Department of Health Services:

The Orange County District Office Needs To Further Improve Its Oversight of Health Care Facilities

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Summary

Audit Highlights ...

While the Orange County District Office has recently improved its enforcement efforts, it:

- ☑ *Was late responding to some complaints and in issuing some citations;*
- ☑ *Did not perform some health facility inspections and was late with others;*
- ☑ *Incorrectly assessed the priority level for two complaints; and*
- ☑ *Has not established guidelines for timely investigations and processing of citations and deficiency notices.*

Results in Brief

The Licensing and Certification program (L&C) of the Department of Health Services (department) is responsible for enforcing state and federal laws and regulations governing the licensing and certification of health care facilities. To carry out its responsibility, the department sends evaluators from its district offices to the facilities to complete periodic standard inspections and to investigate complaints. The department issues deficiency notices to the facilities for violations. In addition, certain long-term care facilities are subject to California Health and Safety Code citations, which include monetary penalties. The department issues these citations for more severe violations.

Our review focused on whether the Orange County District Office (OCDO) meets its responsibility to help the department ensure that health care facilities provide the highest level of care possible. Specifically, we reviewed the OCDO's compliance with department policies and procedures for processing complaints, performing inspections, and issuing citations. In fact, the OCDO did not effectively use these procedures to the maximum level to ensure health care facilities provide the best care possible. Specifically, the OCDO did the following:

- responded from one to 213 days late for 35 percent of the complaints reviewed, with late responses in all three fiscal years reviewed, from July 1, 1992, through March 31, 1995;
- did not perform all required inspections of health facilities during our review period, and performed some inspections late;
- incorrectly assessed priority levels for 2 of 60 complaints reviewed;
- issued deficiency notices instead of higher level citations in 4 of 20 cases;

- issued 29 percent of the citations we reviewed from 2 to 12 days late;

- has not established guidelines for timely investigations and processing of citations and deficiency notices and, as a result, took longer than allowed to investigate and process them;

- did not always ensure health care facilities submitted timely plans of corrective action, as required, in 13 of 20 cases we reviewed; and

- has improved enforcement efforts, as demonstrated by an increase in the number of citations issued in the last two fiscal years reviewed.

When the OCDO fails to assess complaints and issue citations at the appropriate level, it is not using its monitoring procedures and enforcement authority effectively to ensure the facilities provide the best possible care. For example, in one instance, the OCDO assessed a complaint alleging inadequate patient care and possible neglect at priority level three, the lowest level available. The OCDO investigated and reported that a resident experienced substantial weight loss and multiple falls in a short time. If the OCDO assesses a lower priority level, the investigation may not be initiated as promptly as the nature of the complaint warrants. Also, in another instance we reviewed, the OCDO issued a facility a deficiency notice for failure to provide adequate supervision to prevent accidents. As a result of this failure, a resident was found badly bruised with multiple injuries. Because the OCDO issued only a deficiency notice, the facility did not receive the maximum penalty.

Recommendations

The Department of Health Services' Licensing and Certification Division (division) should ensure that the OCDO effectively does the following:

- monitors health care facilities by responding to complaints promptly, performing all required inspections on time, and assessing complaints correctly at the appropriate level; and

- uses its enforcement authority to the maximum level by issuing citations when appropriate within statutory timeframes and requiring facilities to submit plans of corrective action within time requirements.

Further, the division should establish guidelines for timely completion of investigations and develop procedures for issuing deficiency notices promptly after complaint investigations.

Agency Comments

The department concurred with the recommendations in the report and provided its plans for improving its oversight of health care facilities.

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Introduction

Background

The Department of Health Services' (department) Licensing and Certification program (L&C) oversees the quality of care delivered in more than 5,000 California hospitals and health facilities. Although the majority of the L&C's staff time is spent in the oversight of nursing homes, the L&C is responsible for the regulation of over 33 different categories of facilities. These include acute care hospitals, psychiatric hospitals, three types of developmentally disabled facilities, home health agencies, congregate living health facilities, end stage renal dialysis centers, ambulatory surgery centers, clinics, and others. The L&C is responsible for ensuring and promoting the highest quality of care provided by health care facilities.

