California State Auditor

October 2014

California Department of Public Health

It Has Not Effectively Managed Investigations of Complaints Related to Long-Term Health Care Facilities

Report 2014-111

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

October 30, 2014 2014-111

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the California Department of Public Health's (Public Health) Licensing and Certification Division's regulation of long-term health care facilities.

This report concludes that Public Health has not effectively managed investigations of complaints related to long-term health care facilities. As of April 2014 Public Health had more than 11,000 open complaints and entity-reported incidents (ERIs), which long-term health care facilities self-report to Public Health. Many of these complaints and ERIs have relatively high priorities—indicating a safety risk to the residents—and have remained open for nearly a year on average. Several factors have contributed to the large number of open complaints and ERIs. Specifically, Public Health does not provide adequate oversight of the processing of facility-related complaints and ERIs by its district offices and complaints against individuals by its Professional Certification Branch. It has also failed to establish formal policies and procedures, including time frames, for ensuring prompt completion of investigations of complaints and ERIs. Further, Public Health data show that district offices vary significantly in the proportions of ERIs they prioritize into various categories, which highlights the need for Public Health to more closely monitor district offices' processing of ERIs and assess whether they can be more consistent and efficient in this area. Moreover, because it has not completed staffing analyses for its district offices, Public Health does not know how many staff it needs to reduce the number of aging complaints to a manageable level and to remain current on new complaints.

Public Health did not always follow its procedures to ensure consistent quality in its complaint and ERI investigations. For example, one district office we reviewed closed complaints without appropriate review by supervisors. Public Health also did not meet certain required time frames when initiating investigations of complaints and closing those complaints. In addition, the four district offices we reviewed did not consistently ensure timely receipt of corrective action plans or evidence of corrective actions when required to do so from facilities that were notified of deficient practices. Finally, Public Health did not report all statutorily required information to the Legislature in two of the four annual reports we reviewed.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Contents

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Summary

Results in Brief

The California Department of Public Health (Public Health) is responsible for licensing and monitoring certain health care facilities, including more than 2,500 long-term health care facilities in the State. Public Health performs this work in accordance with a cooperative agreement with the federal Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, to ensure that facilities accepting Medicare and Medicaid payments meet federal requirements. According to the California Association of Health Facilities, as many as 300,000 Californians receive care annually in facilities licensed for long-term health care.

Federal and state laws, federal and state regulations, and department policies require Public Health to investigate complaints about long-term health care facilities and about certain individuals, including certified nurse assistants and home health aides, who provide care at those facilities. Complaints related to long-term health care facilities are investigated by the 15 district offices of Public Health's Licensing and Certification Division (licensing division), which include a contractor—the Los Angeles County Department of Public Health (LA County), that serves as the district office for that county—and the licensing division's State Facilities Unit. These entities also investigate incidents that the facilities self-report and that are generally referred to as *entity-reported incidents* (ERIs). The Professional Certification Branch (PCB) within the licensing division is responsible for investigating complaints against certified individuals.

As of April 2014 Public Health had more than 10,000 open complaints and ERIs related to long-term health care facilities and nearly 1,000 open complaints against individuals. Many of these open complaints and ERIs had relatively high priorities—indicating a safety risk to the residents—and had remained open for nearly a year on average. For example, the Santa Rosa–Redwood Coast district office prioritized 102 open complaints and ERIs related to facilities as *immediate jeopardy*—indicating a situation that poses a threat to an individual's life or health. These complaints and ERIs had remained open for an average duration of almost a year. Similarly, a significant number of complaints against individuals have remained open for long periods. By not ensuring that all complaints and ERIs are processed promptly, Public Health is placing at risk the well-being of residents of long-term health care facilities.

Audit Highlights . . .

Our audit of the California Department of Public Health's (Public Health) regulation of long-term health care facilities highlighted the following:

» *As of April 2014 Public Health had more than 10,000 open complaints and entity-reported incidents (ERIs) related to long-term health care facilities and nearly 1,000 open complaints against individuals.*

» *Public Health's oversight of complaints processing is inadequate and has contributed to the large number of open complaints and ERIs.*

- *Until late 2013 it did not have a standardized method for monitoring the status of open complaints and ERIs at the district offices and for assessing whether these complaints were being addressed promptly.*
- *It does not have accurate data about the status of investigations into complaints against individuals.*

» *Public Health has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or to the individuals it certifies.*

» *Some district offices may be performing more on-site investigations of ERIs than others, while other offices may be closing more ERIs and categorizing them as* no action necessary.

continued on next page . . .

- *Three of the four district offices we visited claim they do not have enough resources to investigate all complaints promptly, and the Professional Certification Branch noted a similar situation.*
- *Public Health did not always follow procedures to ensure consistent quality of complaint investigations.*
- *The four district offices we reviewed did not consistently ensure timely receipt of corrective action plans or evidence of corrective actions when required to do so from facilities that were notified of deficient practices.*
- *Public Health also did not consistently meet certain time frames for initiating complaints and ERIs.*

Several factors have contributed to the large number of open complaints and ERIs. Specifically, Public Health does not provide adequate oversight of complaint processing by the district offices and PCB. Until late 2013, when it established a tracking log of open complaints and ERIs, Public Health did not have a standardized method for monitoring the status of open complaints and ERIs at the district offices and for assessing whether these complaints were being addressed promptly. Further, PCB lacks accurate data about the status of investigations into complaints against individuals, and this deficiency prevents management from providing proper oversight and monitoring of complaint handling. PCB uses a spreadsheet to track the progress of its complaints; however, the spreadsheet's information displayed inaccuracies. As a result, PCB does not yet have an effective process for monitoring whether it is addressing those complaints in a timely manner.

Further, Public Health has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or the individuals it certifies. It also does not have any time frames for district offices to complete their investigations of complaints related to facilities. Public Health's data show that during 2012 and 2013, district offices took an average of 150 days to complete investigations of facility-related complaints. During the same period, district offices took an average of 119 days to close their investigations for ERIs. Similarly, Public Health did not have time frames for PCB to complete investigations of complaints against individuals. Although it now has a goal that PCB investigators will complete five to six complaints every month on average, Public Health has not formalized these expectations. PCB also does not have any formal policies and procedures for ensuring prompt completion of all complaints lodged against individuals. In fact, PCB did not assign an investigator to 14 of the 33 complaints closed in 2012 and 2013 that we reviewed until more than a year after it received those complaints. Having formal policies and procedures for processing complaints is important, especially considering that federal regulations require Public Health to conduct timely investigations of all complaints against individuals.

Moreover, Public Health data show that district offices vary significantly in the proportions of ERIs they prioritize into various categories. The data suggest that some district offices may be performing more on-site investigations of ERIs than others, while other offices may be closing more ERIs and categorizing them as *no action necessary.* For example, the Chico district office completed the investigations for 97 percent of the ERIs it received during 2012 and 2013 through on-site visits, while the Orange County district office and LA County generally performed on-site investigations for less than 20 percent of the ERIs they received during 2012 and 2013. Such large differences in how

district offices assign priorities—which dictate whether to perform a site visit, to complete a desk review, or to close an ERI as *no action necessary*—highlight a need for Public Health to more closely monitor district offices' processing of ERIs and to assess whether the district offices can be more consistent and efficient in this area.

Three of the four district offices we visited claim they do not have enough resources to investigate all complaints promptly, and PCB noted a similar situation. However, Public Health has not performed staffing analyses to identify the number of staff it needs to eliminate the aging of outstanding open complaints and ERIs and to remain current on new complaints. In 2013 Public Health contracted with a consultant to develop a remediation plan that provides a road map for further and more detailed program assessments. The consultant made several recommendations in August 2014, including one specifying that Public Health should develop a staffing model and work plan to ensure appropriate staffing levels across all district offices. Public Health expects that implementing the consultant's recommendations will take more than two years. In the meantime, Public Health has obtained temporary positions for PCB to support its efforts to complete investigations more quickly. The interim deputy director of Public Health's licensing division stated that Public Health's Center for Health Care Quality has contracted with a consultant to perform an assessment of PCB's business processes.

Public Health did not always follow procedures to ensure consistent quality of complaint investigations. For instance, the San Francisco district office closed complaints without appropriate review by supervisors in four of the 10 investigations we reviewed there. For three of these four complaints, the supervisor both performed the investigation and signed off on his or her own work. When complaint investigations do not receive proper reviews, Public Health cannot ensure that it consistently follows procedures to properly determine the validity of complaints, to identify deficiencies that require correction, and to verify that facilities implement any required corrective actions.

In addition, the four district offices we reviewed did not consistently ensure timely receipt of corrective action plans or evidence of corrective actions when required to do so from facilities that were notified of deficient practices. CMS requirements state that a facility with identified instances of noncompliance must provide an appropriate plan of correction within 10 days of receiving the notification of deficient practices. This plan must specify how the facility will correct the deficient practices and ensure that they do not recur. In lieu of making on-site revisits, Public Health may require facilities to provide evidence of corrective actions taken, depending on the severity of the noncompliance. However,

if actual harm has occurred at a facility, Public Health must reinspect the facility to verify corrective action. A manager for the San Francisco district office stated that the district office did not realize that such submissions were mandatory. Managers of the Bakersfield, Riverside, and Sacramento district offices were aware of the requirement but gave other reasons for not meeting it, such as overlooking the requirement erroneously or asserting that they had staffing shortages. Without obtaining evidence of completed corrective actions from facilities when required, Public Health cannot demonstrate that it is complying with federal requirements or ensuring the safety and well-being of residents in those facilities.

Public Health also could do more to ensure that district offices, including LA County, are conducting complaint investigations and ERIs appropriately. Specifically, although it has a process to review investigations stemming either from complaints categorized as *immediate jeopardy* or from complaints related to deficiencies that resulted in actual harm to residents of long-term health care facilities, Public Health does not routinely review other complaint investigations. In 2012 and 2014 CMS issued letters to Public Health, in which it identified a number of weaknesses in Public Health's management of the complaint investigation process, including a lack of policies and procedures governing investigation protocols and inconsistencies in the district offices' intake process. At the direction of CMS, Public Health conducted a quality review of LA County's complaint investigations and found, among other things, that it incorrectly prioritized complaints it received, leading to delayed investigations of serious allegations. Our review of complaint investigations also identified instances in which district offices inappropriately closed complaints. Public Health's limited review of the district offices' complaint investigations increases the risk that they could perform investigations that do not comply with the law or with Public Health's policies and procedures.

Public Health also did not consistently meet certain time frames for investigating complaints and ERIs. The four district offices we visited did not always initiate investigations or address appeals within required time frames established in state law or Public Health policy. For example, the Sacramento district office did not initiate two of the 10 investigations we reviewed within 10 days, as required. Further, PCB failed to comply with the statutory time frames for hearing appeals within 60 days and for making determinations on those appeals within 30 days. PCB—through its contractor—did not meet the hearing requirement for any of the 10 appeals we reviewed, in one case taking nearly 1,200 days to hear the appeal. Further, it did not meet the notification requirement in seven of nine appeals that were heard. Unless Public Health's investigative determination is effective immediately, individuals

who are the subject of investigations and who are appealing Public Health's investigative determinations are not prohibited from working in facilities until the appeals are adjudicated. Thus, when Public Health does not comply with the required time frames, it may risk the safety and welfare of residents in long-term health care facilities.

Finally, Public Health did not report all statutorily required information to the Legislature in two of the four years we reviewed. Specifically, Public Health omitted from its 2012 and 2013 reports information related to the timeliness of its complaint investigations. When Public Health does not include statutorily required information in these reports, the Legislature does not have complete information to make fully informed decisions.

Recommendations

To protect the health, safety, and well-being of residents in long-term health care facilities, Public Health should do the following:

- By January 1, 2015, establish and implement a formal process for monitoring the progress of open complaints and ERIs at all district offices.
- By January 1, 2015, improve the accuracy of information in the spreadsheet that PCB uses to track and monitor the status of complaints related to individuals.
- By May 1, 2015, establish a specific time frame for completing complaint investigations and ERIs.
- By May 1, 2015, develop formal written policies and procedures for the timely processing by PCB of complaints against certified individuals. These policies and procedures should include time frames for prioritizing and assigning complaints to investigators as well as for completing the investigations.

To ensure that district offices address ERIs consistently and that they investigate ERIs in the most efficient manner, Public Health should assess whether each district office is prioritizing ERIs appropriately. Using the information from its assessment, Public Health should provide guidance to district offices by October 1, 2015, on the best practices for the consistent, efficient processing of ERIs.

To make certain that district offices have the necessary resources to process facility-related complaints and ERIs promptly, Public Health should complete a staffing assessment to identify the resources necessary for district offices to investigate open complaints and ERIs and to promptly address new complaints on an ongoing basis. Public Health should use this assessment to request additional resources, if necessary.

To ensure that PCB has the resources necessary to promptly complete investigations of complaints about certified individuals on an ongoing basis, Public Health should assess whether the temporary resources it has received are adequate to reduce the backlog of open complaints to a manageable level and also should determine whether permanent resources assigned to PCB are adequate to address future complaints. Public Health should use this assessment to request additional resources, if necessary.

To make certain that district offices investigate complaints and ERIs properly, Public Health should ensure that the district offices follow procedures requiring supervisory review and approval of their complaint and ERI investigations.

To ensure that its district offices comply with federal requirements regarding corrective action plans, Public Health should establish a process for its headquarters or regional management to inspect district office records periodically to confirm that district offices are obtaining corrective action plans and verifying that facilities have performed the corrective actions described in the plans when required.

To improve oversight of its district offices' complaint and ERI investigation process, Public Health should increase its monitoring of the district offices' compliance with federal and state laws as well as with its policies. Public Health should further establish a formal process to periodically review LA County's compliance with the terms of its contract, including compliance with the terms for investigating complaints.

To ensure the safety of residents in long-term health care facilities, Public Health should direct its district offices to comply with required time frames for initiating investigations and should direct PCB to comply with time frames for addressing appeals.

To make certain that the Legislature has information about the timeliness of Public Health's complaint processing related to long-term health care facilities, Public Health should include all statutorily required information in its annual report.

Agency Comments

Public Health agrees with many of our recommendations and stated that it will take steps to implement them. However, Public Health disagrees with our recommendations that it should establish time frames for completing investigations of complaints and ERIs. It also does not believe that it is subject to statutory time frames for adjudicating appeals related to individuals.

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Introduction

Background

The California Department of Public Health (Public Health) is responsible for licensing, certifying, and monitoring certain health care facilities, including more than 2,500 long-term health care facilities in the State. As of July 2014 Public Health's Licensing and Certification Division (licensing division), part of its Center for Health Care Quality, had licensed various types of long-term health care facilities, as Table 1 on the following page shows. In addition to ensuring that health care facilities comply with state requirements, Public Health has a cooperative agreement with the federal Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, to ensure that facilities accepting Medicare and Medicaid payments meet federal requirements. To perform part of this process, the licensing division periodically surveys, or inspects, facilities to ensure compliance with federal participation standards. The licensing division's Professional Certification Branch (PCB) also certifies nurse assistants and other health care professionals, allowing these individuals to work in nursing and other facilities in the State. Federal and state laws, as well as regulations and department policies, require Public Health to investigate complaints about long-term health care facilities and about certain certified individuals who provide care at facilities licensed for long-term health care.

According to the California Association of Health Facilities (CAHF), as many as 300,000 Californians receive care annually in facilities licensed for long-term health care. Many of these individuals reside in nursing facilities, also referred to as *skilled nursing facilities* and broadly defined as health facilities that provide skilled nursing care to residents who require such care for extended periods. These residents may depend on the facility operator for everything from food and medicine to every aspect of their daily living while at the facility. According to CAHF, approximately 82 percent of residents at nursing facilities are age 65 or over. Moreover, as population demographics in the United States indicate, more individuals will need long-term care services in the future. As demand for such services increases, the quality of care provided at these facilities will continue to be an ongoing and growing concern for residents, residents' families, the public at large, and policy makers.

Table 1
Type and Number of Long-Term Health Care Facilities Licensed by the California Department of Public Health as of July 2014

TYPE AND DESCRIPTION OF FACILITY	NUMBER OF FACILITIES
Skilled Nursing Provides skilled nursing care and supportive care to patients whose primary need is the availability of skilled nursing care for extended periods. This category includes nursing facilities that provide this care in the Medicare program, the Medicaid program, or both.	1, 129
Intermediate Care/Developmentally Disabled—Habilitative Provides 24-hour personal care, habilitation, developmental services, and supportive health services to 15 or fewer patients with developmental disabilities who have intermittent recurring needs for nursing services but who have been certified by a physician and surgeon as not requiring continuous skilled nursing care.	756
Intermediate Care/Developmentally Disabled—Nursing Provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but who have been certified by a physician and surgeon as not requiring continuous skilled nursing care. These facilities have a capacity of four to 15 beds and serve medically fragile persons who have developmental disabilities or who demonstrate significant developmental delays that may lead to developmental disabilities if not treated.	421
Specific Parts of General Acute Care and Acute Psychiatric Hospitals Only the distinct parts of these hospitals that provide skilled nursing facility, nursing facility, intermediate care facility, intermediate care facility/developmentally disabled, or pediatric day health and respite care facility services.	151
Congregate Living Health Provides inpatient care including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in the law. This inpatient care takes place in a residential home with the capacity, except under certain circumstances, of no more than 12 beds, and the primary need of the home's residents is skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than the care that general acute care hospitals provide but more intense than skilled nursing facilities provide.	74
Pediatric Day Health and Respite Care Provides an organized program of therapeutic social and day health activities and services and limited 24-hour inpatient respite care to medically fragile children 21 years of age or younger, including terminally ill and technology-dependent children. These facilities are licensed under the California Health and Safety Code, Chapter 8.6 (beginning with Section 1760).	16
Intermediate Care/Developmentally Disabled Provides 24-hour personal care, habilitation, developmental services, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.	10
Intermediate Care Provides inpatient care to ambulatory or nonambulatory patients who have a recurring need for skilled nursing supervision and who require supportive care, but do not require continuous skilled nursing care.	5

Sources: California Health and Safety Code, sections 1250, 1418, and 1760, and the acting chief of the California Department of Public Health's Field Operations Branch.

Responsibility for Investigating Complaints Related to Facilities and Certified Individuals

The licensing division has a field operations branch that oversees 15 district offices. As Figure 1 shows, these district offices are divided geographically throughout the State. They include a contractor, the Los Angeles County Department of Public Health (LA County), which functions as a district office within Los Angeles County and operates four offices. In addition to fulfilling other duties, the district offices are responsible for investigating complaints about long-term health care facilities located within their respective jurisdictions and investigating the incidents that facilities self-report—known as *entity-reported incidents* (ERIs). In addition to overseeing the 15 district offices, the licensing division, through its State Facilities Unit, investigates complaints against health care facilities operated by other state agencies.

Figure 1
Locations and Service Areas for District Offices of the California Department of Public Health's Licensing and Certification Division

Sources: California Department of Public Health's Web site and the interim deputy director of the Center for Health Care Quality.

* The San Diego North district office is physically located at the same address as the San Diego South district office.

† The Riverside district office is physically located in the city of San Bernardino.

