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State of California Department of Justice

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OPERATION GUARDIANS

2001-02 and 2002-03 Results[1]

(Inspections conducted between April 2001 and March 2003)

PROGRAM DESCRIPTION

Operation Guardians is a multi-agency task force established and led by Attorney General Bill Lockyer to conduct surprise, on-site inspections of California's skilled nursing facilities. The task force aims to protect and help improve the quality of care for elderly and dependent adult residents by identifying and correcting violations of applicable federal, state, and/or local laws and regulations.

Working together on the task force are regulatory and law enforcement officials, such as district attorneys, city attorneys, fire marshals, and geriatric care specialists, including physicians from the University of Southern California's School of Geriatric Medicine.

Operation Guardians currently operates in the following 16 counties:

Alameda	Contra Costa	Fresno	Humboldt
Los Angeles	Monterey	Napa	Riverside
Sacramento	San Bernardino	San Diego	San Francisco
Santa Barbara	Santa Clara	Sonoma	Ventura

Additionally, the Operation Guardians program makes all attempts to oblige the requests of counties, outside of the aforementioned 16, to inspect specific facilities within their jurisdictions. Between April 2001 and March 2003, the following three counties made such special requests:

Marin	San Mateo	Yolo

As more resources become available, the Attorney General plans to expand this pioneering program to include all fifty-eight counties in California.

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[1]The 12 month cycle for Operation Guardians begins in April and concludes in March of the following year.

Regular inspections, no less often than every 15 months, are conducted by the California Department of Health Services (DHS), which is responsible for licensing, regulating, and promoting compliance among the state's more than 1,400 skilled nursing facilities. Inspections by Operation Guardians complement those conducted by the DHS and demonstrate a multi-prong approach by the State of California to protect the health, safety, and welfare of the more than 250,000 elders and dependent adults who reside in these facilities.

THE ORIGIN OF OPERATION GUARDIANS

This revolutionary program was established in March 2000 to address the growing concern regarding the poor quality of care in many of California's skilled nursing facilities. These concerns were based on complaints from private citizens, long-term care ombudsmen, patient advocacy groups, and disturbing empirical data, which included the following:

- In 1998, the United States General Accounting Office reported that one in three California nursing homes was cited for serious or potentially life-threatening care problems.[2]

- In 1999, the United States Congress Committee on Government Reform (CCGR) reported that only one of the 439 nursing homes in Los Angeles County was in total compliance with federal standards of care.[3]

- In 2000, the CCGR reported that only 18 of the 288 nursing homes in the San Francisco Bay Area were in full or substantial compliance with federal standards of care.[4]

In response, Attorney General Lockyer directed the Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) to aggressively use its criminal, civil and other statutory enforcement powers to protect the safety, welfare and dignity of the vulnerable residents of these facilities. This directive led to unprecedented quantitative and qualitative prosecutorial achievements, including a 749% increase in criminal filings and a 574% increase in criminal convictions.[5] Moreover, the state's two largest providers of skilled nursing care — Sun Healthcare and Beverly Enterprises — were criminally convicted and placed under court-ordered permanent injunctions requiring them to significantly improve the quality of care provided to their residents.

In addition to more aggressively prosecuting criminal malfeasance in skilled nursing facilities, the Attorney General sought to establish a prevention-oriented program to identify and remedy problems before they could gestate into more serious or potentially life-threatening crises.

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[2]California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (Sen.Rep. No. 105-HEHS-98-202, 2d. Sess., p. 3 (1998).)

[3]Nursing Home Conditions in Los Angeles County: Many Homes Fail to Meet Federal Standards for Adequate Care (H.R.Rep. No. 106, 1st Sess., p. 2 (1999).)

[4]Nursing Home Conditions in the San Francisco Bay Area: Many Homes Fail to Meet Federal Standards for Adequate Care (H.R.Rep. No. 106, 2d. Sess., p. 1 (2002).)

[5]See attachment A

Whether by prompting the repair of broken call lights to insure that patients receive immediate medical attention during a diabetic seizure, by requiring the proper disposal of biological waste to prevent the spread of disease, or by reviewing personnel files to insure that patients are receiving care from professionally certified staff, the Attorney General envisioned an early prevention program that was more proactive and preventative rather than reactive and punitive in shielding residents from harm. This vision led to the establishment of Operation Guardians, which has since become a model studied various Attorneys General around the nation.

