The National CONSUMER VOICE for Quality Long-Term Care formerly NCCNHR

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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3255-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Tavenner,

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is dedicated to advocating for the health, safety, and welfare of nursing home residents and other long-term care consumers throughout the country. Our network, comprised primarily of long-term care consumers, family members, long-term care ombudsmen, citizen advocacy groups and independent advocates, has almost 40 years of experience advocating for quality long-term care.

We look forward to meeting with you, along with representatives of several other advocacy organizations, at the end of October. We, the Consumer Voice, are writing now to express our great concerns about the current system of enforcement that forms the framework for protecting nursing home residents and ensuring their quality of care and quality of life. The issues we raise have been identified repeatedly in a history of evaluative reports (see Addendum to this letter) and continue to be evident in the findings of the recent DHHS Office of Inspector General (OIG) report on our nation's nursing homes (Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, 02/14 OEI-06-11-00370); in the concerns and experiences of consumers, families and advocates in our network; and in many horrific accounts that are regularly reported in the news media. Yet, as quality of care continues to diminish, enforcement actions are actually decreasing.

The OIG report is only the most recent evaluation identifying problems with CMS's oversight of states' surveillance and enforcement of nursing home non-compliance. In just a five year period - between 2007 and 2012 - nursing home enforcement actions decreased by 65%.[1] These statistics reflect the concerns and observations members of our network have reported: the failure of their state survey agencies to vigorously enforce the federal nursing home regulations. This is something that must be confronted in a

[1] http://www.ltccc.org/news/documents/EnforcementTrends--2007-2013-June2013.xls

serious way. Below are just a few of the many reasons for this weak and declining enforcement, along with actions we believe must be taken.

Failure to identify serious care issues
For years residents and their families, long-term care ombudsmen and citizen advocates have told us about care problems that are not identified or recorded during the survey or complaint investigation process. Their concerns have been validated by at least two GAO studies:

- *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517, May 9, 2008
- *Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, But Implications for the Longer-Term Trend Are Unclear,* GAO-10-434R: Apr 28, 2010.

A third study that was conducted for CMS, *Improving Nursing Home Enforcement: Findings from Enforcement Case Studies*, March 22, 2007, found that "very basic and openly practiced deficient care and documentation irregularities were often missed by a survey team …. These practices were not incidental or isolated occurrences; rather, they were common and affected many residents."

Years after these investigations and studies, the same problems persist. On April 2, 2014, Senators Charles Grassley and Bill Nelson wrote to you expressing their concern regarding the findings of the February 2014 OIG Report. Their letter accurately stated that "…surveys [to ensure quality of care] should be able to identify problems that exist before they compromise patient care."

Their point, and that of the advocate and consumer communities, is that "you cannot correct what you don't detect." The failure to identify or record deficiencies results in no enforcement actions. With no corrective action, serious problems can harm, injure or cause the death of residents, while less severe problems continue and worsen, placing residents at risk of harm and death, as was likely the case in the facilities included in the OIG report.

Failure to appropriately assign scope and severity
The OIG report clearly demonstrates that a much higher level of harm is occurring in our nation's nursing homes than the scope and severity levels of deficiencies indicate, yet people intimately familiar with care in many facilities feel that the level of harm is understated in the OIG report. There is no doubt that these adverse events are not limited to Medicare beneficiaries who have recently transferred out of a hospital – the focus of the OIG report – and that the numbers/percent of residents suffering preventable harm and adverse events is significantly greater when applied to the entire nursing home

population, including Medicaid beneficiaries that comprise the majority of nursing home residents.

Our long-standing and increasing concern is that the vast majority of deficiencies are assigned a "no harm" level of scope and severity - a level which rarely leads to any enforcement actions.

Below is just one example of a deficiency that was assigned a D level (as you know, D level means the deficiency is considered to affect very few residents and to have the potential for more than minimal harm) despite the injury and physical decline sustained by a resident:

> One of 27 residents in the sample was given Haldol, sometimes intramuscularly, sometimes PRN. As a consequence, the resident fell frequently, breaking several teeth in one fall; declined in activities of daily living (from requiring limited assistance to requiring total care); became incontinent of bowel; and slept frequently (in the dining room, on the floor).[2]

In 2012, the percentage of deficiencies with a scope and severity level less than actual harm was 96.9% - the highest level since 2003.[3] At the same time, enforcement actions declined to an all-time low of 3,152.[4]

Inadequate monitoring of states performance; failure to hold states accountable
Since CMS contracts with states to ensure nursing home compliance with federal nursing home regulations, CMS must monitor the performance of each state. This is accomplished through the use of State Performance Standards System Guidance. However, these standards focus more heavily on process than the quality of state oversight. For instance, there is little or no attempt to assess whether sanctions that the state proposed or imposed are appropriate.[5] The standards do not require CMS to look at whether the absence of deficiencies or low citations of deficiencies are appropriate.

