Date of Hearing: April 21, 2015

ASSEMBLY COMMITTEE ON AGING AND LONG-TERM CARE
Cheryl Brown, Chair
AB 348 Brown – As Amended April 14, 2015

SUBJECT: Long-term health care facilities.

SUMMARY: Creates a 40-day timeframe for the Department of Public Health (DPH) to complete a long-term care facility complaint investigation and requires DPH to provide additional information about the investigation of the complainant. Specifically, **this bill**:

1) Requires DPH to complete investigations of complaints against long-term health care facilities within 40 working days of the receipt of the complaint.

2) Allows DPH to extend an investigation up to 30 additional working days if DPH has been unable to obtain necessary evidence related to the investigation despite its diligent attempts.

3) Requires DPH, when it extends an investigation under 1) above, to notify the complainant and provide the basis for the extension, a description of outstanding evidence and sources, and the anticipated completion date.

4) Effective July 1, 2015, requires DPH to include specific findings concerning each alleged violation and a summary of the evidence in the written determination it is required to make at the investigation's conclusion.

5) Increases, from five days to 15 days, the amount of time a complainant has to request an informal conference with DPH, if the complainant is dissatisfied with DPH's determination.

6) Expands provisions related to timeframes for a complaint investigation to include self-reports of violations by facilities.

EXISTING LAW:

1) Defines Health Facilities in Health and Safety Code Section 1250 as "general acute care hospital," "acute psychiatric hospital," "skilled nursing facility," "intermediate care facility," "intermediate care facility/developmentally disabled habilitative," "special hospital," "intermediate care facility/developmentally disabled," "intermediate care facility/developmentally disabled-nursing," "congregate living health facility," "correctional treatment center," "nursing facility," "intermediate care facility/developmentally disabled-continuous nursing," or "hospice facility."

2) Requires DPH to initiate investigations within 24 hours, and *complete* investigations of written or oral complaints made in regards to dangerous situations within acute hospital settings within 45 days.

3) Requires DPH to initiate an investigation with an onsite inspection within 10 working days of the receipt of a valid written or oral complaint in a skilled nursing facility. In cases of imminent danger of death, or serious bodily harm, DPH is required to initiate an investigation

with an onsite inspection within 24 hours. There is no corresponding mandate to complete the investigation, as there is for a complaint in a general acute hospital setting.

4) Provides that any duly authorized officer, employee, or agent of the state department may enter and inspect any long-term health care facility, including, but not limited to, interviewing residents and reviewing records, at any time to enforce the law.

5) Requires that inspections conducted pursuant to complaints filed with the state department be conducted in such a manner as to ensure maximum effectiveness while respecting the rights of patients in the facility.

6) Forbids advance notice of inspections unless previously and specifically authorized by the director or required by federal law, and provides that any public employee giving any advance notice of an inspection, or a visit related to an investigation, is in violation of law and subject to dismissal, demotion, suspension, or other disciplinary action.

7) Requires DPH to notify the complainant of the name of the inspector or investigator and permits the complainant to accompany the inspector to the site of the alleged violation.

8) Requires DPH to notify the complainant of its determination within 10 working days of the completion of the complaint investigation. Permits the complainant to request in writing an informal conference within five business days after receipt of the notice. Offers additional levels of appeals if the complainant is dissatisfied with the determination of DPH.

9) Requires a long-term health care facility to report all incidents of alleged abuse or suspected abuse of a resident of the facility to DPH immediately, or within 24 hours, as specified.

10) Under state regulations, requires a long-term health care facility to report unusual occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes, or other catastrophes which pose health or safety threats within 24 hours to the local health officer and to DPH.

11) Excludes, for the purposes of these complaint investigation requirements, a self-report from a facility of an alleged violation of applicable requirements of state or federal law.