The L&C has preventive and reactive procedures that help the department monitor and oversee the care health care facilities provide. The California Health and Safety Code requires the department to ensure health care facilities comply with laws and regulations about health care standards. To meet this responsibility, the department established two main procedures for two basic processes.

The first procedure requires the L&C to perform periodic inspections of health care facilities. The L&C conducts licensing and certification inspections through a network of 11 district offices statewide and through a contract with the County of Los Angeles. The L&C evaluators inspect the facilities for both state licensing and federal certification for Medicare and Medicaid (Medi-Cal) under Titles 18 and 19 of the Social Security Act.

The second procedure—investigating complaints about health care facilities—also helps the department meet its responsibility of ensuring that health care facilities provide the best care possible. Complaints may be received via telephone or mail from anyone outside of the department, or may be received during a facility inspection. Processing complaints allows the district offices to monitor the facilities between standard inspections. For

example, if a district office receives multiple complaints about one facility, it may result in closer monitoring of the facility or an additional inspection.

In addition to these preventive and reactive procedures, the L&C also has enforcement powers. The L&C's enforcement powers include the issuance of citations and deficiency notices. If the L&C evaluators determine that a long-term health care facility, subject to the citation system, violates state or federal laws or regulations relating to facility operation or maintenance, the California Health and Safety Code requires the evaluator to issue a notice to correct the violation. The evaluator must also issue a notice of intent to cite the licensee. Additionally, the Health and Safety Code requires the department to issue a deficiency notice and to require the licensee to provide a plan of correction for any violations found. When the violation is not severe enough to meet the criteria for a citation or when the facility is a type not subject to a monetary penalty, deficiency notices are the maximum penalty.

Scope and Methodology

The purpose of this audit was to evaluate the performance of the L&C program of the Orange County District Office (OCDO). In conducting this audit, we developed and verified information for the OCDO's evaluating, monitoring, and enforcing activities. We also reviewed state and federal laws and regulations related to monitoring and enforcement activities. Additionally, we reviewed the OCDO's procedure manuals to determine whether sections related to our audit scope were complying with state and federal laws for investigating complaints and issuing citations regarding health care facilities.

To determine whether the OCDO properly monitored and evaluated health care facilities, we reviewed complaint and inspection files. We reviewed a sample of complaint files to assess the timeliness of the OCDO's response to complaints and the reasonableness of the OCDO's conclusions. We examined a sample of inspection files to assess whether the OCDO properly monitored health care facilities by performing required inspections within time requirements.

Further, we examined a sample of deficiency notices and a sample of citation files to determine whether the OCDO properly processed citations and enforced penalties and corrective action as required. We also reviewed the citation files to assess the reasonableness of the OCDO's conclusions and the timeliness of

citations. Additionally, we reviewed the citation files to assess collection of penalties and enforcement of corrective action. To further evaluate the OCDO's performance, we determined the total number of citations the OCDO issued for fiscal years 1992-93, 1993-94, and 1994-95 (to March 31, 1995). We compared the number of citations to the number issued in other district offices. For comparative purposes, we obtained annual statistical reports from the Office of Statewide Health Planning and Development.

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Chapter 1

The Orange County District Office Does Not Always Comply With Laws and Regulations When Overseeing and Evaluating Health Care Facilities

Chapter Summary

The Orange County District Office (OCDO) does not always comply with federal, state, and Department of Health Services (department) requirements for oversight and evaluation of health care facilities. For example, the OCDO sometimes takes too long to investigate complaints. Twenty-one of the 60 complaints we reviewed were from one to 213 days late. Also, the OCDO did not perform required inspections during our review period for two home health agencies, and performed five late inspections during our review period for skilled nursing facilities and intermediate care facilities. Furthermore, in two instances, the OCDO assessed complaints below the appropriate priority level. By not responding to complaints on time, failing to perform required inspections, and assessing the priority level for complaints at too low a level, the OCDO has not adequately used the preventive and reactive procedures available to ensure that long-term health care facilities provide the best care possible.

