



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

**“Examining Federal Efforts to Ensure Quality of Care
and Resident Safety in Nursing Homes”**

Testimony of:

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Good morning, Chairman Harper, Ranking Member DeGette, and other distinguished Members of the Subcommittee on Oversight and Investigations. Thank you for the opportunity to appear before you to discuss one of the most consequential issues in health care today: ensuring safe, quality care for residents in the Nation's nursing homes.

KEY TAKEAWAYS

High-quality nursing homes can deliver enormous benefit as places of comfort and healing. For Medicare beneficiaries, nursing homes provide a clinically managed recovery period after illness and injury that can make the difference between more good years ahead or a downward spiral. For long-term-care residents and their families, often insured through Medicaid, nursing homes can provide responsible and much-needed care to those in fragile health.

Many nursing homes provide excellent care and are diligent in protecting their residents. But an alarming number of residents are subject to costly medical harm, unsafe conditions, and abuse and neglect, much of it preventable with better practices and oversight.

Nursing home care is a critical component of the continuum of care. Quality and safety of care in nursing homes affect the provision and cost of care in other settings. With an aging population and heightened focus on value-driven care, it is increasingly critical that Federal and State funds are used to purchase safe, high-quality care for vulnerable elderly and disabled patients.

Decades of OIG work on nursing homes has uncovered widespread problems in providing safe, high-quality care and reporting problems when they occur. We found that one in

three Medicare residents in skilled nursing facilities experienced harm from the care provided, and half of these harm events were preventable. In addition, nursing homes affected by disasters, such as hurricanes, often struggle to execute emergency plans and protect residents. We have also raised concerns about failures to report potential cases of abuse and neglect. Criminal and civil enforcement actions have uncovered misconduct and grossly substandard care. State Agencies play a crucial role in ensuring quality and safety in nursing homes. However, OIG has found mixed results in these agencies' attention to nursing home deficiency corrections and complaints.

Addressing the challenge of improving nursing home safety and quality of care requires strong leadership by CMS and serious, sustained commitment and effort by CMS, States, and the provider community.

My testimony today will focus on significant OIG findings and recommendations regarding nursing home quality and safety in three key areas:

- Harm to residents in nursing homes
- Nursing home emergency preparedness
- State Agency enforcement

OVERVIEW OF ACCOUNTABILITY FOR NURSING HOME CARE AND OVERSIGHT

According to CMS, Federal expenditures on nursing home care totaled \$73 billion in 2016, including \$44 billion for Medicaid long-term care and \$29 billion for Medicare post-acute and other skilled care. Most nursing homes are certified to serve as both long-term-care facilities and skilled nursing facilities (SNFs). Long-term-care facilities provide health-related care and services needed as a result of a mental or physical condition and may serve beneficiaries whose condition may not rise to the level of needing skilled nursing care. SNFs provide skilled nursing

care and rehabilitation services for residents who require such care because of injury, disability, or illness, typically following a hospital stay. Meeting the needs of these two different populations, long-term care and skilled post-acute care, can complicate the effective management of facilities, and make oversight more challenging.

CMS and States share responsibility for ensuring that nursing homes meet Federal requirements for quality and safety. State Agencies are required by CMS to conduct a “survey” (inspection) of nursing homes at least every 15 months to certify each facility’s compliance. CMS oversees the State certification process and provides guidance regarding the survey process in its State Operations Manual (SOM) and Interpretive Guidelines.

When State Agencies identify deficiencies during their surveys, nursing homes must submit correction plans, and State Agencies must verify that the facility corrected its deficiencies. CMS and State Medicaid agencies may also take enforcement actions to address nursing home deficiencies, including imposing civil monetary penalties or terminating the nursing home from the Medicare Program, among other actions, as appropriate.

OIG WORK ADDRESSING HARM TO RESIDENTS IN NURSING HOMES

OIG found that that one in three SNF residents experienced adverse events during their nursing home stays, including infections, pressure ulcers, and misuse of medication.