District offices receive complaints from members of the public, including residents of long-term health care facilities and residents' family members. The district offices also receive ERIs from facilities. Under state law and regulations, facilities must self-report events, such as "epidemic outbreaks, poisonings, fires, major accidents, or other catastrophes and unusual occurrences which threaten the welfare, safety, or health of patients, personnel, or visitors" as well as alleged or suspected abuse that occurs at the facility. State regulations do not define what constitutes an unusual occurrence. According to data from Public Health's *Licensing and Certification Annual Fee Report, Fiscal Year 2014–15*, ERIs made up 76 percent of the total complaints related to facilities received during 2012 and 2013.

According to Public Health's data, 31 percent of the district offices' workload relates specifically to investigating complaints and ERIs about long-term health care facilities. The remainder of the district offices' workload includes licensing and certification activities to ensure that facilities comply with federal and state standards as well as investigating complaints related to other types of facilities. Specifically, district offices are responsible for licensing facilities operating in the State, recommending federal certification of health care facilities that meet applicable federal standards so that they are eligible to receive federal funding, and recertifying them at least every 15 months. The district offices conduct these certification activities, along with investigations, for approximately 30 types of health care facilities.

The investigation section for Public Health's PCB has offices in two locations—Sacramento and Los Angeles—that are responsible for investigating complaints against nurse assistants and other health care professionals that it certifies or licenses and for enforcing disciplinary actions against those individuals. According to data provided by the investigation section chief, 36 percent of PCB's workload relates to investigations of complaints about individuals it certifies. These investigations may occur at long-term health care facilities or at facilities that are not normally associated with long-term care, such as general acute care hospitals. In addition to conducting these investigations, PCB is responsible for the certification of individuals in three types of positions—certified nurse assistants, home health aides, and hemodialysis technicians—and for the licensure of nursing home administrators. PCB also maintains a registry indicating the certification status of certain of these individuals.

Receiving and Processing Complaints

Complaints may be received by Public Health at its headquarters office or directly by a district office. Complainants may submit complaints online through the Health Facilities Consumer Information System Web site, and these complaints are then

forwarded to the appropriate district office for investigation based on the facility involved. Additionally, a complainant may submit a complaint in person or by phone, fax, e-mail, or letter. According to Public Health, individuals file most complaints directly with district offices, and the vast majority of facilities report ERIs directly to district offices. Public Health's headquarters office and its district offices notify PCB when a complaint against a facility involves allegations of abuse, neglect, or misappropriation of resident property by an individual certified by PCB so that it can determine whether disciplinary action is necessary. In addition to receiving these referrals, PCB also accepts complaints directly from the public, facilities, or other entities. As Table 2 on the following page indicates, during 2012 and 2013 Public Health received more than 53,000 complaints—nearly 13,000 facility-related complaints and almost 41,000 ERIs—related to long-term health care facilities. Public Health also received approximately 1,800 complaints against individuals certified by PCB.

Prioritizing and Assigning Complaints and ERIs Related to Long-Term Health Care Facilities

When district offices receive facility-related complaints and ERIs, staff retrieve complaint details from faxes, voice-mail systems, e-mail, or postal mail and enter the facility-related complaint or ERI details into the Automated Survey Processing Environment Complaints/Incidents Tracking System—the federal database that CMS requires the State to use for tracking the details of all facility-related complaints and ERIs. A district office supervisor is then responsible for assigning a priority level to each complaint and ERI according to categories established by CMS, as the text box shows. State law requires Public Health to investigate through on-site visits of relevant facilities all facility-related complaints from the public, except those complaints that Public Health deems not to have merit.

District offices have discretion in the methods they use to assign complaints to staff. For example, at the district offices we visited, a supervisor and his or her staff are assigned responsibility for specific facilities, and that supervisor and his or her staff generally handle complaints related to those facilities. However, a former district manager at the Orange County district office, which we did not visit, told us that her district office has formed a

Prioritization Categories for Complaints and Entity-Reported Incidents Related to Long-Term Health Care Facilities

1. **Immediate jeopardy:** A situation that has caused or that is likely to cause serious injury, harm, impairment, or death to a resident.
2. **Non-immediate jeopardy (high):** A situation that may have caused harm that negatively affects the individual's well-being.
3. **Non-immediate jeopardy (medium):** A situation that has caused or may cause limited harm and no significant impairment to an individual's well-being.
4. **Non-immediate jeopardy (low):** A situation that may have caused an individual discomfort without injury or damage.
5. **Administrative review:** A situation that does not necessitate an on-site review, but the California Department of Public Health (Public Health) may conduct an off-site review to determine whether further action is necessary.
6. **No action necessary:** A situation in which Public Health has determined with certainty that no further investigation, analysis, or action is necessary.

Source: Federal Centers for Medicare and Medicaid Services' *State Operations Manual*, Chapter 5, Section 5075.

team that investigates only facility-related complaints. She noted that this team is not involved in the certification activities for any facility. Regardless of how district offices assign facility-related complaints to investigators, those investigators must initiate investigations of complaints within required time frames based on the priorities assigned to those complaints.

Table 2
Types and Numbers of Complaints and Entity-Reported Incidents Received by the California Department of Public Health in 2012 and 2013

TYPE OF COMPLAINT OR INCIDENT	2012	2013	TOTAL RECEIVED
Complaints against individuals certified by the California Department of Public Health's (Public Health) Professional Certification Branch (PCB)*	937	904	1,841
Complaints against long-term health care facilities	6,496	6,257	12,753
Entity-reported incidents	20,963	19,711	40,674

Sources: California State Auditor's analysis of data obtained from Public Health's PCB's investigation section's Case Management Spreadsheet from January 1, 2011, through March 31, 2014, and the Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014.

* PCB is responsible for certifying three types of health professionals and for licensing another type, and for investigating complaints against these health professionals. Of the complaints PCB received during 2012 and 2013, 97 percent were against those individuals that held certifications for nurse assistants or home health aides.

State law, CMS requirements, and Public Health's policies set certain time frames for initiating investigations and closing facility-related complaints. For example, state law and Public Health policy require Public Health to initiate an investigation of a facility-related complaint within 24 hours or 10 working days, depending on the priority assigned to the complaint. Similarly, CMS's *State Operations Manual* and Public Health policy dictate if or when the district offices must initiate on-site investigations of ERIs. State law also requires district offices to notify complainants and the facilities, within 10 business days of the close of the investigation, whether the investigation substantiated the complaint. Finally, state law also provides a right of review for a complainant who is dissatisfied with the outcome of Public Health's investigation. State law requires that the deputy director for Public Health's Center for Health Care Quality request that the Complainant Appeals Unit conduct an independent review of the facts gathered during the initial investigation. Based on this review, the deputy director must make his or her own determination and notify the complainant and the involved facility within 30 days of completing the investigation.

Through its investigations, Public Health substantiated 6,419 facility-related complaints and 13,700 ERIs active during 2012 and 2013, as shown in Table B.2 on page 67 of Appendix B.

Assessing and Assigning Complaints Against Certified Individuals

Public Health's PCB assigns an assessment level to the complaints it receives against certified individuals, as the text box indicates. Beginning in December 2012, PCB began assigning levels to incoming complaints at its Sacramento office. Before that time, complaints were assigned levels in either the Sacramento office or the West Covina satellite office. Currently, once staff designate a level for a complaint, they assign the complaint to an analyst who will investigate it. At any given time, PCB management expects each analyst to be working on five to 10 complaints. PCB assigns complaints to staff in order of the assessed level, the age of the complaint, and the location or subject of the complaint.

The investigations of complaints against PCB-certified individuals have generally fewer time frames than do investigations of facility-related complaints. State law does not require Public Health to initiate investigations of certified individuals within a certain time frame. However, Public Health, under federal law, is responsible for the timely review and investigation of allegations of resident neglect, resident abuse, and misappropriation of resident property. If Public Health makes a preliminary determination that one of these alleged actions occurred, federal regulations require Public Health to notify—in writing within 10 working days of the investigation—the individual implicated in the investigation and the current administrator of the facility in which the incident is alleged to have occurred.

State law also provides a right of appeal for individuals certified by PCB and against whom Public Health has made a determination. Public Health contracts with the California Department of Health Care Services to conduct administrative hearings for any appeals. State law requires that Public Health hold an appeal hearing within 60 days of the receipt of the individual's

Assessment Levels for Complaints Against Individuals Certified by the Professional Certification Branch

1. A **Level A** complaint involves death of a resident, law enforcement, or situations that may pose harm to a resident, and it also includes one or more of these factors:
   - Physical abuse, such as forced physical contact, injury, or restraint of a resident.
   - Sexual misconduct, such as inappropriate or forced contact.
   - Unprofessional conduct, including neglect or negligence.
   - Theft, forgery, or similar activities, depending on the circumstances.
   - A repeat offense, depending on the circumstances.
2. A **Level 1** complaint does not involve law enforcement but includes at least one of these circumstances:
   - Unobserved physical abuse, such as forced physical contact, evidenced injury, or restraint of a resident.
   - Unobserved physical sexual misconduct, such as inappropriate touching or contact during care.
   - Unobserved unprofessional conduct, such as neglect or negligence.
   - Witnessed verbal abuse, such as threats, humiliation, or intimidation.
   - Witnessed theft or acceptance of gifts, forgery, borrowing from a resident, or similar activities.
   - A repeat offense, depending on the circumstances.
3. A **Level 2** complaint does not involve law enforcement but includes at least one of these factors:
   - Physical abuse, such as injury or rough handling of a resident during care, but without supporting evidence.
   - Witnessed sexual misconduct, including suggestive language or talking about sex.
   - Witnessed unprofessional conduct, such as delayed responses to call lights, poor care of a resident, or failure to report abuse or misconduct by another individual.
   - Unobserved verbal abuse, including threats, humiliation, or intimidation.
   - Unobserved theft or acceptance of gifts, forgery, borrowing from a resident, or similar activities.
4. A **Level 3** complaint does not involve law enforcement, but includes one or more of these situations:
   - Physical abuse, such as minor physical contact or the slapping of a resident's hand, knee, leg, or other body part.
   - Unobserved sexual misconduct, such as using suggestive language or talking about sex.
   - Unobserved unprofessional conduct, such as delayed responses to call lights, poor care of a resident, or failure to report abuse or misconduct by another individual.
   - Unobserved verbal abuse, such as direct profanity, indirect profanity, or unprofessional remarks.
   - Unobserved acceptance of nonmonetary gifts.
5. A **Level 4** complaint involves fraudulent use of a resident's Social Security number or identity.

Source: California Department of Public Health's policies for its Professional Certification Branch.

written request for an appeal. State law also requires Public Health to ensure that a written determination of the hearing is sent to the individual within 30 days of the appeal hearing.

Recent Concerns Related to Public Health's Management of Complaints

Concerns about Public Health's management of its complaint investigation process have resulted in federal mandates for improvement, state legislative inquiries related to the timing of Public Health's investigations of complaints against long-term health care facilities and the individuals it certifies, and the filing of a lawsuit. Specifically, in May 2012, CMS identified areas of improvement for Public Health, including some involving Public Health's processing of facility-related complaints. For example, CMS directed Public Health to close complaints within 60 days of ending the related investigations. Further, in October 2013, a nonprofit elder advocacy group filed a lawsuit in San Francisco Superior Court against Public Health, alleging that Public Health was delinquent in completing complaint investigations. Moreover, according to a field operations regional chief for Public Health, the department received legislative questions in the latter half of 2013 and in a hearing in January 2014 regarding complaints that had been open for more than three years and about the status of complaints reported as backlogged.

In February 2014 Public Health also learned that LA County—its contractor in Los Angeles County for performing the licensing, certification, and investigations of complaints related to long-term health care facilities—had implemented an unsanctioned policy related to the closure of backlogged complaints. Specifically, the policy advised staff, in part, to prioritize as *no action necessary* any complaint generated by an anonymous complainant or without a listed complainant. Later that month, Public Health directed LA County to discontinue use of the unsanctioned policy. In March 2014 a nonprofit news organization published an article highlighting the issues in Los Angeles County. The news in the article spurred Public Health and the Los Angeles County Department of Auditor-Controller (LA County Auditor) to conduct audits and a review of the county's investigation practices. Tables A.1 and A.2 in Appendix A summarize the results of the audits performed by the LA County Auditor.

In April 2014 CMS again issued directives for Public Health to improve its complaint processing, among other issues. CMS also directed Public Health to provide by June 2014 the results of Public Health's review of LA County's complaint investigation processes as well as Public Health's evaluation of the structure of LA County's

processes for investigating complaints along with Public Health's recommendations for improvement. Table A.3 on page 64 in Appendix A includes a summary of Public Health's review of LA County.

Scope and Methodology

The Joint Legislative Audit Committee directed the California State Auditor to perform an audit of the regulation of long-term health care facilities by Public Health's licensing division. Table 3 lists the objectives and the methods we used to address them.

Table 3
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant state and federal laws, regulations, policies, and other guidance applicable to the investigation and resolution of complaints against long-term health care facilities, of entity-reported incidents (ERIs), and of complaints against certain individuals, such as certified nurse assistants.
2	For the last two years, identify the following for complaints filed by the public, complaints self-reported by facilities, and complaints filed against nursing assistants and home health aides who are certified by the Professional Certification Branch (PCB) within the Licensing and Certification Division (licensing division) of the California Department of Public Health (Public Health):	• Obtained electronic data regarding complaints against facilities, ERIs, and complaints against certified individuals. • Interviewed Public Health staff to gain an understanding of how to interpret data. • Analyzed complaint and ERI data related to long-term health care facilities to determine the duration of completed investigations, whether complaints and ERIs were substantiated, and how long complaints and ERIs had remained open as of various dates. • We present in Chapter 1 of this report the number of closed on-site investigations related to ERIs for long-term health care facilities. For long-term health care facility-related complaints, the data showed that nearly all complaints were investigated on-site. However, according to Public Health, it did not track which complaints against certified individuals PCB investigated on-site until January 2014.
	a. The number of complaints filed with the licensing division and the proportion that the licensing division investigated through on-site reviews.	
	b. The average duration of completed investigations and, for complaints related to those investigations, the percentages that were substantiated both on a statewide and a district-office basis.	
	c. The number of investigations that have been open for two months, four months, six months, one year, 18 months, two years, and three years or more.	

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
3	Assess whether the licensing division is meeting applicable state and federal requirements regarding the timely investigation of complaints.	To conduct this assessment, we did the following: • Randomly selected from each of the four district offices that we visited—Bakersfield, Riverside, Sacramento, and San Francisco—five facility-related complaints and five ERIs that were closed during 2012 and 2013. We also randomly selected from PCB 15 complaints against individuals. • Reviewed investigation files and determined whether these cases met required timelines. • Haphazardly selected six additional facility-related complaints (three per calendar year) for which the complainants appealed the findings in 2012 and 2013, and we determined whether appeals were resolved within the statutory time frame. • Judgmentally selected 10 additional complaints against certified individuals in which the individuals appealed the findings in 2010 through 2013, and we determined whether the appeals were heard and decisions communicated within statutory time frames.
4	Determine whether the licensing division has an effective plan to eliminate the complaint backlog and investigate incoming complaints in a timely manner. Identify what changes in staffing the licensing division has made, or needs to make, to achieve this purpose.	Interviewed appropriate management at Public Health to identify and understand the extent of Public Health's current backlog. We also obtained, reviewed, and assessed the rationale for any staffing changes as well as any studies or plans Public Health developed to address the backlog.
5	For a selection of investigations completed that addressed complaints that were backlogged for at least six months, determine whether the licensing division complied with state and federal requirements, as well as with its own policies, regarding the quality of investigations.	• Randomly selected from each of the four district offices we visited, five facility-related complaints and five ERIs where the investigations were complete and that were open for six months or longer. In addition, we randomly selected from PCB 15 complaints against individuals that had remained open for six months or more. • Determined whether the licensing division consistently applied its approach in investigating these cases. To do so, we reviewed these cases and assessed whether their files contained evidence of key investigative activities before the cases were closed.
6	For a selection of investigations that resulted in the complaint being classified as substantiated during the last two years, determine whether the licensing division consistently applied its approach for substantiating complaints.	For the four district offices we visited and for PCB, we did the following: • Determined how district offices and PCB ensure consistency in substantiating complaints. • Randomly selected from each district office five complaints and five ERIs and from PCB 15 complaints against individuals, making certain that each case closed during 2012 and 2013 resulted in an identification of a regulatory violation by a facility or an adverse action against an individual. • Reviewed the investigation files for these complaints and determined whether district offices and PCB consistently applied their approach when substantiating the complaints. Nothing came to our attention to suggest that Public Health did not consistently apply its approach for substantiating complaints.
7	Determine whether the licensing division evaluates compliance with both state and federal facility standards during complaint investigations. If it does, determine the following for a selection of complaints filed during the last two years for which violations of such standards were identified: a. Whether the process for doing so is effective and efficient, including whether the licensing division is taking appropriate enforcement actions. b. Identify to what extent, if any, the degree of the enforcement actions varies by district office.	To obtain the information specified in this audit objective, we did the following: • Determined how district offices and PCB ensure consistency in enforcement actions. • Reviewed the investigation files for the same complaints used in audit objective 6 and determined whether the district office and PCB consistently took enforcement actions. • Assessed Public Health's perspective for any instances in which corrective actions were not enforced appropriately.

	AUDIT OBJECTIVE	METHOD
8	Determine whether the licensing division failed to report on the timely investigation of complaints in its statutorily required annual licensing fee reports to the Legislature and, if so, why.	• Obtained the most recent four annual reports that Public Health submitted to the Legislature to determine whether Public Health reported on the timeliness of its complaint investigations as required under state law. • Interviewed Public Health staff to obtain their perspectives on any noncompliance that we identified.
9	Review and assess any other issues that are significant to the audit.	To understand reported concerns related to complaint investigations performed by the Los Angeles County Department of Public Health (LA County), we reviewed the audit results reported by the Los Angeles County Department of Auditor-Controller and the review results by Public Health. To assess Public Health's process for monitoring various activities—including backlogs—related to complaint investigations at district offices and LA County, and to assess Public Health's perspective on its contract with LA County, we took the following steps: • Interviewed Public Health officials to understand their processes for monitoring workload and the investigations performed by the district offices and LA County as well as to obtain their perspectives on recent concerns raised about the LA County contract. • Obtained documents relating to Public Health's monitoring of district offices and of LA County and also relating to Public Health's plans to monitor LA County's investigations in the future.

Sources: California State Auditor's analysis of Joint Legislative Audit Committee audit request number 2014-111, and information and documentation identified in the table column titled *Method*.

Methods to Assess Data Reliability

In performing this audit, we obtained electronic data files extracted from the information systems listed in Table 4. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support our findings, conclusions, or recommendations. Table 4 describes the analyses we conducted using data from these information systems, our methodology for testing them, and the limitations we identified in the data. Although we recognize that these limitations may impact the precision of the numbers we present, in total there is sufficient evidence to support our audit findings, conclusions, and recommendations.