The Orange County District Office Takes Too Long To Investigate Complaints

The OCDO is responsible for responding to complaints about health care facilities in its district. The California Health and Safety Code requires the department to conduct an onsite inspection within ten working days of receiving a long-term care complaint unless the department determines the complaint is willfully intended to harass a licensee or is without any reasonable basis.

Priority level one complaints allege an imminent threat to life and safety of a patient and must be investigated within 24 hours.

Additionally, department procedures require that complaints be assessed a priority level when received. A priority level one is assessed for a complaint that alleges an imminent threat to the life and safety of patients. For example, one priority level one complaint we reviewed alleged patient abuse. The patient had a cut on the lip, bruised eye, other facial bruises, and four teeth knocked out. A priority level two is assessed for a complaint that alleges a direct or immediate relationship to the health, safety, or security of a patient. For example, one priority level two complaint we reviewed alleged resident neglect. A resident had not received any oral hygiene and was found in bed, soaked with urine. A priority level three is assessed for all other complaints deemed appropriate for investigation. For example, one priority level three complaint we reviewed alleged that the facility was using leftover food to feed patients on puree diets instead of using fresh foods.

The department requires that an evaluator investigate complaints assessed at priority level one within 24 hours. Priority level two complaints and priority level three long-term care facility complaints must be investigated within 10 days. All other priority level three complaints must be investigated within 90 days. The OCDO received approximately 1,080 complaints during the three fiscal years we reviewed, from July 1, 1992, through March 31, 1995.

Based on our review of 60 complaints for July 1, 1992, through March 31, 1995, we found 21 complaints (35 percent) for which the OCDO did not respond within time requirements. As shown in Table 1, the OCDO responded late to complaints in each priority level. The OCDO exceeded the required response time for priority level one complaints by one to three days for 4 cases. These 4 complaints alleged possible patient abuse, lack of patient care, illegal eviction, and inadequate staffing at the facility. Although the OCDO responded within four days, the complaints were priority level one—alleging an imminent threat to the life and safety of a patient. Such complaints should have been investigated within 24 hours.

For priority level two, the OCDO exceeded the response requirement of 10 working days by one to 142 days in 12 cases. Priority level two complaints are generally related to inadequate patient care, patient neglect, or abuse. Complaints within the categories of neglect or abuse can be assessed different priority levels by the Licensing and Certification (L&C) staff based on the severity of the allegation. Finally, for priority level three, the OCDO exceeded the 90-day response requirement by 66 to 213 days for 5 cases.

Table 1

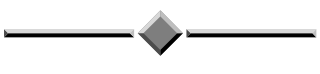
Late Complaints by Priority Level

Priority	Total Reviewed	Days Late					Late	Percent Late
		1-10	11-30	31-60	61-90	90+		
1	15	4					4	27%
2	35	5	3	2	1	1	12	34
3	10				1	4	5	50
Totals	**60**	**9**	**3**	**2**	**2**	**5**	**21**	**35%**

Complaints reviewed July 1, 1992, to March 31, 1995.

By responding to complaints, the OCDO reacts to problems occurring in health care facilities. This reactive process helps the department maximize assurance that health care facilities provide the highest level of care possible. When the OCDO is late responding to complaints, it is not adequately meeting its responsibility to ensure health care facilities are providing the best care possible.

The OCDO also responded late to complaints in all three fiscal years reviewed (as shown in Table 2). The OCDO district administrator cited a memorandum from headquarters as an explanation for some of the late responses for priority levels two and three. The policy according to this memorandum, dated January 16, 1992, was for the district offices to wait to process priority level two and three complaints until visiting facilities for an annual inspection or until receiving a priority one complaint. Because of the change in workload priorities, directed by L&C management, the OCDO response times for priorities two and three did not always meet state statutes and prior department procedures. According to a memorandum dated June 16, 1993, the L&C management changed the policy back to require district offices to respond to complaints within required response times.



The OCDO has improved response times to complaints for the current fiscal year.

The OCDO has improved response times for the current fiscal year. The OCDO responded late to only 2 of 16 complaints we reviewed for July 1, 1994, through March 31, 1995. The late responses for fiscal year 1994-95 amounted to 13 percent as opposed to 39 percent in 1992-93 and 46 percent in 1993-94. Of the two late responses in fiscal year 1994-95, one complaint was priority level one, and one complaint was priority two. The OCDO responded late by one day for each of the two complaints.