In a nation-wide review, OIG found that one-third of residents in SNFs experienced harm from the care provided in the nursing homes and more than half of the harm (adverse events) were preventable had the facilities provided better care. This report was one in a decade-long OIG series regarding adverse events in various healthcare settings, including hospitals.

The adverse events OIG identified in nursing homes resulted in a range of harmful outcomes for residents, including extended stays in the SNF, transfers to hospital emergency departments, and the need for life-sustaining intervention. For 6 percent of the adverse events,

the harm contributed to residents' death. Over half of the residents who experienced harm returned to a hospital for treatment, incurring millions of dollars in additional Medicare expenditures.¹

Some adverse events involved medical errors such as supplying incorrect medication, but most preventable harm resulted from daily substandard care, such as inadequate resident monitoring and failure or delay of necessary care. For these adverse events, residents and families may not know that they were harmed, thinking instead that the residents' suffering and decline were the result of their illness or conditions and inevitable. Nursing home staff also failed to identify harm in some cases; for example, a number of adverse events started with dehydration, which can quickly result in kidney damage. One nursing home resident died of cardiac arrest after progressive kidney failure that was not detected until the resident was awaiting discharge from the SNF.

Most nursing home residents who died or were harmed from adverse events had multiple, complex co-morbidities that made their care challenging. We found a wide range of adverse events not typically associated with nursing home care, such as internal bleeding due to medication. While some events are widely recognized as risks for patients in nursing homes, such as falls and pressure ulcers, fewer nursing home staff may be aware of the risks posed by aspiration and blood clots, both of which harmed numerous patients in our study sample. In our review of CMS and other guidance, we noted a tendency to focus narrowly on a subset of the most extreme harm events, many of which are rare, while missing the broad range of possible, more common harms that cause patient declines.

¹ OIG, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (OEI-06-11-00370), issued February 2014. For this evaluation, OIG contracted with physicians who were experts in SNF care, surgery, cardiology, and infectious disease to conduct an extensive medical review of SNF stays.

What is needed is a shift in thinking about the care provided in nursing homes. Our work identifying adverse events in nursing homes and other settings showed that nursing home residents often had care needs similar to patients in hospitals, with residents sometimes seriously ill and impaired. The hospital community has focused keenly on patient safety and, while still experiencing high harm rates in some categories, has made substantial changes in the provision of patient care and safety systems. Sustained improvements in nursing homes will require a cultural shift that recognizes clinical harm and elevates reduction of harm as a priority for nursing home care.

The foundation of OIG's recommendations to reduce harm is that CMS (and the Agency for Healthcare Research and Quality) raise awareness of adverse events in nursing homes (and other post-acute-care settings) with the same methods used to promote hospital safety. Broadening these and other patient safety improvement efforts to include the nursing home environment would ensure that safe care practices promoted in acute care hospitals extend to the critical periods of post-acute recovery and long-term care.

To address the high rate of harm in nursing homes, OIG made two recommendations to CMS: (1) provide guidance to nursing homes about detecting and reducing harm to be included in facility Quality Assurance and Performance Improvement programs, and (2) instruct State Agencies to review facility practices for identifying and reducing adverse events, and link related deficiencies specifically to resident safety practices. OIG determined that CMS fully implemented these recommendations on adverse events in SNFs as of August 2018. It is too early to assess the effectiveness of CMS's actions in changing practices, but they hold promise for improving quality of care and reducing adverse events for nursing home residents.

Meaningful improvement will rest on diligent execution by CMS and States, and continued evaluation of the effectiveness of these changes.

OIG has raised concerns about failure to report allegations or potential cases of abuse and neglect of nursing home residents.

It is both required and expected that nursing homes will report allegations of abuse or neglect to law enforcement or other appropriate agencies to ensure resident safety and protect victims of crimes. However, OIG has documented serious deficiencies in reporting of abuse and neglect of nursing home patients dating back several years and continuing in our recent and ongoing work. OIG found that, in 2012, nearly one in four nursing facilities did not have policies for reporting allegations of abuse or neglect and the subsequent results of an investigation, and facilities reported only half of allegations and investigation results as federally required.² In response to OIG recommendations that CMS ensure nursing homes maintain policies for reporting allegations of abuse or neglect and report allegations in a timely manner, CMS revised the SOM in 2017 to instruct State Agency surveyors to assess facility policies and practices.

