a 9% error rate.

1. Six residents received medications that were not given within the appropriate time frames as ordered by the physician at the 4 pm drug pass on 10/24/89 and the 7 am drug pass on 10/25/89.

2. One resident had an order to crush all medications except for Pericolace. No medications given at the 4 pm drug pass on 10/24/89 were crushed.

The facility's response stated:

> Inservice will be held reviewing correct medication administration and all correct times. Emphasis will be placed on following correct procedures and introduction of a red dot system. A red dot will be put on the sleeves and also the medication sheet entry for all PC medications. This will alert the nurse not to give a medication with a red dot with the regular medications.
>
> Continued supervision and periodic monitoring of medication passes will be taken two times a week on each shift and documented. Disciplinary measures will be taken for incorrect medication administration. Three disciplinary actions will result in termination. The nurse that made the majority of medication errors has been terminated for this reason.
>
> Pharmacist and DON will review all MARS for correct time frames for each medication according to physicians orders. All medications are to be in the correct time frames. The Director of Nursing will be held responsible for all the parts and plan of correction for medication administration.

The August 24, 1990 survey (fourth straight) included the identical deficiency. The findings stated:

1. Resident #67 received his Sinement after breakfast on 8/21/90 when the order stated to give it before meals.

2. Resident #79 received her Dipyrdimole 50mg after breakfast was served on 8/21/90 when the order stated to give it before meals.

3. Resident #53 received Hyroxyzine 10mg at 12:40 a.m. on 8/21/90 and the order stated to give at 11:00.

4. Resident #94 received Oscal 500g, Cardizem 30mg, Thioridazine 25mg, and Digoxin 0.125 mg at 12:50 pm on 8/21/90. The order stated to give at 11:00 am.

> These errors constitute a 13 % error rate.

The facility's response to the August 24, 1990 deficiency stated:

> Preparation and submission of this plan of correction is not an admission that the cited deficiencies exist or that the facility failed to meet any regulatory requirements.

> Only two nurses made time errors while passing medication. Two errors were made by one nurse and five errors were made by the other nurse. A total of only 51 medications were reviewed. The pharmacist and the DON [*director of nursing*] will meet quarterly to review medication times for all residents. They have already met on 9-06-90. All nurses and medication aides will be in-serviced quarterly as to the importance of medication timing. All nurses and medication aides will be in-serviced as to the proper use of the unit-dose system. Each nurse and medication aide will be monitored monthly by one of the following, DON, ADON [*assistant director of nursing*], or peers. All results will be recorded.
>
> Date of in-service 9-26-90
> Date of completion 9-28-90

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating:

> On 8/24/90, there were no documented outcomes from the errors. The surveyor recommended F&C because of a repeat deficiency, but both myself[1] and Mr. Bennett disagreed since there were no outcomes. Therefore, it was not presented for F&C. *[fining and citation]*

The next annual survey (July 26, 1991) included the identical deficiency. The findings stated:

> The facility had a 6% drug administration error rate:
>
> 1. Resident #101 had a physician order for Senemet 25/250 one tablet four times a day after meals and at bedtime. On 7/24/91 the medication was given at 7:26 a.m. and the meal was served at 7:50 a.m.
>
> 2. Resident #104 had a physician order for K-Dur 20mEq one tablet daily with food. The medication was given at 7:32 a.m. There was no food available and breakfast was not served until 7:50 a.m. (7/24/91)
>
> 3. Resident #117 had a physician order for K-Norm 10mEq one tab three times a day after meals. The medication was administered at 7:13 a.m. which was prior to the meal being served. (7/25/91)
>
> 4. Resident #81 had a physician order for K-Tab 10mEq one tablet twice a day with food. No food was offered when the medication was administered at 4:20 p.m. on 7/24/91.
>
> 5. Resident #61 had a physician order for Slow K 600mg one tablet with food. The medication was administered at 4:27 p.m. on 7/24/91 with out food being offered.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission of agreement of this provider of the truth, acts, or conclusions

[1] Elaine Escue, Health Facilities Officer I (Area Supervisor)

alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals and the Provider over whether or not the deficiency exists.

Medication passes by Charge Nurses and Certified Medication Assistants will be monitored and documented four times weekly, two times on the 6a.m.-2p.m. shift, and two times on the 2p.m.-10p.m. shift. Twenty residents will be monitored on each medication pass. Monitoring will be done by the Assistant Director of Nursing and the Director of Nursing. An in-service class reviewing the correct procedures for medication passes will be held on 8-15-91 with all RN's, LPN's, and CMA's in attendance. Special emphasis will be placed on medications that need to be taken with food and medications that need to be taken after eating. A special color coded clip will be placed on each Cardex medication sheet holder designating PC medications and medications to be given with food.

The next annual survey (August 7, 1992) included a deficiency under F351, referencing federal rule 42 CFR 483.25(m)(2).

This deficiency was nearly identical to the July 26, 1991 deficiency which referenced F310. HCFA had revised the federal rule numbers and "F-tags" in between the two surveys. Documentation provided by DIA (Health Standards and Quality Regional Letter No. 92-23 from HCFA Region VII in Kansas City, Missouri) indicates deficiencies formerly referenced under F310 were renumbered to F350. Under the revised federal scheme, F350 and F351 were organized as follows:

(m) Medication errors. The facility must ensure that--

(1) It is free of medication error rates of five percent or greater [*F350*]; and

(2) Residents are free of any significant medication errors. [*F351*]

The federal "Guidance to Surveyors for Long Term Care Facilities," states in part:

"Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety....

... The relative significance of medication errors is a matter of professional judgment....

The August 7, 1992 findings under F351 stated in part:

Resident #10 had a physician order for Feasol, one tablet with each meal, dated 6/2/92. Records indicated that the resident had not received the medication which is used to replace iron stores for red blood cell development since it was ordered on 6/26/92. The resident on 6/24/92 had a Hemoglobin of 8.9 g/dl with the normal range being 12-16 g/dl and a red blood cell count of 2.9 million with the normal being 4.2-5.4 million. On 8/5/92 the residents blood count was again checked. The hemoglobin was 10.9 g/dl and the red blood cell count was 3.74 million, both still below normal levels. On 8/5/92 the physician again ordered the medication to be given.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission or agreement of this provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals over whether or not the deficiency exists.
>
> We will continue to assure that residents are free of significant medication errors. On 8-19-92 and 9-24-92 the nurses were in-serviced to the correct procedure for medication administration. All new daily medication orders from physicians will be checked Monday to Friday for accurate orders and for accurate placement on resident medication records. Friday, Saturday, and Sunday's orders will be checked with Monday's orders. Medication cassettes will be checked weekly for accuracy by charge Nurse. This will be monitored by D.O.N. weekly.

The next survey (November 18, 1992) included the identical deficiency. PCRRs indicate it had not been found to be corrected since the August 7, 1992 survey. The November 18, 1992 findings stated:

> 1. Based on observation and record review, the facility failed to assure that residents were free of significant medication errors. During the medication pass observation on 11/17/92 there were 71 chances for error and 2 errors were made (3%) however one error was a significant error that had occurred over a period of time. Findings include:
>
> a. Resident #27 had a physician's order for the daily administration of Coumadin 2.5mg written on 10/30/92. The facility administered 5mg 10/31/92 through 11/17/92 when the error was discovered by the surveyor. (18 doses) A protime was drawn 10/27/92 and found to be 25.3 (N-11.5 to 13.5). This caused the physician to change the order to the lower dose. The protime drawn 11/17/92 was 20.5.
>
> b. Resident #10 had a physician's order for Unilan II (antiacid) to be given 1 hour after meals. On 11/17/92 the medication was given with the meal.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission or agreement of this provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals over whether or not the deficiency exists.
>
> In-service was given on 11-24-92 to all Nurses and CMA's [*certified medication aides*] reviewing proper procedures for medication passes. At least two nurses and one CMA will be monitored weekly by D.O.N. for proper procedure. Medication sheets for the following month will be

compared with cassettes in medication charts by A.D.O.N. and monitored monthly by D.O.N. All new medication orders will be checked by A.D.O.N. with doctors order, charts, Medication Sheets, Pharmacy Communication Sheets, and cassettes in medication carts daily, Monday thru Friday. This will be monitored two times a week by D.O.N. All new cassettes delivered to facility by pharmacy will be checked with doctors orders and signed off on pharmacy communication sheet by RN or LPN only. This will be monitored two times a week by D.O.N. Medication Sheets will not be accepted by facility from pharmacy if previous changes were not made. This will be monitored by D.O.N. monthly. All Nurses and CMA's that contributed to the significant medication error in example 1 were reprimanded and medication error reports were written and placed in their personnel file.

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating:

> On 11/19/92 the medication error rate was 2.8% which was not considered a deficiency. The coumadin was given incorrectly, but during the time of incorrect administration, there were no outcomes. In fact, the prothrombin time decreased. The surveyor did not recommend fining and citation for the error.

ALLEGATION #1— INSTANCES #7 through #11

The federal "Guidance to Surveyors for Long Term Care Facilities" states in part:

> ... If the restraint is used to enable the resident to attain or maintain his or her highest practicable level of functioning, a facility must have evidence of consultation with appropriate health professionals, such as occupational or physical therapists. *This consultation should consider the use of less restrictive therapeutic intervention prior to using restraints....* [emphasis added]

> ... For the resident to make an informed choice about the use of restraints, the facility should explain to the resident potential negative outcomes of restraint use. Potential negative outcomes might include incontinence, decreased range of motion, and decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. 42 CFR 483.20 requires a resident to be comprehensively assessed by an appropriate health professional to determine the resident's specific medical symptoms. *Therefore, if a resident is restrained, the assessment must show the presence of a specific medical symptom that would require the use of restraints, those symptoms that are being treated, and how the use of restraints will assist the resident in reaching his or her highest level of physical and psychosocial well-being....* [emphasis added]

> In the case of a resident who is incapable of making a decision, the surrogate or representative may exercise this right.... *However, the surrogate or representative cannot give the facility permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.* [emphasis added]

> The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR 483.20(d) and 483.10(b), respectively, *and include the right to accept or refuse restraints.* [emphasis added]

The August 24, 1990 survey included a deficiency under F80 and stated:

> This element requires that chemical and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.

The findings stated:

> Resident #22, 50, 70, 83 did not have orders for restraints being used. Resident #83, 88, 101 had orders for restraints that were not being used.

The facility's response stated:

> Preparation and submission of this plan of correction is not an admission that the cited deficiencies exist or that the facility failed to meet any regulatory requirements.
>
> All orders for restraints have been reviewed by Director of Nursing (hereafter referred to as DON). Orders have been obtained for those needed. An in-service will be provided for all nursing staff as to the importance of carrying out restraint orders as written. The Charge Nurse will monitor each shift for compliance. The DON will monitor on a monthly basis for correct restraint orders and use.
>
> Date of in-service 9-06-90
>
> Date of completion 9-28-90

The deficiency was found to be corrected on October 5, 1990, according to the PCRR. A survey six months later (February 12, 1991) included the identical deficiency. The findings stated:

1. Ten of twelve residents reviewed with orders for and currently using physical restraints had no documentation of resident or legal representative involvement in the decision for the use of restraints Residents #18, #24, #41, #44, #46, #61, #64, #75, #104, #112.

   Interviews with facility staff reveals that involvement in the decision for the use of restraints is not always sought from residents or legal representative....

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute admission or agreement of this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department and the Provider over whether or not the deficiency exists.

Forms are already prepared and being used so that all residents and/or responsible parties will be notified and involved in the decision for restraint use. This procedure will be accomplished by the charge nurse at the time of the doctor's order for a restraint. This form will document that date, the restraint(s) used, the family member notified, the resident's notification, the nurse giving notification, and any comments made. The DON will monitor charge nurse restraint progress and implementation.

The February 12, 1991 deficiency was found to be corrected on March 21, 1991, according to the PCRR. The next survey (July 26, 1991) included the same deficiency. The findings stated:

1. Resident #107 had a physician order for a geri-chair and a soft tie restraint when out of bed. The given reason for use of the soft tie restraint was for positioning as the resident sometimes leans when in the geri-chair. *No evaluation had been done to determine if a less restrictive device could be utilized for positioning. The family of this non oriented resident, according to documentation, was not involved in the decision to use a soft tie restraint.* [emphasis added]

2. Resident #47 had a current physician order which stated "Up in geri-chair as tolerated with hip restraints, siderails up in bed with chest restraint." There was no statement included in the order indicating why this level of restriction was required. This resident was identified on the record as being under weight. The resident was also identified as having a "red bottom" due to recent loose stools. The current assessment identifies the resident as incontinent of bowel and bladder, in need of extensive assist with bed mobility, partial hemiplegia of the trunk and total loss of ability to reposition or turn her body. Also that the resident requires manual lifting for transfers.

   On 7/23/91 at 12:48 p.m. the resident was put in bed on her back with vest restraint applied. The resident was left in this position until 3:49 p.m. when the surveyor notified the Director of nursing for intervention. Facility staff did not intervene until 3:57 p.m. *Upon examination the residents coccyx and gluteal fold was observed to be a deep red along with a Stage II pressure sore* approximately .25x.75cm on the right upper inner gluteus. *This pressure sore had not been identified on the residents record.* [emphasis added]

   On 7/24/91 the resident was placed in bed on her back with the chest restraint applied prior to 1:11 p.m. The resident remained this way without repositioning until 3:44 p.m. when the surveyor again intervened and informed the Director of nursing and her assistant.

   Facility documentation revealed that the resident was ambulating 160 feet five times a week in 10/90, 140 feet with minimum assist of two in 11/90 and currently ambulates 60 feet with assist of two.

   An interview with the residents family stated they had been informed about the restraint use, however when asked if they felt the continued use of restraint the response [sic] was "She doesn't seem to want to get up any more." *There was no evidence of a trial of less restrictive*

measures or that consultation with other appropriate health professionals had been requested. [emphasis added]

3. Resident #91 was readmitted to the facility within the past month with a diagnosis including weight loss weakness and open areas on the cocyx. Admission orders included "hip restraint when up in chair, weakness and times of confusion", "in bed-chest restraint with siderails". *The physicians order also stated "keep resident off back". The resident was observed restrained in bed with a chest restraint during the initial tour on 7/22/91, on his back in bed on the afternoon of 7/24/91 and in the a.m. of 7/25/91. The residents record documentation revealed near constant restraint night and day since admission.* [emphasis added]

   There was no evidence that less restrictive measures had been attempted or that other professional consultation had been sought. *There was a high potential for increased loss of functional ability and further skin breakdown.* [emphasis added]

4. Resident #3 had a physician order for chest restraint in the wheelchair and chest retrain with siderails up while in bed. There was no reason for this level of restriction given in the physicians order. The residents assessment stated she slept well at night, was independent in transfers and needing limited assist with locomotion. The assessment also stated "had a wanderguard when she first came but was discontinued on 4/24/91 as the resident is unable to ambulate now." *The resident appears to have lost functional mobility.* Documentation on 1/24/91 stated "up ad lib with walker, gait fairly steady." *The resident was observed to wear a vest restraint throughout the survey.* There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other health professionals had been requested. [emphasis added]

5. Resident #31 had a current physician order for "side rails up in bed, safety belt in wheelchair, chest restraint when in bed." The order did not state a reason for restraint usage. *This resident has a history of pressure sores and recently had a pressure sore healed on the right outer ankle giving a potential for recurrent skin breakdown for someone restrained 24 hours a day.* There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other appropriate health professionals had been requested. [emphasis added]

6. Resident #21 had a current physician restraint order for "siderails up when in bed to prevent sliding," "hip restraint in geri-chair to prevent sliding and falling forward related to poor balance."

   On 1/21/91 this residents ambulation exercises were discontinued due to "unable to stand." *There was no apparent plan for range of motion exercises to maintain this residents maximum functional ability.* There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other health professionals had been requested. [emphasis added]

7. Resident #52 had a current physician order for a hip restraint for positioning in wheelchair to prevent sliding. The order does not indicate any further reason for the restraint. *There was no documentation that this resident, identified as alert by facility staff had agreed to the use of the restraint.* On 7/25/91 the resident was observed in her room in geri-chair with a tray and hip restraint. There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other health professionals had been requested. [emphasis added]

8. Resident #49 had a current physician order for siderails while in bed and hip restraint while in wheelchair to prevent sliding. There was no further reason for restraint use documented. The resident was observed on 7/24/91 in her room in a geri-chair with a tray and the hip restraint. There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other health professionals had been requested.