12) Requires DPH to prepare an annual staffing and systems analysis to, among other things, ensure the effective and efficient utilization of licensing and certification fees and proper allocation of DPH resources to licensing and certification activities. Requires the analysis to contain specified information, including the number and timeliness of complaint investigations.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

PURPOSE OF THIS BILL: Unlike investigations of complaints about hospitals, DPH staff members are not required by law to complete investigations of complaints in nursing homes. The author points to extensive testimony received by the Legislature during two joint oversight hearings of the Assembly Committee on Aging and Long-Term Care and the Assembly

Committee on Health which indicates that DPH, despite well-established statutory mechanisms to assure adequate financial and personnel resources to conduct and complete necessary investigations, fails to meet its workload demands. It should be noted that DPH failed to report to the legislature, for two years, a statutorily required workload analysis that would have demonstrated performance challenges that the DPH staff were confronting, and through licensing fee adjustments - not General Fund allocations - the staff shortages could have been managed. Despite a continued focus upon the problem, a back-log of uninvestigated complaints about physical abuse, mistreatment, poor care and entity reported incidents (ERIs) continues to grow - now, according to DPH, estimated at nearly 12,000. Oversight exercises revealed that thousands of complaints have languished with incomplete investigation, some for years. The author asserts that each complaint represents a potentially serious injustice, potential pain, and ongoing suffering, potentially caused by predators who seek employment among vulnerable populations who become unwitting prey in long-term health care facilities, or, business practices that place individuals at risk of serious harm such as poor staffing patterns, poor management, or other practices over which DPH is charged with state and federal oversight responsibilities.

The author asserts that timely investigations are critical to reduce, even eliminate known risk. According to the author, acting to protect dependent adults in care environments regulated by the state is a governmental priority. This bill is intended to address this issue by enhancing existing laws which require investigations to be initiated within no more than 10 days. The specific enhancement AB 348 proposes is to establish a reasonable, statutory timeframe (40 working days, plus one 30 working day extension, if necessary) within which the investigation must be completed. According to the author, AB 348 improves current law so that DPH which is already under statutory obligation to open investigations, remains obligated to complete, and close the investigation. Ongoing reporting requirements will provide periodic evidence establishing a basis for additional resources through licensing-fee adjustments, not tax-payer supported general funds, to assure that abused, mistreated and injured citizens, or their families, receive dignity and justice. Completed investigations may also help facilities recognize management or business practices which unwittingly create unnecessary risk for a medically frail population, and place their Medicare "Star" rating at risk.

According to Supporters: According to the California Advocates for Nursing Home Reform (CANHR), the sponsor of AB 348, "lives are at risk: years often go by before DPH responds when it receives a complaint that a nursing home resident died due to neglect" and provide three recent examples of the types of complaints that become overlooked at DPH:

- On November 13, 2013, DPH issued a $100,000 fine to Rosewood Post-Acute Rehab, a skilled nursing facility in Carmichael; nearly seven years after the patient died on January 1, 2007 by an overdose of Warfarin, a powerful blood thinning medication. DPH offered no explanation for the extreme delay.

- An April 12, 2014 article by Kaiser Health News, "Frustrating Wait for the Nursing Home Inspector," tells the story of Sui Mee Chiu, a former resident of the Arcadia Health Care Center. Ms. Chiu died in 2011 at age 85 after developing severe bedsores, including one on her backside that was so deep it exposed the bone. Following her death, her daughter, Mary Chiu, filed a 7-page complaint with the Los Angeles County Department of Public Health in September 2011. At the time of the article in April 2014, the Department had still not completed its investigation.

- The Department also ignores victims of physical and sexual abuse. For example, after learning in November 2009 that a male nurse sexually assaulted a female resident at the Palos Verdes Health Care Center, the Department took four years before issuing a citation in October 2013.

CANHR concludes that "when nursing home residents die from neglect or suffer from abuse, DPH is usually nowhere to be found."

According to the California Association of Area Agencies on Aging, "although the Department of Public Health reports that it completes 90 percent of their investigations within 40 days, the response time is not sufficient. These are investigations involving poor care, mistreatment and abuse. Timely investigations are not only critical because of the threat of danger or death, but the need to investigate and collect evidence before it deteriorates or memories fade."

The California Retired Teachers Association states that "by establishing an investigation completion timeline, AB 348 provides some certainty about DPH's responsiveness and dedication to completing investigations, thereby prioritizing the health and safety of long-term care residents. It is critically important that allegations of mistreatment, misconduct, and abuse be fully investigated in timely manner. This bill will strengthen and improve the State oversight and enforcement process for long-term care facilities, making important strides to ensure the safety of California's seniors."