Table 4
Methods of Assessing Data Reliability

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
California Department of Public Health (Public Health) Professional Certification Branch's (PCB) investigation section's Case Management Spreadsheet Data related to complaints received from January 1, 2011, through March 31, 2014, against certified individuals and individuals who had a certification in progress	• To determine the total number of complaints against certified individuals and individuals who had a certification in progress that PCB received during each calendar year. • To age open complaints against individuals certified as nurse assistants or home health aides as of January 2012, December 2013, and March 2014. • To calculate the average number of days complaints against individuals certified as nurse assistants or home health aides were open as of March 31, 2014, by priority level.	• We performed data-set verification procedures and did not identify any errors. We also conducted electronic testing of key data elements and did not identify any significant issues. • To assess the accuracy of the PCB's Case Management Spreadsheet data, we intended to test a random selection of 29 case files by verifying that key data elements matched the source documents. However, after completing our testing for seven of the 29 files, we identified three exceptions in the field that captures the date on which the incident is claimed to have occurred and four exceptions in the field that captures the date on which PCB received the complaint about the incident (received date). Furthermore, PCB acknowledged that as a result of inconsistencies in staffs' data entry into the Case Management Spreadsheet, the received date field could have been populated with either the date the complaint was received, the date the complaint was entered into the spreadsheet, or the date the complaint was assigned to an investigator. Due to the prevalence of the errors we identified and their significance to our analysis, we discontinued both our accuracy and completeness testing.	Not sufficiently reliable for the purposes of this audit. Although we identified limitations in the data that may impact the precision of the numbers we present, in total there is sufficient evidence to support our audit findings, conclusions, and recommendations.
Public Health Automated Survey Processing Environment Complaints/Incidents Tracking System (ACTS) Public Health's complaints against facilities and entity-reported incidents (ERIs) data as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014	• To determine the total number of complaints and ERIs related to long-term health care facilities that Public Health received during each calendar year. • To age the number of open complaints and ERIs related to long-term health care facilities as of January 2012, December 2013, and April 2014. • To calculate the average number of days complaints and ERIs related to long-term health care facilities were open as of April 2014, and to categorize them by district office and priority type. • To determine the number of ERIs related to long-term health care facilities that Public Health received in 2012 and 2013 and the number of related closed investigations, by district office and type of investigation. • To determine the number of complaints and ERIs received and the number closed in 2012 and 2013 that were related to long-term health care facilities, by district office.	• We performed data-set verification procedures and electronic testing of key data elements and did not identify any significant issues. • We did not perform accuracy and completeness testing of the ACTS data because the source documents required for this testing are stored at various locations throughout the State, making such testing cost-prohibitive.	Undetermined reliability for the purposes of this audit. Although this determination may impact the precision of the numbers we present, in total there is sufficient evidence to support our audit findings, conclusions, and recommendations.

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
	• To determine the number of complaints and ERIs that were active during 2012 and 2013, had substantiated allegations, and related to long-term health care facilities, by district office. • To make a selection of complaints and ERIs with substantiated allegations and related to long-term health care facilities.	• We performed data-set verification procedures and found no errors. • We performed electronic testing of key data elements and found that allegation information was not available for nearly 13 percent of complaints and ERIs active during 2012 and 2013 and related to long-term health care facilities. • We did not perform accuracy and completeness testing of the ACTS data because the source documents required for this testing are stored at various locations throughout the State, making such testing cost-prohibitive.	Not sufficiently reliable for the purposes of this audit. Although we identified limitations in the data that may impact the precision of the numbers we present, in total there is sufficient evidence to support our audit findings, conclusions, and recommendations.
Public Health Electronic Licensing Management System (ELMS) List of state-owned facilities as of June 26, 2014	To identify complaints, ERIs, and investigations related to state-owned long-term health care facilities.	• We performed data-set verification procedures and electronic testing of key data elements and found no errors. • We did not perform accuracy and completeness testing of the ELMS data because some of the source documents required for this testing are stored at a location we did not visit.	Undetermined reliability for the purposes of this audit. Although this determination may impact the precision of the numbers we present, in total there is sufficient evidence to support our audit findings, conclusions, and recommendations.

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from Public Health.

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Chapter 1

THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH MUST BETTER MANAGE THE NUMBER OF OPEN COMPLAINTS RELATED TO LONG-TERM HEALTH CARE FACILITIES

Chapter Summary

As of April 2014 the California Department of Public Health (Public Health) had more than 11,000 open complaints and entity-reported incidents (ERIs): More than 10,000 related to long-term health care facilities that its district offices investigate and nearly 1,000 related to certain individuals that its Professional Certification Branch (PCB) certifies and investigates. Many of these complaints and ERIs related to long-term health care facilities have relatively high priorities assigned to them, indicating a safety risk to residents, and have remained open for an average of nearly a year. Several factors contributed to the large number of open complaints and ERIs. Specifically, Public Health does not provide adequate oversight of the processing of complaints by its district offices and PCB. Until late 2013 Public Health did not have a standardized process for reviewing the status of open complaints and ERIs, and it still does not have any formal policies and procedures for ensuring prompt completion of complaint and ERI investigations. Further, PCB also lacks accurate data regarding the status of complaint investigations against individuals. Public Health data show that district offices vary significantly in the proportion of ERIs they prioritize into various categories, which determine whether they perform on-site investigations, perform desk reviews, or close them without any investigations. Some district offices performed more on-site investigations of ERIs, while other district offices closed more ERIs using the category *no action necessary.*

Finally, we visited four district offices—Bakersfield, Riverside, Sacramento, and San Francisco—and staff at three district offices and PCB noted that they do not have enough resources to investigate all complaints promptly. However, Public Health has not performed a staffing analysis to determine the appropriate staffing level at each district office. Public Health noted that it contracted with a consultant in 2013 to perform a workload and organizational assessment. In its August 2014 report the consultant made several recommendations, including that Public Health improve its workforce planning and staffing plan methodologies to ensure appropriate staffing levels across all district offices. However, Public Health expects that implementing the consultant's recommendations will take more than two years. Public Health entered into a contract with a consultant in September 2014 to,

among other things, assess PCB's current business processes and implement process improvements to address complaints timely and effectively.

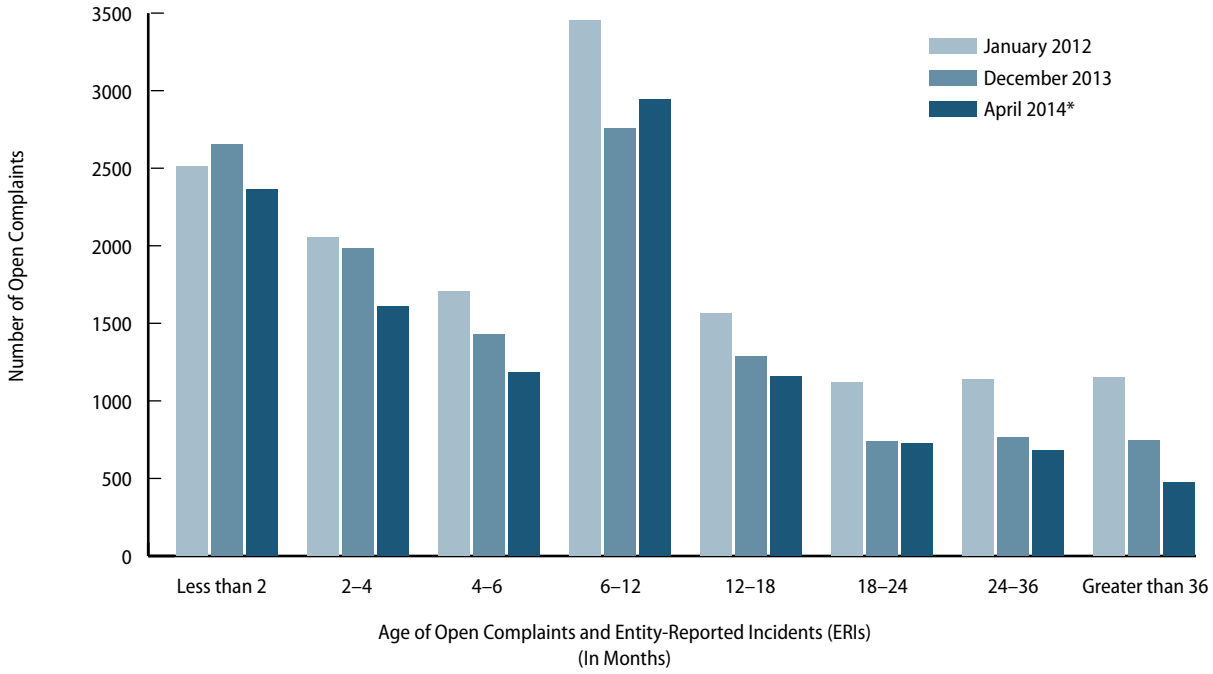
Public Health Had More Than 11,000 Open Complaints and ERIs Related to Long-Term Health Care Facilities and Certain Health Care Staff

As of April 2014 Public Health had more than 11,000 open complaints and ERIs—many of which had relatively high priorities and had remained open for an average of nearly a year.

During the last two years, Public Health has made some progress in reducing the number of open complaints and ERIs; however, as of April 2014, it still had more than 11,000 open complaints and ERIs. Many of these complaints and ERIs had relatively high priorities and had remained open for an average of nearly a year. Although some complaints and ERIs may remain open because of postinvestigation activities, such as obtaining corrective action plans or processing appeals, for 8,127 of the complaints and ERIs open as of April 2014, Public Health had not yet completed the investigation phase of the process. When it does not complete investigations and close complaints promptly, Public Health may risk the safety and well-being of individuals residing in long-term health care facilities.

In late 2013 and early 2014, Public Health took some steps to reduce the number of open complaints and ERIs. According to a field operations regional chief in Public Health's Licensing and Certification Division (licensing division), in November 2013, because of legislative inquiries about three-year-old complaints, Public Health undertook an effort to review the status of its open facility-related complaints and ERIs. As we discuss in Chapter 2, Public Health identified in December 2013 nearly 9,400 open facility-related complaints and ERIs, more than 500 of which had been received before 2009. Public Health sent a list of the 9,400 complaints and ERIs to the district offices and directed them to review the ones opened in 2012 or before. Public Health also directed the district offices to correct data-processing errors, if found. As of February 2014 Public Health had closed 3,900 complaints and ERIs through this effort. Public Health continues its process of working with the district offices to close aged open complaints and ERIs. Figure 2 shows Public Health's progress in reducing the overall age of all three types of its open complaints—facility-related complaints, ERIs, and complaints against individuals. As Table B.1 on page 66 in Appendix B shows in more detail, Public Health reduced the number of open complaints from more than 14,700 at the beginning of 2012 to just over 11,100 as of April 2014.

Figure 2
California Department of Public Health's Progress in Reducing the Number of Aged Complaints and Entity-Reported Incidents
January 2012 Through April 2014



Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's Professional Certification Branch's (PCB) investigation section's Case Management Spreadsheet from January 1, 2011, through March 31, 2014, and the Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014.

Note: PCB is responsible for certifying three types of health professionals and for licensing another type, and for investigating complaints against these health professionals. However, our audit and this figure focus on individuals certified as nurse assistants or home health aides who were the subjects of 97 percent of complaints that PCB received in 2012 and 2013.

* The number of open complaints includes ERIs and complaints against long-term health care facilities as of April 11, 2014, and complaints against individuals as of March 31, 2014.

We noted that despite its efforts to close complaints and ERIs that have been open for a long time, many of the more than 10,000 facility-related complaints and ERIs still open as of April 2014 were assigned relatively high priorities and have remained open for long periods. As Table 5 on page 27 shows, district offices assigned 368 of the open complaints and ERIs a priority of *immediate jeopardy,* indicating that a facility's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident. As of April 2014 these 368 complaints and ERIs had been open for an average of 340 days. Moreover, district offices prioritized another 4,400 and 4,239 open complaints and ERIs as *non-immediate jeopardy (high)* and *non-immediate jeopardy (medium),* respectively. Complaints and ERIs classified as *non-immediate jeopardy (high)* involve situations in which a facility's noncompliance may have caused harm that negatively affects the resident and has such consequence for his or her well-being that a

rapid response is indicated. Those complaints and ERIs classified as *non-immediate jeopardy (medium)* are situations in which the facility's noncompliance caused or may cause harm that has limited consequence and does not significantly impair the resident. Statewide, more than 8,600 facility-related complaints and ERIs under both of these classifications were open for an average of 300 days or more. When we asked Public Health why it did not implement improvements sooner, the interim deputy director stated that Public Health was not focusing on open cases as much as it does now because the law specifies time frames for initiating investigations but not for completing them. Considering that district offices have determined that these complaints and ERIs represent some level of danger to the residents' well-being, such long delays in closing the complaints and ERIs are very concerning.

Although all district offices had open complaints and ERIs, certain offices had fewer than others, or the complaints and ERIs they handle were not open for as long as other district offices. Table 5 shows that as of April 2014, the Orange County district office had facility-related complaints and ERIs open for one priority level for as many as 172 days on average. However, across all priority levels, its numbers of open complaints and ERIs ranged from only four to 25. Generally, the East Bay and Sacramento district offices had higher numbers of open facility-related complaints and ERIs than did the Orange County district office. On the other hand, complaints and ERIs had remained open for averages of 14 to 80 days at the East Bay district office and 35 to 43 days at the Sacramento district office—some of the shorter averages among all of the district offices.

Some district offices had high numbers of open complaints and ERIs, or the average number of days that complaints and ERIs had remained open at these district offices was significantly high.

In contrast, some district offices had high numbers of open complaints and ERIs, or the average number of days that complaints and ERIs had remained open at these district offices was significantly high, and this situation indicates inadequate management of complaint investigations. Table 5 shows that as of April 2014, the Santa Rosa–Redwood Coast district office had 102 open complaints and ERIs prioritized as *immediate jeopardy*—the highest number of open complaints and ERIs in this priority level at any district office. Further, these complaints and ERIs had been open for an average of 345 days, or nearly a year. Similarly, Los Angeles County's San Gabriel office had 65 open complaints and ERIs prioritized as *immediate jeopardy* that had been open for an average of 514 days. It also had 1,017 open complaints and ERIs prioritized as *non-immediate jeopardy (high)* that may have caused harm negatively affecting a resident, and these cases had been open for an average of more than a year. Although the San Francisco district office had only eight open facility-related complaints and ERIs prioritized as *immediate jeopardy,* these complaints were open for an average of almost three years.

Table 5
Number of District Offices' Facility-Related Open Complaints and Entity-Reported Incidents by Complaint Priority as of April 2014

		PRIORITY LEVEL FOR COMPLAINTS AND ENTITY-REPORTED INCIDENTS (ERIs)*								
		IMMEDIATE JEOPARDY		NON-IMMEDIATE JEOPARDY						
				HIGH		MEDIUM		LOW		
OFFICE		CASES OPEN	AVERAGE NUMBER OF DAYS OPEN	CASES OPEN	AVERAGE NUMBER OF DAYS OPEN	CASES OPEN	AVERAGE NUMBER OF DAYS OPEN	CASES OPEN	AVERAGE NUMBER OF DAYS OPEN	OTHER CASES OPEN†
District Offices										
1	Bakersfield	12	214	155	242	14	1,569	3	3,503	55
2	Chico	22	135	156	157	65	270	137	150	4
3	East Bay	1	14	77	48	47	80	3	32	8
4	Fresno	12	112	135	111	76	332	3	54	70
5a	Los Angeles County East‡	22	179	302	205	198	215	5	202	4
5b	Los Angeles County North‡	26	392	508	372	151	368	14	249	4
5c	Los Angeles County San Gabriel‡	65	514	1,017	377	129	303	144	240	2
5d	Los Angeles County West‡	7	336	306	453	477	593	20	284	2
6	Orange County	4	120	20	82	25	172	0	–	4
7	Riverside	3	518	152	442	416	515	4	180	7
8	Sacramento	9	38	110	41	17	35	21	43	70
9	San Bernardino	8	335	133	485	240	499	0	–	11
10	San Diego North	7	316	183	108	73	116	2	201	3
11	San Diego South	3	17	140	102	82	257	2	36	1
12	San Francisco	8	1,042	79	525	547	343	7	178	2
13	San Jose	3	392	44	40	54	177	0	–	7
14	Santa Rosa/Redwood Coast	102	345	483	316	140	281	9	409	43
15	Ventura	1	25	47	218	56	298	3	772	113
State Office										
1	State Facilities Unit	53	309	353	245	1,432	237	174	346	9
Statewide Totals										TOTAL
Cases open		**368**		**4,400**		**4,239**		**551**		**419**	**9,977**
Average number of days open			**340**		**300**		**342**		**264**		

Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's (Public Health) Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014, and the Electronic Licensing Management System as of June 26, 2014.

* We identified 166 open complaints or ERIs—an immaterial amount for the purposes of this analysis—with an invalid or no priority assigned. As a result, this table does not include these 166 complaints.

† *Other cases open* includes complaints or ERIs categorized as *administrative review*, *no action necessary*, and *transfer*.

‡ Public Health contracts with the Los Angeles County Department of Public Health (LA County) to perform the licensing and certification function, including investigations of complaints in that county. Although Public Health considers LA County to be one district, LA County maintains offices in four geographic locations.

In certain cases it is reasonable and appropriate for a complaint to remain open for an extended period. For example, a complaint might involve the death of a resident, and the district office cannot complete the investigation until it receives the coroner's report on the circumstances of the death. However, according to our review, these instances are uncommon. Instead, we noted several factors contributing to high numbers of open complaints and ERIs and to lengthy average times that complaints and ERIs remain open. The sections that follow discuss these factors in detail.

Some of these averages might be affected by a handful of complaints or ERIs that remained open for much longer periods compared to those needed to investigate and close other complaints or ERIs. For example, the Ventura district office had three facility-related complaints and ERIs prioritized as *non-immediate jeopardy (low)* that remained open for an average of 772 days. However, one of these three complaints had been open for nearly 1,800 days, a number that contributed to the higher average. The remaining two complaints were open for 242 and 289 days, respectively. Conversely, in other cases, the numbers of days that complaints and ERIs remained open were evenly distributed. For instance, of the 14 *non-immediate jeopardy (medium)* complaints and ERIs at the Bakersfield district office that remained open for an average of 1,569 days, six were open for more than the average, and the remaining eight were open for less than the average. Regardless of the precision of the averages, the fact remains that Public Health must take steps to ensure that it closes complaints and ERIs more promptly.

For most of the open facility-related complaints and ERIs, Public Health had not yet completed the investigation phase of the process. As the Introduction explains, district office staff conduct the actual investigation of a complaint or ERI by either making a site visit or performing a desk review. After Public Health staff complete the investigation and determine whether the complaint or ERI is substantiated, Public Health must notify the complainant, if applicable, and the facility or the individual being investigated about the results of the investigation. The involved facilities, individuals, and complainants then have an opportunity to appeal the findings. The facilities must also provide, if applicable, an acceptable plan of corrective action before Public Health can close the complaint or ERI. However, Public Health's data show that for 8,127 of the more than 10,000 open facility-related complaints and ERIs, district office staff may have initiated the investigations by visiting the facility or reviewing documents and interviewing witnesses, but they had not closed the investigations as of April 2014. In these instances, Public Health may not yet have determined whether the complaint allegations were substantiated and whether the residents in those facilities' care were at risk.

Public Health's data show that for 8,127 of the more than 10,000 open facility-related complaints and ERIs, district office staff may have initiated the investigations by visiting the facility or reviewing documents and interviewing witnesses, but they had not closed the investigations as of April 2014.

Similarly, Public Health's PCB data related to complaints against certified nurse assistants and home health aides show many open complaints that have remained open for long periods. Specifically, Table 6 shows that as of March 31, 2014, nearly 1,000 complaints had remained open for an average of eight months. Only 30 of these open complaints had received the highest priority—priority level A—indicating that the complaints included serious allegations of physical abuse, sexual misconduct, unprofessional conduct, or misappropriation of residents' property and that the complaints may have involved death, law enforcement, or situations that may pose harm to residents. However, these complaints had remained open for an average of 100 days, as Table 6 shows. Further, nearly 700 open complaints had been assigned priority levels 2 and 3—involving less serious physical or verbal abuse, sexual misconduct, unprofessional conduct, or misappropriation of resident property—and they had remained open for an average of 326 days and 259 days, respectively.