9. Resident #72 had a current physician order for "hip restraint in wheelchair attempts to slide out of chair." There was no further reason for the restraint. *The resident stated that the restraint was frequently to tight.* There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other appropriate health professionals had been requested. [emphasis added]

10. Residents #45 and 88 had current physician orders for geri-chair with hip restraint due to sliding and/or muscle weakness with no further reason for restraint use. There was no evidence that the facility had attempted a trial of less restrictive measures or that consultation from other appropriate health professionals had been requested.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission or agreement of this Provider of the truth, facts, or conclusions alledged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals and the provider over whether or not the deficiency exists.
>
> Evaluations will be made for all restrained Residents other than side rails every four months by a Licensed Physical Therapist to determine that least restrictive measures are taken. All Residents will have trial periods of less restrictive measures when ordered by the Physical Therapist. Families will be contacted and involved in the decision to use a restraint. Documentation will be made by the Assistant Director of Nursing in the Nurses Notes about the discussion with the family about restraint use. The Resident and/or family will give consent for all Resident restraints used. This will be documented in the Nurses Notes by the Assistant Director of Nursing and will be monitored by the Director of Nursing bi-weekly. Documentation in the Nurses Notes will include reason or reasons why restraint is used, even if it is not included in the Doctor's order. This will be done by the Assistant Director of Nursing and monitored by the Director of Nursing bi-weekly. All Doctors' orders for restraints will be

given to the Assistant Director of Nursing within seventy-two (72) hours for appropriate measures and documentation.

The July 26, 1991 deficiency was found to be corrected February 23, 1992, according to the PCRR. The next annual survey (August 7, 1992) included the identical deficiency. The findings stated:

> Based on record reviews and observations, the facility failed to assure that the residents right to be free from any physical restraints for convenience, and not required to treat the resident's medical symptoms were not abridged in five of eleven residents reviewed. Findings include:
>
> a. Resident #19 was observed to be tightly restrained to their wheelchair under direct supervision during the 8/4/92 breakfast meal, 8/5/92 at breakfast and lunch and evening meal, on 8/6/92 at breakfast meal any where from ten minutes to sixty minutes. The resident was admitted approximately three months ago and has been restrained with the soft tie since that time.
>
> b. Resident #17 was restrained with a soft tie restraint while out of bed. The plan of care indicated that the restraint was to be released during meal time when the resident was supervised. The resident was observed to be restrained at both breakfast and the noon meal on 8/5/92.
>
> c. During noon and evening meal observation on 8/5/92 Resident #13 was observed in a wheelchair with a soft belt restraint in place. There were nursing staff in close proximity during this observation. These restrains were not released.
>
> 2. Based on record reviews, observations and staff interviews the facility failed to use wrist restraints properly. Findings included:
>
> a. Resident #15 was observed during the orientation tour to have a wrist restraint on the left wrist. Nursing staff stated the restraint was needed because the resident pulled at the feeding tube. The resident was not observed to pull at the feeding tube during the survey. It was observed that a padded mitt was used during part of the survey and the feeding tube was not pulled out by the resident when using this less restrictive type of restraint.
>
> b. On 8/5/92 at 5:45 p.m. and at 6:25 p.m. Resident #23 was observed restrained in the chair with a soft tie restraint and with both wrists restrained. Facility staff had stated that the resident was combative with cares and that the wrist restraints were used when cares were being performed. At the time the resident was observed with the wrist restraints in place there were no staff members in the room and no cares were being performed.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission or agreement of this provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of

correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals over whether or not the deficiency exists.

We also believe that residents should be free from restraints and will continue to work toward this in all resident cases. We will continue to reduce the numbers of restraints as well as use least restrictive measures. All new admissions that have restraints will be assessed by the Asst. D.O.N. upon admission and least restrictive measures will be used. Our Asst. D.O.N. will continue to accomplish this and the D.O.N. will continue to monitor on a quarterly basis.

DIA found this deficiency to be corrected November 18, 1992, according to the PCRR.

The April 20, 1994 survey included the identical deficiency. Findings indicated 12 restrained residents were reviewed and:

> ... Problems were identified with ten of the twelve residents. Findings include:

1. Residents with restraints imposed which were imposed for the convenience of staff:

a. Resident #17 was identified as being restrained in a wheelchair when up during the day. *The resident was also observed to be restrained with a soft tie belt in their wheelchair and to their chair in the room throughout the survey on 4/12, 13, 14 and 18/94.* According to the physician's order, this "safety belt" was due to the resident sliding down in their chair. There was no evidence a positioning device had been attempted or considered. In addition, there was no less or least restrictive device assessed to keep this resident from sliding down and out of the chair or protect from injury or harm. [emphasis added]

b. Resident #23 had a physician's order for a self releasing safety belt to prevent falls. This resident did not have the ability to release this device due to a decreased cognition. The resident was observed to be restrained in their wheelchair, with a waist restraint and an upper shoulder harness on 4/15/94, and a soft tie belt restraint in their reclined easy chair on 4/12 and 14/94. On 4/14/94 at 8:34 am the restraint was tied tightly up around the residents upper chest area while the resident was in a reclined position, sleeping. There was no evidence that a less or least restrictive device had been attempted or considered.

c. Resident #16 had a physician's order for a self releasing safety belt when up, due to falls and their husbands request. *The resident was observed to be restrained to a chair through out the survey 4/11-15 and 18/94. The restraint used was not a self releasing device. On 4/12, 13 and 14, the restraint was observed to be applied tightly and the resident tried but was unable to reposition themself.* There was no evidence that a less restrictive device had been attempted, considered or explained to the family member as an option to offer the same amount of safety for the resident. [emphasis added]

d. Resident #13 was observed during the initial tour on 4/11, and on 4/12 and 13/94, to be restrained in their wheelchair with a soft tie belt. *The facility identified this restraint as being a self releasing device, however, on 4/13/94, when requested, the resident was unable to release the device or even comprehend simple commands or conversation.* When asked directly, a staff member agreed the resident was or would be unable to release this device. The staff member then removed the soft tie belt and placed pillows between the resident and the sides of the wheelchair. The resident was observed throughout the rest of the survey to have no falls or attempts to get out of the wheelchair unaided. The resident suffered a fractured hip on 3/30/94. There was no evidence that a lesser restrictive devise had been considered to protect the resident from further injury. [emphasis added]

e. Resident #75 was observed restrained to their wheelchair on 4/12, 13, 14 and 15/94, with a soft tie belt around their upper abdomen and on 4/15/94 at 7:25 am and on 4/13/94 at 12:08 pm the restraint was up around their chest, *which was not only inappropriate but can pose a risk for choking or making it difficult to breathe. This was especially risky because this resident wanders throughout the facility and is not within direct visual contact of facility staff at times.* The soft tie was removed on 4/15/94 and replaced with a bolster device over the residents lap that appeared to offer the same amount of protective positioning, however was less restrictive and was more dignified (according to family members). The resident was admitted on 1/6/94 after they fell at home and fractured their ribs. A family member wanted this resident restrained so they would not fall and injure themselves again. There was no evidence that a less or least restrictive device had been attempted or considered prior to the use of the soft tie waist restraint. [emphasis added]

f. Resident #14 was observed to be restrained with a tie restraint in bed on the a.m. of 4/12/94. The restraint was again applied to the resident after he was assisted to bed on the p.m. of 4/18/94. At this time the staff person providing care stated that she had just learned that the resident was not to be restrained in bed. She also stated that the resident had been restrained in bed when she had assisted him out of bed that morning. The plan of care did not make provision for this restraint while the resident was in bed. Also the resident was observed to be restrained at all times, except meals, in the wheel chair. There was no evidence that a less or least restrictive restraint had been attempted.

g. Resident #15 was observed to be restrained when out of bed and in the wheel chair. Facility staff stated, and documentation indicated, that the residents spouse had requested that the restraint be used. *There was no evidence that the spouse had been made aware of possible risks involved with restraint use or been made aware of alternate methods of providing safety for the resident.* [emphasis added]

h. Resident #18 had a physician order to use a soft belt restraint while in wheel chair as needed when the resident was agitated. The resident was observed in her wheel chair in her room on the a.m. of 4/12/94 with a soft belt self release restraint in use. This resident stated twice that she was unable to release the restraint. The resident was observed at the table in the dining room on 4/15 and 19/94 at breakfast time with the restraint in

place. The restraint was also placed on the resident after she was assisted out of bed on the afternoon of 4/18/94. *At none of these times did the resident appear to be agitated or combative with staff.* [emphasis added]

i. Resident #20 was observed to be restrained in a wheel chair after she was assisted out of bed at 11:14 a.m. on 4/18/94. The restraint was of a self releasing type but the resident would be unable to release the restraint. Documentation indicated that the family did not desire any further restraint reduction than the restraint currently in use. During an interview with the family it was stated that the family was not opposed to further restraint reduction if the resident could be safe from falls. *There was no documentation to indicate that the family had been made aware of potential risks related to restraint use nor had they been offered less or least restrictive devices to consider.* [emphasis added]

j. Resident #19 had a physician's order for a safety belt restraint in the wheelchair when up. The resident was observed restrained with a soft tie belt inappropriately tied on their upper abdomen from 4/12 through 15/94. *According to documentation this restraint was due to a family request, however, on 11/19/93 it is also documented that a family member complained about the restraint and that the resident cried indicating they did not want to be "tied up."* The assessment on that date stated "attempts to reduce in November were not successful." There was no explanation as to what that meant, what the reductions consisted of or if a less restrictive device had been tried. On 4/18/94 the resident was observed to be using a lap bolster (less restrictive than a soft tie restraint) and it appeared to offer adequate protection if the resident attempted to ambulate unassisted. There was no evidence the facility considered or attempted a less or least restrictive device prior to application of the soft belt restraint. [emphasis added]

The facility's response stated:

Preparation and execution of this plan of correction does not constitute an admission or agreement of this Provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals and the Provider over whether or not the deficiency exists.

All residents will be free from any physical or chemical restraints, except where required to treat residents medical symptoms and then the facility will assure that only the least restrictive form of physical restraint will be used. Family and residents will be involved in all attempts to have the least restrictive. Other methods will be tried to attempt to meet the medical and safety of the residents and the facility will continue to strive for the least restrictive. If a problem arose with not being able to identify least restrictive device or family conflicts, we will involve P.T./O.T. to provide least restrictive. D.O.N., A.D.O.N. will monitor weekly.

ALLEGATION #1— INSTANCE #12

The August 14, 1989 survey included a deficiency under F180/F262. The findings stated:

> The facility did not always have an effective system that was established or adequately maintained to assure that each resident was provided with the amount of food and fluid on a daily basis necessary to maintain their appropriate minimum average weight. Daily food and fluid intake was not always observed and encouraged as evidenced by:
>
> 1. Resident #29 had a 14% weight loss in July. There was no documentation of the physician being notified. The dietary assessment lacked protein and calorie intake and needs. The resident had a grade III pressure sore on his left foot and a grade II on his cocyx.
>
> 2. Resident #76 had a 10% weight loss since April. The dietary assessment lacked protein and calorie needs and intake.
>
> 3. Resident #81 had a 16.9% weight loss for the past 6 months and resident #4 had a 10% weight loss in 6 months. The dietary assessments lacked protein and calorie needs and actually intake.
>
> 4. Resident #64 had a 14% weight loss in the past 6 months and has skin ulcers. The dietary assessments lacked protein and calorie needs and intake.
>
> 5. Two other residents #59 and 71 were below their ideal body weight range and had been losing weight for the past 3 months. The dietary assessments were incomplete and lacked protein and calorie needs and intake.
>
> 6. Several alert residents stated that the food was bland, tasteless with no seasoning or of poor quality.

The facility's response stated:

> All proportions are set by diets from the Simplified Diet Manual. The cook will read, follow and prepare each diet as described by menu and diet card. Proportions of all food items will be measured by the cook, to assure that each resident is provided with the necessary food and fluid on a regular daily basis. This process will be monitored and supervised on a daily basis by the Food Services Supervisor, who will also be responsible for compliance.
>
> All nursing assistants will observe and encourage food and fluid intake discussed at Inservice 9-12-89. All intake will be written down on new Intake Forms which will separate out all food and fluid items. The Charge Nurse will supervise and monitor nursing assistants to make sure they encourage residents to eat and to fill out new Intake Forms. New forms will be in use by 9-25-89.
>
> The Registered Dietitian will do a Basil Energy Evaluation on all residents who have lost more than 5 lbs. in a month. This was started on 9-8-89. The Registered Dietitian will also do a BEE on all residents that have open

areas. This will be monitored and supervised by the DON. The doctor will be notified of every 5 lbs. weight loss in a single month by the Charge Nurse. The Charge Nurse will also notify the DON of such weight loss. The BEE will be performed in order to assess resident calorie and protein needs. The BEE will be performed on the visit after the 5 lbs. weight loss is discovered. Residents that have higher protein needs will receive high protein, high calorie snacks, three times daily. The Registered Dietitian will be responsible for monitoring assessments and for compliance. Started 9-8-89. The Food Services Supervisor has devised new snack intake sheets to monitor snack consumption. She will be responsible for monitoring and compliance. Started 9-8-89.

ALLEGATION #1— INSTANCE #13

The July 26, 1991 survey included a deficiency under F283, referencing federal rule 483.25(c)(1):

> Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

The findings stated:

> Resident #45 who returned from the hospital on 6/6/91 had nurses notes which indicated that the skin was intact with no marks or abrasions. On 6/12/91 a pressure sore documentation sheet was started with nothing noted in the nurses notes until 6/19/91 which stated "coccyx red". By 7/3/91 the coccyx had a Stage II pressure sore 2cm in diameter and by 7/19/91 it was a Stage III pressure sore 3cm x 2cm x 1cm. Staff had not followed up on this area when it was still at Stage II on 7/4/91 according to the Director of Nursing. During this same period the resident had experienced a 9% weight loss from 6/6/91 to 7/2/91. The care plan approach was to prevent pressure at all times, however the resident was observed in a geri-chair with a tray and a hip restraint on 7/24/91 and 7/25/91 for at least an hour over the noon meal period and up again later. The plan of care had no nutritional approaches for protein supplement to facilitate healing. During the observations on 7/23/91 the coccyx area was red and the gluteal area was excoriated.

The facility's response stated:

> All open areas will be monitored daily by the Charge Nurse and documented weekly by the Charge Nurse. The Director of Nursing will monitor all open areas periodically and chart findings in the Residents' chart. The Food Service Supervisor will be consulted for nutritional approaches and/or for protein supplements for any Resident with open areas. These approaches will be stated in the Resident's Plan of Care. This entire correction will be monitored by the Director of Nursing weekly.

ALLEGATION #1— INSTANCE #14

The December 30, 1991 survey included a deficiency under F224, referencing federal rule 483.15(e)(2):

> A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

The findings stated:

> Three of seven residents identified by the facility as alert and interviewable who had recent intrafacility transfers stated that they had not received advance notice of the transfer.
>
> Resident #31 with multiple coronary diagnosis and a recent hospitalization was found to have been moved on 11/25/91 without prior notification or consent, causing the resident distress and anxiety which lasted to the time of the investigation.
>
> There was no documentation of consent for the move of Resident #38. Documentation in the record indicated this resident was upset by the move.
>
> There was documentation for consent of the move of Resident #57, however it was signed by a son of the resident who did not have P.O.A. This was signed on the day of the move.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute and admission or agreement of this Provider of the truth, facts, or concussions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals and the Provider over whether or not the deficiency exists.
>
> Notification will be documented in the Resident's record and will be signed by the Resident or responsible party. This too will be completed by our social worker. Our social worker will be responsible for maintaining this system's compliance. Our facility social worker will notify the Director of Nursing upon completion of these steps. The Director of Nursing will be responsible for monitoring this system's compliance and will then check these steps.

ALLEGATION #1— INSTANCES #15 and #16

The federal "Guidance to Surveyors for Long Term Care Facilities" states:

> Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual dose reduction should be under close supervision....
>
> ... While the facility can refer to a physician's justification as a valid justification for use of a drug, it may not justify the use of a drug, its dose, its duration, etc. solely on the basis that "the doctor ordered it."

The federal guide goes on to indicate that "clinically contraindicated" applies only under specific criteria to residents with one of 10 listed medical diagnoses, including schizophrenia, acute psychotic episodes and Huntington's disease.

The July 26, 1991 survey included a deficiency under F309, referencing federal rule 483.25(l)(2)(ii):

> Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, drug holidays or behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

The findings stated:

1. Resident #31 had an increase in Mellaril dosage from 10mg at bedtime to 20mg at bedtime on 5/7/91. There was no documented justification for this medication increase other than "can become agitated at times." The resident was also documented as "friendly and cooperative". There was no evidence that there had been any previous dose reduction, drug holidays or that alternative behavior programs had been used. The resident was observed sleeping, restrained, in her wheelchair at various times throughout the survey. This resident did not have an diagnosis to justify the use of Mellaril.