Table 2

Late Complaints by Fiscal Year

Fiscal Year	On Time	Late	Percent Late	Days Late 1-10	11-30	31-60	61-90	90+
1992-93	11	7	39%	2	1	1		3
1993-94	14	12	46	5	2	1	2	2
1994-95*	14	2	13	2				
Totals	**39**	**21**		**9**	**3**	**2**	**2**	**5**

*Current fiscal year through March 31, 1995.

The Orange County District Office Has Not Always Performed Required Inspections

The California Health and Safety Code requires the department to periodically inspect health facilities based on the type and complexity of the facility. Specifically, the code requires the department to inspect health facilities at least once every two years except for facilities that are federally certified.

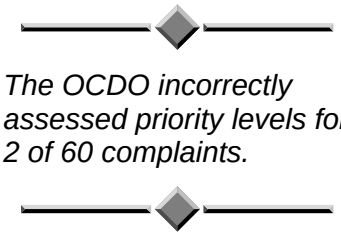
In addition, the Social Security Act (act) requires the department to inspect skilled nursing facilities, nursing facilities, and home health agencies that participate in the Medicare and Medicaid (Medi-Cal) programs under Titles 18 and 19 of the act. The act requires the department to perform the inspections within 15 months of the date of the previous standard inspection, and the statewide average is not to exceed 12 months. The inspections of home health agencies may include a review of the parent agency, branch locations, or both. By periodically evaluating the facilities, the department maximizes its efforts to ensure the facilities provide the best care possible.

Some health facilities were not inspected or inspections were late.

Based on our review of files for 44 facilities, we found 7 facilities where the OCDO either did not perform the inspections required during our review period or the inspection during our review period was late. Specifically, the OCDO did not perform inspections required during our review period for two home health agencies. Although these inspections are required every 15 months, they had not been performed for at least 39 months. Additionally, we found the OCDO exceeded the 15-month requirement for inspecting long-term care facilities for 5 of 44 facilities reviewed. The OCDO performed the inspections from 11 to 28 days late. Because the OCDO did not perform some

inspections required during our review period and performed other inspections during our review period late, the facilities may have violations that are not being addressed and corrected. Facilities with uncorrected violations continue to provide less than optimal care.

The Orange County District Office Incorrectly Assessed Priority Levels for Two Cases



The OCDO incorrectly assessed priority levels for 2 of 60 complaints.

For 2 of the 60 complaints we reviewed, the OCDO assessed a priority level three although we believe the complaints met the criteria for priority level two. (For more detail about the distinctions among the three priority levels, please see page 6.) Both of these complaints were received in fiscal year 1992-93. One of the complainants alleged inadequate patient care because the patient had experienced substantial weight loss and multiple falls in a short time. Since the complaint has a direct relationship to the health and safety of a patient, it clearly met the criteria for a priority level two, not a priority level three.

The second complaint, from facility staff, alleged abuse of patients by other staff members. The OCDO investigated and reported that the facility failed to document verification of licenses and certifications for four employees. The facilities eventually terminated the employees for alleged abuse. Although the complaint has a direct relationship to the health and safety of patients, it was assessed at priority level three.

By not assessing complaints at the proper level, the health, safety, and security of patients is compromised. When complaints are assessed at priority levels lower than appropriate, the severity of a

potential problem may be missed. Also, the OCDO may not investigate the complaint as quickly as is necessary to prevent additional problems from occurring.

Conclusion

Although the OCDO has shown improvement in the current fiscal year in responding to complaints, it has still taken too long to investigate complaints, possibly allowing health care facilities to provide less than the optimal level of care. Additionally, during our review period, the OCDO has not performed all required inspections and has not always inspected on time. Furthermore, the OCDO has not always assessed complaints at the appropriate priority level and, thus, may fail to investigate quickly enough to safeguard the well-being of residents or to prevent additional problems from occurring. As a result, the OCDO is not effectively using required preventive and reactive procedures to ensure that health care facilities provide the best care possible.