Table 6
Number of Open Complaints Against Individuals and the Average Number of Days Open According to Assessed Complaint Priority Levels as of March 31, 2014

INITIAL COMPLAINT PRIORITY LEVEL*	COMPLAINTS OPEN	AVERAGE NUMBER OF DAYS THAT COMPLAINTS WERE OPEN
A	30	100
1	194	212
2	304	326
3	378	259
4	32	47
Not yet assessed†	49	14
Total open complaints	**987**	
Average number of days complaints open		**247**

Source: California State Auditor's analysis of data obtained from the California Department of Public Health's Professional Certification Branch's (PCB) investigation section's Case Management Spreadsheet from January 1, 2011, through March 31, 2014.

Note: PCB is responsible for certifying three types of health professionals and licensing another type, and for investigating complaints against these health professionals. However, our audit and this table focus on individuals certified as nurse assistants or home health aides who were the subjects of 97 percent of complaints that PCB received in 2012 and 2013.

* For a detailed description of the priority levels, see page 15 of the report.

† According to the chief of the investigations section within PCB, a staff member in her section assessed the appropriate level for a complaint as PCB received it. However, she stated that PCB updated the spreadsheet once a week, creating a lag in uploading this information to the tracking spreadsheet, which may be why these complaints do not show priority levels.

Several Factors Have Contributed to the High Number of Open Complaints and ERIs and to the Length of Time They Remain Open

Several factors have contributed to Public Health's high volume of open complaints and ERIs. Until late 2013 Public Health's management did not have a standardized method for regularly monitoring the status of open complaints and ERIs. Additionally, PCB does not maintain accurate data tracking its progress regarding the status of complaint investigations into certified individuals' actions to allow management to provide proper oversight. Further, Public Health has not established time frames within which district offices and PCB must complete their complaint investigations, nor has it established a process to monitor district offices' and PCB's management of complaint processing. Public Health has also not assessed whether all district offices consistently assign priorities to ERIs even though these assignments can affect the time required to close the ERIs. Moreover, Public Health has not determined the appropriate staffing levels of its district offices and PCB to adequately handle the workload related to the licensing and certification of long-term health care facilities and certain individuals, which include investigating complaints. As a result, some of the district offices and PCB offices are struggling to close complaints in a timely manner.

Public Health Has Not Provided Adequate Oversight of Complaint Processing

Until late 2013 Public Health's licensing division had not adequately monitored the number of open complaints and ERIs at the district offices and at the PCB offices. According to the acting chief of field operations, the licensing division's managers conduct biweekly telephone meetings with the district offices to discuss such topics as the numbers of targeted and completed federal recertification surveys, state licensing surveys, complaint investigations, pending citations, management reports, and staffing issues. In addition, Public Health holds quarterly in-person regional meetings with the district office managers, branch chiefs, directors, and consultants to discuss issues and share insights on district office operations. However, until November 2013, the licensing division had not established a tracking log to standardize its monitoring of open complaints and ERIs.

Until November 2013 the licensing division had not established a tracking log to standardize its monitoring of open complaints and ERIs.

The interim deputy director acknowledged that in the past the licensing division had not focused on the district offices' workload for open complaints because the law specifies a time frame to initiate investigations but no time frames to complete them. She noted that at least monthly, beginning in December 2013, a branch chief in the licensing division has sent a list of open complaints to

each district office with the date each investigation was started. Public Health plans to monitor district office workload in the future by using the tracking log. Additionally, beginning in October 2014, Public Health plans to post to its Web site metrics related to the volume, timeliness, and disposition of complaint and ERI investigations, to help the district offices monitor and manage their workloads.

Further, Public Health has not maintained accurate information for tracking its progress in investigating complaints against certified individuals. As a result, PCB does not yet have an effective process for Public Health's management to monitor whether PCB is promptly addressing those complaints. PCB uses a spreadsheet to track its processing of complaints about certified individuals. However, the data included in the tracking spreadsheet are not always accurate. For example, in one case the tracking spreadsheet showed that the branch received a complaint in December 2011 even though PCB had originally received the complaint in February 2011, 10 months earlier. PCB's investigation section chief acknowledged that the dates in the spreadsheet are not consistent because dates are not consistently documented in the case files, especially before 2012. Also, before 2013, investigators and office staff both entered dates into the spreadsheet, and the received dates may have been the dates assigned or the dates entered. She stated that as of the first half of 2013, PCB revised its process and now allows only two individuals to access and update the tracking spreadsheet.

Not only has it failed until recently to monitor the open complaints and ERIs, but Public Health also has not established any policies regarding time frames for completing complaint investigations.

Not only has it failed until recently to monitor the open complaints and ERIs, but Public Health also has not established any policies regarding time frames for completing complaint investigations. State law requires Public Health to conduct an on-site investigation of a facility-related complaint within either 24 hours or 10 days, depending on the severity of the complaint, and to send certain written notifications within specified time frames once the investigation has concluded. However, there is no statutory requirement specifying that Public Health must complete investigations of facility-related complaints and ERIs within certain time frames. Similarly, there is no statutorily required time frame for Public Health to complete an investigation of a complaint about a certified individual. In fact, unlike the situation for facility-related complaints, there is no statutorily required time frame for initiating an investigation of a complaint about a certified individual.

With respect to facility-related complaints, Public Health did not always lack time frames for completing investigations. Public Health's 2004 policies and procedures manual had a goal that the district offices complete investigations of facility-related complaints within 40 days of receiving them. According to the

Public Health's lack of accountability has contributed to its district offices' failure to complete investigations within reasonable periods.

acting assistant deputy director, the licensing division eliminated this goal in 2009 because the district offices were unable to meet it for various reasons. In offering an example of these reasons, he noted that some complaints may involve the death of a resident, and the district office cannot complete such investigations until it receives the coroner's report on the circumstances of the death. However, we disagree with Public Health's decision to eliminate the goal. Although there may be instances in which district offices cannot comply with established time frames for valid reasons, Public Health's lack of accountability has contributed to its district offices' failure to complete investigations within reasonable periods. Public Health's data show significant delays in conducting investigations. Specifically, Public Health's data indicate that district offices took an average of 150 days to conduct investigations for complaints and 119 days to conduct investigations for ERIs.[1] For example, the Riverside district office received a facility-related complaint in February 2012 alleging that the long-term health care facility refused to readmit a resident after the resident was hospitalized. Although the district office initiated the investigation within the required time frame, it did not complete the investigation and notify the facility of the outcome until May 2013—more than a year after the district office received the complaint. Public Health's holding district offices accountable for promptly completing investigations is critical to ensuring the safety and well-being of residents in long-term health care facilities.

Public Health's PCB also has not established formal policies or procedures that include specific time frames for staff to complete their investigations of complaints about individuals it certifies. According to PCB's former chief, before fiscal year 2012–13, PCB staff had large caseloads, and management focused on completing investigations of new complaints. Aged complaints were investigated as time allowed. For 14 of 33 complaints we reviewed, PCB did not even assign the complaints to investigators until more than a year after it received those complaints. In one case, PCB received a complaint in April 2012 about a certified nurse assistant alleging rudeness and her slapping a resident, actions that constitute abuse. PCB assigned this complaint a level 3 priority, meaning the complaint involved a less serious instance of physical abuse. However, PCB management did not assign staff to investigate this complaint until August 2013, about 16 months later. According to PCB's investigation section chief, at that time the investigators were focused on completing aged investigations received in 2009 and 2010 as well as the most egregious current cases. She stated that due to the age and number of pending complaints, PCB's staffing

[1] This analysis includes all complaints and ERIs that were open at any point during 2012 or 2013 and had a related closed investigation.

levels, and the assessed level of severity for this particular complaint, the case was not assigned until PCB had completed the complaints received before 2012. PCB ultimately closed the complaint in November 2013 with a warning to the nurse assistant. The PCB investigator could not interview the resident, who was the only witness, because the individual was no longer at the long-term health care facility. In this case, PCB's delayed investigation allowed the certified nurse assistant to continue to work with residents, potentially placing the well-being of those residents at risk.

Public Health's development of formal policies and procedures for PCB, including the establishment of specific steps and time frames for completing those steps, is especially important because federal regulations require Public Health to investigate complaints about certified individuals in a timely manner. To fulfill this requirement, Public Health must act at the first reasonable opportunity after it receives the complaint. PCB's investigation section chief stated that in August 2012 she informally instituted some procedures for assigning complaints. PCB's investigation section chief stated that the new practice assigns batches of complaints to investigators, limiting the number of complaints assigned to each investigator at one time. She also noted that the overall goal is for the investigation section to complete an average of five to six investigations per investigator each month. Although these goals have been shared with the investigators, they have not been formalized in policy or procedures.

Opportunities May Exist to Address ERIs More Efficiently

Public Health data show that 76 percent of the complaints that district offices receive are ERIs that long-term health care facilities self-report to Public Health. Specifically, state law requires long-term health care facilities to report any unusual incident to Public Health within 24 hours; failure to do so may result in penalties for facilities. Additionally, Public Health's regulations require long-term health care facilities to report to Public Health within 24 hours all unusual occurrences, such as epidemic outbreaks; poisonings; fires; major accidents; deaths from unnatural causes; or other catastrophes that threaten the health, safely, or welfare of patients, personnel, or visitors. The acting assistant deputy director stated that facilities do not want to be liable and receive penalties for not reporting incidents that should have been reported. Thus, many facilities report incidents that may not involve any regulatory violations. Not all ERIs require the same level of effort for district offices to complete a review. Specifically, Public Health assigns a priority level to each ERI according to categories established by the federal Centers for Medicare and Medicaid Services (CMS). The priority assigned to an ERI dictates whether the district office staff must conduct an on-site investigation,

perform a desk review, or whether they can close the ERI without an investigation. All ERIs prioritized as *immediate jeopardy or non-immediate jeopardy (high)* require on-site investigations. Otherwise, district office staff can perform desk reviews for ERIs prioritized as *administrative review,* and they may close without investigations or reviews those ERIs assigned a priority level of *no action necessary.* For example, one of the ERIs that we reviewed identified an instance in which a resident had a seizure while at the facility despite receiving prescribed medications, and the patient was taken and admitted to the hospital. In this instance, after staff had a conversation with the facility director, the district office concluded that no regulatory violation had occurred, and it closed the ERI, classifying it as *no action necessary.*

The acting assistant deputy director indicated that Public Health has chosen not to further define *unusual incidents* in its regulations because it is concerned that identifying a list of such incidents might lead to a facility's not reporting an incident that does not appear on the list, and this omission could negatively affect the residents' welfare, safety, or health. According to the interim deputy director, Public Health allows facilities to report all unusual incidents and have district office staff determine whether the incidents warrant investigations. This practice has resulted in a large volume of ERIs for each district office. However, Public Health has not provided guidance to district offices on best practices for consistent, efficient processing of ERIs. According to the acting assistant deputy director of Public Health's Center for Health Care Quality, headquarters tries to remind the district offices of CMS policy allowing them to conduct administrative reviews or to prioritize as *no action necessary* for certain ERIs. However, he believes that these actions should occur at the discretion of the district manager, and he does not want to issue a directive as these priorities may be overused or used inappropriately.

***Some district offices may be performing more on-site investigations of ERIs than others, and some may be classifying and closing more ERIs as* no action necessary.**

Public Health data show that district offices vary significantly in the proportions of ERIs that they prioritize into various categories, suggesting that some district offices may be performing more on-site investigations of ERIs than others and that some may be classifying and closing more ERIs as *no action necessary*. For example, as Table 7 shows, of the ERIs Chico and San Diego North district offices received during 2012 and 2013, 97 percent of the ERIs with a closed investigation were reviewed on site. Conversely, three of the four Los Angeles County offices and the Orange County district office completed on-site investigations for fewer than 20 percent of the ERIs with closed investigations and 79 percent or more were closed under the classification *no action necessary.*

Table 7
Number of Entity-Reported Incidents Received in 2012 and 2013, and Related Closed Investigations for Long-Term Health Care Facilities by District Office and Type of Investigation

OFFICE/FACILITY	TOTAL ENTITY-REPORTED INCIDENTS (ERIs) RECEIVED	TOTAL INVESTIGATIONS CLOSED		TYPE OF INVESTIGATION CLOSURE					
				ON-SITE INVESTIGATION *		ADMINISTRATIVE REVIEW		NO ACTION NECESSARY	
		NUMBER CLOSED	PERCENTAGE OF TOTAL ERIs RECEIVED	NUMBER CLOSED	PERCENTAGE OF TOTAL CLOSED	NUMBER CLOSED	PERCENTAGE OF TOTAL CLOSED	NUMBER CLOSED	PERCENTAGE OF TOTAL CLOSED
District Office									
1 Bakersfield	2,637	2,589	98%	1,006	39%	82	3%	1,501	58%
2 Chico	1,205	1,113	92	1,079	97	16	1	18	2
3 East Bay	2,179	2,135	98	1,108	52	11	1	1,016	48
4 Fresno	3,661	3,079	84	833	27	646	21	1,600	52
5a Los Angeles County East†	1,077	381	35	131	34	8	2	242	64
5b Los Angeles County North†	1,103	808	73	84	10	17	2	707	88
5c Los Angeles County San Gabriel†	1,926	836	43	156	19	21	3	659	79
5d Los Angeles County West†	856	500	58	91	18	14	3	395	79
6 Orange County	1,549	1,539	99	268	17	0	0	1,271	83
7 Riverside	1,917	1,693	88	762	45	300	18	631	37
8 Sacramento	3,867	3,857	100	1,366	35	1,754	45	737	19
9 San Bernardino	4,050	3,892	96	1,154	30	1	0	2,737	70
10 San Diego North	1,118	758	68	733	97	0	0	25	3
11 San Diego South	1,002	986	98	767	78	3	0	216	22
12 San Francisco	1,350	1,061	79	690	65	5	0	366	34
13 San Jose	1,484	707	48	372	53	224	32	111	16
14 Santa Rosa–Redwood Coast	1,514	1,229	81	690	56	323	26	216	18
15 Ventura	1,540	1,288	84	453	35	741	58	94	7
State Office									
1 State Facilities Unit	6,639	4,808	72%	1,608	33%	1,593	33%	1,607	33%
Statewide Totals	**40,674**	**33,259**	**82%**	**13,351**	**40%**	**5,759**	**17%**	**14,149**	**43%**

Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's (Public Health) Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014, and the Electronic Licensing Management System as of June 26, 2014.

Note: This table does not include a small number of ERIs that were referred to other control agencies for investigation or informational purposes.

* On-site investigation includes ERIs prioritized as *immediate jeopardy* and *non-immediate jeopardy*.

† Public Health contracts with the Los Angeles County Department of Public Health (LA County) to perform the licensing and certification function, including the investigation of complaints related to long-term health care facilities in that county. Although Public Health considers LA County to be a single district, LA County maintains offices in four geographic locations.

The interim deputy director of the licensing division stated that factors beyond the priority level may affect a district office's decision to conduct an on-site investigation of an ERI. For example, she stated that a district office might choose to perform an on-site investigation because of a long-term health care facility's history of violations. Although we agree that various factors may influence a district office's determination of the priority assigned,

such significant variances in the proportions of ERIs prioritized into various categories indicate that district offices are not using a consistent prioritization method. These variances highlight a need for Public Health to more closely monitor district offices' processing of ERIs and to assess whether district offices can be more consistent and efficient in this area. Using information gained from its monitoring of the district offices' practices, Public Health should identify and share with all the district offices those practices that best promote consistency and efficiency. When we discussed this suggestion with Public Health, the acting assistant deputy director stated that headquarters is trying to encourage district offices not to go on-site immediately for every ERI, because lower-priority ERIs do not indicate significant patient care issues and can wait until the next recertification or a facility-related complaint requiring a site visit, or until a group of ERIs can be investigated together.

Public Health Has Not Adequately Managed Staffing Levels for Its District Offices and PCB

Public Health has not completed staffing analyses for its district offices; therefore, it does not know how many staff it needs to reduce the number of aging complaints to a manageable level and to remain current on new complaints.

Public Health has not completed staffing analyses for its district offices; therefore, it does not know how many staff it needs to reduce the number of aging complaints to a manageable level and to remain current on new complaints. In addition to investigating facility-related complaints, district offices are responsible for performing federally required annual recertification of long-term health care facilities and other types of facilities. Public Health certifies long-term health care facilities on behalf of CMS, and it investigates complaints related to those other types of facilities. For example, Public Health is required to conduct an on-site survey of each long-term health care facility at least once every 15 months in order to recertify the facility as eligible for Medicaid and Medicare service reimbursements. Additionally, the statewide average interval between standard surveys cannot exceed 12 months. Public Health estimates that the investigation of facility-related complaints and ERIs represents 31 percent of the work that district offices perform.

Public Health's complaint data for the entire State suggest it managed to close slightly more complaints and ERIs related to long-term health care facilities than it received during 2012 and 2013. Specifically, as Table 8 shows, Public Health received more than 53,000 facility-related complaints and ERIs during these two years. During this same period, Public Health closed more than 56,000 complaints and ERIs. Although Public Health closed more complaints and ERIs than it received during this two-year period, all four district offices we visited stated that staff worked some overtime to accomplish mandated workload, including completing complaint and ERI investigations.

Table 8
Facility-Related Complaints and Entity-Reported Incidents Received and Closed by District Offices and State Facilities Unit During 2012 and 2013

	OFFICE/FACILITY	NUMBER OF COMPLAINTS AND ENTITY-REPORTED INCIDENTS (ERIs) RECEIVED	NUMBER OF COMPLAINTS AND ENTITY-REPORTED INCIDENTS (ERIs) CLOSED	DIFFERENCE: MORE (FEWER) COMPLAINTS AND ERIs CLOSED THAN RECEIVED
District Office				
1	Bakersfield	3,150	3,334	184
2	Chico	1,687	1,389	(298)
3	East Bay	3,157	3,211	54
4	Fresno	4,287	4,112	(175)
5a	Los Angeles County East*	1,641	1,554	(87)
5b	Los Angeles County North*	1,957	1,629	(328)
5c	Los Angeles County San Gabriel*	2,600	2,132	(468)
5d	Los Angeles County West*	1,571	1,720	149
6	Orange County	2,012	2,370	358
7	Riverside	2,594	2,788	194
8	Sacramento	4,918	6,385	1,467
9	San Bernardino	5,339	7,357	2,018
10	San Diego North	1,677	1,905	228
11	San Diego South	1,738	1,781	43
12	San Francisco	1,762	1,771	9
13	San Jose	2,112	2,146	34
14	Santa Rosa–Redwood Coast	2,088	2,036	(52)
15	Ventura	2,029	2,836	807
	Totals	**46,319**	**50,456**	**4,137**
State Office				
1	State Facilities Unit	7,108	5,570	(1,538)
Statewide Totals		**53,427**	**56,026**	**2,599**

Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's (Public Health) Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014, and the Electronic Licensing Management System as of June 26, 2014.