2. Resident #17 had her dosage of Mellaril increased from 50mg daily to 60mg daily on 6/28/91. Documentation on 6/27 and 28/91 stated the resident was becoming more aggressive, combative with agitation, however, monthly nursing assessments in March, April, May, June and July 1991 stated the resident was "usually friendly and cooperative, pleasant and friendly". There was no further documentation to justify this medication increase nor was there an appropriate diagnosis. There was no documentation of previous dose reductions or drug holiday.

3. Resident #115 had a physician order to increase the dosage of the psycotropic drug Mellaril from 10mg three times a day to 10mg twice a day and 25mg at bedtime in April 1991 and then in May of 1991 the medication was again increased to 10mg in the morning, 20mg later in the day and 25mg at bedtime. This represents an increase in the total daily dose from 30mg to 55mg. There was no quantitative documentation to indicate frequency of behavior problems; at infrequent intervals it was documented that the resident was uncooperative and/or combative. The resident had fallen six times after the medication had been increased. There was no indication of falls prior to the increase in medication. There was no documentation of any attempt of dose reduction.

4. Resident #25 had a physician order for Mellaril 10mg three times a day since admission in June 1990. No attempt had been made to reduce the dosage of this psychotropic medication. There was no behavior documented to indicate continued need and was assessed consistently as friendly, cooperative and pleasant.

5. Resident #103 had a physician order for Mellaril 25mg three times a day since at least 9/1/91.[2] No attempt had been made to reduce this psychotropic medication.

6. Resident #88 had a current physician order for Mellaril 10mg three times per day and 25mg three times per day. This represents an increase of 45mg since July 1990. The only behaviors documented to indicate a need for this medication were "restless and nervous" and one isolated instance of wondering into another residents room. These documentation's were intermittent with no quantitative figures to represent frequency. There was no documentation of previous attempts at dose reduction.

The facility's response stated:

> Preparation and execution of this plan of correction does not constitute an admission or agreement of the Provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals and the Provider over whether or not the deficiency exists.
>
> Physicians will be notified concerning the possibility of reducing anti-psychotic drugs that are ordered by the physicians for their Residents. A record of the Residents' behaviors will accompany this request. This notification will be completed by the Director of Nursing by 8-15-91. Behaviors of all Residents receiving anti-psychotic drugs will be monitored daily by the Charge Nurse and documented daily by the Charge Nurse on an anti-psychotic Monthly Flow Record kept in the Cardexes with the Residents' medication records. The Director of Nursing will monitor residents' behaviors and documentations on the Antipsychotic Monthly Flow Records two times weekly and record findings in a special monitor record book. The anti-psychotic Monthly Flow Record will contain specific behaviors for each Resident receiving anti-psychotic drugs as well as side effects. Evaluations by the Director of Nursing and physicians will be completed on a quarterly basis for all Residents receiving anti-psychotic drugs for possible reduction or stop orders. The consulting pharmacist will also monitor dosage of anti-psychotic drugs and the behaviors of the Residents receiving the drugs on a monthly basis as part of his monthly medication review.

The next annual survey (August 7, 1992) included a deficiency under F348, referencing federal rule 483.25(l)(2):

> (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

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[2] Since the date of the survey was July 26, 1991, this reference to "9/1/91" appears to be a typographical error.

The findings stated:

1. Based on record review it was noted that the facility failed to assure that residents were not given antipsychotic drugs when there was no evidence of a specific condition demonstrating the need for this type of drug for four of ten residents reviewed who receive antipsychotic medications. Findings include:

a. Resident #12 was receiving Mellaril 10mg twice a day. The last dose reduction was 9/4/91. This resident had no behaviors documented and no specific condition which would necessitate the use of an antipsychotic drug. This drug was discontinued during the survey.

b. Resident #21 was receiving Mellaril 10mg every bedtime. This resident had no behaviors documented and no specific condition which would demonstrate the need for this type of drug. The director of nursing said the medication was started back in 1987 because the resident was climbing over the side rails at night. This medication was discontinued the 2nd day of the survey.

c. Resident #79 was receiving Mellaril 50mg. every bedtime. There were no specific behaviors documented in the residents record to justify this level of sedation. Although the facility had documentation of notification of this residents physician on 1/4/92 requesting a dose reduction it was not responded to until 5/13/92 at which time the physician denied a dose reduction without explanation, even though available documentation stated the resident "behavior is fairly calm and relaxed during the day" and "rests well at night." On 8/6/92 the resident was observed to have symptoms of Tardive Dyskenesia (uncontrolled and irreversible tongue thrust), a direct side effect of antipsychotic drug use. The residents record and facility personnel did not reflect or recognize this symptom.

d. Resident #17 had received Mellaril 10mg. twice a day and 25mg. three times a day since the dose was reduced 9/7/91. Since that time the facility had requested twice to have the dose reduced as the resident, according to documentation, had had only one episode of agitation. The Physician declined to reduce the dose and the facility failed to investigate a reason for not reducing the dosage. The pharmacist was aware of the dosage and behaviors. Neither the pharmacist nor the medical director were requested to assist in determining why the dose could not be reduced.

The facility's response stated;

Preparation and execution of this plan of correction does not constitute an admission or agreement of this provider of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies. This plan of correction is being submitted only in an attempt to settle a dispute between the Department of Inspections and Appeals over whether or not the deficiency exists.

Residents who are on antipsychotic medications for a specified diagnosis or behavior will be reviewed daily on each shift by the Charge Nurse. When resident behavior changes so that medication can be reduced, the interdisciplinary team will discuss the need for drug reduction. The pharmacist will be notified of behavior changes and the need for reduction. The physician will be sent a written notice of change in resident's condition and a request for a specific reduction by the Asst. D.O.N. Follow-up telephone calls with the physician for reductions will be done weekly by the D.O.N. beginning one week after the written notice has been sent until a reply is obtained. These telephone calls will be documented in the Nurses Notes by the D.O.N. Follow up with physicians and pharmacists for drug reduction requests will be done at least quarterly by the A.D.O.N. If no reductions have been received from physicians, the A.D.O.N. will request that the medical director assist with the reduction plan. This will be monitored by the D.O.N. monthly. When a new order for antipsychotic medication is received or a resident is admitted with antipsychotic medications, an assessment to reduce these medications will be started at the first care planning conference. This will be monitored by the A.D.O.N.

ALLEGATION #1— INSTANCES #17 through #19

Beginning October 1, 1990, both federal and state law mandated the "denial of payment" remedy for any facility failing to correct any deficiency within 90 days after its discovery by DIA. The federal mandate is in OBRA 1987 at 42 USC 1396r(h)(2)(C). The state mandate (as of October 1, 1990) was in 441 IAC 81.19(2)[3], which stated:

a. No payment shall be made for newly admitted Medicaid residents when the following conditions exist:

(1) The facility has failed to correct deficiencies within 90 days....

c. A deficiency statement issued by the department of inspections and appeals shall include information that failure to correct deficiencies within three months shall result in denial of payment for new admissions. *Three days after the deficiency statement is mailed, the three-month time period shall begin.* [emphasis added]

Review of surveys involving Elmwood Care Centre, as well as Post-Certification Revisit Reports, indicates DIA did not find the following deficiencies to be corrected within the required period:

1. One deficiency in the October 5, 1990 survey was not documented as corrected until February 12, 1991 (approximately four months after the facility administrator signed and dated the facility's response on October 16, 1990.[4]) This deficiency was tagged as F262.

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[3] This rule was rescinded effective July 1, 1995 and replaced with a rule that produces a nearly identical mandate. The primary difference is that under the new rule [at 441 IAC 81.40(2), identical to a new federal rule that became effective July 1, 1995], the mandate does not apply if the deficiency upon revisit is found to pose no greater risk to resident health or safety than the potential for causing minimal harm.

[4] Because DIA's records do not indicate when deficiency statements were mailed, this review will attempt to rely on the date the facility signed its response to establish the begin date for the denial of payment remedy.

2. Eight deficiencies in the July 26, 1991 survey were not documented as corrected until February 28, 1992 (approximately six and a half months after the facility administrator signed and dated the facility's response on August 12, 1991.) These deficiencies were tagged as F172, F177, F203, F309, F310, F340, F436 and F283.

3. Three deficiencies in the August 7, 1992 survey were not documented as corrected until February 22, 1993 (approximately six months after staff had been in-serviced on August 19, 1992, in response to a particular deficiency, according to the facility's response.[5]) These deficiencies were tagged as F351, F316 and F328.

4. One deficiency in the June 3, 1993 survey was not documented as corrected until October 22, 1993 (approximately three and a half months after the facility administrator signed and dated the facility's response on July 8, 1993.) This deficiency was tagged as F301.

5. Three deficiencies in the April 20, 1994 survey were not documented as corrected until August 11, 1994 (approximately three months after the facility administrator signed and dated the facility's response on May 9, 1994.) These deficiencies were tagged as F221, F322 and F344.

6. Six deficiencies in the April 5, 1995 survey were not documented as corrected until September 12, 1995 (approximately three months after the facility administrator signed and dated the facility's response on July 6, 1995.[6]) These deficiencies were tagged as F183, F260, F317, F367, F377 and F459.

Information received from DIA indicates it did not issue denial of payment in connection with the facility's failure to correct these deficiencies within the required period.

ALLEGATION #1— INSTANCE #20

The April 19, 1996 survey included a deficiency under F312, referencing federal rule 42 CFR 483.25(a)(3):

> A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

The findings stated:

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[5] The facility administrator signed and dated the facility's response on October 26, 1992. However, other information indicates the facility actually received the statement of deficiencies some time before August 19, 1992 — the facility's response to a deficiency under F351 states in part, "... On 8-19-92 and 9-24-92 the nurses were in-serviced to the correct procedure for medication administration...." The top of the first page of the survey states, "Revision as a Result of Informal Conference of October 12, 1992," which apparently explains the delay.

[6] Similar to example #3 in this list, the cover sheet to this survey states "REVISED," indicating the facility appealed some or all of the deficiencies, thereby delaying the facility's formal plan of correction. However, unlike example #3, the facility's response does not include any dates that would appear to establish the date by which the facility had received the survey.

Based on surveyor observations and record review, the facility failed to assure that dependent residents were given services to maintain good nutrition and grooming. Eighteen residents were reviewed and fifteen were dependent and needed assistance with grooming and/or eating. Problems were found with cares provided to four of those fifteen residents. Findings include:

Nutrition:

1. Resident #13 was assessed as having a stage two pressure sore, sustaining a significant weight loss, being incontinent and needing extensive assistance with grooming and limited assistance with eating. The resident was observed on 4/16/96 at breakfast from 7:50 until 8:30 am to eat only ½ of the egg, a few bites of cereal and ½ of the juice. The resident was not encouraged or cued or assisted to eat more of his breakfast.

   The resident was observed at breakfast on 4/17/96 at 7:45 a.m. Staff were observed to assist the tablemate with eating but this resident was not offered any assistance. At 8:00 am, the resident left the table. The resident had not eaten any of his breakfast. The resident did not return to the table and his breakfast was taken away at 8:30 am. *The resident had sustained a significant weight loss of 11% in the past three months. Failure to assist the resident in the area of eating resulted in weight loss and was a risk factor in the formation of a stage two pressure sore.* [emphasis added]

2. Resident #2 was observed at the breakfast table at 7:45 a.m. on 4/17/96. The resident's breakfast was served at 7:55 a.m. and the resident was observed to sit and not eat nor be encouraged nor assisted to eat until 8:10 a.m. At 8:20 the staff person assisting and/or feeding the resident left the resident when she'd eaten less than half of the meal. *Failure to assist the resident in a timely fashion placed the resident at risk for inadequate food intake and potential weight loss.*

Grooming:

1. Resident #13 was observed on 4/16/96 to be given incontinence cares at 9:30 am. The nurse aide cleansed the resident's rectal area then cleansed the resident's penis and abdominal folds in front. At 11:30 am, the resident was observed during incontinence cares and the nurse aide did not wash the resident's buttocks or hips which had become soiled with urine. The resident was next observed at 1:40 pm to be placed on the toilet. The resident had been incontinent and his buttocks and hips were not cleansed. The aide did cleanse the scrotum and penis but used only warm water. *Failure to adequately cleanse the resident after incontinence could result in excoriation of skin and increased chance of pressure sore formation and discomfort for the resident.* [emphasis added]

2. Resident #12 was observed on 4/16/96 to have been incontinent of urine. His pants were soaked with urine. The resident's hips and buttocks were not cleansed. On 4/17/96 at 9:30 am, the resident was observed to have been incontinent. The resident was transferred back

to bed but did not receive any incontinence care. The resident was observed at 1:15 pm to have been incontinent of urine and stool. The resident's rectal area and buttocks were cleansed but the resident's penis and abdominal folds were not cleansed. The care plan stated that the staff were to apply a moisture barrier after the resident received incontinence care but this was not done any time when incontinence cares were observed. *Failure to adequately cleanse the resident following incontinence episodes could result in excoriated skin and increases the risk for pressure sore formation.* [emphasis added]

3. Resident #6 had exercises and was helped to walk beginning at 3:10 p.m. on 4/16/96. When the resident was assisted out of the wheel chair for ambulation it was observed that the resident's trousers were wet with urine in both the front and back. After ambulation the resident was assisted back to the wheel chair, was involved in additional activity with the restorative nursing staff and at 3:30 p.m. was taken to the dining room to have coffee. At 3:50 p.m. staff returned the resident to his room and the wet clothes were removed. The residents hips, buttocks and posterior thighs were washed, however the penis, scrotum nor abdominal folds were washed. [*sic*] The resident was observed to be incontinent of urine again on 4/17/96 at 9:50 a.m., with trousers wet in the back as well as the front. The resident was taken to his room where a staff person provided perineal care for the resident, however only the residents penis and pubic area were washed. The hips and buttocks were not washed.

   Failure to adequately cleanse the resident following incontinence episodes could result in excoriated skin and increases the risk for pressure sore formation. Lack of providing opportunity for toileting also placed the resident at risk for additional episodes of incontinence. [emphasis added]

The facility's response stated:

Preparation and execution of a plan of correction does not constitute an admission or agreement on the part of Elmwood Care Centre of the truth, facts, or conclusions alleged and set forth in this statement of deficiencies.

F312-1

Nutrition:

Reference Residents #13 and #2: Residents needing dining room assistance was moved to Assisted Dining room on 4/19/96. Staff are in attendance and assist at all meals in this area. The meal times will be monitored weekly by both QARN and Health Services Supervisor for residents who appear to need assistance for consideration, through the care planning process, to be transferred to the Assisted Dining area. This surveillance will be on-going.

F312-2

Grooming:

Reference Resident #13, #12, and #6: Staff will give adequate incontinence cares. The process of evaluating all incontenance care staff for effectiveness of their procedures began immediately upon the Survey Team departure. The evaluation and training (where indicated) has been very effective except in one case and that care giver is no longer a member of our team. All individuals were evaluated by 5/19/96. Inservicing of staff is on-going (written 4/24/96, discussed at staff meeting and change of shift conference). There is random monitoring schedule being worked by QARN and Health Services Supervisor. The Surveyor at Elmwood investigating ILT96-347 was aware of the effectiveness of this evaluation and training effort.

Reference Resident #6: Restorative Aids were apprised of necessity of checking their wards for incontinence before returning them to their routine. For those needing care, they are to inform responsible CAN of the residents need. Accomplished 5/10/96 and re-inforced at follow on staff meeting. Monitoring will be on-going by QARN.

Appendix I

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ALLEGATION #2 — INSTANCE #1

The May 6, 1994 survey included a deficiency under F309, referencing federal rule 42 CFR 483.25:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The identical deficiency was included in surveys of March 5, 1992 and November 21, 1991.

The May 6, 1994 findings stated in part:

> ... The facility staff did not always totally assess and intervene in a timely manner when there was a change in a resident's condition.... Findings include:
>
> 1. On 05/03/94, at 9 a.m. Resident #60 was observed to be crying out. A CAN stated that he was having trouble with his foley catheter. A moderate amount of bleeding was noted around the catheter site and on the bed linen.
>
>   Documentation indicated that the resident had been found to have a large amount of bleeding around the catheter site at 1 a.m. on 05/03/94. The penis was edematous at that time and there was a large amount of blood in the foley tubing. At 7:30 a.m. the resident was complaining of severe pain in the lower abdomen. His abdomen was hard and distended and profuse bleeding continued from around the catheter site. At 8:30 a.m. the resident continued to have profuse bleeding and severe pain.
>
>   The physician's office was called at 9:15 a.m. and the office staff stated the doctor was not in yet and would have him call when he arrived at the office. The doctor returned the call at 11 a.m. and ordered the resident transferred to the hospital.
>
>   The resident was admitted to the local hospital with a diagnosis of hemorrhagic cystitis and was transferred to another hospital to see a specialist.
>
>   This resident was transferred back to the facility on 05/05/94, with a diagnosis of neurogenic bladder and a physician's order to leave the catheter in.
>
>   *There had been no vital signs taken on this resident from the time the bleeding was first observed over ten hours before transfer. There was no indication the staff had attempted to notify the physician of the bleeding and pain for eight hours.* [emphasis added]

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   This resident was transferred back to the facility on 05/05/94, with a diagnosis of neurogenic bladder and a physician's order to leave the catheter in.