OPERATION GUARDIANS' INSPECTION METHODOLOGY

The following provides a general overview of the approaches, resources, and techniques employed by Operation Guardians in fulfilling its mission:

- All efforts are made to not disrupt the facility's normal operations and resident care. The members of the Operation Guardians' inspection team perform their roles discreetly and professionally with a particular focus on not creating an atmosphere of anxiety or fear for the facility's residents.

- Generally, facilities are chosen at random by the Department of Justice's Bureau of Medi-Cal Fraud and Elder Abuse. However, some are selected based on referrals from other public agencies and private citizens who suspect that a specific facility is failing to provide adequate care.

- To maintain the program's integrity, no advance notice is provided to the facility to be inspected.

- The Operation Guardians' inspection team generally uses inspection guidelines and survey tools developed by the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services. These guidelines and survey tools are used across the United States and represent the generally recognized criterion by which the operation of skilled nursing facilities are appraised.

- *Original Inspections*

  Typically, an Operation Guardians' inspection team (i.e., the unit which conducts the onsite inspection) is comprised of the following personnel:

  < Two Special Agents, one of whom is a registered nurse and former nurse evaluator with the Department of Health Services
  < An Investigative Auditor
  < A nurse evaluator
  < The local fire inspector; and
  < A medical doctor specializing in geriatric medicine

  Original inspections, which typically last six hours, include the following:

  < Review of between six to fifteen resident medical files;
  < Physical examinations of selected residents;
  < Review of trust accounts and resident inventories to ensure proper stewardship over residents' money and property;

- < Inspection of the building infrastructure, both inside and outside, to identify hazards and problems that can impact residents' health, safety, and/or quality of life;
- < Observation of staff interaction with, and treatment of, residents to ensure that proper care is being delivered and the dignity of residents is being protected;
- < Review of employee records to ensure facility compliance with the state mandated minimum number of actual nursing hours of 3.2 per resident per day[6]; and
- < Visits with patients to identify problems and ascertain their degree of satisfaction with the level of care and treatment provided.

■ *Re-visit Inspections*
To ensure that problems identified during an original inspection have been adequately remedied, Operation Guardians will sometimes re-inspect the facility. This abbreviated inspection (i.e., lasting two to four hours in duration) is conducted by a smaller team typically comprised of the following Department of Justice personnel:

- < Two Special Agents;
- < One Nurse Evaluator; and
- < One Investigative Auditor

While primarily focused on resolving previously-identified problems, the team remains vigilant in identifying other deficiencies and problems.

■ At the conclusion of both original and re-visit inspections, the team conducts an exit interview with the facility staff for the purpose of disclosing problems requiring remediation. Inspected facilities later receive a letter documenting the identified non-compliance problems. The facilities are invited to respond, in writing, to the team's findings[7].

■ Non-compliance problems rising to more egregious levels are referred to regulatory, licensing, or law enforcement agencies for further investigation that could result in criminal, civil, and/or administrative enforcement actions.

[6]See Health and Safety Code §1276.5, effective January 1, 2000.

[7]Pursuant to our invitation, there were 15 facilities that responded to our findings in writing. Their responses can be found attached to their respective inspection report summary (See Attachment D).

OPERATION GUARDIANS' FINDINGS

During the past two years, the Operation Guardians program conducted 150 inspections, comprised of 112 "original inspections" and 38 "re-visits."

The following is a breakdown, by county, of the number of inspections completed in 2000-01, the aggregated number of inspections completed in 2001-02 and 2002-03, the number of licensed Medi-Cal facilities, and the percentage of those facilities inspected by Operation Guardians.