* Public Health contracts with the Los Angeles County Department of Public Health (LA County) for the licensing and certification function, including the investigation of complaints related to long-term health care facilities in that county. Although Public Health considers LA County to be one district, LA County maintains offices in four geographic locations.

All four district offices we visited stated that they received more facility-related complaints and ERIs than their existing resources allowed them to complete without their working overtime. For example, as Table 8 shows, the San Francisco district office received 1,762 facility-related complaints and ERIs during 2012 and 2013, and it closed 1,771 complaints and ERIs during the same time. However, the district manager told us that district office staff had to

work overtime to sustain this level of production. The Bakersfield, Riverside, and Sacramento district managers also stated they needed to work overtime to keep up with the workload.

With the exception of the Sacramento district office, the remaining three district offices we visited told us that they currently do not have adequate staffing to complete mandated work without their staff working overtime.

In fact, with the exception of the Sacramento district office, the remaining three district offices we visited told us that they currently do not have adequate staffing to complete mandated work without their staff working overtime. In particular, five of the 28 investigator positions authorized for the San Francisco district office were vacant. These positions are responsible for overseeing long-term health care facilities, including investigating facility-related complaints. Additionally, the district manager told us that two investigators were on extended leave as of April 2014. Further, only three of its six authorized supervisory positions were filled. According to the district manager, one of the three supervisors was also on long-term leave, and the other supervisor and the district manager have to perform multiple duties to cover shortages. She stated that the district has been unable to fill its vacant positions for several reasons. For example, the cost of living in the San Francisco Bay Area is very high, state salaries are not competitive with those in the private sector, and the available pool of applicants is small due to other district offices located nearby.

In September 2013 Public Health submitted a proposal to the California Department of Human Resources (CalHR) to revise the health facilities evaluator classification series; this process is referred to as *reclassification.* In addition to suggesting other changes, this proposal memorialized increases for some positions from $7 to $279 per month to the upper limit of the salary ranges for the supervisors and managers of nurse inspectors for long-term health care facilities. According to the interim deputy director, Public Health began the process of reclassifying the investigator supervisor and manager positions at district offices in 2012. She also stated that while the reclassification effort was pending, Public Health initially chose not to give civil service exams to update the eligibility lists for the existing classifications. However, the reclassification process was taking longer than expected, so in July and August 2014 the licensing division re-advertised vacant positions using the existing job classifications. The interim deputy director stated that as of August 2014, Public Health was awaiting approval of the reclassifications from CalHR and was not certain when the reclassification effort will be completed. Finally, she stated that in September 2014 Public Health reopened testing for the existing job classifications.

Public Health has not developed performance measures for its staff—that is, the number of facility-related complaints and ERIs that staff are reasonably expected to complete each month. The interim deputy director stated that since 2010 Public Health has

developed an annual estimate of statewide staffing needs for accomplishing district offices' workload, including licensing and certification activities and their complaint and ERI investigations. However, she acknowledged that Public Health has not developed such estimates for individual district offices. Additionally, she acknowledged that the estimates sometimes failed to accurately project workload and resource needs. She stated that Public Health is reviewing the data it used in prior estimates to improve future estimates. For example, according to the interim deputy director, the estimates did not take into account the time needed to address open facility-related complaints and ERIs, in addition to the new complaints and ERIs that district offices must process. She also stated that the licensing division is working with the staff to ensure accurate data in the timekeeping system. The licensing division plans to use the Automated Survey Processing Environment Complaints/Incidents Tracking System—which is the federal database that CMS requires the State to use for tracking the details of all facility-related complaints and ERIs—to more accurately reflect a district office's workload. The interim deputy director stated that Public Health will consider the recommendations by a consultant it hired when developing new estimates.

In August 2013 Public Health contracted with a consultant to conduct a program assessment and to determine where organizational gaps were occurring. Additionally, the consultant was to create a remediation plan that would facilitate quality improvement activities and improve internal practices for licensing and certification. The remediation plan was to incorporate actionable recommendations, including process and quality improvement initiatives. The remediation plan should allow for a phased-in approach and provide the road map for further, more detailed program assessments.

In August 2014 Public Health received the consultant's report, which recommended, in part, that Public Health develop a staffing model and work plan to ensure appropriate staffing levels across all district offices. According to the interim deputy director, Public Health is developing a plan to address the consultant's recommendations; however, implementing these recommendations is expected to take more than two years. Until Public Health determines and ensures that it has the necessary staffing levels at each district office to address adequately the district office's workload related to licensing and certification of long-term health care facilities, including prompt investigations of complaints, Public Health is hampered in its ability to ensure the safety, health, and well-being of residents living in these facilities.

In August 2014 Public Health received the consultant's report, which recommended, in part, that Public Health develop a staffing model and work plan to ensure appropriate staffing levels across all district offices.

On the other hand, Public Health has performed some assessment of the staffing levels for PCB and requested additional resources. Additionally, it plans to perform a more detailed assessment of PCB's staffing levels. Public Health's data show that PCB, which is responsible for investigating complaints against certain individuals that it certifies, received 1,841 complaints during 2012 and 2013, and it closed 1,578 complaints during the same two-year period—thus increasing the total number of open complaints. Public Health has taken some temporary measures to address the number of PCB's open complaints, including obtaining 18 two-year positions for fiscal years 2014–15 and 2015–16. In its budget change proposal, Public Health noted that despite making some process improvements related to investigating complaints against individuals, it cannot keep current with the number of new, incoming cases if it uses existing staff resources.

Public Health plans to further assess the needs of PCB to promptly address complaints against individuals on an ongoing basis. We believe such an assessment is critical because, beginning in fiscal year 2016–17, PCB will lose all of the two-year positions it received for fiscal years 2014–15 and 2015–16. In September 2014 Public Health entered into a contract with another consultant to assess PCB's current business processes, propose redesign recommendations, and implement improvements to support achievement of the vision, including addressing complaints effectively and in a timely manner. Specifically, the contract calls for addressing identified program challenges to achieve effective management of the complaint workload by enhancing program efforts to resolve existing backlogs, by establishing mechanisms to prevent the future accumulation of open investigations, and by defining processes for managing delayed investigations. The contract specifies that services will be complete by the end of February 2015.

Recommendations

To protect the health, safety, and well-being of residents in long-term health care facilities, Public Health should improve its oversight of complaint processing. Specifically, Public Health should do the following:

- By January 1, 2015, establish and implement a formal process for monitoring the status and progress in resolving open facility-related complaints and ERIs at all district offices. This process should include periodically reviewing a report of open complaints and ERIs to ensure that all complaints and ERIs are addressed promptly.

- By January 1, 2015, improve the accuracy of information in the spreadsheet that PCB uses to track the status of complaints against individuals and review the reports of open complaints to ensure that all complaints are addressed promptly.

- By May 1, 2015, establish a specific time frame for completing facility-related complaint investigations and ERI investigations and inform staff of the expectation that they will meet the time frame. Public Health should also require district offices to provide adequate, documented justification whenever they fail to meet this time frame.

- By May 1, 2015, develop formal written policies and procedures for PCB to process complaints about certified individuals in a timely manner. These policies and procedures should include specific time frames for prioritizing and assigning complaints to investigators, for initiating investigations, and for completing the investigations. Public Health should also inform staff of the expectation that they will meet these time frames. It should require PCB to provide adequate, documented justification whenever PCB fails to meet the time frames.

To ensure that district offices address ERIs consistently and to ensure that they investigate ERIs in the most efficient manner, Public Health should do the following:

- Assess whether each district office is appropriately prioritizing ERIs. Specifically, it should determine, on a district-by-district basis, whether district offices' assigning ERIs a priority level that requires an on-site visit is justified. This assessment should also determine whether each district office is prioritizing ERIs appropriately when determining that on-site investigations are not necessary.

- Use the information from its assessment to provide guidance to district offices by October 1, 2015, on best practices for consistent and efficient processing of ERIs.

- Review periodically a sample of the priorities that district offices assign to ERIs to ensure compliance with best practices.

To protect the residents in long-term health care facilities from potential harm, Public Health should ensure that its district offices have adequate staffing levels for its licensing and certification responsibilities, including staffing levels that allow prompt investigations of complaints. Specifically, Public Health should do the following:

- Continue working with CalHR to complete the reclassification of district offices' investigator supervisor and manager positions and then quickly fill the vacant positions at district offices.

- Complete by May 1, 2015, a staffing assessment to identify the resources necessary for district offices to investigate open complaints and ERIs and to promptly address new complaints on an ongoing basis. Public Health should use this assessment to request additional resources, if necessary.

- Establish by January 1, 2015, a time frame for fully implementing the recommendations that its consultant identified related to the processing of complaints about long-term health care facilities.

Public Health should take steps to ensure that PCB has the resources necessary on an ongoing basis to complete investigations of complaints against individuals. Specifically, Public Health should assess whether the temporary resources it has received are adequate to reduce the number of open complaints to a manageable level. This assessment should also determine whether permanent resources assigned to PCB are adequate to address future complaints. Public Health should use this assessment to request additional resources, if necessary.

Chapter 2

THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH DOES NOT MANAGE THE COMPLAINT INVESTIGATIONS PROCESS EFFECTIVELY

Chapter Summary

The California Department of Public Health (Public Health) did not always follow its procedures to ensure the consistent quality of investigations of complaints and entity-reported incidents (ERIs). For instance, in four of the 10 investigations we reviewed at the San Francisco district office, the office closed complaints and ERIs without appropriate review by a supervisor. None of the four district offices we visited—Bakersfield, Riverside, Sacramento, and San Francisco—consistently collected corrective action plans from facilities in a timely manner, nor did any of the four district offices consistently verify that facilities had implemented corrective actions when required.

Public Health can also do more to ensure that its district offices are conducting complaint and ERI investigations appropriately. Although Public Health performs a secondary review of certain complaint and ERI investigations, recent events indicate a critical need for Public Health to do more to protect residents of long-term health care facilities. Specifically, in 2012 and 2014, the federal Centers for Medicare and Medicaid Services (CMS) identified numerous shortcomings in Public Health's management and oversight of its program responsibilities, in particular its management of complaint investigations. In February 2014 CMS informed Public Health that the Los Angeles County Department of Public Health (LA County)—its contractor for licensing and investigating complaints regarding facilities in Los Angeles County—was using an unsanctioned policy to close complaints and ERIs without properly conducting investigations.

Public Health also did not consistently meet certain legal time frames when investigating complaints and ERIs. The district offices we visited did not always initiate or close investigations within required time frames established in state law or in Public Health's policies. For example, the Sacramento district office did not initiate two of the 10 investigations we reviewed within 10 days, as required. Further, Public Health's Professional Certification Branch (PCB) failed to process appeals of deficiency determinations in a timely manner. In one instance we reviewed, the appeal was heard 1,189 days after the request for appeal was received—substantially longer than the 60 days specified in law. Unless Public Health's investigative determination is effective immediately, individuals

certified by PCB are not prohibited from working in health care facilities while their appeal is processed, meaning that residents may be at risk of inadequate or unsafe care during the appeal period.

Finally, Public Health did not report all statutorily required information to the Legislature in two of the four annual reports we reviewed. Specifically, it omitted from its 2012 and 2013 annual reports information related to the timeliness of its complaint investigations.

Public Health Did Not Always Follow Procedures to Ensure Consistent Quality of Complaint Investigations

One of the four district offices we reviewed did not always ensure that it properly reviewed its investigations. Specifically, the San Francisco district office did not always conduct sufficient supervisory reviews. In each of the four district offices we visited, we also found instances in which the office failed to obtain documentation of the corrective actions completed by facilities. Further, as part of a process to clean up its database, Public Health closed a number of open complaints and ERIs that it had received before 2009 and that had completion dates recorded in the database. However, it did so without first ensuring that those investigations were truly completed and ready for closure and, as a result, it inappropriately closed at least one complaint. Finally, Public Health can do more to ensure that its district offices are appropriately conducting complaint and ERI investigations related to long-term health care facilities. Although Public Health has a process to review certain complaint and ERI investigations by its district offices, it does not routinely review other complaints and ERIs.

One District Office We Visited Did Not Review Some Cases Appropriately, and All Four Failed to Verify That Facilities Implemented Required Corrective Actions

We noted that the San Francisco district office's investigations did not consistently include evidence of supervisory review.

In reviewing investigations of facility-related complaints and ERIs at each district office we visited, we consistently observed evidence of on-site investigations, such as documentation of interviews, observations, and record reviews. However, we noted that the San Francisco district office's investigations did not consistently include evidence of supervisory review. Public Health's policies and procedures require that a supervisor approve the investigation before a complaint or ERI investigation can be closed. These supervisory reviews are important to ensure accuracy and completeness of the complaint packets that document investigations. In reviewing the 10 complaints and ERIs in the

San Francisco district office, we found that four had been closed without sufficient evidence of supervisory review. For three of these complaints, supervisors conducted the investigation and then signed off on their own work. In the fourth complaint lacking evidence of sufficient review, although a workload report indicated that some supervisory review hours were recorded, no supervisor signed off as having reviewed the investigation. The district manager stated that she did not know why a supervisor had not signed off on this investigation.

San Francisco's district office manager also told us that staffing shortages have resulted in supervisors—rather than investigators—regularly completing investigations, and there are not enough supervisors to enable them to review one another's investigations. The district office manager stated that she allows supervisors to sign off on their own work in certain instances. Specifically, she allows this practice when the investigation results in no finding of deficiency or when the investigation identifies a deficiency without actual harm having occurred. However, without supervisory review of investigations, Public Health has no assurance that district offices have completed the investigations appropriately. In addition, this practice is not consistent with Public Health's procedures requiring supervisory approvals of investigations. In the event that staffing shortages require supervisory-level staff to conduct the investigation, the district office should have another supervisor review and approve it. If that is not possible, the district office manager should seek assistance from Public Health's field operations branch to ensure proper reviews. When complaint investigations are not properly reviewed, Public Health cannot ensure that investigators consistently follow procedures and conduct accurate and complete investigations to determine the validity of complaints, identify specific deficiencies requiring corrective action, and verify that facilities implement appropriate corrective actions to ensure appropriate levels of care to residents in long-term health care facilities.

Without supervisory review of investigations, Public Health has no assurance that district offices have completed the investigations appropriately.

Additionally, we found that the four district offices we reviewed did not consistently collect from long-term health care facilities timely corrective action plans or evidence of corrective actions completed, when required, by facilities notified of deficient practices. CMS requirements state that each facility with identified instances of noncompliance must provide an appropriate plan of correction specifying, within 10 days of receiving the notification of deficient practices, how the facility will correct the deficient practice and ensure that it does not recur. The facility must also specify the date by which it will complete the correction. Further, depending on the severity of the noncompliance, Public Health may require facilities to provide evidence of corrective actions taken in lieu of an on-site revisit. However, if actual harm has occurred, Public Health

must reinspect the facility to verify that corrective action was taken. Examples of acceptable evidence of corrective action may include an invoice or receipt confirming purchases or repairs, or it may include sign-in sheets verifying staff attendance at required trainings.

The four district offices we visited did not always ensure that long-term health care facilities submitted acceptable corrective action plans within 10 days, as required.

The four district offices we visited did not always ensure that long-term health care facilities submitted acceptable corrective action plans within 10 days, as required. In 15 of the 40 facility-related complaint and ERI investigations that we reviewed at the four district offices—including the State Facilities Unit, which is colocated with the Riverside district office—the long-term health care facilities submitted corrective action plans from one to 78 days after the required date. For example, the State Facilities Unit investigated one ERI and found that the long-term health care facility failed to ensure that the client received safe, considerate care based on the client's condition when he was allowed to ingest inedible items. However, the facility did not submit a corrective action plan until 88 days after the State Facilities Unit notified it of the deficiencies. When Public Health does not ensure that facilities submit corrective action plans in a timely manner, facilities may prolong their deficient practices unnecessarily.

Further, the district offices did not consistently obtain evidence of the corrective actions taken when required to do so. Specifically, the Sacramento district office failed to obtain evidence of corrective action in all three cases we reviewed that required such evidence. Similarly, the San Francisco district office failed to obtain evidence for all four of the cases we reviewed that required this evidence. For example, investigators in San Francisco cited one facility with a deficient practice related to infection control, and the facility's plan of correction identified staff training on infection control protocols and the administration of injections. Although the severity of this deficiency required the district office to verify that corrective action was taken in lieu of an on-site revisit, San Francisco closed this ERI without obtaining documentation verifying that the facility had implemented its corrective actions. In this instance, the district office could have obtained the class roster for the training as appropriate evidence of compliance, but it did not. A manager at the San Francisco district office stated that district office staff did not realize that collecting evidence of compliance is mandatory for certain deficiencies identified during complaint investigations in addition to staff doing so for recertification surveys. Therefore, the district office did not ensure that their staff collected required evidence of corrective action during 2012 and 2013. However, as a result of several

training sessions from Public Health, the San Francisco manager asserted that the district office has been collecting evidence more consistently since the beginning of 2014.

Similarly, the Bakersfield and Riverside district offices also failed to consistently collect evidence of corrective actions taken by facilities before these district offices closed complaints and ERIs. Bakersfield failed to obtain evidence for five of the six complaints and ERIs that required verification. For example, the Bakersfield district office found that a facility had failed to ensure that two nursing assistants were certified when working on the skilled nursing floor, but it did not collect any documentation to verify the corrective action taken. When its district offices do not obtain evidence of corrective actions when required, Public Health cannot demonstrate that it is complying with federal requirements, and it is not ensuring the safety and well-being of residents in those facilities.

When its district offices do not obtain evidence of corrective actions when required, Public Health cannot demonstrate that it is complying with federal requirements, and it is not ensuring the safety and well-being of residents in those facilities.

The manager of the Bakersfield district office stated that for a case of this nature, she would expect to receive verification that the two identified nursing assistants had valid certifications—and to receive verification that all the nursing assistants in the facility had valid certifications. Nevertheless, the district office staff failed to collect evidence of compliance in this case. Consequently, the Bakersfield district office could not be certain that all nursing assistants working in the facility were qualified to provide proper care for residents needing skilled nursing care. Riverside staff obtained evidence for only two of the three complaints that required verification of corrective action, collecting staff training sign-in sheets as evidence in both these instances, but failing to collect any evidence that corrective action had been taken for the third case.

Although the managers of the district offices in Bakersfield, Riverside, and Sacramento all stated that they were aware of the requirement to verify corrective action taken, they provided various reasons for not complying with the requirement consistently. The manager for the Bakersfield district office indicated that the office's staff erroneously overlooked or forgot to collect evidence consistently from facilities in 2012, but she stated that they have been consistently collecting evidence since the middle of 2013. The manager of the Riverside district office indicated that the office's staff had relied historically on the credibility of the facility to decide what follow-up to conduct. As a result, there was a learning curve, and the Riverside district office started obtaining evidence of corrective action sometime in 2013. The manager for the Sacramento district office cited a competing workload, a backlog of complaint intakes, and a shortage of staff as reasons why the office's staff had not consistently collected evidence of corrective action, and she indicated that at the beginning of 2014, staff were directed to implement the process for obtaining evidence.

Public Health Did Not Have a Process to Verify That Its Administrative Closure of Complaints Was Appropriate

Public Health's headquarters closed administratively 258 open complaints and ERIs that had been received before 2009, but did not first verify with the district offices that these complaints and ERIs were, in fact, complete and should be closed.