   There had been no vital signs taken on this resident from the time the bleeding was first observed over ten hours before transfer. There was no indication the staff had attempted to notify the physician of the bleeding and pain for eight hours. [emphasis added]

The failure of the facility to totally assess the resident and notify the physician timely resulted in delay in the provision of needed care and services and could have resulted in further complications for the resident. [emphasis added]

2. Resident #1 closed record, was sent to the hospital on 02/15/94, with a fasting blood sugar of 404. This resident had elevated blood sugars, ranging from 263 to over 500, since 02/01/94. The physician had been notified of the abnormal blood sugars and orders were received for low doses of insulin. The blood sugars continued to be elevated.

   This resident expired at the hospital on 02/18/94, three days after admission, with the cause of death listed as sudden death with electro mechanical dissociation. [emphasis added]

   The facility failed to intervene further when low dosages of insulin were not controlling the elevated blood sugars. [emphasis added]

3. Resident #3 closed record, sustained a fall on 02/12/94. Vital signs were taken and neuro checks were done.

   It was documented that the resident was very restless, lips and nail beds cyanotic and skin was cool and clammy to touch on 02/13/94, at 12:45 a.m. Her vital signs were 97.6-110-36 with a blood pressure of 100/58. *Despite continued notation of abnormal vital signs, color pale, etc., there was no indication an attempt was made to contact the physician until 5 a.m. on 02/14/94,* [28 hours later] when a FAX was sent to him. [emphasis added] The physician responded at 4 p.m. on 2/14/94, and a blood sugar was drawn at that time. The doctor requested that the resident be sent to the clinic the following day. The resident continued to be sweaty, have an unsteady gait and was weak.

   The clinic was notified that the resident would not be able to be sent to the clinic on 02/15/94, due to not having a ride.

   The resident was sent to the clinic at 9:45 a.m. on 02/16/94, (three days after significant problems noted) and was admitted to the hospital at 12:30 p.m.

   The physician when interviewed per telephone stated that the resident was having tachycardia, elevated temperature, and elevated white blood count when he arrived at the clinic.

   The resident died at the hospital on 03/07/94 with the number one cause of death being renal failure.

   The failure of the facility to totally assess the resident and notify the physician timely resulted in delay in the provision of needed care and services which could have contributed to his death. [emphasis added][1]

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[1] About two weeks after this resident's death, Charles Sweeney, then-director of DIA, was quoted in an article in the Des Moines Register: "We don't believe the quality of care is deteriorating. We don't believe regulation is too lax. We have nursing homes screaming at us all the time that regulation is too

4. Resident #63 sustained a fall on 11/28/93, at 3:45 a.m. The only injuries noted at that time was a 1 cm. laceration by the left outer eye. Vital signs and neurochecks were taken and found to be in the normal range.

   There was no record of the physician being notified until 11/29/93 at 10:15 a.m. of the resident's fall and complaints of left arm and wrist pain (there had been no notation in the medical record until 8:00 a.m. about any pain in the arm area).

   The physician returned the call at 12:15 p.m. and ordered the resident be brought to the clinic for an x-ray of the left arm, wrist, and hand.

   The next entry was at 4:35 p.m. when the family was called but could not be reached. At 6:40 p.m. a relative was contacted. That relative stated no family member was able to take the resident to get x-rays taken. "Will pass on to 7-3 shift to make transportation arrangements in a.m. Resident complaining of slight left wrist pain". Oral pain medication was given.

   The resident was taken to the clinic at 3:30 p.m. on 11/30/93, by a staff member for x-rays. The resident returned to the facility at 5:15 p.m. with an order to wear a wrist splint continuously except when bathing and re-x-ray left wrist in 7-10 days. The resident had sustained a sprain in the fall and this was the same wrist that had been fractured immediately prior to her admission which had required hospitalization.

   The failure of the facility to totally assess the resident, notify the physician timely, and then get her to the clinic resulted in delay in the provision of needed care and services. The delay in treatment of the injury to the wrist caused this resident to suffer needless pain. [emphasis added]

The facility's response stated:

> Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all following pages....
>
> A nurses' meeting will be held weekly for three months to address "total assessments and intervention in a timely manner." Prompt transportation will be provided for residents for appointments and when physician ordered. This area will be monitored closely by DON and reported to ADM.

DIA took no enforcement action as a result of this deficiency or the other 10 found at the May 6, 1994 survey.

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating:

> Unknown. The program coordinator was out of the office and not involved in processing survey findings.

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rigid. *And we certainly see no signs that due to the quality of care that people are dying....*" [emphasis added]

ALLEGATION #2 — INSTANCES #2 and #3

The December 18, 1992 survey included a deficiency under F351, referencing federal rule 42 CFR 483.25(m)(2):

> **(m) Medication errors.** The facility must ensure that--
>
> ... (2) Residents are free of any significant medication errors.

This was the second straight survey to include this deficiency — it was included the month before in the November 9, 1992 survey and the year prior in the November 21, 1991 survey.

The federal "Guidance to Surveyors for Long Term Care Facilities," states in part:

> "Significant medication error" means one which causes the resident discomfort or jeopardizes his or her health and safety....
>
> ... The relative significance of medication errors is a matter of professional judgment....

The December 18, 1992 findings stated:

> Based on closed record review, it was determined that the facility made a significant medication error on one of the five closed records reviewed. Findings include:
>
> 1. Resident #1's closed record revealed delays in initiation of antibiotics ordered for prevention and treatment of an infected arm. Please reference F0164 item 3.

Item 3 of F164 stated:

> The closed record of Resident #4 noted that on 11/27/92 at 7:30 pm the resident returned from the hospital after treatment for an injury resulting from a human bite. The physician ordered Augmentin 250mg to be taken three times a day and a note to return to E.R. with any sign of infection. The resident did not receive the first dose of the antibiotic until 12 noon on 11/28/92, seventeen hours after the medication was ordered. There was no documentation that the physician was notified of that time lapse.
>
> There were notes of inflammation, swelling and yellow drainage beginning 11/28/92. There was no indication a physician was contacted until a call was made to the clinic 11/30/92, at 10 a.m. with a followup appointment at 2:30 p.m. The physician changed the antibiotic to Amoxicillin 500 mgm. three times a day. According to the medication administration record, the medication was not started until 8 a.m. the following day, about 16 hours later.
>
> There were no descriptions of the site from 11/30/92, until 7 p.m. 12/02/92, when the physician was notified that the left hand was swollen and there was a reddened area under the left forearm. The physician changed the antibiotic to Cipro twice a day.

> At 6 a.m. on 12/07/92, the nursing notes describe the left hand and fingers as swollen with 1 plus edema and the arm was warm to touch and very tender. At 10 a.m. a call was made to the physician at which time there was a notation of a 4cm. draining area and that the left arm was three times larger than the right. At 12:40 p.m. a physician called and requested to see the resident. His notes indicated the resident had been seen in the emergency room 11/29/92, for a bite but the resident did not get the medication ordered "for twenty four hours at which time the wound was red, swollen, and pussy". He described the arm on 12/07/92 as "swollen and erthematous from mid arm through elbow- skin dusky over radial surfaces of forearm. Open area radial aspect of left hand and proximal forearm". He admitted the resident to the hospital with cellulitis and for treatment with intravenous antibiotics.

The facility's response stated:

> Residents are free from any significant medication errors. This will be met by:
>
> All doctor's orders will be reviewed by the DON or designated RN in a timely manner for completeness. All phone orders are reviewed before sent to physician. DON or designated RN will follow-up with each doctor's order to verify proper documentation.
>
> Addendum to F0351 for survey on 12/18/92. DON will inform nurses of this deficiency at scheduled staff meeting 1/8/93 and advise of importance of no delays in medication administration. DON will assure that nurses notify pharmacist who is on call (if med is order after hours) and obtain medication as soon as possible. If nurse cannot contact pharmacist they will be required to notify DON when a new med is ordered.
>
> Use of "Pharmacy Communication Sheet" will be implemented by 1/11/93. (see attachment).

Item 3 of F164 was also cross-referenced in the December 18, 1992 survey to F299 — a deficiency involving the need to meet "professional standards of quality" — as follows:

> The closed record of Resident #4 revealed lack of ongoing assessment and intervention including starting the antibiotics ordered in a timely manner. Reference F0164 item 3.

The December 18, 1992 findings under F299 referenced problems involving three other residents.

After the previous survey, November 9, 1992, DIA fined the facility $500 for a deficiency under F299. The fining and citation report required the facility to correct it "upon receipt." But since it was found again December 18, 1992, DIA issued a mandatory $50 per day fine until the facility corrected it. The fining and citation log kept by DIA indicates the $50 per day fine became effective when the facility received the notice December 28, 1992. It was rescinded December 30, 1992 when DIA found the deficiency had been corrected, for a total new fine of $100.

DIA took no other enforcement action as a result of the December 18, 1992 survey, which included a total of seven deficiencies, including the one under F351 (significant medication error).

The next survey, February 3, 1993, included the identical deficiency. The findings stated:

> Based on review of incident reports and open/closed medical records it was determined that the facility was not free of any significant medication error. Two of ten medical records reviewed revealed significant medication error. Findings include:
>
> 1. The closed medical record of Resident #76 revealed that he/she had received Keflex 250 milligrams at 8:00 am on 12/25/92 in error. The medication had been prescribed for another resident with the same last name and had been placed in the wrong drawer.
>
>   Review of the open record of Resident #53 indicated that the Keflex was ordered on 12/18/92 and should have been discontinued when Resident #53 was hospitalized 12/20/92.
>
> 2. Resident #1 returned to the facility from the hospital on 01/19/93 with new orders for Diabeta 2.5 milligrams to be given three times a day. The order prior to hospitalization read: Diabeta 5 milligrams 1/2 tablet at 8:00 am and 1 tablet at noon and 5:00 pm.
>
>   Due to a mix-up, the resident received 7.5 milligrams of the Diabeta at 8:00 am and noon on 01/22/93 prior to the recognition of the error.

The facility's response stated:

> Preparation and execution of these plans of correction should not be construed as an admission of the deficiencies cited.
>
> An inservice to be given on 2-18-93 by the DON - the facility pharmacist is going to be present and will also observe med passes. This will be monitored by the DON and administrator.

DIA took no enforcement action as a result of this deficiency or the other one found at the February 3, 1993 survey.

ALLEGATION #2— INSTANCE #4

The September 17, 1992 survey included a deficiency under F354, referencing federal rule 42 CFR 483.30(a)(1):

> (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
>
> (i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

The federal "Guidance to Surveyors for Long Term Care Facilities" states in part:

> ... A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to resident care, even when adverse effects have not occurred, or there is a lack of residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat.
>
> ...° Do residents, family, and ombudsmen report insufficient staff to meet resident needs?
> ° Are staff responsive to residents' needs for assistance, and call bells answered promptly?
> ° Do residents have difficulty in locating a staff member when the need arises, or do call bells go unanswered?

This was the *fifth straight* survey to include this identical deficiency. It was previously cited on the surveys of October 3, 1991; November 21, 1991; March 5, 1992; and June 30, 1992. PCRRs following those surveys indicate the deficiency was found to be corrected once, on March 24, 1992.

The September 17, 1992 findings stated:

1. Based on resident interview and observation it was determined that the facility failed to provide sufficient nursing care to meet the needs of the residents. Findings include:

a. 10 residents interviewed indicated that staff did not respond to call lights promptly. They sometimes had to wait for 1 to 1.5 hours.[2] This time frame was ordinary for weekends. Numerous times during the week days the waiting period was 30 minutes. The residents indicated the 3-11 shift was the worst. The hours of 10 pm to 11 pm was the roughest time period. The staff often had to go to the other wings to get help. The residents felt that the B wing had the most problem with call lights not being promptly answered.

b. Resident interviews revealed that staff offer assistance to go to the bathroom after meals but there was a prolonged waiting period.

c. 5 of 10 residents interviewed indicated that they did not receive 2 baths per week.

d. Residents #6 and 13, did not have call light cords within reach on 09/08/92.

e. Resident #41 did not have a call cord available to him on 09/08/92. The wall receptacle had but one string that was attached to the roommate's bedrail. *The resident was calling out for help.* [emphasis added]

[2] A wait of 50 minutes was reported by one resident in the previous survey's findings.

f. Refer also to F0319 [*facility-acquired pressure sores, for which DIA issued a $300, Class II citation*], 0322 [*treatment and services for residents who are incontinent of bladder, for which DIA issued a $300, Class II citation*], 0323 [*reduction in residents' range of motion*], 0330 [*adequate supervision and assistance to prevent accidents*].

g. Refer to F0242 Item 3 and F0314. [*F0242 Item 3 stated, "Resident interviews revealed that dependent residents were not allowed to go outside the building for fresh air because of shortage of staff]* and F0314 *[which stated in part, "... the facility failed to provide sufficient staff assistance to supervise four of six residents that needed assistance and/or encouragement to consume their meals...."]*

The facility's response stated:

> Preparation and execution of this Plan of Correction should not be construed as an admission of the deficiencies cited.
>
> Facility is currently using an employment agency to search for and obtain new employees for the facility and has been running ads for staff. Facility has hired new employees since survey visit. The use of the employment agency will be used on an ongoing basis to assure qualified staffing. Staffing will be monitored by Dept. heads and Adm. on an on-going basis. A weekend incentive program to encourage staffing on weekends has been implemented. Employee evaluations have been done and raises given to increase and retain staff.

DIA took no enforcement action as a result of this deficiency. DIA did issue two Class II citations, both with $300 fines, following the same survey for deficiencies involving prevention of pressure sores and care for incontinent residents. DIA found a total of 20 deficiencies in the survey.

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating:

> Inadequate staffing is cited when supported by care outcomes. The facility was fined for deficiencies in incontinence and pressure sores. *The determination sheet indicated surveyors identified the underlying problem was related to staff training and turnover*. The determination sheet is part of the documentation presented during the determination meeting. [emphasis added]

ALLEGATION #2— INSTANCE #5

The September 17, 1992 survey included a deficiency under F496, referencing federal rule 42 CFR 483.75(e)(2):

> A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis unless:
>
> (i) That individual is competent to provide nursing and nursing related services; and

(ii) (A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or

(B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).

The federal "Guidance to Surveyors for Long Term Care Facilities" states in part:

> Facilities may use, as nurse aides, any individuals who have successfully completed either a nurse aide training and competency evaluation program or a competency evaluation program. However, if an individual has not completed a program at the time of employment, a facility may only use that individual as a nurse aide if the individual is in a nurse aide training and competency evaluation program (not a competency evaluation program alone) and that individual is a permanent employee in his or her first four months in the facility.
>
> Facilities may not use non-permanent employees as nurse aides unless they have either completed a training and competency evaluation program, or a competency evaluation program.

The findings stated:

1. Based on review of personnel records and incident reports, it was determined that the facility failed to ensure that newly hired nurse's aides had completed the required training and competency evaluation. These findings include:

a. Five out of six nurses aides hired did not have the required 16 hour training before hands on contact with residents were made. (staff members #2,3,4,5 and 6)

b. Six out of six newly hired nurses aides were not enrolled in a required nurse aide training and competency evaluation program.

c. Two out of two newly hired certified nurses aides hired did not have documentation of completion of certification or competency evaluation program. (Staff members #7 and 8.)

d. Review of incident reports revealed on 07/08/92, resident #64 was getting ready for bed with the assist of an aide. *When the aide pulled the resident's shirt off, the resident's arm was caught on the wheelchair resulting in a 3 cm skin tear at the elbow area.* [emphasis added]

e. Review of incident reports revealed that on 07/09/92 at 5 pm, *Resident #82 received a skin tear to the right outer elbow when a nurse aide attempted to put the resident to bed.* [emphasis added]

f. Review of incident reports revealed that on 7/14/92 at 8:30 a.m., it was necessary to lower resident #62 to the floor. *The following injuries were noted: the right eyelid was red and swollen and there was a one inch bruise encircling the right wrist.* [emphasis added]

g. Review of incident reports revealed that on 7/13/92 at 2:45 p.m., resident #49 was in a wheelchair and *the staff member bumped the resident's arm upon exiting the room, resulting in a 1 cm skin tear on the right elbow.* [emphasis added]

h. Closed record review revealed that on 7/22/92 at 6:40 p.m., two aides were lifting resident #82 from the geri chair to the commode. *The nurses aides heard a "pop sound, like the resident's collar bone popped."* The resident was sent to the hospital and returned with a sling and physician's orders to see a specialist on 7/23/92. On 7/23/92, when the resident returned from the specialist, *it was noted there may be a hair-line fracture of the shoulder.* [emphasis added]

i. Personnel records reviewed that on 5/23/92, *a resident was observed being pushed in a wheelchair by staff member #10 and the resident's feet were bent backwards under the wheelchair. The resident's feet were noted to be ran over with the wheelchair wheels.* [emphasis added]

j. Review of incident report and observations indicated 4 residents received skin tears and bruises from unknown origin.

k. There were 5 incidents of falls and or minor injury noted in July and August related to staff assisted ambulation and/or transfer.