Yet concerns about unreported abuse and neglect remain. OIG reviewed hospital emergency room records from 2015 and 2016 for SNF residents sent to hospitals whose injuries may have been the result of potential abuse or neglect in the SNF. In preliminary work, OIG found 134 such incidents across 33 States. We further found that many of these incidents may not have been reported to law enforcement. Pending completion of the full review, OIG alerted CMS that it had inadequate procedures to ensure that incidents of potential abuse and neglect at

² OIG, *Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect* (OEI-07-13-00010), issued in August 2014.

SNFs are properly identified and reported.³ OIG made immediate suggestions for improvement, including that CMS analyze Medicare claims (including matching claims for emergency room services to claims for SNF services) to identify incidents of potential abuse and neglect and take specific steps to enhance its ability to impose civil monetary penalties for reporting failures.

OIG investigations and enforcement cases illustrate that nursing home harm can involve conduct by individual bad actors, as well facility and chain-wide conduct

OIG investigates potential criminal conduct and pursues enforcement actions to hold accountable those who victimize residents of nursing homes. In some cases, this involves criminal activity by bad actors. For example, in 2018, the owner of a long-term-care facility was convicted of engaging in the physical and emotional abuse of one of its residents, following an investigation by OIG and our law enforcement partners.

In other cases, facility-wide or chain-wide grossly substandard care can harm patients. Such cases may result in civil False Claims Act resolutions or administrative actions, such as exclusion. Patient neglect, often due to understaffing, is a recurring issue in False Claims Act cases. Other allegations that commonly arise in these cases include overmedication of nursing home residents, which may lead to falls and fractures; failure to follow physicians' orders; and failure to provide a habitable living environment, with concerns including mold and roof leaks.

NURSING HOME EMERGENCY PREPAREDNESS

Despite enhanced guidance from CMS, nursing homes hit by disaster often struggle to execute emergency plans and protect residents.

Nursing home residents and their families rely on facility administrators to plan and execute appropriate procedures during disasters. Through years of visiting nursing homes after

³ OIG, *Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures to Ensure That Incidents of Potential Abuse or Neglect at SNFs Are Identified and Reported in Accordance With Applicable Requirements* (A-01-17-00504), issued in August 2017.

disasters, we have learned that facilities may ostensibly meet CMS guidelines prior to the disaster, but at the time of crisis fail to follow requirements and prior planning.

In 2006, following Hurricanes Katrina, Rita, and others, OIG found that 94 percent of the Nation's nursing homes met Federal regulations for emergency plans. In visiting 20 nursing homes affected by hurricanes, however, we found that these plans were often not practical or up to date, and that during the crisis many administrators did not know how to navigate CMS guidelines and instructions from local authorities, and they often did not have adequate supplies, staffing, or transportation in place to care for residents. These findings indicated that State Agency reviews of emergency plans were insufficient, and that the plans themselves were often not useful.⁴ In a followup study by OIG in 2012, after CMS had revised its guidance to include a suggested checklist for preparedness, we visited nursing homes affected by a range of disasters and found that only half had plans that included the checklist items.⁵

For nursing homes that continued to operate without adequate emergency planning, the omissions were often a matter of common sense and the consequences for residents extreme. One nursing home that flooded during a storm had no plan for responding to floods, despite residing in a flood plain. Other homes evacuated residents to facilities far away and without sufficient tracking or methods to ensure residents traveled with personal equipment and supplies, such as wheelchairs and medication. Administrators from most nursing homes that OIG studied reported that residents experienced deteriorating health conditions, skin issues, and falls resulting in serious injury. This occurred in nursing homes that evacuated and those that sheltered in place. In some cases of evacuation, residents' poor conditions necessitated hospitalization.