As Chapter 1 discusses, Public Health's field operations branch made an effort to understand its open complaints and ERIs, particularly those opened in 2012 and earlier, and to close as many as possible. In December 2013 it identified 9,375 open complaints and ERIs and forwarded them all to the district offices with instructions to determine why they were still open and to give priority to the older complaints and ERIs. In addition, Public Health's headquarters closed administratively 258 open complaints and ERIs that had been received before 2009. The database identified the complaints as open and also included dates identifying the investigations' completion. However, Public Health did not first verify with the district offices that these complaints and ERIs were, in fact, complete and should be closed.

Public Health's interim deputy director stated that the field operations branch made a strategic decision to close these cases administratively because it believed, due to the completion dates recorded in the database, that the risk was low that any of the cases were actually still open after five years or more. She stated that staff at headquarters relied on the information in the database to close the complaints and ERIs, without reviewing the file or verifying with the district offices that they had completed the investigations and sent out all the necessary notifications. Without an adequate process to verify that its administrative closure of complaints and ERIs was appropriate, Public Health may have closed complaints that facilities should have been required to address and, as a result, may have unnecessarily increased risk to residents in these facilities.

As part of our testing, we reviewed three facility-related complaints and three ERIs closed between December 2013 and February 2014 at each of the four district offices we visited. One of these 24 complaints the field operations branch closed administratively. According to the district office manager, although the staff had finished investigating the complaint, they had not had time to close it in accordance with Public Health's policies and procedures. Specifically, the district office supervisor had not yet reviewed and approved the investigation, and staff had not entered the relevant investigation information into the database or sent the required notifications of the outcome to the facility and complainant. Therefore, the district office had not completed this complaint investigation, and the complaint should not have been closed.

Public Health's Oversight of Complaint and ERI Investigations Is Limited

Public Health can do more to ensure that its district offices are appropriately conducting complaint and ERI investigations related to long-term health care facilities. CMS, for which Public Health inspects facilities to ensure compliance with federal standards, identified shortcomings in how Public Health manages its complaint investigation process through letters it issued in 2012 and 2014. In its 2012 letter, CMS indicated that Public Health lacked policies and procedures governing its investigation of complaints, and CMS directed Public Health to address this issue. Its 2014 letter stated, among other things, that Public Health needed to develop a plan to ensure consistency of the intake process for its district offices and evaluate complaint processes at all district offices with federal protocols, including improving timely closure of complaint investigations.

When we discussed district office oversight with Public Health, the acting assistant deputy director of the Center for Health Care Quality (acting assistant deputy director) stated that district office managers do not need specific directions on how to manage their facility-related complaint and ERI workload. He further stated that the managers clearly know the statutory mandates to initiate long-term health care complaints and that there are no statutory mandates to complete long-term health care complaints or ERIs. He explained that the district office managers must balance their workforce with all the competing priorities within the district office in the most efficient manner. He stated that some activities take precedence over others, and it is up to the managers to strike the balance.

Although Public Health's quality improvement section has a process to review certain complaint and ERI investigations—those that a district office identifies as having deficiencies that resulted in actual harm to residents of long-term health care facilities and those stemming from cases assigned the priority level *immediate jeopardy*—it does not routinely review other complaints. As a result, it cannot ensure that district offices are complying with its policies and with federal and state law when investigating these other complaints. As we described earlier, we found that the San Francisco district office did not conduct appropriate supervisory reviews of its complaint and ERI investigations in four of the 10 complaints and ERIs we reviewed. However, under its current policies, management at Public Health's headquarters would never see these investigations to be able to detect the types of deficiencies we found, because none of the investigations fit its criteria for review. The acting chief of field operations stated that it would be beneficial for the quality improvement section to randomly sample investigations for quality and adherence to policy.

Although Public Health's quality improvement section has a process to review certain complaint and ERI investigations, it does not routinely review other complaints.

Public Health's limited review and oversight of its complaint and ERI investigations increases the risk that district offices could deviate from its policies and procedures for investigating complaints without detection, as Public Health found in February 2014. According to the acting assistant deputy director, in February 2014, Public Health learned from CMS that it had received press inquiries indicating that LA County may be inappropriately closing complaints without properly conducting investigations. As the Introduction describes, Public Health maintains a contract with LA County to perform its licensing and certification function as well as to carry out investigations of complaints and ERIs against long-term health care facilities located within the county. Public Health retains responsibility for establishing program policies and for supervising and overseeing LA County's conduct of the licensing and certification surveys performed under the contract. Public Health learned that LA County was using an unsanctioned policy that advised staff to close administratively any complaint generated by an anonymous complainant or complaints without a listed complainant and to prioritize such complaints as *no action necessary.* LA County discontinued its use of the unsanctioned policy on February 28, 2014, at the direction of Public Health.

Subsequently, a news article published in March 2014 reported on the unsanctioned policy, stating that LA County officials had told investigators to close cases without fully investigating them. The news article spurred the Los Angeles County Board of Supervisors to direct the Los Angeles County Department of Auditor-Controller (LA County Auditor) to conduct an audit of LA County's complaint investigations. The audit findings were published in two reports in April and August 2014.

The LA County Auditor identified 3,044 open investigations in the county—945 had been open for more than two years—and concluded that the county does not centrally monitor open investigations, the time frame for staff to complete investigations, or the number of hours it takes to complete investigations.

The LA County Auditor identified 3,044 open investigations in the county—945 of which had been open for more than two years—and it concluded that the county does not centrally monitor open investigations, the time frame for staff to complete investigations, or the number of hours it takes to complete investigations. Additionally, the LA County Auditor found that the county does not have a mechanism to effectively manage its overall district workload that would enable it to identify the status of the investigations or evaluate the reasons for the delays in investigations. The LA County Auditor also found that in several instances the county inappropriately closed cases without conducting or completing the investigations when an on-site investigation was required. We describe the findings and recommendations from the LA County Auditor's reports in more detail in tables A.1 and A.2 beginning on page 62 in Appendix A.

In its April 2014 letter to Public Health, CMS identified concerns with the activities occurring at the LA County district office and issued a number of directives to Public Health indicating areas in which it must improve. One of those directives required Public Health to provide CMS with a plan for managing LA County's contract by June 2014. As a result, Public Health conducted a quality review of complaints investigated by LA County. The report states that LA County's unsanctioned policy of complaint closure had limited impact, as only two of the 18 complaints it reviewed had been closed as a result of the unsanctioned policy. However, it also found that incorrect prioritization of complaints led to delayed investigations of serious allegations, including one *immediate jeopardy* complaint and two *non-immediate jeopardy (high)* complaints that LA County had not investigated. The interim deputy director indicated that Public Health later reviewed these complaints and determined that all three complaints were unsubstantiated with no deficiencies. In addition, the report states that insufficient supervisory review and investigator knowledge resulted in incomplete investigations and incomplete application of the requirements for documentation of deficiencies. Table A.3 on page 64 in Appendix A describes the findings and recommendations of Public Health's quality review in more detail.

When asked about Public Health's limited oversight of LA County, the acting assistant deputy director stated that Public Health's oversight and monitoring of LA County were lacking in the past and could be improved. The interim deputy director stated that having a contract for the work performed by LA County requires some balancing and that Public Health did not want to dictate to LA County how to perform the services as long as the county could produce the deliverables in the contract. For example, the contract requires monthly survey workload and quality assurance reports. Nevertheless, Public Health's limited review and monitoring of LA County's work increases the risk that the county could be performing investigations that do not comply with Public Health's policies and procedures, federal requirements, and the law.

The interim deputy director stated that the backlog of open cases and the management issues highlighted in the April 2014 LA County audit were known to Public Health before the release of the audit. She stated that, given the recent incidents, Public Health has increased its management and oversight of LA County. The interim deputy director also stated that Public Health is working with LA County to improve their processes and ensure adherence to Public Health policy. Further, she said that Public Health has placed temporary on-site management at the county to provide additional oversight.

Public Health has placed temporary on-site management at LA County to provide additional oversight.

Public Health Did Not Meet Certain Required Time Frames for Investigating and Closing Complaints and ERIs

District offices we visited either did not consistently initiate investigations or close complaints and ERIs within required time frames established in state law or in Public Health policy. Both CMS requirements and state law require Public Health to meet certain time frames when initiating an on-site investigation of a complaint from the public about a facility. Public Health follows the state law, which is more stringent than CMS requirements. Specifically, state law requires that Public Health initiate an investigation by visiting the facility within 24 hours of receiving a complaint that involves a threat of imminent danger of death or serious bodily harm, which Public Health would prioritize as *immediate jeopardy.* Unless Public Health determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, state law also requires that Public Health initiate an investigation by visiting the facility within 10 days of receipt for all complaints from the public.

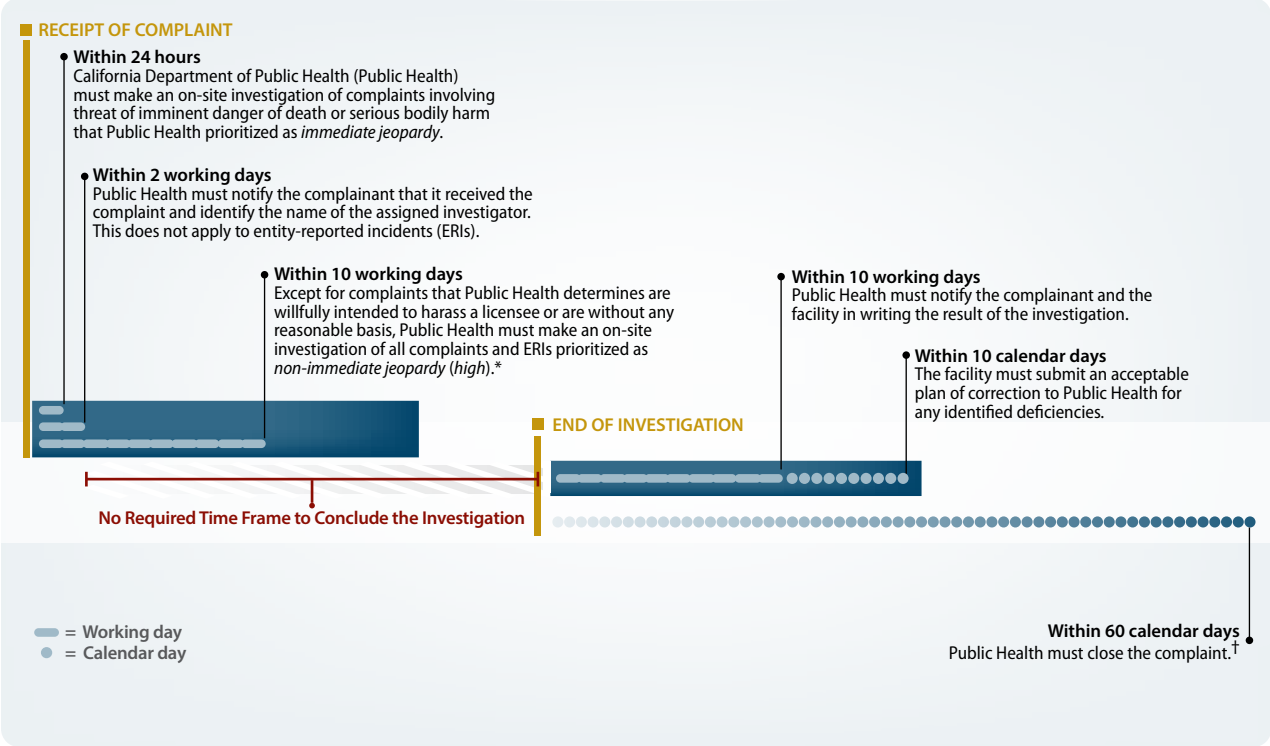
For ERIs, CMS requirements and Public Health's policies require district offices to follow the same requirements for ERIs prioritized as *immediate jeopardy* and *non-immediate jeopardy (high)* as those for facility-related complaints with the same prioritization. Although Public Health's policy requires district offices to conduct on-site investigations for ERIs prioritized as *non-immediate jeopardy (medium)*, it does not specify time frames for making the site visit. For ERIs prioritized as *non-immediate jeopardy (low)*, CMS requirements and Public Health's policy specify that district offices must investigate such incidents during the next on-site survey for that facility. When an ERI is prioritized as *administrative review,* Public Health's policy does not require an on-site visit or a time frame for initiating the review. Finally, district offices may close any ERI prioritized as *no action necessary* without any investigation.

After a district office completes an investigation of a facility-related complaint, state law requires it to notify the complainant and the long-term health care facility in writing of the results of the investigation within 10 working days. Additionally, Public Health's policy requires district offices to close a facility-related complaint within 60 calendar days after completing an investigation.[2] Under federal regulations, closing a facility-related complaint generally requires the facility involved to submit an acceptable plan of correction for deficient practices that Public Health identified through its investigation within 10 calendar days.

[2] Before May 2012 Public Health's recommended time frame to close complaints after completing investigations was 30 working days.

In 2012 Public Health aligned its policies more closely with CMS requirements, specifying that district offices must require facilities, depending on the severity of the noncompliance, to submit documentation that they had implemented their plans of correction. In lieu of a revisit to verify corrective action, district offices obtain evidence of corrective action for certain less serious deficiencies—specifically, for those without a finding of substandard quality of care, with no actual harm, and with potential for more than minimal harm that is not immediate. Figure 3 shows key time frames for Public Health's investigation of facility-related complaints.

Figure 3
Key Time Frames for Various Aspects in the Investigation of Complaints Against Long-Term Health Care Facilities and Entity-Reported Incidents



Sources: California Health and Safety Code, Section 1420(a); Public Health's Licensing and Certification Division's *Complaint Policy and Procedures Manual*; and the federal Centers for Medicare and Medicaid Services' *State Operations Manual* (CMS requirements).

* Although Public Health's policy requires an on-site investigation of ERIs prioritized as *non-immediate jeopardy* (*medium*), it does not specify time frames for making the site visit. Further, CMS requirements and Public Health's policy specify that district offices must investigate ERIs prioritized as *non-immediate jeopardy* (*low*) during the next on-site survey for that facility.

† Before May 2012 Public Health's recommended time frame to close the complaint was 30 working days after completion of the investigation.

State law provides a right of review for a complainant who is dissatisfied with the outcome of an investigation. Specifically, a complainant may request in writing an informal conference after he or she receives the results of the investigation. The informal conference is held with a designee for the county in which the facility is located—usually the manager for the local district office, according to the interim deputy director. If dissatisfied with the determination of the designee, the complainant may appeal the decision to the deputy director of Public Health's licensing division. The deputy director assigns the appeal to the complaint appeals unit for a review of the facts that led to the initial determination and the decision of the designee. Within 60 days of receiving a request for appeal, the deputy director must make a determination based upon this review and must notify the complainant and the facility within 30 days of reaching the determination. State statute does not provide for appeals beyond Public Health's deputy director.

In our review of 10 investigations of complaints and ERIs at the Sacramento district office, we found that the office did not initiate investigations of two ERIs within the required time frames.

In our review of 10 investigations of complaints and ERIs at the Sacramento district office, we found that the office did not initiate investigations of two ERIs within the required time frames. Specifically, the district office assigned these two complaints a priority of *non-immediate jeopardy (high),* for which Public Health's policy requires the district office to initiate an on-site investigation within 10 working days. However, the district office initiated one investigation nearly nine months after the facility reported a fall sustained by a 97-year-old resident, and it initiated another investigation 14 months after the facility reported the incident—in both cases well outside the 10-working-day requirement. According to the district office manager, Sacramento did not have adequate staffing at that time to conduct on-site investigations for these complaints within the required time frame.

Further, Table 9 shows that the three other district offices we visited did not always meet the required time frames for required notifications. Specifically, the Bakersfield and San Francisco district offices and the State Facilities Unit colocated in the Riverside district office did not always notify within 10 working days following an investigation's completion the relevant facility and complainant about the results of the respective district office's investigation. For example, San Francisco failed to meet these timing requirements in three of the 10 complaints we reviewed, in one case sending the notification more than three months after it completed its investigation. A district office manager in San Francisco stated that the district office had no particular reason for the delays but suggested that staffing shortages may have been a factor.

Table 9
Number of Facility-Related Complaints and Entity-Reported Incidents for Which the California Department of Public Health Did Not Comply With Required Time Frames, by District Office Reviewed

	DISTRICT OFFICE (NUMBER OF COMPLAINTS REVIEWED)*				
DESCRIPTION OF NONCOMPLIANCE	BAKERSFIELD (10)	RIVERSIDE/ STATE FACILITIES UNIT† (10)	SACRAMENTO (10)	SAN FRANCISCO (10)	TOTAL
The California Department of Public Health (Public Health) did not notify complainants within two working days that it had received their complaints.‡	-	-	-	1	**1**
Public Health did not initiate on-site investigations within required time frames.	-	-	2	-	**2**
Public Health did not notify complainants and long-term health care facilities within 10 working days following completion of their respective investigations about the outcome of those investigations.	2	1	-	3	**6**
Public Health did not close the complaints within 60 days of completing the relevant investigations.§		2	-	3	**5**
Totals	**2**	**3**	**2**	**7**	**14**

Source: California State Auditor's analysis of Public Health's complaint files.

* We reviewed five complaints and five entity-reported incidents (ERIs) at each of the four district offices we visited.

† The State Facilities Unit is colocated with the Riverside district office. The exceptions are related to the State Facilities Unit.

‡ This requirement applies only to complaints and not ERIs.

§ Before May 2012 Public Health's recommended time frame to close a complaint was 30 working days.

When Public Health's district offices do not comply with required time frames for initiating complaint investigations, it may expose residents in long-term health care facilities to unnecessary risks of inappropriate treatment or unsafe conditions, because there is a delay in identifying deficiencies that the facility needs to address. Further, when Public Health's district offices fail to communicate the outcomes of investigations to facilities within required time frames, they are not ensuring that the facilities promptly address any deficiencies identified; therefore, residents may continue to be at risk of inadequate or unsafe care. Additionally, late communication of investigation results delays complainants' opportunity to request an informal hearing to challenge the results of the investigation or to appeal determinations they believe were made in error, thus delaying the prompt mitigation of those factors causing inappropriate treatment or unsafe conditions for residents of long-term health care facilities.

Our review also found that Public Health's PCB did not comply with statutory time frames governing appeals of investigative determinations against individuals—nurse assistants and home health aides—certified by Public Health. Specifically, state law requires Public Health to hold a hearing within 60 days of the receipt of a written request for an appeal of an investigative

determination against a certified individual. State law also requires that within 30 days of the hearing, Public Health must notify in writing the certified individuals about the determination of the appeal.

In all 10 appeals we reviewed, hearings were not held within 60 days, as required. When Public Health does not ensure that the appeal hearing is conducted promptly, residents in facilities may be at risk.

Public Health failed to comply with both of these requirements in the appeals we reviewed. Public Health contracts with the California Department of Health Care Services (Health Care Services) to provide an administrative hearing process to adjudicate such appeals. In all 10 appeals we reviewed, hearings were not held within 60 days, as required. The time between the appeal request and the hearings for the 10 appeals ranged from 136 to 1,189 days. Further, Health Care Services was slow to make its determinations after holding the hearings, resulting in Public Health not meeting the required time frame of 30 days to notify certified individuals of the outcome in seven of the nine appeals that we reviewed where Health Care Services heard the appeal. In one case, Health Care Services took 73 days—or 43 days longer than allowed—to make its determination of the appeal. Unless Public Health's investigative determination is effective immediately, individuals who are the subject of investigations and are appealing Public Health's investigative determinations are not prohibited from working in facilities until the appeals are adjudicated.[3] Therefore, when Public Health does not ensure that the appeal hearing is conducted promptly, residents in facilities may be at risk.