The facility's response stated:

> Preparation and execution of this Plan of Correction should not be construed as an admission of the deficiencies cited.
>
> DON, ADON will get all appropriate documentation from newly hired CNAs. Sixteen hour nurse aide training program was held 10/2-3. Five people were enrolled and completed the 16 hour training. A second 16 hour class will be held 10/16-17 for employees hired without training since survey. Remainder of 75 hour CNA class is scheduled to being 10-19. DON and ADON will monitor newly hired nurse aides for completion of the 16 hour nurse aide training. Newly hired nurse aides without appropriate training are working as auxilary aides and will not do hands on care until they obtain 16 hours of training and are enrolled in the 75 hour CNA class. Nurse aides were enrolled as soon as a class was offered within our area.

DIA took no enforcement action as a result of this deficiency. DIA did issue two Class II citations, both with a $300 fine, following the same survey for deficiencies involving prevention of pressure sores and care for incontinent residents. DIA found a total of 20 deficiencies in the survey.

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating:

> In November of 1992 [*Ombudsman's note: following the next survey*], we did cite the facility for nurse aide care issues by citing [*state rule*] 58.20(2)(3) which holds the Director of Nursing accountable for care provided in the facility.

ALLEGATION #2— INSTANCES #6 and #7

The May 20, 1993 survey included a deficiency under F331, referencing federal rule 42 CFR 483.25(i)(1):

> Based on a resident's comprehensive assessment, the facility must ensure that a resident ... maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

Previous surveys indicate the identical deficiency was also cited at the March 5, 1992 and November 21, 1991 surveys (under F296, the predecessor to F331.)

The May 20, 1993 findings stated:

> Based on review of weight records and resident records, it was determined that the facility did not ensure that each resident maintained acceptable parameters of nutritional status, such as body weight. Seventeen of 69 residents showed weight loss since January 1993. *Five of the seventeen showed severe weight loss.* [emphasis added] Findings include:

1. Resident #55 was admitted to the facility 04/05/93 and weighed 138.5 pounds. The resident showed a severe weight loss in May of 7% and was hospitalized May 11, 1993 with *a diagnosis of "malnutrition with significant recent weight loss*, and altered mental status."

   The resident stated that he could not feed himself because he shook so bad and staff did not assist him very often. Family indicated that the resident was sometimes scolded for spilling his food and fluids. [emphasis added]

2. Resident #58 showed a weight loss of 16.5% in a three month period of time. The resident was hospitalized on January 14, 1993, and was diagnosed with a closed supra condylar fracture on the left femur resulting from a fall from the wheelchair. On 05/07/93, the resident developed an open area on the left knee which was diagnosed as a spikula (bone fragment) from the fracture. That same day the doctor was notified of a 9 ½ pound weight loss in the past month. The resident had a poor appetite, loose stools and emesis at times, pain, and also was treated since 04/19/93, with three different antibiotics for a urinary tract infection.

   She was receiving medications for pain as well as the antibiotics and had a history of chronic gastritis which could explain the nausea and lack of appetite.

   On 05/18/93, an order was obtained for Compazine for nausea. Refer also to F0299 Item 2. [*Which stated as follows:* "Resident #58, with a history of chronic gastritis, was hospitalized in January, 1993, for a fracture of the left femur resulting from a fall from the wheelchair. From January through April the resident lost twelve pounds or a loss of 8% of her body weight. On 05/07/93, the resident developed an open area on the left knee as a result of a bone fragment from the fracture. The physician was also notified of a 9½ pound weight loss from April to May, for a loss of 24½ pounds since January. The resident was documented as having a poor appetite, nausea and vomiting and loose stools. The resident had been

receiving pain medications for the leg fracture, and antibiotics since 04/19/93, for a urinary tract infection. The resident had not been assessed for the relation these medications could have to her nausea and vomiting in view of her history of gastritis. On 05/18/93, an order was obtained for Compazine for nausea."]

3. Resident #53 had a weight loss of 18.2% in three months. The resident was hospitalized on 02/18/93, and diagnosed with a fracture of the tibia and fibia of the right leg. The resident returned from the hospital with a large open area on the back of the right leg and heel. The resident's diet was changed on 04/08/93, to an 1800 calorie ADA pureed diet with 4 ounces of house supplement. The resident was also ordered to receive a multiple vitamin with zinc at that time.

   On 04/15/93, the physician ordered a speech evaluation due to the resident chewing food and spitting it out. Medlink Management was notified on 04/22/93, (one week later) regarding the order for the evaluation. A therapist visited the facility on 04/23/93, and stated he would return the first of the week to evaluate the resident. The therapist did not return until 05/18/93. There was no documentation on the record regarding the evaluation and the therapist indicated the evaluation was not yet completed when the surveyor visited with him.

   At the time of the investigation the resident was still taking food and fluids poorly.

   Refer also to F287 Item 4.

4. Resident #48 had a weight loss of 11.6% in three months. This resident also had a hospital acquired pressure sore while he was being treated for medication adjustment.

5. Resident #36 had a 9% weight loss in four months. This resident had sustained a fractured pelvis on 04/23/93, from a fall from the wheelchair after wandering outside of the facility.

   Refer also to F0287 Item 5 and F0330 Item 1.

The facility's response stated:

Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all of the following pages.

A. The consultant nurse and the Health Services Supervisor will review the facility's policy and procedures regarding resident weight maintenance by 6-21-93.

B. The consultant nurse will incorporate into her training program the role and expectations of each member of the nursing department staff in support of the weight maintenance program no later than 6-21-93.

C. The QA nurse will be assigned to monitor this deficiency on an on-going basis.

DIA took no enforcement action as a result of this deficiency. In total, the May 20, 1993 survey included 19 deficiencies. DIA did take several enforcement actions as a result of other deficiencies involving failure to:

1. *Prevent pressure sores:* Class II citation with a $1,500 trebled fine.

2. *Adequately care for incontinent residents:* Class II citation with a $1,200 trebled fine.

3. *Adequately assess residents:* Class II citation with a $900 trebled fine.

4. *Adequately supervise residents:* Class II citation with a $500 fine.

5. *Assume responsibility for overall operation:* Class III citation, no fine.

In addition, DIA initiated proceedings to revoke the facility's license and recommended DHS terminate the facility's Medicaid contract effective August 18, 1993 (about three months later).[3]

When asked why it took no enforcement action in connection with this deficiency, DIA provided a written response stating, "Unknown."

The next annual survey (June 20, 1994) included a deficiency under F317, referencing federal rule 483.25(a)(3):

> A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

The findings stated:

> Based upon review of sixteen (16) residents with identified weight loss and/or low body weight and observation at meal time at three (3) of three (3) meals, the facility failed to ensure that residents were provided the necessary services to maintain good nutrition.
>
> Findings include:
>
> A. Based on the complaint concerning weight losses among residents, a review of facility monthly weight records was conducted. Sixteen (16) residents were targeted for further review. Five (5) of the sixteen (16) identified unplanned weight losses and/or low body weights were found to be avoidable and significant.
>
> Examples are as follows:
>
> 1. Resident #44 had sustained a 9.9 percent loss of body weight in the period from 1/94 to 6/94 and a 6.3 percent weight loss in the last month. A review of the Dietary Assessment indicated that the weight

[3] Both of these actions were later rescinded. The license revocation action, was rescinded July 14, 1993 "based on the findings of the revisit of July 2, 1993," according to a subsequent DIA notice to the facility. The Medicaid termination action was rescinded effective August 6, 1993 (before going into effect) according to an August 20, 1993 letter to the facility from DHS.

loss was caused by the presence of a pressure sore. Though the weight loss was a gradual one over a period of time, no nutritional interventions were planned to prevent weight loss and promote the healing of the pressure sore. A comparison of estimated caloric and protein needs and actual daily food intake had not been completed to assist in planning additional nutritional support needed.

2. Resident #42 had sustained a 16 and ¼ pound or 8.9 percent loss of body weight in the four (4) month period from 2/94 to 6/94. Thirteen (13) pounds of 7.7 percent of this weight loss occurred in a one (1) month period from 2/94 to 3/94. This resident was on renal dialysis. The Dietary Assessment stated that this weight loss was due to the dialysis. Persons on dialysis do experience daily fluctuations in weight, yet the weight loss of this resident was a gradual continual one over a period of time. The Dietary Assessment of 4/13/94 recommended that a sandwich be added for a snack if the weight loss continued. A review of the facility nourishment list indicated that this had not been done. There was no documentation available that further interventions had been planned to avoid this weight loss or that communication had been established with the professional staff where the resident was receiving dialysis concerning possible causes or resolution.

3. Resident #47 had a 19 and ¼ pound or 12.2 percent loss of body weight in the period from 10/93 to 6/94. At the noon and evening meal on 6/14/94, this resident was observed to consume approximately fifty (50) percent of the meal and to receive minimal and sporadic prompting to eat. The current comprehensive plan of care indicated the resident was to receive a supplement at each meal, but there was no plan for monitoring or assistance at meal time. The weight loss of this resident was a gradual one over an extended period of time and the facility had not continued to reassess the interventions offered.

4. Resident #63 had sustained an eight (8) pound or 9.5 percent loss of body weight since admission in 1/94. The resident was at a low body weight of 84 pounds when admitted and continued a gradual weight loss to 76 pounds in 6/94. When observed at three (3) of three (3) meals, the resident received minimal encouragement or assistance to eat. *This resident is blind and was not always told the location of food at the beginning of the meal.* The comprehensive plan of care indicated the resident should be assisted at meals. [emphasis added]

5. Resident #75 had sustained an 8.8 percent loss of body weight in the period from 1/94 to 6/94. When observed at the evening meal on 6/14/94, the resident received minimal cueing or assistance and consumed approximately fifty (50) percent of the meal. The Dietary Assessment of 4/26/94 indicated that the resident needed more encouragement at meal time.

B. Based on observation and staff and resident interviews, the facility failed to provided oral and or dental care to 7 of 9 residents observed for morning cares on 6/14/94.

1. Resident #71 did not have the dentures taken out or oral cares when assisted to get ready for bed on 6/13/94 and at 5:10 AM on 6/14/94 the

dentures were still in the mouth. The resident complained that staff did not know how to care for the elderly and were in such a hurry to go home, that they didn't even finish getting her ready for bed.

2. Resident #72 did not have her dentures taken out or oral cares before being assisted to get ready for bed on 6/13/94 and the dentures were observed to be in the mouth at 6:00 AM 6/14/94 when gotten up. This resident said she would prefer to have the dentures removed at night. Resident #45 was observed at 6:15 AM on 6/14/94 with dentures in the mouth. According to staff, this resident had not had the dentures removed before being assisted to go to bed. This resident was in the special care unit for residents with confusion.

3. Resident #48 was observed at 6:40 AM on 6/14/94 to have a container for dentures and staff reported that he wore dentures but these dentures were not in the denture cup and could not be found.

4. Resident #21, was observed at 6:30 AM on 6/14/94. The staff member assisted the resident to wash and dress prior to breakfast, however no oral care was provided. The resident had her natural teeth.

5. Resident #16, was observed to receive AM cares (assisted by the staff to toilet, wash, dress, comb hair), at 5:40 AM on 6/14/94, however no oral care was provided.

6. Resident #29 was observed on 6/15/94 at 1010 with a thick build up of white substance between the teeth and along the gum line. When reported to the Director of Nursing she confirmed that the teeth had not yet been brushed.

Failure to provide proper oral care or cleaning of dentures could result in sore gums and/or deterioration of natural teeth with problems chewing.

The facility's response stated:

> Dietitian Consultant and FSS [*food service supervisor*] will review intake as related to weight loss. Weekly weights on residents who have potential for weight loss will be charted and identified. A monthly chart will be posted in DON's [*director of nursing's*] office and FSS's office to monitor gradual weight loss also. Nutritional interventions will be done. Monitored by FSS. Dietician reports to ADM.

ALLEGATION #2 — INSTANCE #8

The June 20, 1994 survey included a deficiency under F446, referencing federal rule 483.65(b)(3):

> The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

The findings stated:

> Based on observations of resident cares on the front unit, staff members did not always wash their hands before and/or after providing resident cares. Problems were noted on 2 of 9 observations of residents receiving incontinency cares and 1 of 2 residents observed to be repositioned in bed. Findings include;
>
> 1. Resident #27, was observed at 4:40 p.m. on 06/15/94, to be incontinent of feces and urine. The two staff members caring for the resident were observed to wear the same gloves to wash, dress, and transfer the resident into a wheelchair and then comb the resident's hair. The staff members did not wash their hands until after finishing all of the resident's cares.
>
> 2. Resident #22 was observed at 2:50 a.m. on 06/14/94, to be given incontinency care. The staff member was observed to carry the soiled linen from the room and place it into the soiled linen bag. The staff member then went to assist another resident without first washing her hands.
>
> 3. A staff member was observed on 06/14/94, at 3:45 a.m. to reposition Resident #38, in bed. The staff member then went directly to Resident #29, without washing her hands and checked the resident for incontinency.
>
> The practices described above can lead to spread of infections.

The facility's response stated:

> An inservice will be held in small groups regarding proper hand-washing. The importance of handwashing has been stressed to prevent infections. This documentation will be placed in employees files. Monitored by DON.

The same survey included a similar deficiency under F447, referencing federal rule 483.645(c):

> Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

The findings stated:

> Based on observations of resident cares, the facility failed to handle linens in a manner to prevent the possible spread of infection. Based on 5 of 9 observations of resident incontinency care.
>
> 1. Resident #32, was observed at 3:55 AM on 6/14/94 to be incontinent of urine. The wet incontinent bed pad was placed on the floor. The wet washcloth used for cleansing the resident was placed on the dresser. After completing the resident cares the staff member picked up the pad off the floor and the washcloths off the dresser and clutched the linens against her uniform while carrying the linens from the room.

2. Resident #34, was observed at 4:00 AM on 6/14/94 to be incontinent of urine and feces. The feces was smeared over the resident's buttocks, thighs, perineum and hands. The bed incontinent pad, top sheet and resident gown were placed on the floor. The linens were then picked up from the floor and placed on the resident's bottom sheet which was not changed.

3. Resident #5, was observed at 3:20 AM on 6/14/94 to be incontinent of urine and had feces smeared over her hands, elbow, perineum and buttocks. The resident was transported to the shower room and given a shower. The soiled bath linens were placed on the floor in the shower room.

4. Resident #27, was observed at 5:30 AM on 6/14/94 to be incontinent of urine. A staff member placed the wet top sheet and blanket on the floor. The resident then began to urinate and a folded gown was placed over the front of the resident to catch the urine. Then the soaked gown was thrown on the floor. The incontinent pad and washcloth used to wash the resident were also placed on the floor.

5. At 3:03 am on 6/14/94 Resident # 21 was observed to be incontinent of feces. The staff member caring for the resident placed the soiled bed pad on the floor.

The failure to properly handle the linens by placing them on the floor or bedstand may result in the spread of infection and odors.

The facility's response stated:

> We are conducting small group inservices regarding transporting and placement of soiled linens and the importance of to prevent the spread of infections. Bags will be taken into rooms to place soiled linens in; then transported directly to laundry area. Monitored by DON.

ALLEGATION #2— INSTANCES #9 through #13

Beginning October 1, 1990, both federal and state law mandated the "denial of payment" remedy for any facility failing to correct any deficiency within 90 days after its discovery by DIA. The federal mandate is in OBRA 1987 at 42 USC 1396r(h)(2)(C). The state mandate (as of October 1, 1990) was in 441 IAC 81.19(2)[4], which stated:

a. No payment shall be made for newly admitted Medicaid residents when the following conditions exist:

(1) The facility has failed to correct deficiencies within 90 days....

[4] This rule was rescinded effective July 1, 1995 and replaced with a rule that produces a nearly identical mandate. The primary difference is that under the new rule [at 441 IAC 81.40(2)], the mandate does not apply if the deficiency upon revisit is found to pose no greater risk to resident health or safety than the potential for causing minimal harm.

c. A deficiency statement issued by the department of inspections and appeals shall include information that failure to correct deficiencies within three months shall result in denial of payment for new admissions. *Three days after the deficiency statement is mailed, the three-month time period shall begin.* [emphasis added]

Review of information provided by DIA indicates the denial of payment mandate was applied twice during this review of DIA's oversight of Mahaska Manor:

1. Based on the findings of the March 5, 1992 survey — which included deficiencies under F284, F296 and F505, none of which had been found to be corrected since inclusion in the November 21, 1991 survey — DIA recommended DHS deny payment for new Medicaid admissions. According to a document titled, "Mahaska Manor History," the denial of payment was to be effective March 31, 1992. It was rescinded on March 24, 1992, based on a finding the deficiencies were corrected, the document states.