Recommendations

The department's Licensing and Certification Division should ensure that the OCDO complies with established procedures to ensure that complaints are investigated and inspections are completed within time requirements and that complaints are assessed at the appropriate priority level.

Chapter 2

The Orange County District Office Does Not Always Maximize Its Enforcement Efforts

Chapter Summary

The Orange County District Office (OCDO) does not always comply with state and federal requirements in its enforcement activities when issuing citations and deficiency notices to health care facilities. For example, the OCDO cited facilities with deficiency notices even though the conditions met criteria that called for a higher level citation. In addition, the OCDO did not

issue timely citations and deficiency notices. Also, the OCDO did not ensure that facilities promptly submitted plans of correction. Although the OCDO did increase the number of citations during fiscal years 1993-94 and 1994-95, it is still not effectively using its enforcement authority to the maximum to ensure the provision of optimal health care. Finally, during our review, we found that although the law permits complainant appeals to the department's deputy director, these appeals are rare.

The Orange County District Office Does Not Always Issue Citations When Appropriate

Citations are more serious than deficiency notices and include monetary penalties.

The California Health and Safety Code requires the department to issue citations and deficiency notices to health care facilities that violate state or federal laws and regulations, depending on the severity of the violation and the type of facility. Citations are more serious than deficiency notices and, therefore, include monetary penalties because they are issued for more severe violations.

The criteria for citations are clearly stated in the California Health and Safety Code. The department is required to issue class A citations for violations that present an imminent danger of death or serious harm to patients or residents of a long-term health care facility or present substantial probability of death or serious physical harm to patients or residents. The department is required to issue class AA citations, the most severe citations, for vs that meet the same criteria as class A but when the violation was also a direct proximate cause of death to a patient or resident. The department is required to issue class B citations for violations that have a direct or immediate relationship to the health, safety, or security of long-term health care facility patients or residents but that do not meet the criteria for class A or class AA citations. Additionally, department procedures require the district offices to obtain medical concurrence for the issuance of class A or class AA citations except for patient abuse and excessively hot water temperatures.

We reviewed 60 complaints and found that the OCDO issued deficiency notices for 20. The Licensing and Certification program (L&C) issues deficiency notices for violations, and these notices can be the maximum penalty for violations that do not meet the criteria for a citation, or for violations by facilities that are not subject to the citation system that includes monetary penalties. Department procedures require the OCDO to obtain a

written plan of correction from the facilities within ten days of the facilities receiving the notices.

The OCDO issued deficiency notices instead of higher level citations in 4 of 20 cases.

In four instances, the OCDO issued deficiency notices for violations we believe met the criteria for citations. For example, one facility received a deficiency for failing to continuously assess a resident to identify new problems and symptoms at an early stage; specifically, failure to identify a large neck mass. The family discovered the neck mass—a malignant lymphoma of the neck—that blocked the resident's airway and ultimately caused his death. The complainant was dissatisfied with the OCDO evaluator's decision to issue only a deficiency notice and appealed the decision to the first level of review, the district administrator. During the appeals process, the OCDO discovered that approximately five weeks before the family discovered the neck mass, it had been discovered by an occupational therapist, and the resident's doctor had been informed. The regulations require that the facility immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when there is a significant change in the resident's physical status.

According to the OCDO, it upheld the decision to issue the facility a deficiency for failure to notify the family of the neck mass since the resident's doctor was informed of it and the family was informed of other matters indicating the resident's declining health, including weight loss and a swallowing problem. The complainant was dissatisfied with the OCDO district administrator's decision and appealed to the second level of review, the deputy director of the Licensing and Certification Division (division). We believe the facility should have been issued a citation because the family was not informed of the neck mass as required; because it is a change in physical status; and because, when the doctor did not act on the condition, the family was precluded from asking the resident's doctor about medical treatment for a medical condition that led to the patient's death.