When we asked Public Health about its contractor's noncompliance with statutory time frames, Public Health's assistant chief counsel stated that these timing requirements do not apply. Specifically, Public Health's legal counsel indicated that state law requiring it to hear appeals and make notifications of determinations within certain time frames is superseded by provisions that require application of the Administrative Procedures Act (APA), which contains no such timing requirements. However, our legal counsel advised us that Public Health's interpretation of the law is incorrect for two reasons. First, rules of statutory construction provide that significance should be given to every word in a statute, which must be read in the light of its historical background and evident objective. The statutory requirements concerning time deadlines for hearings affecting these individuals specifically state that APA procedures apply unless those procedures conflict with the specific statutory provisions governing appeals by nurse assistants and home health aides. Because the statutory time deadline for hearing an appeal clearly conflicts with otherwise applicable APA provisions, we conclude that the deadline supersedes the APA.

[3] State law provides statutory authority to revoke or suspend a certificate before a hearing when immediate action is necessary to protect the public welfare. A certificate is needed to work in a facility.

Second, when two laws upon the same subject are passed at different times and are inconsistent with each other, the one last passed must prevail. In this case, the pertinent section referring to the APA was enacted in 2007 and has not been amended since. The section of state law prescribing the time frames for Public Health was last amended in 2013, at which time the Legislature declined to remove the 60-day time requirement, thereby evidencing an intention to preserve this provision. When Public Health does not ensure that it complies with statutory requirements for processing appeals, individuals who are the subject of complaints may continue to work in long-term health care facilities unless Public Health's determination is effective immediately, which may put residents at risk of mistreatment or inadequate care.

Public Health Did Not Report All Statutorily Required Information to the Legislature

Public Health failed to report to the Legislature information related to the timeliness of its complaint investigations for two of the four annual reports we reviewed. Specifically, state law requires that Public Health submit to the Legislature, on or before February 1 of each year, a report identifying, among other things, the number and timeliness of the investigations of facility-related complaints. Thus, Public Health must at least report on the number of facility-related complaints it investigated during the year and on the number of those complaints it initiated within the required time frame. Although it reported the number of facility-related complaints requiring investigations for all of the four most recent annual reports, Public Health omitted any information related to the timeliness of its complaint investigations in the reports it submitted to the Legislature in 2012 and 2013. The reports it submitted in 2011 and in 2014 contained this information. When Public Health does not include the required information in its reports, the Legislature does not have complete information to make fully informed decisions.

Public Health omitted information related to the timeliness of its complaint investigations in the reports it submitted to the Legislature in 2012 and 2013.

The omissions were due to a lack of oversight by Public Health management. The acting assistant deputy director stated that he was not sure why the annual reports did not include the necessary information. He stated that management may have been remiss in checking the reporting requirement statute, and he has since included the branch chief for policy and regulations in the report review process as well as convened a working group in 2013 to review Public Health's various legislative reporting requirements.

Public Health submitted two of the four annual reports we reviewed more than a month late. Specifically, it submitted the report in 2011 approximately seven months late and the report due in 2012 nearly two months late. The chief of the resources and operations

management branch acknowledged that Public Health has not always submitted its reports on time and stated that last-minute changes and additional analyses requested by various offices prevented the report from being submitted by the statutory due date. Public Health's failure to submit reports on time may delay the Legislature's ability to make timely decisions.

Recommendations

To ensure that its district offices properly investigate complaints and ERIs, Public Health should make certain that all district offices follow procedures requiring supervisory review and approval of complaint and ERI investigations. If the district offices do not have a sufficient number of supervisors to review investigations they did not conduct, Public Health should arrange to assist the districts until such time that they do have a sufficient number of supervisors.

To make certain that its district offices comply with federal requirements regarding corrective action plans, Public Health should establish a process for its headquarters or regional management to inspect district office records periodically to confirm that they are obtaining corrective action plans according to the required time frame and verifying that facilities have performed the corrective actions described in the plans when required.

To ensure that it has closed complaints and ERIs appropriately, Public Health should take steps by April 2015 to verify that complaints that its field operations branch closed administratively were closed appropriately. For example, it could request the district offices to verify that the closures were appropriate.

To improve oversight of its district offices' complaint and ERI investigation process, Public Health should increase its monitoring of the district offices' compliance with federal and state laws as well as with its policies. For example, Public Health could accomplish this by directing its regional managers to spend more time at the district offices to enforce district office compliance with policies, or by directing its quality improvement section to review a random sample of investigations for quality and adherence to policy. Public Health should further establish a formal process to review periodically LA County's compliance with the terms of its contract, including compliance with the terms for investigating complaints.

To better protect the safety of residents in long-term health care facilities, Public Health should direct its district offices to comply with required time frames for initiating and closing completed investigations. If a district office lacks sufficient resources to initiate

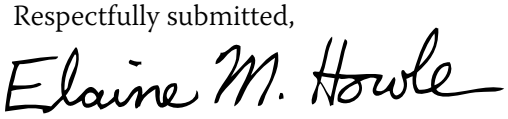
or close investigations within those time frames, Public Health should arrange to assist that district until such time that the district complies with the statute.

To make certain that it complies with statutory time frames for adjudicating appeals related to individuals, Public Health should establish a process to monitor its contractor's performance with contract terms.

To ensure that the Legislature promptly receives information about the timeliness of Public Health's complaint processing related to long-term health care facilities, Public Health should continue to include all of the statutorily required information in its annual report and submit it by the due date.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Date: October 30, 2014

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

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Appendix A

RESULTS OF TWO RECENT AUDITS AND ONE REVIEW OF LOS ANGELES COUNTY'S COMPLAINT INVESTIGATIONS

The California Department of Public Health (Public Health) contracts with the Los Angeles County Department of Public Health (LA County) to investigate complaints related to long-term health care facilities located within Los Angeles County. In March 2014 media in Los Angeles reported that LA County's management had instructed staff to close administratively many complaints without fully investigating them.

In February 2014 Public Health initiated a quality review of LA County to assess the county's compliance with state and federal policies regarding investigations of complaints and entity-reported incidents (ERIs) and case closure. The Los Angeles County Board of Supervisors also directed the Los Angeles County Department of Auditor-Controller (LA County Auditor) to audit LA County's investigation activities. The following sections summarize the audits of the LA County Auditor and the review performed by Public Health.

Summary of the LA County Auditor's Reports

In April 2014 the LA County Auditor released the first of two audit reports on the quality and integrity of nursing home investigations by LA County. This audit focused on four key areas: the backlog of complaint investigations as of March 2014, the reasons for the backlog, the resources needed to promptly address the backlog, and LA County's corrective action plan to address the backlog. Table A.1 on the following page lists the findings and the related recommendations related to those findings for the April 2014 report.

Table A.1
Summary of the Los Angeles County Department of Auditor-Controller's April 2014 Report

REPORT FINDING	SELECTED RECOMMENDATIONS TO LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH MANAGEMENT
As of March 14, 2014, the Los Angeles County Department of Public Health's Health Facilities Inspection Division (division) had 3,044 open investigations. Approximately 1,103 of these investigations had been open for more than 12 months, with 945 of the 1,103 cases open for more than two years. Further, the division does not centrally monitor open investigations by the dates received, the time frame for staff to complete investigations, or the time or number of hours it takes to complete investigations.	Generate an aging report from the information in the Automated Survey Processing Environment Complaint Tracking System (ACTS), centrally manage the open investigations by the date received and priority, and require district managers to provide division management with justifications for the delays and corrective action plans for closing older investigations in a timely manner.
	Consider working with the state and federal governments to generate various reports (such as aging reports) directly from ACTS.
The division is not monitoring its expenditures to ensure that it maximizes the funding available under the state contract. The division estimates that it will not bill approximately $1.2 million of the $26.9 million available on the contract. Further, for fiscal years 2011–12 and 2012–13 the division did not spend approximately $2.8 million and $2.4 million, respectively.	Monitor the division's expenditures to fully expend the state contract's budgeted allocations.
The division is not able to identify the number of full-time equivalent (FTE) positions currently performing investigations, or the total number of FTE positions needed to ensure that investigations are completed in a timely manner.	Identify the total FTE staff needed to complete the current and pending investigations in compliance with the state contract.
	Request and provide support for a budget increase from the State to fund the additional positions, if needed.
Division management does not have a mechanism that would give it the ability to identify the status of investigations or evaluate the reasons for delays so that it could effectively oversee the overall district workload.	Establish and implement a centralized mechanism to manage and track the status of individual investigations and overall workload.
	Require the division's district office managers and supervisors to report monthly to management the status of their investigations.
	Evaluate disparities in the number of hours required to complete investigations.
Neither the state contract nor the division identifies specific time frames for staff to complete investigations after initiating them.	Establish benchmarks, budgets, and due dates to ensure that investigations are performed within reasonable time frames and are closed in a timely manner.

Source: Los Angeles County Department of Auditor-Controller's audit of the quality and integrity of nursing home investigations in Los Angeles County, April 2014.

In August 2014 the LA County Auditor released the second of its two audit reports. This report focused on evaluating the quality and integrity of nursing home investigations and whether LA County is complying with applicable guidelines for initiating, conducting, reviewing, and closing investigations. Table A.2 lists the findings and the related recommendations for the August 2014 report.

Table A.2
Summary of the Los Angeles County Department of Auditor-Controller's August 2014 Report

REPORT FINDING	SELECTED RECOMMENDATIONS TO LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH MANAGEMENT
For the 50 open and closed complaint and entity-reported incident (ERI) case files reviewed, four (8 percent) were entered into the Automated Survey Processing Environment Complaint Tracking System (ACTS) up to four workdays after receipt of the complaints and ERIs. The four were not prioritized as *immediate jeopardy*; however, since they were all received on county business days, they should have been entered into ACTS on the day they were received.	The Los Angeles County Department of Public Health's Health Facilities Inspection's Division's (division) management should ensure that all complaints and ERIs are entered into ACTS upon receipt.
For six (12 percent) of the 50 complaint and ERI cases files reviewed, the division did not document the justification for designating a priority that was less severe than the priority recommended by the State. Three (50 percent) of the six cases involved complaints or ERIs that could be considered *immediate jeopardy* to the nursing home residents, which would have required the investigators to initiate an investigation within 24 hours. However, since the division managers selected a lower priority, the surveyors had up to 10 days to initiate the investigations.	Division management should ensure that complaints and ERIs are prioritized in accordance with state guidelines and that the justification for prioritizing the complaints and ERIs is documented.
For 12 (40 percent) of the 30 closed case files reviewed, supervisors deleted or downgraded the investigators' recommended deficiencies and citations. Five (42 percent) of the 12 cases involved the deaths of residents as young as three years old. Nine (75 percent) of the 12 case files lacked documentation to support the downgrading, deletions, or both of the deficiencies and citations by the supervisors or the division's Consulting Unit's physicians. In four (33 percent) of the cases, the supervisors did not discuss the changes with the investigators as required. In five (42 percent) of the cases, the district manager who deleted or downgraded the citation or deficiencies could not provide justification for the changes.	Division management should: • Ensure that all staff who review and approve the investigators' recommended deficiencies and citations, appropriately document the justification for approving or changing the investigators' results. • Ensure that review staff discuss all changes to investigators' recommended deficiencies and citations and that investigators gather missing evidence, as appropriate, to support their results before downgrades are made and cases are closed.
The division did not issue the Results of Complaint Investigation Letter (letter) to three (15 percent) of the 20 complainants, as required, and also did not issue letters to two (10 percent) of the complainants within the required time frame.	Division management should comply with state requirements and issue the letter to the complainants within 10 business days of the formal exit, as required.
For five (17 percent) of the 30 closed case files reviewed, the division closed the cases inappropriately without conducting or completing the investigations when on-site investigations were required. In one instance, the division closed the case before it was investigated. According to the division, the case was closed because the complaint was withdrawn. However, the case file did not contain documentation to show who withdrew the complaint or when it was withdrawn.	Division management should: • Establish a policy for staff to validate and document withdrawals of complaints and incidents. • Ensure that on-site investigations are completed appropriately for all complaints and ERIs in accordance with the state contract.
For one (5 percent) of the 20 open cases reviewed, the division did not reassign the investigation when the investigator retired in January 2014. As of May 2014 the division had not reassigned this case or any of this investigator's other open cases.	Division management should reassign open investigations promptly when investigators retire or are transferred.
The division could not locate two (6 percent) of the 32 closed case files that were originally requested.	The division management should ensure that an inventory of closed cases is maintained and closed cases are purged in accordance with the state requirements.

Source: Los Angeles County Department of Auditor-Controller's audit of the quality and integrity of nursing home investigations in Los Angeles County, August 2014.

Summary of Public Health's Review of LA County

In February 2014 Public Health learned that LA County had implemented an unsanctioned policy for the closure of complaint investigations. In March 2014 Public Health's Staff Education and Quality Improvement Section, part of the Licensing and Certification Division, conducted a review of 136 complaint files, interviewed LA County staff, and observed the LA County offices

around the county to assess the county's compliance with state and federal complaint investigation and closure policies. In June 2014 Public Health released its report on the quality and integrity of nursing home complaints investigated by LA County between January 1, 2009, and December 31, 2013. Table A.3 identifies the findings and recommendations related to Public Health's June 2014 report.

Table A.3
Summary of the California Department of Public Health's Review of the Los Angeles County Department of Public Health

FINDING	RECOMMENDATION
The unsanctioned policy of case closure at Los Angeles County Department of Public Health (LA County) had limited impact. Although the California Department of Public Health (Public Health) determined that LA County's compliance with state and federal policies for complaint closure was deficient, Public Health identified only two cases in which the unsanctioned policy's implementation was responsible for the lack of compliance.	No recommendation. Public Health had previously directed LA County to stop its unsanctioned policy requiring case closures.
Incorrect prioritization led to delayed investigations. LA County's deficient practices for complaint and entity-reported incident (ERI) prioritization delayed investigations of serious allegations, including one prioritized as *immediate jeopardy* and two prioritized as *non-immediate jeopardy* (*high*) that LA County did not investigate.	Public Health should immediately initiate investigations of the three complaints and ERIs identified as uninvestigated *immediate jeopardy* or *non-immediate jeopardy* (*high*) allegations. Experienced Public Health investigators or supervisors should conduct and review these investigations.
LA County was deficient in implementing the Principles of Investigation and Documentation. Insufficient supervisory review and investigator knowledge deficits resulted in incomplete complaint and ERI investigations and inconsistent application of requirements related to the documentation of deficiencies.	LA County and Public Health should require retraining for all LA County investigators and supervisors to retrain on applying the Principles of Investigation and Documentation.
LA County failed to prioritize and manage complaints and ERIs appropriately. LA County's processes for complaint and ERI intake, prioritization, and assignment, and its methods for monitoring the progress of open cases, are inconsistent among its offices.	LA County should ensure that all of its offices consistently follow state policies and procedures related to intake, prioritization, and assignment. LA County should provide standardized training to support staff and supervisors on these processes.
	LA County should develop and implement a standardized system for all of its offices to enable supervisors and managers to track the initiation and status of open cases.
	LA County and Public Health should require retraining for supervisors related to appropriate supervisory review of complaint and ERI investigations.
	LA County should develop a system to monitor staff's training needs, including compliance with mandatory training requirements and the need for refresher training. This system should include a post-training quality review process that enables LA County managers and supervisors to identify when competencies have not yet been established and refresher training is needed.

Source: Public Health's quality review of the LA County investigations of long-term care complaints, June 2014.

Appendix B

NUMBER OF OPEN AND SUBSTANTIATED COMPLAINTS AND ENTITY-REPORTED INCIDENTS

The California Department of Public Health (Public Health) investigates complaints against long-term health care facilities, entity-reported incidents (ERIs) that are self-reported by long-term health care facilities, and complaints against certain individuals—nurse assistants and home health aides—whom it certifies. As Chapter 1 discusses, Public Health has many open complaints and ERIs that have languished for long periods. Our audit focused primarily on a two-year period from January 2012 through December 2013. During this time, Public Health made some efforts to reduce the number of open complaints and ERIs. Table B.1 on the following page shows the number of complaints and ERIs, by age, that remained open as of the beginning of 2012, the end of 2013, and in April 2014, when we received the complaint and ERI data from Public Health. As Table B.1 shows, Public Health has generally reduced the numbers of complaints and ERIs that have remained open for more than one year. Further, Table B.2 on page 67 shows the number of facility-related complaints and ERIs active during 2012 or 2013 that Public Health substantiated. Finally, Public Health substantiated 253 of 2,531 active complaints against nurse assistants and home health aides during 2012 or 2013.

Table B.1
Aging of Open Complaints and Entity-Reported Incidents at Three Points in Time

	NUMBER OF MONTHS OPEN								
	<2	2 – 4	4 – 6	6 – 12	12 – 18	18 – 24	24 – 36	>36	TOTAL
Entity-Reported Incidents (ERIs)									
January 2012	1,685	1,294	1,040	2,183	1,110	724	601	748	**9,385**
December 2013	1,871	1,282	900	1,700	586	311	200	383	**7,233**
April 2014	1,434	1,049	766	1,835	555	307	181	219	**6,346**
Percent Change January 2012 to April 2014	(15%)	(19%)	(26%)	(16%)	(50%)	(58%)	(70%)	(71%)	**(32%)**
Complaints Against Long-Term Health Care Facilities									
January 2012	711	617	507	937	455	396	540	406	**4,569**
December 2013	660	550	399	770	487	330	560	366	**4,122**
April 2014	707	444	320	818	438	328	488	254	**3,797**
Percent Change January 2012 to April 2014	(1%)	(28%)	(37%)	(13%)	(4%)	(17%)	(10%)	(37%)	**(17%)**
Complaints Against Certified Individuals									
January 2012	112	142	160	335	-	-	-	-	**749**
December 2013	123	148	129	283	216	97	1	-	**997**
March 2014	223	117	95	293	163	88	8	-	**987**
Percent Change January 2012 to March 2014	99%	(18%)	(41%)	(13%)	-	-	-	-	**32%**
Total Complaints and ERIs									
January 2012	2,508	2,053	1,707	3,455	1,565	1,120	1,141	1,154	**14,703**
December 2013	2,654	1,980	1,428	2,753	1,289	738	761	749	**12,352**
April 2014*	2,364	1,610	1,181	2,946	1,156	723	677	473	**11,130**
Percent Change January 2012 to April 2014	6%	(22%)	(31%)	(15%)	(26%)	(35%)	(41%)	(59%)	**(24%)**

Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's Professional Certification Branch's (PCB) investigation section's Case Management Spreadsheet from January 1, 2011, through March 31, 2014, and the Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014.

Notes: PCB is responsible for certifying three types of health professionals and for licensing another type, and for investigating complaints against these health professionals. However, our audit and this table focus on individuals certified as nurse assistants or home health aides who were the subjects of 97 percent of complaints that PCB received in 2012 and 2013.

* The number of open complaints includes ERIs and complaints against long-term health care facilities as of April 2014 and complaints against individuals as of March 31, 2014.