2. Based on the findings of the March 12, 1993 survey — which included a deficiency under F351, which had not been found to be corrected since inclusion in the November 9, 1992 survey — DIA recommended DHS deny payment for new Medicaid admissions. The denial of payment was effective April 9, 1993, according to an April 20, 1993 letter from DHS to the facility. A PCRR indicates the deficiency was found to be corrected on July 2, 1993, and the denial of payment action was rescinded effective August 6, 1993, according to an August 20, 1993 letter from DHS to the facility.

Review of surveys involving Mahaska Manor, as well as Post-Certification Revisit Reports, indicates DIA did not find the following deficiencies to be corrected within the required period:

1. In the first instance described above, the deficiency referenced under F505 had previously been included in the October 3, 1991 survey. The facility administrator signed and dated the facility's response on October 30, 1991, indicating the deficiency was mandated to be corrected no later than January 30, 1993.[5] The deficiency was not documented as corrected until March 24, 1993.

2. Four deficiencies in the June 30, 1992 survey were not documented as corrected until December 18, 1992 (approximately five months after the facility administrator signed and dated the facility's response on July 17, 1992.) These deficiencies were tagged as F354, F320, F322 and F319.

3. Three deficiencies in the May 20, 1993 survey were not documented as corrected until December 20, 1993 (seven months later. The facility administrator did not include the date on the facility's response.) These deficiencies were tagged as F508, F509, and F510.

[5] Because DIA's records do not indicate when deficiency statements were mailed, this review will attempt to rely on the date the facility signed its response to establish the begin date for the denial of payment remedy.

4. Four deficiencies in the May 6, 1994 survey were not documented as corrected until October 14, 1994 (approximately five months after the facility administrator signed and dated the facility's response on May 24, 1994.) These deficiencies were tagged as F299, F320, F309 and F502.

5. One deficiency in the June 20, 1994 survey was not documented as corrected until November 30, 1994 (approximately four and a half months after the facility's administrator signed and dated the facility's response on July 14, 1994.) This deficiency was tagged as F367.

Review of information from DIA indicates it did not initiate the denial of payment remedy in connection with the facility's failure to correct these deficiencies within the required period.

ALLEGATION #2— INSTANCES #14 and #15

Code section 135C.40 states in relevant part:

> ... Failure to correct a violation within the time specified, unless the licensee shows that the failure was due to circumstances beyond the licensee's control, **shall** subject the facility to a further penalty of fifty dollars for each day that the violation continues after the time specified for correction. [emphasis added]

Fining and Citation Report #969 (F & C 969) dated October 5, 1992, included two Class II citations in connection with two deficiencies found in the September 17, 1992 survey. Both citations included a $300 fine with the correction date listed as "upon receipt."

F&C 969 referenced the deficiencies as follows:

1. The first citation referenced a violation of state rule 481 IAC 58.19(2)(b), "decubitus care." The findings listed in F&C 969 appear identical to the survey findings under F319, referencing federal rule 42 CFR 483.25(c)(1).

2. The second citation referenced a violation of state rule 481 IAC 58.19(1)(j)(3), "care for incontinent residents." The findings listed in F&C 969 appear identical to the survey findings under F322, referencing federal rule 42 CFR 483.25(d)(2).

The following survey, November 9, 1992, included the following deficiencies:

1. One under F319, referencing 42 CFR 483.25(c)(1) — *both matching back to the first citation in F&C 969 which listed the correction date as "upon receipt."*

2. One under F322, referencing 42 CFR 483.25(d)(2) — *both matching back to the second citation in F&C 969 which listed the correction date as "upon receipt."*

The fining and citation log for F&C 969 states both deficiencies were "in compliance" on the revisit of November 9, 1992. However, the PCRR dated November 2-9, 1992, does not list either deficiency as having been found to have been corrected.

When asked why it did not take enforcement action in these instances, DIA issued a written response stating:

> A determination was held, but we have no way of knowing why the fining and citation log stated the citations were met at the revisit.

ALLEGATION #2— INSTANCES #16 and #17

The August 19, 1994 survey included a deficiency under F367, referencing federal rule 42 CFR 483.225(d)(2), "Food that is palatable, attractive, and at the proper temperature."

The identical deficiency had been cited on the July 2, 1993 and June 20, 1994 surveys.

The August 19, 1994 findings stated:

> Based on surveyor's observations at four meals, the facility failed to provide food that was palatable, and maintained at the proper temperatures....
>
> Failure of the facility to maintain food at proper temperatures can lead to food borne illness. Food that is not of proper temperatures makes the food less palatable for the residents, which can lead to decreased consumption and weight loss.

The facility's response stated:

> Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all following pages....
>
> Measures have been taken to ensure the hot foods are at the proper temp. Service has been done on the steam table and insulated domes have been purchased to ensure proper temps. Measures have been taken also to make sure the milk temp. are below 40 degrees. The cooler has been checked and milked is placed in ice water before serving. FSS to monitor.

DIA took no enforcement action as a result of this deficiency. A total of eight deficiencies were included in the survey and DIA took two enforcement actions. First, DIA issued a Class II citation with a $500 fine for a deficiency involving treatment of pressure sores.

Second, DIA issued a mandatory $50 per day fine for a repeat deficiency involving notifying physicians of adverse changes in resident's conditions and nursing care services, treatments and procedures.

The October 14, 1994 survey included the same deficiency. Findings stated in part:

> ... The facility failed to serve food at proper temperatures, hot foods at 140 degrees or above and cold foods at 45 degrees or below. Improper temperatures affect palatability and promotes the growth of bacteria which can lead to food borne illnesses.

The facility's response stated:

> Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited - and on all following pages....
>
> The facility has installed a new steam table to ensure food is served at proper temperatures. Rearrangement of seating schedules, room tray assignments, and reassignment of staff completed to ensure timely delivery of trays and encouragement and assistance given as needed to all residents. Monitored by Cook and charge nurse daily.

DIA took no enforcement action as a result of this deficiency or the three others included in the October 14, 1994 survey.

ALLEGATION #2— INSTANCE #18

DIA issued a July 6, 1994 Notice of Conditional Nursing Facility License to Mahaska Manor which stated in part:

> The facility must substantially correct the attached violations by July 8, 1994. Failure to correct the attached violations may result in the suspension or revocation of your license.

The documentation submitted by DIA did not indicate which particular violations the July 6 notice was referring to. In a May 9, 1996 phone conversation with Mr. Burnham, Mr. Bennett said notices of adverse licensure action generally are based upon:

- Those violations which resulted in a citation, if any were issued; or
- All violations referenced in the survey.

This indicates the July 6, 1994 notice was based, at least in part, upon the two deficiencies included in "F&C 1069" — state rule 58.14(5) and state rule 58.20(2). The "fining and citation log" provided by DIA indicates these two items were still deficient on the revisit of August 19, 1994 — and two $50 daily fines were issued pursuant to Code section 135C.40(1).

However, no further licensure action was taken. When asked why it did not take further licensure action, DIA provided a written response stating:

> ... We do not know why two years after the fact the license was not revoked.

ALLEGATION #2— INSTANCES #19 through #21

Former rule 441 IAC 81.19(1)(b) [rescinded July 1, 1995] stated:

> Grounds for appointing a temporary manager. A temporary manager ***shall*** be requested by the department of inspections and appeals when any of the following conditions exist: emergencies, immediate jeopardy, a pattern of violations, chronically substandard care, *initiation of decertification or license revocation proceedings*, and acts such as foreclosure or seizure of the facility. [emphasis added]

DIA issued a November 23, 1992 letter to Mahaska Manor stating in part:

> ... As a result of our most recent Federal findings ... the Department is recommending the Department of Human Services terminate your Medicaid (Title-19) contract effective February 7, 1993....

When asked why it did not request appointment of a temporary manager, DIA provided a written response stating:

> Various options were discussed at the fining and citation determination. Decertification [*of the facility's Medicaid contract*] and Conditional license were initiated.

The termination action was rescinded based on DIA's finding that the deficiencies triggering the termination action had been corrected, according to a December 23, 1992 letter from DIA to the facility.

DIA issued a May 28, 1993 letter to Mahaska Manor stating in part:

> ... As a result of our most recent Federal findings ... the Department is recommending that the Department of Human Services terminate your Medicaid (Title-19) contract effective August 18, 1993....

Also on May 28, 1993, DIA issued a "Notice of Revocation of Nursing Facility License" to Mahaska Manor, effective thirty days after receipt.

When asked why it did not request appointment of a temporary manager, DIA provided a written response stating:

> As we discussed during the June 6 [*1996*] meeting [*with Mr. Burnham of the Ombudsman's office*], the Department's philosophy on temporary managers (receivership) is to work with the provider to adhere and maintain correction as opposed to bringing an outside entity in to fix a problem and then turn the facility back to the entity that allowed the problem to develop without assurance they could maintain correction.

Both the termination action and license revocation action were rescinded after DIA found the deficiencies triggering the actions had been corrected on July 2, 1993.

DIA issued a December 19, 1994 letter to Mahaska Manor stating in part:

> ... As a result of our most recent Federal findings ... the Department is recommending that the Department of Human Services terminate your Medicaid (Title-19) contract effective February 28, 1995....

Also on December 19, 1994, DIA issued a "Notice of Revocation of Nursing Facility License" to Mahaska Manor, effective thirty days after receipt.

When asked why it did not request the appointment of a temporary manager pursuant to 441 IAC 81.19(1)(b), DIA provided a written response referencing the above-mentioned response concerning the same issue following the May 28, 1993 "Notice of Revocation of Nursing Facility License."

Both the termination action and the license revocation action were rescinded after DIA found the deficiencies triggering the actions had been corrected on January 12, 1995.

Appendix J

(Proposed) State Fining Grid

Immediate jeopardy	(10) Required: Class I if any points; Class II if zero points Optional: Class I	(11) Required: Class I	(12) Required: Class I
Actual harm that isn't immediate jeopardy	(7) Required: Class II if any points; Class III if zero points Optional: Class I or Class II	(8) Required: Class II Optional: Class I	(9) Required: Class II Optional: Class I
No actual harm with potential for more than minimal harm	(4) Required: Class II if ≥ 5 points; Class III if 3-4 points Optional: Class II or Class III	(5) Required: Class II if ≥ 4 points; Class III if 3 points Optional: Class II or Class III	(6) Required: Class II if ≥ 3 points; Class III if 1-2 points Optional: Class II or Class III
No actual harm with potential for minimal harm	(1) NO STATE FINE	(2) NO STATE FINE	(3) NO STATE FINE
	Isolated	**Pattern**	**Widespread**

(Note: Class I, II and III refer to the violations classified in Iowa Code section 135C.36)

Appendix K

This appendix shows how the proposed table (*see Appendix J*) would be applied to the 41 instances presented in the first two allegations [*except for the 14 that did not involve application of the state fining and citation option — instances #17-19 under the first allegation; and instances #9-15 and #18-21 under the second allegation.*]. Factors are coded as follows:

- *Harm.* No actual harm with potential for minimal harm = 1
  No actual harm with potential for more than minimal harm = 2
  Actual harm that isn't immediate jeopardy = 3
  Immediate jeopardy = 4

- *Frequency.* Isolated = 1
  Pattern = 2
  Widespread = 3

- *History.* Cited on last general survey or any survey in last 12 months = 1
  Cited on the two prior surveys or the two prior general surveys = 2
  Cited on the three prior surveys or the three prior general surveys = 3

- *Length.* Occurred for at least three months but not more than six months = 1
  Occurred for six months or more = 2

- *Grid location.* Each of the 12 boxes will be given a number, starting with the bottom row and counting left to right; then moving up through the rows and counting left to right.

Instance	Harm	Frequency	Grid location	History	Length	Minimum action required
Elmwood #1	3	1	7	0	0	Class III
Elmwood #2	2	2	5	2	2	Class II
Elmwood #3	2	2	5	3	0	Class III (treble fine)
Elmwood #4	2	2	5	2	0	None
Elmwood #5	2	2	5	3	0	Class III
Elmwood #6	2	2	5	3	0	Class III (treble fine)
Elmwood #7	3	2	8	0	0	Class II
Elmwood #8	3	2	8	1	0	Class II (treble fine)

Instance	Harm	Frequency	Grid location	History	Length	Minimum action required
Elmwood #9	3	2	8	1	0	Class II (treble fine)
Elmwood #10	3	2	8	2	0	Class II (treble fine)
Elmwood #11	3	2	8	0	0	Class II
Elmwood #12	3	2	8	0	1	Class II
Elmwood #13	3	1	7	0	0	Class III
Elmwood #14	3	1	7	0	0	Class III
Elmwood #15	2	2	5	0	2	None
Elmwood #16	2	2	5	1	2	Class III
Elmwood #20	3	1	7	0	0	Class III
Mahaska #1	4	2	11	0	1	Class I
Mahaska #2	3	1	7	1	0	Class II
Mahaska #3	2	1	4	2	0	None
Mahaska #4	2	2	5	3	0	Class III
Mahaska #5	3	2	8	0	0	Class II
Mahaska #6	3	2	8	0	0	Class II
Mahaska #7	3	2	8	0	0	Class II
Mahaska #8	2	2	5	1	0	None
Mahaska #16	2	2	5	1	0	None
Mahaska #17	2	2	5	2	1	Class III

Appendix L

This appendix shows how the proposed table (*see Appendix J*) would have been applied in the 22 instances where DIA issued state-authorized citations against Mahaska Manor during the period under review.

It is worth noting that the proposed table would have resulted in the identical enforcement action in 15 of the 22 instances where DIA took action.

Regarding the other seven instances:

- In five instances, DIA took more severe action than would have been required under the proposed table (though the table would given DIA the discretion to take those more severe actions.)

- In the other two instances, the table would have required more severe action be taken:

  -- DIA issued a Class II citation, $500 fine following the November 9, 1992 survey. The proposed table would have required a Class I citation. (This action is examined in a later section of the report. See page 48, "Allegation #3 — Instance #1.")

  -- DIA issued a Class II citation, $900 treble fine following the May 20, 1993 survey. The proposed table would have required a Class I citation. (This action is examined in a later section of the report. See page 51, "Allegation #3 — Instance #2.")