COUNTY	INSPECTIONS COMPLETED 2000-01 *Total* (original / re-visits)	INSPECTIONS COMPLETED 2001-02 AND 2002-03 *Total* (original / re-visits)	# OF LICENSED FACILITIES	PERCENTAGE INSPECTED
Alameda	*6* (5/1)	*7* (5/2)	70	14%
Contra Costa	*Established in 9/2002*	*4* (4/0)	28	14%
Fresno	*4* (4/0)	*9* (5/4)	40	22%
Humboldt	*Established in 1/2003*	*2* (2/0)	7	29%
Los Angeles	*11* (9/2)	*29* (24/5)	405	8%
Monterey	*2* (2/0)	*9* (4/5)	14	43%
Napa	*1* (1/0)	*3* (3/0)	12	33%
Riverside	*3* (3/0)	*17* (15/2)	45	40%
Sacramento	*6* (4/2)	*14* (9/5)	37	35%
San Bernardino	*4* (4/0)	*2* (2/0)	53	11%
San Diego	*5* (5/0)	*19* (14/5)	80	24%
San Francisco	*Established in 2/2003*	*2* (2/0)	20	10%
Santa Barbara	*2* (2/0)	*5* (2/3)	17	23%
Santa Clara	*3* (3/0)	*18* (12/6)	58	26%
Sonoma	*Established in 6/2001*	*1* (1/0)	21	5%
Ventura	*3* (2/1)	*6* (6/0)	21	38%
TOTALS	***50* (44/6)**	***147* (110/37)**	**928**	**17%**

By special request, an additional inspection was conducted in each of the following counties: Marin, San Mateo, and Yolo.

Results of the 150 inspections over the past two years fell across the spectrum of compliance with federal and state standards of care, from near-complete compliance to levels of non-compliance that triggered referrals to law enforcement, regulatory, and/or licensing agencies. However, the majority of the facilities fell somewhere in the middle --- substantial compliance with the federal and state standards, but not completely free of problems that impact the safety, welfare, and/or quality of life of their residents.

The most prevalent and disturbing trends found during these 150 inspections include the following:

- Failure to meet the state's minimum staffing requirements
  While 3.2 hours of nursing per resident per day is the state's absolute minimum staffing requirement[8] for SNFs, the overwhelming majority of facilities treat it as the ideal staffing level. Treating 3.2 hours as the proverbial ceiling versus the basement is troubling because there is no more accurate indication of failure or success in the delivery of care than that of staffing levels. This is best evidenced by the fact that every corporate neglect case prosecuted by the BMFEA has involved understaffing as one of the underlying problems. See "Staffing Level Non-Compliance" for more detailed findings.

- Failure to document TB tests
  Federal regulations require facilities to have new employees undergo a physical examination that includes a tuberculosis (TB) test. TB is an insidious disease whose danger lies in the fact the carrier can infect a large number of facility residents before the carrier is appropriately diagnosed. Once infected, the disease can have catastrophic consequences for elderly residents whose immune systems are already weakened. Current employees are required to be tested for TB annually. In our sampling of personnel files in each facility, we found that 37% of the 75 facilities inspected in 2002-2003[9] had not properly documented test findings. In four of the 75 facilities, an employee's TB test results were positive, but there was no documentation indicating the positive findings were followed up with further diagnostic testing to confirm or rule out infection.

- Failure to prevent the loss of residents' property
  Facilities are charged with maintaining inventory records of residents' property. Yet, in 33% of the facilities inspected in 2002-2003[9], administration personnel were not keeping proper inventory records. This failure often results in residents' property disappearing with no way for the facility to track the lost items. During routine interviews with residents of three facilities, we were told that jewelry, purses, money and other items had disappeared without explanation. The residents told us they had informed the staff. However, the loss was not documented.

- Failure to verify whether nurse assistants possess valid professional certification
  An increasing practice is the employment of persons to serve as Certified Nurse Assistants (CNA) who have not been properly certified. It is important for employers to verify that applicants for these positions possess proper certification because upwards of 70% of the care provided at skilled nursing facilities is delivered by CNAs. Certification can be withheld or revoked by DHS for various reasons, including criminal convictions, fraudulent identification, or fraudulent passing of the nursing assistant examination. Attachment B lists some of the duties of a CNA, many of which can result in serious

[8]See Health and Safety Code §1276.5, effective January 1, 2000.

[9] Review of this area was added to the Operation Guardians methodology in 2002-2003.

injury or death if not performed competently.