Table B.2
Number of Substantiated Complaints and Entity-Reported Incidents Related to Long-Term Health Care Facilities Active During 2012 or 2013

	OFFICE/FACILITY	COMPLAINTS	ENTITY-REPORTED INCIDENTS
District Office			
1	Bakersfield	264	934
2	Chico	324	1,000
3	East Bay	497	838
4	Fresno	245	749
5a	Los Angeles County East*	206	562
5b	Los Angeles County North*	262	134
5c	Los Angeles County San Gabriel*	147	533
5d	Los Angeles County West*	549	256
6	Orange County	337	236
7	Riverside	363	623
8	Sacramento	825	1,462
9	San Bernardino	596	1,254
10	San Diego North	273	533
11	San Diego South	367	565
12	San Francisco	177	646
13	San Jose	362	1,071
14	Santa Rosa–Redwood Coast	293	631
15	Ventura	250	162
State Office			
1	State Facilities Unit	82	1,511
Statewide Totals		**6,419**	**13,700**

Sources: California State Auditor's analysis of data obtained from the California Department of Public Health's (Public Health) Automated Survey Processing Environment Complaints/Incidents Tracking System as maintained by the Department of Health and Human Services' Centers for Medicare and Medicaid Services as of April 11, 2014, and the Electronic Licensing Management System as of June 26, 2014.

* Public Health contracts with the Los Angeles County Department of Public Health (LA County) for the licensing and certification function, which includes investigations of complaints related to long-term health care facilities in that county. Although Public Health considers LA County to be one district, LA County maintains offices in four geographic locations.

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State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

October 3, 2014

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Enclosed is the California Department of Public Health's (CDPH) response to the Bureau of State Audits draft report, "California Department of Public Health: It Has Not Effectively Managed Investigations of Complaints Related to Long-Term Health Care Facilities" Report 2014-111, October 2014

Thank you for the opportunity to respond. If you have questions, please contact William Young, Manager-Internal Audits, at 916-650-0266.

Sincerely,

Kathleen Billingsley for Dr. Ron Chapman

Ron Chapman, MD, MPH
Director & State Health Officer

Enclosure

Director's Office, MS 0500, P.O. Box 997377, Sacramento, CA 95899-7377
(916) 558-1700
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* California State Auditor's comments begin on page 81.

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Recommendations

1. **To protect the health, safety, and well-being of residents in long-term health care facilities, Public Health should improve its oversight of complaint processing. Specifically, Public Health should do the following:**

   a. **By January 1, 2015, establish and implement a formal process for monitoring the status and progress in resolving open facility-related complaints and ERIs at all district offices. This process should include periodically reviewing an aging report of open complaints and ERIs to ensure that all complaints and ERIs are addressed promptly.**

      CDPH agrees with this recommendation.

      CDPH distributes to the district offices a monthly report detailing open complaints and ERIs. These reports are accompanied by directions from headquarters for addressing these open investigations.

      In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of long-term care health facility complaint and ERI investigations. By January 1, 2015, CDPH will provide district-specific data to the district offices to use as a management tool. CDPH will work with the district offices to monitor performance on these performance metrics.

   b. **By January 1, 2015, improve the accuracy of information in the spreadsheet that PCB uses to track the status of complaints against individuals and review the aging reports of open complaints to ensure that all complaints are addressed promptly.**

      CDPH agrees with this recommendation.

      PCB has modified its data collection process to improve tracking of the timeliness of the open investigations. These modifications improved data accuracy and consistency and allow management to create specific reports to track the timeliness of investigations. Additionally, CDPH hired a contractor to review PCB's Investigation Section processes, practices, policies, and data technology. The contractor will make recommendations to enhance efficiencies, data collection and maintenance, and timeliness. By May 1, 2015, PCB will begin implementing the contractor's recommendations.

   c. **By May 1, 2015, establish a specific time frame for completing facility-**

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related complaint and ERI investigations and inform staff of the expectation that they will meet the time frame. Public Health should also require district offices to provide adequate, documented justification whenever they fail to meet this time frame.

CDPH disagrees with this recommendation. ①

CDPH recognizes the importance of timeliness in completing complaint and ERI investigations and is 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.

In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of long-term care health facility complaint and ERI investigations. By January 1, 2015, CDPH will provide district-specific data to the district offices to use as a management tool. CDPH will work with the district offices to monitor and improve investigation timeliness.

d. By May 1, 2015, develop formal written policies and procedures for PCB to process complaints against certified individuals in a timely manner. These policies and procedures should include specific time frames for prioritizing and assigning complaints to investigators, initiating investigations, as well as for completing the investigations. Public Health should also inform staff of the expectation that they will meet these time frames. It should require PCB to provide adequate, documented justification whenever it fails to meet the time frames.

CDPH partially agrees with this recommendation. ②

PCB is developing and implementing written policies and procedures for investigating complaints against certified individuals. As part of this process, CDPH hired a contractor to review the current processes, practices, policies, and data technology. The contractor will make recommendations to enhance efficiencies, data collection and maintenance, and timeliness.

In addition, as part of the 18 two-year limited term positions received July 1, 2014, PCB hired an analyst whose duties include developing formal written policies and procedures. Based on the recommendations of the contractor, this analyst will continue with the development of these policies and procedures.

CDPH disagrees with establishing specific timeframes for investigations. ②

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CDPH recognizes the importance of timeliness in completing investigations of complaints against certified individuals and is committed to reducing the average time to complete these investigations through enhanced monitoring of workload activities, public reporting of workload performance, and implementation of process improvements.

In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of long-term care health facility complaint and ERI investigations. By January 1, 2015, CDPH will provide district-specific data to the district offices to use as a management tool. CDPH will work with the district offices to monitor and improve investigation timeliness.

2. **To ensure that district offices are addressing ERIs consistently, and to ensure that they investigate ERIs in the most efficient manner, Public Health should do the following:**

   a. **Assess whether each district office is appropriately prioritizing ERIs. Specifically, it should determine, on a district-by-district basis, whether district offices' assigning ERIs a priority level that requires an on-site visit is justified. This assessment should also determine whether each district office is appropriately prioritizing ERIs when determining that an on-site investigation is not necessary.**

   b. **Using the information from its assessment, by October 1, 2015, provide guidance to district offices on best practices for consistent and efficient processing of ERIs.**

   c. **Periodically review a sample of the priorities that district offices assign to ERIs to ensure compliance with best practices.**

   CDPH agrees with these recommendations.

   By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this evaluation, CDPH will identify any training needs by district office, including any training needed related to prioritization and processing of ERIs.

3. **To protect the residents in long-term health care facilities from potential**

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harm, Public Health should ensure that its district offices have adequate staffing levels for its licensing and certification responsibilities, including for promptly investigating complaints. Specifically, Public Health should do the following:

a. Continue working with the California Department of Human Resources to complete the reclassification of district office investigator supervisor and manager positions and then quickly fill the vacant positions at district offices.

CDPH agrees with this recommendation.

Pending approval of the reclassification package, CDPH has taken steps to recruit and fill the vacancies under the current specifications. On September 16, 2014, CDPH posted promotional examination announcements for the Health Facilities Evaluator II (Supervisor), Health Facilities Evaluator Manager I, and Health Facilities Evaluator Manager II classifications under the current specifications. CDPH will continue to recruit for these positions until we receive a decision on the reclassification.

b. By May 1, 2015, complete a staffing assessment to identify the resources necessary for district offices to investigate open complaints and ERIs and to promptly address new complaints on an ongoing basis. Public Health should use this assessment to request additional resources, if necessary.

CDPH agrees with this recommendation.

Since 2010, CDPH has developed an annual estimate of the workload and the staffing needs of the Licensing and Certification Field Operations Division. This estimate methodology is detailed and is based on the workload activities to be completed, the number and types of facilities in which those activities need to occur, the frequency with which those activities need to occur (for activities with an assigned periodicity), and an estimate of the standard average hours it takes to accomplish each type of activity. This estimate process forms the basis for any requests for health facilities evaluator nurses and associated support staff in the district offices. ③

CDPH will complete an assessment of workload by district office by May 1, 2015.

c. By January 1, 2015, establish a time frame for fully implementing the

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recommendations that its consultant identified related to the processing of complaints about long-term health care facilities.

④ CDPH agrees with this recommendation but not the January 1, 2015 timeline.

CDPH views the assessment report recommendations as opportunities to improve the program in the long-term to enable us to better accomplish our mission. CDPH intends to address all of the report recommendations while ensuring we maintain focus on our core mission. We are prioritizing the recommendations, considering such factors as impact on the program's core mission, importance to stakeholders, and interdependency among recommendations. Based on our initial prioritization, CDPH will share a draft implementation work plan with stakeholders to receive their feedback. Those recommendations we rank as our top initial priorities will have timelines identified in the initial work plan.

CDPH will post the work plan and all activity and progress on our Center for Health Care Quality stakeholder website: http://cdph.ca.gov/programs/Pages/CHCQStakeholderForum.aspx. Changes to the website will generate an automatic email to stakeholders to alert them to updates and changes.

4. **Public Health should take steps to ensure that PCB has the resources necessary to complete investigations of complaints against individuals on an ongoing basis. Specifically, Public Health should assess whether the temporary resources it has received are adequate to reduce the number of open complaints to a manageable level. This assessment should also determine whether permanent resources assigned to PCB are adequate to address new complaints going forward. Public Health should use this assessment to request additional resources, if necessary.**

CDPH agrees with this recommendation.

PCB has developed management tools and reports allowing statistical data to be retrieved and analyzed to assist with the assessment of resources needed going forward. This assessment addresses current and aging investigations.

In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of PCB complaint investigations. PCB will use these performance metrics and other management tools and reports to monitor performance and assess resource needs.

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5. **To ensure that its district offices properly investigate complaints and ERIs, Public Health should make certain that all district offices follow procedures requiring supervisory review and approval of complaint and ERI investigations. If the district offices do not have a sufficient number of supervisors to review investigations they did not conduct, Public Health should arrange to assist the districts until such time that they do have a sufficient number of supervisors.**

   CDPH agrees with this recommendation.

   By October 31, 2014, CDPH will issue a reminder to all district office staff that includes a link to our current complaint procedures, which include supervisory review.

   By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this evaluation, CDPH will identify any training needs by district office, including any training needed related to supervisory review and approval.

   CDPH has implemented procedures to assist district offices that that do not have sufficient supervisors to review complaint investigations. As needed, CDPH will recruit retired annuitants and permanent intermittent staff, request assistance from other district offices, and realign district office workload responsibilities.

6. **To ensure that its district offices comply with federal requirements regarding corrective action plans, Public Health should establish a process for its headquarters or regional management to periodically inspect district office records to confirm that they are obtaining corrective action plans according to the required time frame and verifying that facilities have performed the corrective actions described in the plans when required.**

   CDPH agrees with this recommendation.

   In March through June of 2014, CDPH provided a plan of correction review in-service training for all district office staff.

   By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and

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compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this evaluation, CDPH will identify any training needs by district office, including any training needed related to corrective action plans.

7. **To ensure that it closed complaints and ERIs appropriately, by April 2015, Public Health should take steps to verify that complaints that its field operations branch closed administratively were appropriately closed. For example, it could request the district offices to verify that the closures were appropriate.**

   CDPH agrees with this recommendation.

⑤ By April 2015, CDPH will include in quarterly district office visits a review of the district office compliance with policies and procedures, including those related to complaint and ERI closure.

   By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this evaluation, CDPH will identify any training needs by district office, including any training needed related to complaint and ERI closure.

8. **To improve oversight of its district offices' complaint and ERI investigation process, Public Health should increase its monitoring of the district offices' compliance with federal and state laws as well as with its policies. For example, Public Health could accomplish this by directing its regional managers to spend more time at the district offices to enforce district office compliance with policies, or by directing its quality improvement section to review a random sample of investigations for quality and adherence to policy. Public Health should further establish a formal process to periodically review LA County's compliance with the terms of its contract, including compliance with the terms for investigating complaints.**

   CDPH agrees with this recommendation.

   By April 2015, CDPH will include in quarterly district office visits a review of the district office compliance with policies and procedures, including those related to ERIs.

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By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this evaluation, CDPH will identify any training needs by district office.

CDPH has taken numerous steps to improve its monitoring and oversight of LA County.

- In March 2014, CDPH began weekly visits to LA County to provide onsite oversight, monitoring, and technical assistance.

- In March 2014, CDPH conducted a quality review of a sample of LA County's investigations of complaints and ERIs. As a result of the review, CDPH developed and provided training related to identified concerns. The trainings include:

- In April 2014, CDPH conducted mandatory webinar training on the principles of documentation and principles of investigation.

- In May 2014, CDPH conducted on-site training for LA County on intake prioritization, complaint investigation policy and procedures, supervisor review for severity and scope, principles of investigation, and principles of documentation.

- In July 2014, CDPH hired a retired annuitant to provide dedicated on-site oversight, monitoring, technical assistance, and consultation. In addition, CDPH is actively recruiting for a Health Facilities Evaluator Supervisor and two (2) Health Facilities Evaluator Nurses. These nurses will be dedicated to the Los Angeles County to conduct periodic quality improvement activities.

- In July 2014, CDPH conducted a focused training with LA County supervisors, assistant supervisors, program managers, and surveyors on plans of correction.

- In August 2014, CDPH conducted two on-site trainings for all LA County supervisors, assistant supervisors, and program managers on state and federal requirements for complaint and ERI investigations.

- In September 2014, CDPH conducted two trainings for LA County surveyors on surveyor conduct, principles of investigation, severity and scope, and principles

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of documentation.

- Beginning in October 2014, CDPH will conduct quarterly reviews of LA County's handling and processing of complaints and ERIs, specifically in the areas of initiation, prioritization, principles of investigations, principles of documentation, and completion. If needed, CDPH will request for a corrective action plan based on the reviews.

- Beginning in October 2014, CDPH will conduct process analyses of federal surveys conducted by LA County to assess compliance with state and federal requirements for survey and certification activities.

9. To better protect the safety of residents in long-term health care facilities, Public Health should direct its district offices to comply with required time frames for initiating and closing completed investigations. If a district office lack sufficient resources to initiate or close investigations within those time frames, Public Health should arrange to assist that district until such time that the district complies with the statute.

CDPH agrees with this recommendation.

By October 31, 2014, CDPH will issue a notification to all district office staff that includes a link to our current complaint procedures, which include required timeframes for initiating and closing completed investigations.

In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of long-term care health facility complaint and ERI investigations. By January 1, 2015, CDPH will provide district-specific data to the district offices to use as a management tool. CDPH will work with the district offices to monitor performance on these metrics, which include timeframes for initiation. As needed, CDPH will request assistance from other district offices and realign district office workload responsibilities.

By April 2015, CDPH will include in quarterly district office visits a review of the district office compliance with policies and procedures, including those related to timeframes for initiating and closing completed investigations.

By October 1, 2015, CDPH will quarterly review a sample of closed complaint and ERI investigations in each district office to evaluate the assigned priority level, the quality of the investigation, supervisory review, corrective action plans, and compliance with state and federal requirements. We will ensure each sample includes complaints and ERIs at a range of priority levels. As a result of this

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evaluation, CDPH will identify any training needs by district office, including any training needed related to timeframes for initiating and closing completed investigations.

10. **To ensure that it complies with statutory time frames for adjudicating appeals related to individuals, Public Health should establish a process to monitor its contractor's performance with contract terms.**

CDPH disagrees with this recommendation. (6)

The statutory provision that governs Administrative Hearings for CDPH is Section 131071 of the Health and Safety Code, which states that notwithstanding any other provision of law, CDPH will conduct hearings pursuant to the Administrative Procedures Act and Section 131071. Those provisions do not designate specific deadlines for setting or conducting hearings.

11. **To ensure that the Legislature promptly receives information about the timeliness of Public Health's complaint processing related to long-term health care facilities, Public Health should continue to include all of the statutorily required information in its annual report and submit it by the due date.**

CDPH agrees with this recommendation.

In October 2014, CDPH will begin posting on our website data on the volume, timeliness, and disposition of long-term care health facility complaint and ERI investigations.

CDPH will continue to provide a staffing and systems analysis in its annual fee report to the Legislature due each February 1. CDPH will ensure that this report includes all statutorily required information and:

- the number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities;
- the percentage of time devoted to licensing and certification activities for the various types of health facilities;
- the number of facilities receiving full surveys and the frequency and number of follow-up visits;
- the number and timeliness of investigations and,

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- data on deficiencies and citations issued, and numbers of appeals and arbitration hearings.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the California Department of Public Health's (Public Health) response to our audit. The numbers below correspond to the numbers we have placed in the margin of Public Health's response.

Public Health fails to provide any reason for why it does not agree with our recommendation to establish a specific time frame for completing facility-related complaints and entity-reported incident (ERI) investigations. As we state on page 32, we believe that Public Health's lack of accountability has contributed to its district offices' failure to complete investigations within reasonable time periods. Public Health states that it will provide data, including data on timeliness, to its district offices as a management tool. However, without first defining what it considers to be timely, the steps that Public Health outlines will be ineffective in ensuring that district offices promptly complete all investigations. ①

Public Health fails to recognize the importance of our recommendation. As we state on page 33, it is especially important for Public Health's Professional Certification Branch (PCB) to establish specific steps and time frames for completing those steps because federal regulations require Public Health to investigate complaints against certified individuals in a timely manner. Without defining what it considers to be timely completion of investigations, it is unclear how the steps that Public Health outlines will ensure that PCB complies with federal regulations. ②

Public Health fails to note that the estimates to which it refers were incomplete and sometimes inaccurate. As we state on page 39, the interim deputy director acknowledged that Public Health did not develop estimates for individual district offices and that the statewide estimates sometimes failed to accurately project workload and resource needs. As Public Health moves forward with implementing our recommendation, it will be important for it to ensure that it has accurate and complete data. ③

We are surprised that Public Health believes it cannot establish a time frame by January 1, 2015, for fully implementing its consultant's recommendations related to processing of complaints about long-term health care facilities. As we state on page 39, Public Health received the consultant's report in August 2014. Although we understand that actually implementing these recommendations might require some time, we believe that ④

Public Health should easily be able to identify within four months of receiving the consultant's report, a time frame for fully implementing each of the recommendations.

(5) Public Health misunderstands our recommendation. As we discuss on page 48, Public Health closed administratively 258 facility-related complaints and ERIs without first verifying that the district offices had completed the investigations. In fact, as we state on page 48, in our review of complaints and ERIs at four district offices, we found that Public Health had closed administratively one complaint for which the district office had not yet completed and closed the investigation. It is unclear how Public Health's proposed ongoing quarterly review of complaints and ERIs closed at its district offices will address this issue.

(6) As we state on pages 56 and 57, Public Health's interpretation of the law is incorrect for two reasons. First, rules of statutory construction provide that significance should be given to every word in a statute, which must be read in the light of its historical background and evident objective. The statutory requirements concerning time deadlines for hearings affecting these individuals specifically state that Administrative Procedures Act (APA) procedures apply unless those procedures conflict with the specific statutory provisions governing appeals by nurse assistants and home health aides. Because the statutory time deadline for hearing an appeal clearly conflicts with otherwise applicable APA provisions, we conclude that the deadline supersedes the APA. Second, when two laws upon the same subject are passed at different times and are inconsistent with each other, the one last passed must prevail. In this case, the pertinent section referring to the APA was enacted in 2007 and has not been amended since. The section of state law prescribing the time frames for Public Health was last amended in 2013, at which time the Legislature declined to remove the 60-day time requirement, thereby evidencing an intention to preserve this provision.