Action taken by DIA	Harm	Frequency	Grid location	History	Length	Minimum action required by proposed grid
9/17/92, F322 (Class II, $300)	3	2	8	0	0	Class II
9/17/92, F319 (Class II, $300)	3	2	8	0	0	Class II
11/9/92, F299 (Class II, $500)	4	2	11	0	0	Class I
5/20/93, F299 (Class II, $900 treble)	4	1	10	1	0	Class I treble
5/20/93, F322 (Class II, $1,200 treble)	3	2	8	0	0	Class II treble

Action taken by DIA	Harm	Frequency	Grid location	History	Length	Minimum action required by proposed grid
5/20/93, F330 (Class II, $500)	3	2	8	0	0	Class II
5/20/93, F319 (Class II, $1,500 treble)	3	2	8	0	0	Class II
5/20/93, F490 (Class III)	2	2	5	0	0	Class III optional
6/20/94, F299/F164 (Class I, $5,000)	4	2	11	0	0	Class I
8/19/94, F320 (Class II, $500)	3	2	8	0	0	Class II
11/30/94 F309 (Class I, $15,000 treble)	4	2	11	0	0	Class I treble
3/28/95 F309 (Class II, $1,500 treble)	3	2	8	1	0	Class II
3/28/95 F320 (Class II, $500)	3	2	8	0	0	Class II
3/28/95 F324 (Class II, $500)	3	2	8	0	0	Class II
3/28/95 F312 (Class II, $500)	3	2	8	0	0	Class II
3/28/95 F322 (Class II, $500)	3	2	8	1	0	Class II
3/28/95 F351 (Class II, $500)	2	3	6	0	1	Class III (Class II optional)
3/28/95 F317 (Class II, $500)	3	2	8	1	0	Class II
3/28/95 F329 (Class II, $300)	2	2	5	0	0	None (Class II optional)

Action taken by DIA	Harm	Frequency	Grid location	History	Length	Minimum action required by proposed grid
3/28/95 F501 (Class II, $300)	2	2	5	0	0	None (Class II optional)
3/28/95 F366 (Class III)	2	2	5	0	0	None (Class III optional)
3/28/95 F260/261 (Class III)	2	3	6	0	0	None (Class III optional)

Appendix M

Critical deficiencies identified by Detroit Free-Press Newspaper (see page 64)

F150	F167	F221	F222
F223	F240	F241	F246
F248	F252	F253	F272
F279	F310	F314	F315
F316	F317	F318	F319
F320	F321	F322	F323
F324	F325	F326	F327
F328	F329	F330	F331
F332	F333	F353	F360
F368	F371	F385	F405
F411	F425	F441	F454
F490	F514		

Appendix N

Sample report card following general survey

FACILITY	Mahaska Manor
CITY	Oskaloosa
COUNTY	Mahaska
INSPECTION TYPE	General
DATE OF INSPECTION	February 4, 1999
COMPLIANCE LEVEL	41/45 (91.1 percent)
ENFORCEMENT ACTIONS TAKEN	
Pressure sores — Class II citation, $500 fine	
Significant drug errors — Class III citation, $100 fine	

Sample report card following revisit survey

FACILITY	Mahaska Manor
CITY	Oskaloosa
COUNTY	Mahaska
INSPECTION TYPE	Revisit (general)
DATE OF INSPECTION	May 10, 1999
COMPLIANCE LEVEL	13/17 corrected (76.5 percent)
ENFORCEMENT ACTIONS TAKEN	
Pressure sores — failed to correct, $50 daily fine until corrected	
Multiple repeat violations — denial of Medicaid payment for new admissions until corrected	

Sample report card following complaint survey

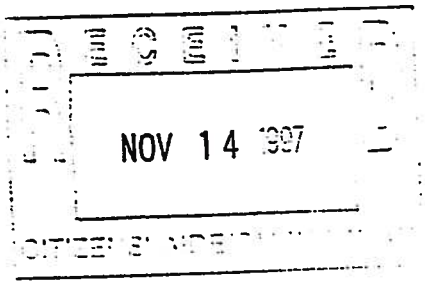
FACILITY	Mahaska Manor
CITY	Oskaloosa
COUNTY	Mahaska
INSPECTION TYPE	Complaint
DATE OF INSPECTION	May 30, 1999
COMPLIANCE LEVEL	4/7 complaints unsubstantiated (57.1 percent)
ENFORCEMENT ACTIONS TAKEN	
None	

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF INSPECTIONS AND APPEALS
KIM D. SCHMETT, DIRECTOR
JOHN T. SCHAFFNER, DEPUTY DIRECTOR

November 14, 1997



William P. Angrick II
Citizens' Aide/Ombudsman
215 East 7th Street
Des Moines, Iowa 50319-0231

Dear Mr. Angrick:

The Iowa Department of Inspections and Appeals (DIA) and our Health Facilities Division appreciate the efforts of the Citizens' Aide/Ombudsman's Office to thoroughly review our agency oversight and regulation at Elmwood Care Centre, Onawa, and Mahaska Manor, Oskaloosa. Our Department also thanks the Ombudsman's Office for allowing us to respond to the issues, conclusions, and recommendations contained in the report.

Regarding the recommendations contained in the report, some have already been implemented by the Health Facilities Division, many of them shortly after the period covered by the Ombudsman's inquiry and prior to the issuance of this report. In general, our Department supports a majority of the Ombudsman's recommendations. We also offer for the Ombudsman's consideration a few suggestions to further increase the effectiveness of his recommendations.

Underlying our Department's concerns about the findings of the Ombudsman's report is its failure to recognize the ongoing regulatory philosophy of our agency and our Health Facilities Division. Our philosophy regarding regulatory enforcement is as follows:

> Our first and foremost concern has been, is, and will continue to be the health, safety, and well-being of residents in Iowa's long-term care facilities, whether they reside in Elmwood Care Centre, Mahaska Manor, or any other facility in the State of Iowa under the regulatory jurisdiction of our Department.
>
> We will use whatever means necessary from the available enforcement actions to bring facilities and providers into compliance.
>
> Facilities and providers who fail to maintain compliance with the established standards of resident care will face the appropriate penalties allowed by law, including license revocation.

Our Department's commitment to the residents of Iowa nursing facilities is further exhibited by

the fact that the DIA is the only state agency to actively encourage the full participation of care review committees to serve as watchdogs at nursing facilities. Care review committee chairs are routinely informed of survey and investigation findings so that they can assist us in monitoring the conditions at nursing facilities. Likewise, our Department was among the first state agencies to join with the federal Health Care Financing Administration (HCFA) in its "Partners Project." The Partners Project's sole purpose is to better the living conditions and the quality of care for nursing facility residents.

Because we believe there can never be too many people watching out for the health, safety, and well-being of our nursing facility residents, our Department would welcome further involvement by personnel from the Citizens' Aide/Ombudsman's Office with a health care background to conduct follow-up studies. To properly prepare itself for this role, the Ombudsman's Office may need additional resources to retain and train personnel so that they become better versed in the complexity of nursing facility regulations.

Before responding to the specific recommendations contained in the report, our Department would like to make several general observations and comments regarding the Citizens' Aide inquiry. First, our agency does not dispute the facts contained in the Ombudsman's report. Indeed, the facts were garnered directly from our Department's files, reports, statements of deficiency, fining and citation actions, etc. It is not our intent to debate the stated facts as contained in the report.

Rather, our Department takes exception to some of the assumptions and conclusions reached by the Ombudsman as a result of his interpretation of those facts. Our concerns arise from several factors including:

> Lack of personnel within the Ombudsman's Office who have adequate health care and/or medical training to make assumptions regarding the quality of care being provided to the residents at the two nursing facilities;
>
> An apparent misunderstanding by the Ombudsman's Office of the inspection/survey process in use at the time action was taken by our Department at the two facilities;
>
> Allegations by the Ombudsman's Office that our Department's "unreasonable" actions constituted a lack of caring for or about the quality of life enjoyed by the residents at the two facilities;

Lack of historical perspective by the staff of the Ombudsman's Office to fully comprehend the significance of federal regulations during the period covered by the report; and

A lack of perspective necessary to adequately distinguish between the different enforcement policies and practices espoused during the period of the report as compared to the current management philosophies.

We find the frequent use of the term "unreasonable" throughout the body of the report to be of great concern. To assume that our Department was "unreasonable" in its regulation of the two nursing facilities is to assume that our Department failed in its mission to protect the quality of life for Iowans. The regulation of health care providers, especially those providers of service to Iowa's elderly and frail residents, is an emotionally-charged subject. It is nearly impossible to present facts in such a way as to avoid emotional entanglements. However, our Department must, as far as is practical, base all of its actions on objective judgements, using established protocols which attempt to eliminate subjective and emotional values from the inspection, certification, and enforcement actions.

It should be further noted that the inspection staff in our Department's Health Facilities Division is composed of licensed or accredited health care professionals who base their opinions on established professional standards and practices. Our Department questions whether an individual who has no health care training is qualified to make assumptions regarding the quality of care being provided to nursing facility residents.

Likewise, it is imperative that the inspection and survey protocols in place during the time of the report be analyzed to fully comprehend the enforcement actions taken at the facilities. The federal Health Care Financing Administration (HCFA) is constantly updating, changing and rewriting its polices and procedures regarding the inspection of federally-certified facilities. Since 1990, HCFA has issued more than 450 clarifications to state surveying agencies. The two facilities examined in this report were both federally-certified and, therefore, subject to the federally-defined survey protocols. As the designated state survey agency, our Department was contractually-bound to follow the HCFA-defined practices existing at the time the enforcement actions were taken.

In the report, the Ombudsman requires nearly seven pages to describe the "length, complexity and status" of the State Operations Manual (SOM). The writer notes the "DIA is obligated to

follow the SOM . . . for regulating long-term care facilities certified by Medicaid." It is further noted that the SOM is "an evolving document." However, the Ombudsman admits the document was not reconstructed to reflect the SOM version in use during the period reviewed.

Our Department believes the Ombudsman's failure to reconstruct the SOM as it existed between 1988 and 1996 is a serious oversight. As the report notes, the SOM embodies the enforcement standards in place at any given time. It is the manual of operation, the standard of reasonableness by which facilities are judged and, if necessary, sanctions are imposed. To use the updated SOM as the measuring stick against which to judge our Department's actions taken nearly a decade ago is totally unreasonable. The regulatory philosophy and structure of 1988 was entirely different than today's standards. If we are to be held accountable for our actions in 1988, we ask only that the judgements be made based on the prevailing standards of that time. To do anything else is to artificially superimpose current remedies on historical deficiencies.

These comments aside, the question then becomes one of "would our Department have done anything different then knowing what it now knows?" Hindsight, the saying goes, is 20-20. Indeed, looking back upon the same situations, our Department may have handled some of the enforcement procedures differently. However, we do not attempt to make excuses for the actions that were taken at the cited facilities. Those actions were, at that time, believed to be the best possible solutions available. To compare current enforcement standards with federal sanctions available during the report period is to ignore the survey protocols in place at the time. Again, it is crucial to the report to maintain the proper perspective on the issues; that is, to measure violations using the applicable standards of the time period.

Also, it is presumptive for the report to assume the reasons for the actions taken at the two facilities. Two key individuals involved in the regulation of nursing facilities during the reported period, the Department Director and Health Facilities Division Administrator, have since retired from our Department and, therefore, are unable to explain or defend their reasoning and actions. We can only assume, based on our observations, that the motives expressed and methods used by these individuals were fair, honest, and reflected genuine concern for the residents at the facilities.

Again, the frequent use of the term "unreasonable" gives rise to a feeling that our Department was uncaring about the level or quality of care being provided to the residents in the Elmwood Care Centre and Mahaska Manor. To even suggest this not only does an injustice to our Department but to our primary constituents, the residents of Iowa's nursing facilities. The

principle focus of our Department has been, is, and will continue to be the safety and well-being of the residents of Iowa's nursing facilities.

At the time the enforcement actions were taken at Elmwood Care Centre and Mahaska Manor, our Department did not have the benefit of yet-to-be-adopted, more stringent federal regulations. Working within the confines of the then-existing sanctions, our Department did what it believed to be in the best interests of all affected persons. The general philosophy espoused by our Department's management at the time of the reported incidents was to keep facilities open, to work with them so that compliance could be maintained. Strong enforcement actions, such as license revocation, termination, receivership, etc., were viewed as enforcement tools of last resort. It was generally believed that closing a facility in all but the most dire situations would serve little, if any purpose. Closures were (and continue to be) a traumatic experience for the residents, their family members, even the facility's staff.

Likewise, placing a facility under receivership had little, if any, guarantee of success. For the most part, a receivership could result in a temporary fixing of a problem rather than a permanent solution. Once a facility's problems were corrected by the receiver, the facility's control was returned to the original owner who may or may not maintain the situation. In February 1995, our Department requested a clarification from the Iowa Department of Justice regarding the issue of receivership, specifically as it applied to Mahaska Manor.

In the response, the then-Assistant Attorney General expressed caution when pursuing receivership actions. The legal counsel stated: "Is . . . the appointment of a receiver . . . appropriate. A receiver can be appointed to bring the facility into compliance or to close it and move residents. At Mahaska Manor, I think that it was assumed that the problems would be corrected and the facility would not have to close. Therefore, any receiver placed in the facility would be to make necessary corrections . . . With Mahaska Manor, it should be noted that the licensee was not operating the facility. The licensee had a contract with another entity to operate the facility. It certainly was not clear that bringing in yet another entity would have resolved any of the problems."

Lastly, as has been previously stated, mandatory federal enforcement procedures are not static; that is, they are fluid and under a constant state of evolution. Since the two facilities in question were federally-certified, the state's most severe remedy was to impose fines and begin license revocation actions. However, as soon as a facility appeals a decision, the sanctions must be held in abeyance until all appeal rights are exhausted. It should be noted that at the time of its closing,

Mahaska Manor was under a license revocation action. Had the facility not closed, it may have been faced with the federal sanctions enacted in July 1995 as part of HCFA's new long-term care facility enforcement regulations. Indeed, our Department believes that it was the future threat of these new enforcement actions which forced the licensee to close the facility's doors. The new federal sanctions give the state surveying agencies more flexibility in dealing with troubled facilities such as immediate termination from the federal health insurance programs, and definitions for "substandard quality of care" and "poor performers."

As previously noted, the philosophy of our agency during the period of time covered by the report as directed by the federal government was to work with troubled facilities to bring them back into compliance as long as such actions did not jeopardize the quality or level of care being provided to the residents. Our Department did attempt to bring troubled facilities into compliance, using various enforcement actions up to and including license revocation. Without offering any excuses for its action, our Department notes that in certification matters regarding the Medicaid or Medicare programs, we had few enforcement options because of federal mandates. The bottom line on certification was and continues to be: If a facility can meet and maintain the minimum standards for participation in the Medicaid or Medicare program, it must be recommended for admission or readmission into these programs. Again, these are federally-mandated requirements over which our Department has no control.

The same, however, cannot be said of state licensure issues. In recent actions, our Department has sought license revocation as the ultimate enforcement tool. Most recently, Oak Terrace, a nursing facility located in Davenport, Iowa, surrendered its license to our Department following a revocation action. Our Department has and will continue to seek state license revocation as the ultimate enforcement tool to protect Iowa's nursing facility population. Several other facilities, too, have faced license revocation actions apart from decertification from the Medicaid or Medicare programs.

The Ombudsman's report criticizes our Department for the state fine levied in those instances when a resident's death occurred. It must be stressed that the range of fines are statutorily established. Also, fines are not levied based upon the death of a resident but, rather, based upon the violation of these rules. Our Department realizes that no amount of fine can be levied which is sufficient enough to compensate for the death of a resident. Nor, do we levy fines based on an individual's death. Our Department's role in all aspects of the regulation of nursing facilities is to determine whether rules were violated which may have contributed to or were evidenced by the injury or death of a resident. We have changed our internal policies during the past year so that

all deficiencies referencing the death of a resident are more closely scrutinized.

When our Department encounters a deficiency at a facility, the deficiency is cited according to established standards. The nine factor formula outlined in the report is used to determine the severity of the deficiency and the class of violation. It is believed that the use of the formula by a determination panel eliminates subjective motives. In fact, the proposed "report card" system offered by the Ombudsman's Office to rate Iowa nursing facilities would appear to use a modified and shortened version of our existing nine-factor formula. The Ombudsman's proposed enforcement table appears to use elements similar to ours to determine the severity of violations.

As part of its new enforcement standards enacted on July 1, 1995, HCFA instituted civil monetary penalties (CMPs) ranging from $50-$3,000 per violation per day to a high of $3,050-$10,000 per violation per day. When significant violations directly impacting the quality of care residents receive are discovered at federally-certified nursing facilities, our Department assesses both a federal CMP and a state fine. Iowa law, however, prohibits the imposition of both sanctions for the same violation. Therefore, if the violation is corrected at the time of the revisit to the facility, the federal CMP is dropped and the state fine imposed.

Finally, it is necessary to address the appeals process utilized by Iowa nursing facilities. Under the state's Administrative Procedure Act, Chapter 17A, all nursing facilities accused of violations have the right to contest the facts upon which our Department has taken its enforcement action. Due process guarantees the facility the right to challenge our Department's determinations. Until the appeal process has been exhausted, a facility retains its license and all fines are held in abeyance. In March 1995, the Iowa Supreme Court upheld our Department's authority to levy fines based upon our findings (Stacyville Community Nursing Home vs. Iowa Department of Inspections and Appeals).

Throughout this report, the Ombudsman repeatedly advises the reader that it is not necessary to understand the inspection process in order to appreciate the severity of the alleged violations. Our Department disagrees with this comment and asks, rather, if it is unreasonable on the part of the Ombudsman not to suggest that understanding the inspection process is necessary? Is it not crucial to understand the system by which facilities are inspected, especially in an ever-evolving system, to better judge the effectiveness of enforcement?

The inspection of nursing facilities is not static, just as the services provided by the facilities are constantly evolving to meet the needs of the residents. As previously stated, this fluid

environment is witnessed by the ever-increasing number of clarifications issued by the federal government in response to questions raised by state survey agencies. Without a true understanding of the existing survey standards in place during the time of the report, the reader cannot truly appreciate the complexity of the process. During the past decade as a result of Congressional action there has been a significant shift in the federal law governing the regulation of nursing homes. What began as a procedurally-driven process changed to an outcome-based procedure, and has further evolved into the current resident-focused standards. Accompanying the changes in federal law and rules were changes in the surveying protocols used by our agency to inspect and regulate the quality of care being provided to nursing facility residents. As has been evidenced, we believe the entire inspection structure has changed dramatically - and continues to change - for the better. The current inspection process relies heavily on resident interaction, including interviews with family members, care review committees, and facility staff.

Before addressing the specific recommendations made by the Citizens' Aide/Ombudsman, allow me to summarize our Department's position. While we acknowledge the facts contained in the report, we do not accept the Ombudsman's final conclusion that our Department failed to adequately or fully protect the residents in the two facilities. Our Department's actions during the reported period were believed by those people who took those actions to be in the best interest of the residents at that time and under those particular circumstances.