Recently, the second level of review was completed. The OCDO issued three citations, two class A citations and one class AA citation, as a result of the complainant appeal to the deputy director of the L&C division. The class AA citation was issued to the facility for failure to ensure that the physician acknowledged being notified when the mass was first identified; failure to provide an initial and continuing assessment of the neck mass and determine care needs of the resident; and failure to update the care plan when the neck mass was identified. In addition, the OCDO stated that the facility failed to inform family members, who had been active in the care planning of the resident. Because

these family members were not informed, they could not assist in exploring treatment options in the resident's interest. Each of the class A citations included monetary penalties of $10,000 and the class AA citation included a penalty of $25,000.

For a second deficiency, the OCDO determined that the facility failed to develop care plans with measurable objectives to meet a resident's medical needs. Specifically, the OCDO reported that a care plan was developed to monitor the impaired physical mobility of a resident, and the plan included an approach to monitor the person. However, the OCDO also noted that the care plan did not say how frequently the resident should be assessed and monitored for signs of complications. Nor did the plan indicate what signs and symptoms to monitor. Additionally, the OCDO reported that the facility did not develop care plans for other medical conditions already noted, resulting in less than the highest practicable well-being of a resident. We believe the facility's failure to develop the appropriate care plans is directly related to the health of the resident and grounds for a citation. In addition, we discussed this case with the assistant deputy director of the division. She agreed the violation should have been at least a class B citation and probably a class A.

A third deficiency notice the OCDO issued was in response to a complaint for a resident who was found badly bruised with injuries to his knees, arms, wrists, the left side of his abdomen, and his head and face. The OCDO reported that the facility failed to adequately supervise a resident and place assistive devices in the resident's environment that would prevent accidents. We believe that the facility's failure meets the criteria for a citation because the violation has a direct relationship to the safety of the resident; however, only a deficiency notice was issued. Again, we discussed this case with the assistant deputy director of the division. She agreed that the violation should have been at least a B citation and maybe an A, depending on a complete investigation.

The OCDO investigated the fourth complaint during a certification inspection of the facility and issued multiple deficiency notices. We believe several of the deficiency notices met the criteria for a citation, but only deficiency notices were issued. Specifically, the OCDO issued a notice because the facility failed to administer medical treatments and provide care necessary to prevent the formation and progression of pressure sores and contractures (restrictions of the full range of motion of joints). Additionally, the OCDO issued notices because the facility failed to implement a system to positively identify patients before administering medications and treatments, failed

When OCDO issues deficiency notices instead of citations, it is not maximizing its enforcement authority.

to provide necessary fluids for hydration, and failed to provide good nutrition via tube feedings. Further, the facility failed to obtain health examinations and tuberculosis screening for two employees employed for more than seven days. These violations are all directly related to the health, safety, or security of residents, and we believe they should have been written as citations with accompanying monetary penalties. Instead, the OCDO issued deficiency notices. We also discussed this case with the assistant deputy director of the division. She agreed that at least B citations should have been issued.

By issuing deficiency notices instead of citations, the OCDO is not using its maximum enforcement authority to ensure prompt action, and it is allowing long-term care facilities to respond to penalties less severe than the violation that occurred.

The Orange County District Office Is Sometimes Late Issuing Citations and Deficiency Notices

29 percent of the citations we reviewed were 2 to 12 days late.

The California Health and Safety Code requires the department to issue citations within three days (excluding weekends and holidays) of the completion of an inspection or investigation. We found that 9 of the 31 citations we reviewed were not issued within three business days as required. Specifically, the OCDO issued these 9 citations from 2 to 12 business days late. Additionally, for 3 citations, the OCDO took from 66 to 101 days to investigate and process the citation.

In addition, for 3 of 20 deficiency notices reviewed, the OCDO took 91 to 191 days after completion of the investigation to issue a deficiency notice. The department issues deficiency notices for violations of state or federal laws and regulations. Although federal instructions direct the department to issue deficiency notices within 10 calendar days after the inspection, there are no federal or state time requirements for issuing deficiency notices promptly after complaint investigations.

The department has interpreted the California Health and Safety Code's discussion of the completion of an investigation to include review of the case by L&C supervisors, medical consultants if applicable, district administrators, and managers. Also, completion includes obtaining any additional information necessary. While the department recognizes timely reporting is important, it has not established guidelines for timely completion of the various levels of review to ensure the department's objectives can be met. For example, there are no timelines for supervisory review. Without time guidelines for individual steps

in the investigation process, the three-day requirement to issue citations is not meaningful. Furthermore, according to the district administrator, one of the citations took a long time to process because the district office staff was gathering information to obtain medical concurrence from the physician consultant.