⁴ OIG, *Nursing Home Emergency Preparedness and Response during Recent Hurricanes* (OEI-06-06-00020), issued August 2006.

⁵ OIG, *Gaps Continue To Exist in Nursing Home Preparedness and Response After Disasters* (OEI-06-09-00270), issued April 2012.

Reports of nursing homes' performance in the aftermath of the 2017 hurricanes—including failures to evacuate residents or to provide safe sheltering in place—raise continued questions about the adequacy of emergency plans and their proper execution.

OIG recommended that CMS require facilities to create effective emergency plans and take other specific actions in preparing for emergencies, such as improving staff training and communication with local authorities. In 2016, CMS revised its emergency preparedness requirements for nursing homes and other healthcare facilities that participate in Medicare and Medicaid, to include specific provisions for planning, training, and communication. State Agencies began assessing compliance for these provisions in November 2017. OIG will continue to monitor these important provisions.

STATE AGENCY ENFORCEMENT

State Agencies play a critical role in ensuring the quality and safety of nursing homes, and OIG has found mixed results in State Agency attention to nursing home deficiencies.

From 2015 to 2018, OIG completed audits of nine States to determine whether the State Agency took appropriate steps to verify that nursing facilities had corrected identified deficiencies. OIG found that State Agencies in seven of nine States were not meeting requirements to verify correction of deficiencies.⁶ Lack of verification was evident in both serious and minor deficiencies. For example, surveyors found that a nursing home failed to provide a resident oxygen per physician orders; the corrective action plan included additional training for nursing staff. Yet the State Agency was unable to confirm that the staff involved attended the training.

⁶ OIG's State audits included Arizona (A-09-16-02013), Florida (A-04-17-08052), Kansas (A-07-1703218), Missouri (A-07-16-03217), Nebraska (A-07-17-03224), New York (A-02-15-01024), North Carolina (A-04-17-02500), Oregon (A-09-16-02007), and Washington (A-09-13-02039).

OIG also found that one of the nine States reviewed did not conduct standard surveys for approximately 40 percent of nursing homes within the required 15 months. For seven States that did not meet requirements, OIG recommended that State Agencies improve verification processes, update internal systems, and for the one State, develop a correction plan to ensure the State conducts timely surveys. OIG found that the remaining two States were in full compliance. Four of the States with recommendations implemented them, including the State not performing timely surveys. Recommendations for three of the States remain outstanding, including two States that received our audit reports only within the last few months.

Other OIG findings indicated that State Agency oversight of SNFs was not sufficient to ensure that SNFs developed and followed care and discharge plans for residents, as required. These care and discharge plans can be the linchpin of effective SNF care, helping to ensure that residents receive needed care, protecting residents from receiving unnecessary care, and assisting them in securing home- and community-based care and personal care services that can prevent them from re-entering the SNF or a hospital.

OIG made extensive recommendations to CMS that the agency address this problem from multiple vantage points: (1) strengthen the regulations on care and discharge planning, (2) provide guidance to SNFs to improve planning, (3) increase surveyor efforts to identify problems, (4) link payments to meeting quality-of-care requirements, and (5) follow up on the SNFs that failed to meet requirements.⁷ In June 2018, OIG determined that CMS had fully implemented these recommendations. We will continue to monitor the extent to which CMS's and State Agencies' actions resolve the problems and improve care.

State Agencies serve as front-line responders to address health and safety complaints in

⁷ OIG, *Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Requirements* (OEI-02-09-00201), issued February 2013.

nursing homes. State Agencies are responsible for onsite investigations of serious complaints of abuse and neglect. OIG work in 2017 found that a few states fell short in timely investigations of the two most serious categories of complaints: immediate jeopardy and high priority.⁸

NEXT STEPS TO IMPROVE NURSING HOME QUALITY AND SAFETY

Sustained commitment by CMS and continued collaboration among HHS, States, providers, and residents and their families will be critical to ensuring quality and safety.