For the convenience of our readers, this report places compliance problems found during the 150 inspections into the four broad categories of (1) environmental, (2) resident care, (3) administrative, and (4) staffing level. The following defines those categories and presents key findings:

■ *ENVIRONMENTAL NON-COMPLIANCE*:

Of the 150 inspections completed, 136 had compliance problems based on substandard maintenance of the grounds or the building which, to varying degrees, violated the facilities' responsibility to provide a habitable, safe, and liveable environment for their residents. Of the 136 compliance problems, 129 rose to a level that warranted referral to DHS for administrative action. The following were some of the problems identified during the inspections:

- Foul odors from urine and fecal matter
- Loose handrails
- Dilapidated residential living quarters
- Infestations by pests (e.g., roaches, ants, flies, wasps, bees, gnats and/or rodents)
- Mildew
- Hazardous walking surfaces
- Improperly wrapped, open food
- Undated wrapped food

■ *RESIDENT CARE NON-COMPLIANCE:*

Of the 150 inspections completed, 132 had compliance problems related to patient care and treatment. All 132 of these compliance problems rose to a level that warranted referral to DHS for administrative action. The following were some of the problems identified during the inspections:

- Failure to adequately document residents' care and condition
- Failure to completely implement medical staff's orders
- Poor maintenance of emergency medical equipment
- Unsafe storage of controlled substances
- Unsafe storage of medical instruments that could harm residents
- Non-response to call lights
- Over-medication
- Alleged abuse not reported to proper authorities
- Medical staff not making required rounds
- Preventable injuries and health problems
- Failure to attend to basic personal hygiene

Attachment C provides an overview of the major clinical correlates and findings from the medical staff of Operation Guardians. It was authored by Dr. Loren G. Lipson, Chief of Geriatric Medicine at the University of Southern California's School of Medicine.

■ *ADMINISTRATIVE NON-COMPLIANCE:*

Of the 150 inspections completed, 108 found compliance problems related to the oversight of personnel matters, patient trust accounts, and other administrative requirements. All 108 of these compliance problems rose to a level that warranted referral to DHS for administrative action. The following were <u>some</u> of the problems identified during the inspections:

- < Personnel files of licensed or certified care staff lacked any evidence of a proper, up-to-date license or certification
- < Failure to protect residents' personal items, i.e., cash and/or property, stolen or misplaced with no action taken by the administration to rectify the situation
- < Personnel files lacked documentation of required tuberculosis (TB) testing. In instances where TB tests showed positive results, there was no documentation that the employee had been properly re-tested (i.e., chest X-rays) and cleared prior to reinstatement to duty
- < Poor accounting practices for resident trust accounts
- < Resident identification tags were missing
- < Resident discharge records were not properly maintained
- < Lack of proper documentation of staff training

■ *FIRE SAFETY VIOLATIONS:*

Of the 79[10] fire code inspections completed, 60 found violations of local fire safety ordinances that, if left unabated, could have resulted in serious harm or death. The following are <u>some</u> of the problems identified during the inspections:

- < Unsafe chemical storage
- < Inoperable fire extinguishers and/or fire alarms
- < Obstructed fire exits
- < Exposed cables
- < Improperly operating fire doors
- < Inoperable emergency generators

[10]Due to funding shortfalls, staff availability, and workload demands, inspectors from local fire departments participated in only 79 of the 112 original inspections conducted (a 70% participation rate). Fire code inspections were not a component of re-visits because fire inspectors have conducted any followup inspection, if necessary, long before we reinspect a facility.

■ *STAFFING LEVEL NON-COMPLIANCE:*

Of the 116[11] staffing level inspections completed, 79 (68%) failed to meet state laws governing proper staffing levels for skilled nursing facilities. State law requires, at a minimum, 3.2 hours of nursing care (i.e., Certified Nursing Assistants, Licensed Vocational Nurses, Registered Nurses, or other appropriately certified staff) per resident per day[12]. The staffing minimum does not include housekeeping, maintenance, kitchen, clerical or other non-certified staff.