The Orange County District Office Did Not Ensure Facilities Promptly Submit Plans of Corrective Action

For long-term facilities that do not participate in the Medicare program under Title 18 or in the Medicaid program under Title 19, or both, and for general acute care hospitals and acute psychiatric hospitals, the maximum enforcement action the department has is the issuance of a deficiency notice. The current laws require a written plan of correction (plan) for deficiency notices, but do not require monetary penalties. The district offices are required to obtain the plans from the facilities within ten days of the facilities receiving the deficiency notices.

The OCDO did not ensure health care facilities submitted timely plans of corrective actions in 65 percent of cases reviewed.

Because a plan is the maximum punitive action permitted for some violations and some kinds of facilities, it is important for the district offices to enforce the timely receipt of the plans. As shown in Table 3, the OCDO often fails to obtain a plan within 10 days, as required by department procedures. Specifically, for 13 (65 percent) of 20 plans required from July 1, 1992, to March 31, 1995, the facilities were from 2 to 115 days beyond the 10-day requirement. By failing to obtain the written plans on time, the OCDO is allowing the health care facilities to provide less than the highest level of care.

Table 3

Late Plans of Corrections

Fiscal Year	On Time	Late	Days Late				Percent Late
			1-10	11-30	31-60	90+	
1992-93	2	5	3	1		1	71%
1993-94	4	4	4				50
1994-95*	1	4	2	1	1		80
Totals	**7**	**13**	**9**	**2**	**1**	**1**	

*Current fiscal year through March 31, 1995.

The Orange County District Office Has Improved Its Enforcement Efforts

The OCDO increased the number of citations it issues.

Since 1992, the OCDO has improved its enforcement efforts as demonstrated by an increase in the number of citations it has issued. We compared the ratio of citations issued per million patient days to the statewide averages for 1992 and 1993. In 1992, the OCDO's ratio was only one third of the statewide average, clearly indicating a problem. The department's headquarters management recognized the problem and intervened. The management reviewed the OCDO's procedures for issuing citations as well as other office procedures. Headquarters staff made recommendations, and the OCDO improved its ratio of citations per million patient days and exceeded the statewide average in 1993. Complete data for 1994 is not presently available. See details for all other districts in the Appendix.

Table 4

Citations Per million Patient days

Year	OCDO	Statewide Average
1992	11.1	31.8
1993	49.2	38.8

Complainants Rarely Appeal Results to the L&C Headquarters Office

The California Health and Safety Code permits a person who is the source of the original complaint to appeal the State's results of an investigation about instances posing a threat to the health, safety, security, welfare, or rights of a resident. The complainant first appeals to the district office and an informal conference is held. If still dissatisfied, the complainant may appeal the results to the deputy director of the L&C Division. The deputy director assigns a representative to review the facts that led to both determinations, and the deputy director then makes a determination.

Although the law establishes a complaint appeals process, such appeals are rare.

Although the law establishes the complainant appeals process, appeals to the deputy director appear to be rare. During 1992, there were two appeals statewide; in 1993, there was one appeal; and in 1994, there were ten appeals. The OCDO had three of the State's ten appeals in 1994. Of the three appeals, we found that the OCDO originally issued class B citations for two of the complaints that were appealed and issued a deficiency for the other one. The deficiency that was appealed is for the first case discussed on page 12 of this chapter.

In one case, where the complaint resulted in a class B citation, the complainant appealed the decision, and the OCDO rescinded the original citation and reissued a citation A through the complainant appeals process. Specifically, the OCDO stated that the resident developed pressure sores that continued to deteriorate yet the facility failed to continuously and accurately assess and report the resident's condition to her physician. Further, the OCDO stated that if the facility had followed its own procedures, the resident might have received more appropriate treatment earlier.