BACKGROUND: DPH leadership has been scrutinized since revelations about misplaced priorities, poor management, ongoing and persistent lack of accountability and a growing back-log of complaints describing abuse, mistreatment and poor care within facilities which they regulate continues to grow. The DPH Licensing and Certification (L&C) Program is responsible for the oversight of licensed health care facilities defined in Health and Safety Code Section 1250, about 1275 of which are skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). SNFs and ICFs account for about 50 percent of the DPH workload - about 6,200 other health facilities, such as acute care hospitals, clinics, adult day health centers, and others account for the other 50 percent.

The Federal Centers for Medicare and Medicaid Services (CMS) contracts with DPH L&C to evaluate facilities accepting payments from Medicare and Medi-Cal, to ensure that they meet federal requirements mandated as a condition for financial participation in those programs. As such, DPH L&C leaders, management and staff act as agents for the federal government to assure federal funds, as well as state funds, serve the purposes for which they are appropriated. The L&C Program evaluates health care facilities for compliance with state and federal laws and regulations through initial and re-licensure surveys, unannounced federal certification surveys, as well as investigations of complaints submitted by citizens who assert that they have received substandard care, or have been abused, mistreated, or exploited in a facility. Entity Reported Incidents (ERI) are also investigated by DPH employees, and often require a facility visit.

The L&C Program relies upon "field operations" that oversee 15 district offices, divided between five geographic areas throughout the state. The majority of L&C activities are performed by health facility evaluator nurses (HFENs). HFENs must be licensed as registered nurses, and undergo extensive training to perform L&C duties and ensure uniform application and enforcement of state and federal laws, rules, and regulations pertaining to patient care.

LA County Contract. Rather than directly performing L&C activities in Los Angeles (LA) County, DPH contracts with LA County's Department of Public Health, Health Facilities Investigation Division to perform the same activities that state staff perform in the rest of the state. Pursuant to this contract, county staff is responsible for approximately 385 nursing homes operating within the county. This contracting arrangement has been in place for decades. The current contract is set to expire at the end of June 2015. According to DPH, the department is currently in negotiations with LA County to renew the contract.

Additionally, the L&C Program's Professional Certifications Branch (PCB) certifies nurse assistants (a key classification of nursing home employees), home health aides, and hemodialysis technicians. The PCB is responsible for investigating complaints against and enforcing disciplinary action against the personnel it certifies. For instance, if a complaint about a facility staff person is received by DPH, and the staff person is found to be at fault for abuse or mistreatment, the PCB receives a referral to begin a licensing action. However, with nearly 12,000 back-logged complaints, as many as 1,000 of them PCB branch related, the question of to what extent is the ongoing back-log contributing to unnecessary risk, or creating an environment where a suspect may have free passage to escape scrutiny, set-up activities in other environments, such as the burgeoning home care industry, or in another state?

Complaint and ERI investigations. Investigations of nursing home complaints and ERIs are carried out pursuant to both federal and state mandates. Current law requires DPH to initiate an onsite investigation of a complaint against a nursing home within 10 working days of receipt, though there is no corresponding mandate to complete that investigation. If the complaint is an immediate jeopardy complaint, meaning that it involves a threat of imminent danger of death or serious bodily harm, DPH is required to make an onsite investigation within 24 hours of receipt, though, again, there is no corresponding statutory obligation for the DPH to do anything beyond "an on-site initiation" of an investigation involving immediate jeopardy.

Longstanding concerns and complaints about the manner in which the L&C program managed complaint and ERI investigations have persisted for many years. In 2006, the Legislative Analyst's Office reported that only one-half of all complaints not classified as immediate jeopardy were investigated within the required10-day timeframe. Further, in 2007, the California State Auditor issued a report finding that DPH struggled to initiate and close complaint investigations and communicate with complainants in a timely manner. In July 2012, CMS sent a letter to DPH expressing concern with their ability to meet many of its L&C responsibilities, including timely complaint investigations. The state was in jeopardy of losing $1 million in federal funds if certain benchmarks were not met. Ultimately, $138,123 in federal funding was withheld.

In March 2014, concerns came to light regarding DPH's oversight of its contract with LA County after an investigative reporter uncovered evidence that the county had an unofficial policy to close certain nursing home complaints without fully investigating them. As a result, DPH performed a review of the county's compliance with state and federal complaint investigation requirements, and directed the county to cease its unsanctioned policy of case closures without proper investigation. The LA County Board of Supervisors requested an audit by the LA County Department of Auditor-Controller. The LA County Auditor released two audit reports, concluding, in part, that the county had a significant workload backlog and lacked a mechanism to effectively track and managed its workload. The LA County Auditor also found

that complaints and ERIs were not always prioritized in accordance with state guidelines, resulting in delays in initiating investigations.