Federal regulations currently do not establish, in quantitative terms, a minimum staffing level. Instead, they require "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident..."[13] In other words, the staffing levels that must be maintained vary and must be at a level such as to adequately care for all resident needs. For instance, if a facility is populated by high need residents with substantial medical difficulties, a ratio exceeding the minimum 3.2 hours would be necessary.

The following is a more detailed breakdown of the results of the 116 staffing level inspections:

HOURS OF NURSING CARE PER RESIDENT PER DAY	NUMBER OF INSPECTIONS SHOWING STAFFING AT THIS LEVEL	% OF ALL 116 INSPECTIONS
3.2 and above	37	32%
3.19 to 3.11	24	21%
3.10 to 3.00	20	17%
2.99 to 2.91	18	15%
2.90 to 2.8	8	7%
Below 2.8	9	8%
TOTALS	**116**	**32% at or above state minimum staffing levels 68% below state minimum staffing levels**

OPERATION GUARDIANS IS MAKING A DIFFERENCE

[11]A review of staffing levels could not be performed in some inspections because staffing records were not physically on the premises. To rectify this problem, Operation Guardians has recently begun requesting copies of time keeping records, for a specified period of time, be sent to the team within one week of our visit.

[12]See Health and Safety Code §1276.5, effective January 1, 2000.

[13]42 C.F.R. § 483.30

- Of the 38 facilities recently revisited (i.e., a follow-up surprise inspection) by Operation Guardians, more than half either had corrected or were in the process of correcting the problems brought to their attention during the original inspection.

- Operation Guardians inspections led to the conviction of two felons. They include:
  (1) An Operation Guardians inspection uncovered a Licensed Vocational Nurse who had stolen narcotic pain medication intended to ease the suffering of residents in an Oxnard facility. The subsequent follow-up investigation by the Bureau's Violent Crimes Unit led to the arrest and conviction of Kimberly Hunt on charges of Possession of Controlled Substances and Grand Theft. During a search warrant served on Hunt's home, agents recovered many medication packets with the names of the residents on the packets, as well as hypodermic syringes and a stolen handgun.
  (2) Information gathered during an Operation Guardians inspection assisted the Violent Crimes Unit in the conviction of Fitz De Guzman, an administrator-in-training at a Napa facility. De Guzman stole approximately $49,000 from facility residents or their families and used threats and intimidation to prevent them from talking about it. De Guzman pled no contest and was sentenced to three years in state prison.

- The California Department of Health Services has responded to Operation Guardians' referrals by conducting their own independent investigations. To date, at least 34 facilities have received DHS-issued deficiencies substantiating Operation Guardians' findings.

- On several occasions, when the loss or theft of residents' property was brought to the attention of administrators, the residents were immediately compensated.

- All inspected facilities, either orally or in writing, acknowledged some or all of the problems identified by Operation Guardians at their respective facility and committed to fixing most, if not all, of those problems.

- Of the 328 fire safety-related violations uncovered as a result of Operation Guardians inspections, all have been corrected or are in the process of being corrected.

- Of the three physicians referred to the Medical Board of California for investigations, two were sanctioned and one is still under investigation.

ATTACHMENTS

- ATTACHMENT A
  "Elder Abuse Prosecutions," tracks the elder abuse criminal filings and convictions over the course of the past decade.

- ATTACHMENT B
  "Fraudulent CNAs: Can They Harm Patients?" lists some of the critical duties of certified nurse assistants, who commonly provide more than 70% of the direct patient care at skilled nursing facilities.

- ATTACHMENT C
  A letter, authored by Dr. Loren G. Lipson, Chief Medical Examiner for the Operation Guardians' team and Chief of Geriatric Medicine at USC, provides an overview of the major clinical correlates and findings from the medical staff of Operation Guardians.

- ATTACHMENT D
  The "Inspection Report Summary" provides a more detailed summary of the compliance problems found at each facility. Any written responses to an Operation Guardians' inspection received from the facilities' owners and/or administrators are also attached.

- ATTACHMENT E
  "Operation Guardians Summary of Compliance Problems" lists all inspections conducted by Operation Guardians during the period of April 2001 through March 2003. It shows the five major compliance areas upon which the team focused during its inspections and whether the facility met the federal standards for that compliance area.