A second complainant appealed two citations related to one resident. The OCDO originally issued one class A citation and two class B citations. The complainant appealed the class B citations, and the OCDO rescinded the citations and reissued them as class A citations. Specifically, for one of the reissued class A citations, the OCDO reported that the facility failed to ensure the resident received a therapeutic diet as appropriate and failed to ensure the resident was provided with sufficient fluid intake to maintain proper hydration and health. The resident was a diabetic, and during his stay at the facility developed nine pressure sores, had an unplanned weight loss of approximately 34 pounds, and suffered from dehydration. The facility's failure to provide proper care compromised the resident's health. In the other reissued class A citation, the OCDO stated that the facility failed to properly administer insulin, failed to ensure that insulin and meals were coordinated to avoid episodes of hypoglycemia, and failed to notify the physician as ordered when low or elevated blood sugars occurred. These failures placed the resident's life at risk. Because of the severity of the violations, the OCDO reissued the citations at class A. Each of the class A citations included monetary penalties of $10,000.

The district administrator stated that the two reissued class A citations were originally issued as class B because the physician assigned did not provide the required supporting medical opinion and there was no procedure to acquire a second medical opinion. Department procedures require the district offices to obtain medical concurrence when issuing class A or AA citations. The district administrator stated that, in the past, if the OCDO could not get medical concurrence from the physician assigned to its district, it believed there was no alternative. They had to issue a lower level citation because, without medical concurrence, it is difficult to prevail in an appeal. Currently, department headquarters has a liaison between the district offices and the physicians. If the district office believes the citation should be a higher level than the medical consultant will agree to, it can work with the headquarters to obtain a second opinion.

Conclusion

The OCDO has not maximized its enforcement efforts by assessing the highest level of citations and penalties to ensure prompt corrective action. In addition, the OCDO does not always issue citations on time and takes too long to complete the citation process and to issue deficiency notices after investigations. Also, for deficiency notices issued, the OCDO does not ensure facilities submit plans of correction within time requirements. Finally, we

found that complainant appeals to department management are rare and that the OCDO has increased the number of citations it issues.

Recommendations

The department's Licensing and Certification Division should ensure the OCDO develops procedures to ensure that citations are issued when appropriate and that facilities submit timely plans of correction. In addition, the division should ensure the OCDO issues citations within three days of the completion of an investigation, as required. Furthermore, the division should develop criteria for how long an investigation should take to reach completion and develop procedures for issuing deficiency notices promptly after complaint investigations.

We conducted this review under the authority vested in the state auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope of this report.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

Date: July 27, 1995

Staff: Philip Jelicich, CPA
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Appendix

Citations per Million Patient Days by District

1992

District	(1) Patient Days	(2) Citations	** Citations/ Patient Days
Berkeley	2,995,767	142	47.4
Chico	1,281,403	71	55.4
Daly City	2,259,638	31	13.7
Fresno	2,007,021	40	19.9
Los Angeles	12,836,614	280	21.8
Orange	**2,436,479**	**27**	**11.1**
Sacramento	3,977,868	178	44.7
San Bernardino	2,913,507	75	25.7
San Diego	3,253,233	143	44.0
San Jose	2,419,117	124	51.3
Santa Rosa	1,637,901	93	56.8
Ventura	1,969,601	68	34.5
Totals	**39,988,149**	**1,272**	**31.8**

1993

District	(1) Patient Days	(2) Citations	** Citations/ Patient Days
Berkeley	2,998,128	111	37.0
Chico	1,305,779	50	38.3
Daly City	2,245,057	40	17.8
Fresno	1,982,200	43	21.7
Los Angeles	12,732,491	407	32.0
Orange	**2,559,541**	**126**	**49.2**
Sacramento	3,958,195	128	32.3
San Bernardino	2,994,499	107	35.7
San Diego	3,341,850	198	59.2
San Jose	2,448,384	178	72.7
Santa Rosa	1,641,640	122	74.3
Ventura	2,015,911	51	25.3
Totals	**40,223,675**	**1,561**	**38.8**

** Per million patient days.
(1) From OSHPD Annual Report of Long Term Care Facilities (Calendar year).
(2) From the Department of Health Services Workload Summary reports (Federal Fiscal year).

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