In August 2014, DPH published the findings of a comprehensive assessment of the L&C Program that was performed when CMS, DPH's federal partner, demanded it due to chronic departmental performance deficiencies. DPH contracted privately with Hubbert Systems Consulting, to perform the assessment. In summary, the assessment found numerous deficiencies within the L&C Program, including timeliness of investigation closures, and set forth 21 recommendations to remediate deficiencies identified in its assessment. Included among these recommendations were the restructure of L&C to improve performance, establishing performance indicators, and improving oversight of LA County workload and management. DPH has accepted all 21 of the recommendations, and has developed a work plan to fully implement the recommendations, though the timeline for completion of the existing backlog exceeds the Governor's term.

At the request of the Chairpersons of the Assembly Committees on Health, and Aging and Long-Term Care, the Bureau of State Audits, directed by the Joint Legislative Audit Committee, studied DPH activities with regard to complaint investigations and assurances of safe living environments for nursing home residents. In October 2014, the California State Auditor released its report regarding the L&C Program citing ineffective management of nursing home complaint investigations, among other deficiencies - some identified in previous audits. The key findings of that report included:

1) DPH should establish timeframes for complaint investigations;

2) As of April 2014, there were more than 11,000 open complaints and ERIs backlogged, many of which had relatively high priorities, and had remained open for an average of nearly a year;

3) Despite backlogs and lengthy investigations, L&C does not have any policies or procedures to ensure prompt completion of complaint/ERI investigations and in many cases did not meet statutory timeframes for initiating complaint investigations;

4) There was no staffing analysis for any of its district offices to determine how much staff is needed to complete workload. Most of the L&C district offices visited by audit staff reported not having the resources needed to investigate complaints properly, and having to work overtime in order to try to keep pace with workload; and,

5) DPH failed to report all statutorily required information to the Legislature in certain years by omitting information related to the timeliness of complaint investigations in their 2012 and 2013 reports to the Legislature.

According to the State Auditor, DPH did not always lack timeframes for completing investigations. The State Auditor cited departmental policies and procedures from 2004, which set forth a goal that district offices complete investigations of facility-related complaints within 40 days of receipt. DPH reported to the State Auditor that it eliminated the 40-day goal because district offices were unable to meet the timeline for various reasons. For example, DPH cited investigations involving the death of residents that could not be completed pending receipt of coroner reports. The State Auditor disagreed with DPH's decision to eliminate the 40-day

timeframe, stating that, while there may be instances in which district offices cannot comply with established timeframes for valid reasons, a lack of accountability has contributed to its failure to complete investigations within reasonable periods.

DPH is in the process of implementing most of the State Auditor's recommendations, but disagrees with the recommendation to establish a timeframe to complete investigations of nursing home complaints (the audit did not address the corresponding existing mandate for DPH to complete investigations in acute hospital settings within 45 days). According to DPH, they recognize the importance of the timeliness in completing complaint and ERI investigations and remains committed to reducing the average time to complete these investigations through enhanced monitoring of workload activities, public reporting of workload performance, and improved district office implementation. However, it should be noted that the response to the audit was composed and issued before the public release of the Governor's request for 237 additional positions at DPH L&C (see below). Additionally, the committee may wish to consider whether the nature of "enhanced monitoring," "public reporting," or "improved district office implementation" leads to improved investigation performance. It is difficult to determine how these largely passive administrative activities can affect more timely investigations.

For instance, in October 2014, DPH began to release quarterly data regarding the volume, timeliness, and disposition of long-term health care facility complaints and ERIs. According to most recent data released, as of December 31, 2014, the total number of open complaints and ERIs, including LA County cases and complaints against PCB-certified personnel, was 12,814. The data indicate that between July and December 2014, DPH completed 70 percent of complaint investigations and 77 percent of ERI investigations in 90 days or less. Despite enhanced monitoring of workload activities, public reporting of workload performance, and improved district office implementation, the backlog has grown.