Quality nursing home care requires a partnership between a large and diverse group of Federal, State, and local entities. Residents and their families are also critical stakeholders. As the Federal agency charged with oversight of nursing home compliance and performance, CMS must demonstrate strong leadership of this group. Effective collaboration will narrow gaps, provide better information and insight, and give greater assurance to residents and their families that they will receive high-quality care.

As an example, following the 2011 OIG report *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, CMS led an effort across HHS to correct improper drug prescribing and use in nursing homes. OIG found that 83 percent of atypical antipsychotic drug claims were for elderly nursing home residents not diagnosed with a condition for which the Food and Drug Administration (FDA) had approved antipsychotic medications. This supported a theory long held by residents' advocates that nursing homes used atypical antipsychotic medications for "off-label" indications, with the purpose of controlling undesirable behavior. Both CMS and FDA took action to make changes to regulations and guidance, and CMS formed a public-private effort, the National Partnership to Improve Dementia Care in Nursing Homes, to engage providers, advocates, and families. Subsequent CMS data show

⁸ OIG, *A Few States Fell Short in Timely Investigations of the Most Serious Nursing Home Complaints: 2011-2015* (OEI-01-16-00330), issued September 2017.

substantial reductions in the use of these drugs among nursing home residents. Given the number of stakeholders involved and the urgency of the problems, this type of public-private partnership would be useful for CMS to foster improvements across nursing home care.

Further, it is critical that States remain active participants in the Federal-State partnership needed to oversee nursing homes. States are on the front line in surveying nursing homes, identifying deficiencies, and verifying corrections. States play an essential enforcement role when residents are victims of abuse and neglect. States' active participation in ensuring that nursing homes are providing safe, high-quality care is essential to improving patient outcomes and reducing adverse events.

To protect nursing home residents, OIG will continue to assess CMS oversight and nursing home and State Agency performance, monitor the impact of program changes, and use our enforcement tools to address misconduct.

Nursing home residents deserve and should expect high-quality care and to be safe from abuse and neglect. OIG will continue to monitor whether CMS's recent actions to improve safety and quality produce the intended positive outcomes. Moreover, OIG will follow up on its findings and recommendations to State Agencies to strengthen the effectiveness of their efforts.

OIG has upcoming work that will assess multiple dimensions of nursing home quality and safety to protect beneficiaries. These audits and evaluations follow up on past findings and recommendations, and examine new areas, such as nursing home compliance with new Life and Safety Code requirements, assessment of the accuracy and use of new nursing home staffing data, and the extent to which State Agencies investigate involuntary resident transfers and discharges.

Allegations involving patient harm remain a top OIG enforcement priority. OIG will continue to investigate potential criminal conduct and pursue administrative actions to hold

accountable those who victimize residents of nursing homes. In resolving False Claims Act cases, OIG may enter into “quality of care” corporate integrity agreements (CIAs) with nursing homes or chains that require actions to improve quality of care and safety. OIG is currently monitoring quality of care CIAs covering more than 200 nursing homes. OIG also collaborates closely with the 50 State Medicaid Fraud Control Units (MFCUs) that often have primary responsibility for enforcement of cases of abuse and neglect in nursing homes.

CALL TO ACTION

To provide guidance, support, and oversight of this industry is a grave and vitally important responsibility. Government policies and leadership, Federal and State, can substantially affect residents’ experience and outcomes. The problems I present today are not new, and they may seem daunting and intractable given the challenges and complexities of nursing home care. But change is possible, and essential. Nursing home care will always be a deeply challenging enterprise, but with dedicated attention and focus, CMS, States, and providers can do better.

While CMS has taken steps to create a framework for correcting problems of resident harm and risk, all progress will be in the execution of that framework and the performance of CMS, States, and providers. CMS must stay alert to the impact of policies and practices and promote meaningful, sustainable change. OIG is committed to working with CMS as it takes action to address problems identified by our work, the Government Accountability Office, and others.

Thank you for your ongoing leadership in this area and for affording OIG the opportunity to testify and discuss with you this vitally important topic.