Having stated our Department's position on the content of the Ombudsman's report, let us now turn to the recommendations contained in the document. In all, our Department accepts and agrees with the recommendations made by the Ombudsman. We would, however, suggest some possible alternatives to the recommendations contained in the report. Such alternatives, we believe, would not only strengthen the state's enforcement actions, eliminate complicated and confusing sanctions, but bring all federally-certified and state-licensed facilities into uniformity.

Response to Ombudsman's Recommendations

1. Adopt and practice a proactive enforcement philosophy as policy.

Our Department believes, in principle, it has always followed a proactive enforcement philosophy. All enforcement actions ultimately have been aimed at improving the quality of life for the residents and clients of Iowa health care facilities and providers. As part of the Division's ongoing commitment to serve its customers, a new mission statement was written and distributed

to all staff. The mission statement embodies our enforcement philosophy as well as outlines the goals for the Division. It reads as follows: "To promote the right of the persons who receive care and services from a licensed or certified health care provider to experience the highest practical quality of life." This mission statement, initially developed by staff at a Departmentwide retreat in September 1995, encompasses the enforcement philosophy of the Division, and dovetails with our Department's mission statement: "To optimize the quality of life in Iowa by maintaining integrity in programs and services administered by the Executive Branch."

In addition to the mission statement, the Division's regulatory role is also guided by the following principle - Our primary concern is the health and safety of care facility residents (implemented in January 1997). To attain this goal:

- All licensure and certification survey activities are conducted objectively, and honestly, in a fair and consistent manner.
- We believe basic health and safety is an outcome of compliance with the regulations we enforce.
- We believe the intent of providers/suppliers is to attain and maintain compliance with the federal certification and/or state licensure requirements.
- When providers/suppliers cannot attain and maintain compliance we apply whatever appropriate remedial action is necessary to attain compliance and assure the safety and protection of residents.

2. Rescind 481 IAC 56.9 and adopt a new rule based on the table attached as Appendix J.

Our Division sees no reason not to adopt the proposed table but makes the following general observations regarding its use. First, while the proposed table does simplify the determination process now in use, the Nine Factor Formula, it does not entirely eliminate subjective opinions. Two of the factors in the Ombudsman's table, Harm and Frequency, still appear to require subjective observations. Secondly, when Appendix L is analyzed it appears that the action taken by our Department at Mahaska Manor during the report period was either identical to or more severe than the Ombudsman's proposal. (Appendix L shows how the proposed table would have been applied in the 22 instances where DIA issued state-authorized citations against Mahaska Manor during the period under review.) In only two instances did the proposed table indicate a more severe penalty.

Rather than create an additional enforcement table, our Department suggests the following alternative. We would seek the Ombudsman's support in securing legislation that would adopt the federal scope and severity chart and accompanying sanctions as Iowa law. We believe most facilities in the state are now familiar with the federal sanctions and feel that a single enforcement tool is more beneficial for proactive enforcement. In addition, the federal sanctions include higher per day monetary penalties when compared to the state's per incident fines. From an administrative perspective, we believe the adoption of the federal sanctions would not only bring facilities into compliance faster but ensure longer compliance. Finally, as most of the facilities in Iowa and all Health Facilities personnel are familiar with the federal scope and severity chart, there would be less opportunity for confusion or miscalculation of penalties.

3. Specify in the new rule that when DIA proposed a non-mandated fine pursuant to both state and federal regulations, DIA will rescind whichever would be greater if the facility corrects the deficiency within the specified time period.

Our Department agrees with the Ombudsman's recommendation and notes that this policy is currently being enforced for all federally-certified facilities. At the time a fining and citation is issued to a facility, it is informed that in addition to a state-imposed fine a federal civil monetary penalty is being recommended. If the deficiency is corrected at the time of the revisit, the federal CMP is rescinded and the state-imposed fine is owed (pending the appeal process). If, however, the deficiency is not corrected at the time of the revisit, the larger federally-assessed CMP is owed. We agree with the Ombudsman's explanation that this action does encourage facilities to correct deficiencies within a shorter amount of time. It should also be noted that our Department conducted fewer survey revists and complaint revisits during the just completed fiscal year (FY 97) than it did during the previous fiscal year (FY 96). The fewer number of revisits is due directly to the speed with which facilities facing stiffer federal CMP corrected violations.

4. Amend 481 IAC 58 to remove the parenthetical notations indicating whether violations are considered Class I, Class II, or Class III.

Our Department would support this recommendation by the Ombudsman's Office. The parenthetical notifications have historically been included with the rules as a 'forewarning' device to facilities. However, having the class of violation indicated did not always predict the final outcome of enforcement actions. Our Department would also note that if the federal sanctions were adopted for state enforcement actions (as we proposed in number 3 above), the three classes of Iowa violations would no longer exist. Again, adoption of the federal sanctions would provide

for consistency in enforcement procedures and eliminate confusion as to which type of deficiency or violation is attributed to which system.

5. Establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to Medicaid residents.

Our Department has long struggled with various actions to reward facilities with the best performance records. However, as a regulatory agency, we do not want to give the impression that our Department is recommending or endorsing any particular facility. In general, all facilities which receive deficiency-free surveys are the first to contact the local media. Public recognition, therefore, may not be a major issue. Regarding a program using "incentive payments," we don't believe it is in the best interest of the taxpayers to financially reward facilities for providing the quality of service expected of them. Again, let us point out that the state's better managed and operated facilities are the first to let the public know of their quality and level of service. The nursing home industry in Iowa, as in most states, is highly competitive and most facilities will not miss an opportunity to alert the public to its status as a deficiency-free operation.

6. Publicize deficiencies and enforcement actions.

Like number five above, our Department has considered several options regarding publicizing deficiencies and enforcement actions. In fact, the DIA's public information office handles several hundred media and public inquires each year regarding nursing facility deficiencies. The release of such information is, we believe, in the public's best interest. However, we also believe that the release of this information by our Department should come after the appeals process has been exhausted.

Some publicity is currently generated by the Health Facilities Division's annual fining and citation report. This report contains information about each state enforcement action taken against a facility during the fiscal year. The report is made available to all media and can also be requested by the general public. Throughout the report, the Ombudsman leaves the reader with the impression that our Department has been lax in it's enforcement actions, especially where fines have been assessed for violations. Again, the report appears focus on past behaviors and not fully consider current philosophies and actions. It must be noted that the dollar amount of state and federal fines imposed against Iowa nursing facilities by our Department during Fiscal Year 1997 nearly doubled when compared to the previous fiscal year. In all, our Department

assessed more than $500,000 in fines as a result of violations found during annual inspections and complaint investigations. (See DIA attachment 1.)

7. Amend Code Section 135C.26 as follows:

As stated earlier in this response, our Department would welcome the Ombudsman's efforts to secure passage of legislation changing the state's fining and citation program. We have for the past several years attempted to have the state fines increased and/or the gap narrowed between a Class I and Class II violation. We would point out again, however, that if the federal enforcement sanctions were adopted for use by the state, the need to amend the fines would be eliminated.

8. Amend Code Section 135C.40(1) as follows:

This change to provide uniformity in the event the Legislature agrees to establish fines for Class III violations would be welcomed by our Department. Currently, no fines are associated with a Class III violation. As a matter of practice, however, all notices of fining and citation action are sent to facilities via certified mail.

9. Amend Code Section 135C.41 as follows:

As with the Ombudsman's recommendation above, our Department would fully agree that all provisions pertaining to a Class III violation be made uniform to the provisions governing Class I and Class II violations.

10. Amend Code Section 135C.44 as follows:

As with the previous three recommendations, our Department supports the Ombudsman's efforts to provide uniformity in the event the Legislature adopts the recommendation to add a monetary penalty to Class III violations.

A Health Facility Report Card

As with most of the Ombudsman's recommendations, our Department believes the establishment of a report card to help consumers understand long-term care facilities would be beneficial. As noted in the report, there are a number of variations which could be included in the score process

such as the number of "critical deficiencies" found during a survey or investigation. Rather than immediately issue a new score/report card for facilities against which our Department takes enforcement action, we feel it might be best to wait until all appeal rights have been used by the facility. Our reasoning for this delay in the issuance of a updated report is the same as our concern for publicizing deficiencies and enforcement actions: Until a facility has exercised all of its appeals rights, a final decision cannot be made. Perhaps, the subject of a report card would best be left to the Iowa Partners for Resident Care. This body, composed of representatives from all aspects of the long-term care industry in Iowa, might best address the factors to be included and the precise scoring and publicity techniques.

In conclusion, our Department again thanks the Ombudsman's Office for allowing us to respond to the issues raised in its report. We remain steadfast in our belief that our Department did not fail in its mission and obligations to the residents of Mahaska Manor and Elmwood Care Centre. While some individuals may always second-guess our Department's actions at these facilities, it is inappropriate to assume our Department failed to protect the residents in question. Regardless of the facts involved, the following questions will always remain: Could our Department have done things differently? Probably so. Who among us hasn't questioned our past actions in light of new information. Are the inspection and enforcement processes perfect? I don't believe so. As outlined above, these processes are constantly undergoing changes. Some of these changes, I am sure, will be generated by individuals such as yourself who perceive injustices in the current system; some will be dictated by the needs of those best served by the affected facilities. Yet other changes will come about as a result of new medical technology. The question then becomes not "did we do everything we could have done in the past" but, rather, are we prepared to make the changes needed to serve the state's elderly and frail residents of the future? To this last question, I can unequivocally answer yes.

Sincerely,

Kim D. Schmett
Director

NEWS RELEASE -------

Iowa Department of Inspections and Appeals

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FOR IMMEDIATE RELEASE
Date: October 3, 1997
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94 Percent of Iowa's Nursing Homes Meet or Exceed Health Care Standards

DES MOINES, Iowa -- Ninety-four percent of the state's 982 licensed or certified health care facilities were either deficiency-free or had only minor problems not requiring disciplinary action during the 1997 fiscal year, Iowa Department of Inspections and Appeals (DIA) Director Kim D. Schmett said. According to the Department's FY '97 Fining and Citation Report, only 62 Iowa facilities faced disciplinary action.

"The vast majority of Iowa's long-term care facilities are operating within substantial compliance with all applicable state and federal rules. That is, they are meeting if not exceeding established standards of health care for their residents," the Director added. The number of deficiency-free nursing facilities, too, continues to increase with 14 percent of the facilities currently surveyed passing all inspections without any problems.

The 62 facilities that received state or federal-imposed sanctions included 57 "nursing homes" (nursing facilities and skilled nursing facilities), and several intermediate and residential care facilities with specialized services for persons with mental illness or the mentally retarded. These 62 facilities were assessed more than $500,000 in state and federal fines as a result of

violations found during annual inspections and complaint investigations.

"More Iowa nursing facilities regulated by the DIA were subject to state and federal enforcement actions during fiscal year 1997 than during any other fiscal year since 1991," Schmett said. "Compared to fiscal year 1996, the number of state-cited facilities alone has increased from 41, while the number of state citations issued to facilities also increased from 47 to 69." The Director said that the dollar value associated with the Department's fining and citation actions has nearly doubled, up from $61,200 in Fiscal Year 1996 to last year's total of $121,200.

During the 1997 fiscal year, a total of 172 rule violations relating to the fining actions were discovered by DIA health facility surveyors during annual inspections or while conducting complaint investigations. The most commonly cited problem found at facilities was the failure to provide required nursing services for residents, the Director said. "This violation directly impacts the quality of care being provided to residents in Iowa nursing facilities, and often affects the level of assistance residents receive with daily living activities," he added.

The second most cited problem dealt with the duties of the health services supervisor in intermediate care facilities. Under the Department's rules, every intermediate care facility is to have a director of nursing who will supervise the implementation of the physician's orders, and plan for and direct the nursing services to be provided to the facility's residents. Both violations are quite serious as they can have a dramatic impact on the health, safety and well-being of the resident, Schmett said, adding: "The failure on the part of a facility to adequately provide for the care of its residents, as evidenced by either of these two violations, could individually or in combination result in the issuance of the maximum state fine of up to $10,000."

Besides state-imposed penalties, all Iowa nursing facilities certified for participation in either the Medicare or Medicaid programs are subject to federal enforcement actions, including civil monetary penalties of up to $10,000 per day per violation. "During this past fiscal year, the

Department's Health Facilities Division imposed federal fines of $455,850 against violating facilities," the Director continued. "This represents a fourfold increase in the amount of federal fines levied against Iowa nursing facilities during the previous fiscal year when the dollar amount totalled approximately $103,000."

As a part of the federal long-term care enforcement standards enacted in July 1995, the Department may impose several sanctions against Medicare or Medicaid-certified facilities. In addition to the civil monetary penalties, the Department can recommend denial of payment for new resident admissions or that a facility's Medicare or Medicaid contract be terminated. "When the new federal enforcement standards were enacted, we blended the existing state enforcement measures with the federal sanctions. Now, when certain federal sanctions are imposed on a facility, the Department automatically issues a 'conditional' state license," Schmett added. "The issuance of a conditional license is one way to put the public on notice that the facility is not meeting minimum state licensing standards, and ultimately failing to meet the needs of its residents."

The Director said the "blended state-federal sanctions" are motivating facilities to come into compliance quicker. "The new federal standards, too, give facilities an opportunity to correct cited violations prior to the imposition of increased penalties," Schmett said. "In general, we're seeing those facilities with problems coming back into compliance sooner and remaining in compliance longer due to the state and federal enforcement measures."

Summary of State-Federal Enforcement Actions

Fiscal Year 1997 versus Fiscal Year 1996

	Fiscal Year 1997	Fiscal Year 1996
Number of Facilities/Number of Cited Facilities	982/62	988/41
State Fines Assessed	$ 121,200	$ 61,200
Federal Fines Imposed	$ 455,850	$ 102,785
Class I Violations Cited	27	1
Class II Violations Cited	93	69
Class III Violations Cited	51	17
Conditional Licenses Issued	38	13
Medicaid/Medicare Decertification Actions	3	6
Denial of Payment Actions	23	14
License Revocations	1	1

Ombudsman's comment to DIA Director's reply

The Ombudsman is encouraged by Mr. Schmett's stated support for a majority of the Ombudsman's recommendations and his suggestions for increasing their effectiveness.

And the Ombudsman agrees with Mr. Schmett's point that the primary concern of the state is the "health, safety and well-being of residents in Iowa's long-term care facilities."

However, the Ombudsman needs to respond to other points in Mr. Schmett's response. He wrote in part:

> ... At the time the enforcement actions were taken at Elmwood Care Centre and Mahaska Manor, our Department did not have the benefit of yet-to-be adopted, more stringent federal regulations. Working within the confines of the then-existing regulations, our Department did what it believed to be in the best interests of all affected persons.... [*page 5*]

Mr. Schmett's comments seem to imply that federal regulations did not allow for any enforcement action in the 41 actual instances analyzed in the report.

While this may be true to a certain extent, it only tells part of the story. There are two enforcement systems for nursing homes. One is authorized by federal law and applies to facilities in the federal Medicaid program. The other is authorized by Iowa law and applies to all facilities in the state.

DIA enforces both systems at the same time — wearing both a federal "hat" and a state "hat." While similar, the two systems are independent. For example, nothing in the federal system can stop DIA from taking enforcement action under the state system.

So when DIA finds a problem at a nursing home, it can take state-authorized enforcement actions — even if federal policies do not allow for any federally-authorized action. Mr. Schmett confirmed this in a meeting with representatives of the Ombudsman's office.

The Ombudsman's review considered that both federal and state enforcement options were available to DIA during the period in question. However, Mr. Schmett's written response focuses almost exclusively on *federal* enforcement options and restrictions on their use. While state enforcement options were also available, his response does not explain why DIA did not take them — particularly fines, which start at $100.

When Mr. Schmett did reference state enforcement options, he portrayed them in an "all or nothing" light:

> ... Strong enforcement actions, such as license revocation, termination, receivership, etc., were viewed as enforcement tools of last resort....

But the report did not advocate these "strong enforcement actions" as a general practice. Mr. Schmett's response fails to mention state-authorized fines, the one tool which would have allowed DIA to take lower-level enforcement action in each of the 41 instances discussed in the report.

Finally, Mr. Schmett questions "whether an individual who has no health care training is qualified to make assumptions regarding the quality of care being provided to nursing facility residents."

But this review did not focus on medically-based assessments, nor did it make any assumptions. Instead, the review relied on DIA's own survey findings and considered whether DIA's enforcement actions — and lack thereof — were reasonable. These are administrative actions for which a health care background is not necessary.

Significantly, while raising general concerns about the Ombudsman's conclusions concerning Allegations #1 and #2, Mr. Schmett's response presents no specific concerns regarding the Ombudsman's analysis of any of the 41 actual instances which formed the basis for those conclusions.