Governor's budget proposal. For the 2015-16 budget year, the Governor proposes funding to support the implementation of the quality improvement recommendations made by Hubbert Systems Consulting, special funds to improve oversight of its LA County contract, as well as funding to fill and add new LA County positions. The Governor proposes 237 new L&C positions and increased expenditure authority to reduce complaint/ERI volume, and decrease investigation time. With these added positions, DPH estimates that it will take *four years* to complete pending, back-logged investigation workload while keeping up with new workload and avoiding backlogs. Given the on-going and historical issues related to DPH's performance, it should be noted that four years places the eventual solution of this well documented problem beyond the authority of the current Governor, and in light of DPH's historical well-documented challenges with accountability, the Legislature may wish to consider if the proposed work-plan to improve DPH performance is at risk of becoming another unaccountable component of the DPH work mandate.

Policy note. Health and Safety Code Section 1279.2 provides for an investigation timeframe of 45 days for acute health care hospital investigations. Does continued bifurcation of investigation timeframes contribute to the often-raised management and training complexities at DPH? With the known obstacles to completing investigations, should acute setting investigation timeframes and skilled nursing facility investigation timeframes be synchronized, both settings allowing for 45 working days, and both settings providing for a 30 working day extension, if and when necessary?

PREVIOUS LEGISLATION:

1) AB 1816 (Yamada) of 2014, was generally identical to AB 348 though dropped by the author when amendments changed the "timeframe" articulated in the measure to a "benchmark," a largely administrative performance measurement.

2) AB 1710 (Yamada), Chapter 672, Statutes of 2012, revises how nursing home administrator licensing fees are adjusted so that fee revenue is sufficient to cover the regulatory costs to DPH, and revises and increases DPH reporting requirements regarding the Nursing Home Administrator Program.

3) SB 799 (Negrete-McLeod) of 2011 would have required DPH to complete long-term care facility complaint investigations within a 90-working day period. SB 799 was held on the suspense file in Senate Appropriations.

4) AB 399 (Feuer) of 2007 contained provisions that are substantially similar to this bill. AB 399 was vetoed by Governor Schwarzenegger with the following message: "While I believe this bill is well-intended, it is premature to place additional investigation requirements on this program as it continues to demonstrate progress in meeting its mandated state and federal workload."

5) AB 1807 (Committee on Budget), Chapter 74, Statutes of 2006, was the health trailer bill for the Budget Act of 2006. Among other changes, AB 1807 establishes a new fee structure for health facilities that are licensed and/or certified by L&C: fees must be calculated based on i) specified workload data provided by DPH to the Legislature and made available to the public on their website; ii) any General Fund support appropriated by the Legislature; iii) any federal grant funds received for this purpose; and iv) any policy adjustments as proposed by the Administration and as adopted by the Legislature. States intent that L&C become entirely supported by fees and federal funds by no later than July 1, 2009.

6) SB 1312 (Alquist), Chapter 895, Statutes of 2006, requires inspections and investigations of long-term care facilities certified by the Medicare or Medicaid program to determine compliance with federal standards and California statutes and regulations.

7) AB 1731 (Shelley), Chapter 451, Statutes of 2000, enacts major reforms for skilled nursing facilities and intermediate care facilities, including the expansion of citations and penalties, an increase in disclosure requirements and inspections, requires DPH to provide specified notice to complainants within specified timeframes, and requires initial onsite investigations within 24 hours in response to complaints where there is a serious threat of imminent danger of death or serious bodily harm.

REGISTERED SUPPORT / OPPOSITION:

Support

American Association of Retired Persons (AARP)
The Arc and United Cerebral Palsy California Collaboration
California Association of Area Agencies On Aging
California Association of Health Facilities

California Commission on Aging (CCoA)
California Communities United Institute
California Continuing Care Residents Association (CALCRA)
California Hospital Association (CHA)
California Long-Term Care Ombudsman Association (CLTCOA)\
California Retired Teachers Association
California Senior Legislature
California State Council of the Service Employees International Union (SEIU California)
Consumer Federation of California
Disability Rights California
Elder and Dependent Adult Abuse prevention Council of Santa Barbara County
LeadingAge California
National Association of Social Workers (NASW)-California Chapter
Office of the State Long-Term Care Ombudsman
Tenet Healthcare – Support if Amended
Three Individuals

Opposition

None on file.

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