The current CMS State Operations Manual (SOM) undermines the ability of CMS to hold states accountable in two essential ways. First, the SOM permits states to offer evidence to rebut the charge or compelling evidence that the state has not accurately cited deficiencies in facility surveys. The state is given the opportunity to correct such deficiencies before more severe sanctions are imposed. Even if the problems are found again, the state has another opportunity to rebut the findings or offer compelling reasons

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[2] http://www.medicareadvocacy.org/cma-report-examining-inappropriate-use-of-antipsychotic-drugs-in-nursing-facilities/#_edn12
[3] Nursing Home Compendium, 2013 edition
[4] http://www.ltccc.org/news/documents/EnforcementTrends--2007-2013-June2013.xls
[5] Government & Oversight of Nursing Home Care: The Relationship Between Federal and State Agencies, 2010. http://www.ltccc.org/publications/documents/LTCCCReportCMSOversight2010.pdf

for the Regional Office to forgo the imposition of sanctions. Second, the SOM says that CMS must consider circumstances beyond the control of the state governor in assessing the degree of culpability of a state. This makes it possible for states to avoid meaningful sanctions no matter how poor their performance in the enforcement of nursing home standards.[6]

Failure to use enforcement remedies or to use them effectively

The Nursing Home Reform Law gives CMS a wide range of remedies to use for corrective action, yet many sanctions that would be appropriate are not imposed or not applied at a level or in a manner to effect change. Some remedies are not employed at all and others are not employed effectively.

Sanctions not used: Feedback from our network indicates state survey agencies are unwilling to impose civil monetary penalties (CMPs) and rarely use temporary management and directed plans of correction. Temporary management can be an alternative to Medicare/Medicaid termination when nursing homes place residents at risk of death or serious injury (Immediate Jeopardy) or widespread risk of actual harm. A temporary manager can take the necessary steps to bring a home back into compliance without forcing residents to leave; as requiring residents to relocate victimizes them twice – first through substandard care and second through the risks of transfer trauma. Not only is CMS not employing this sanction, its use is being blocked. Two years in a row, Ohio's state survey agency tried to impose temporary management instead of facility closure. The CMS Regional Office denied this effort on both occasions. With these denials, state survey agencies have come to rely too heavily on the threat of termination instead of using the full range of available remedies.

Directed plans of correction are another example of an infrequently used enforcement remedy even though states using them have reported success in increasing compliance with federal and/or state quality requirements.[7]

Sanctions not used effectively: When sanctions are imposed, they are often too minimal to have a deterrent effect. This is particularly the case with civil monetary penalties. A GAO study found that CMS does not utilize the full dollar range allowed for civil monetary penalties. Instead, fines tend to be toward the lower ends of the ranges.[8] This case in Connecticut illustrates how ludicrously small many fines often are, particularly when compared to the harm caused to the resident:

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[6] Ibid.

[7] Promising Practices in State Survey Agencies: Issue Brief: Achieving Better Outcomes Using Survey & Certification Enforcement Strategies. 12/18/07

[8] Nursing Home Enforcement: The Use of Civil Monetary Penalties. Department of Health and Human Services, Office of Inspector General. April 2005.

> Whitney Manor of Hamden was fined $1,360 on March 11 (2014) in connection with an incident in which a resident lodged his or her head between the vertical slats of a bed rail, records show.
>
> On Feb. 25, the resident was found between the slats, bleeding from the mouth, with some teeth on the floor and some embedded in the bed rail, records show. The resident was hospitalized and received dental care. The home determined that the side rails were seven and three-quarters inches apart, records show. It replaced many of the beds with rails with smaller openings between slats, records show. DPH found that the director of nursing had not directed the staff to assess the 52 residents' behavior or condition to identify whether they were at risk for entrapment in the side rails until March 3.[9]

Penalties this low are insufficient to deter repeat or continued violations; they must be large enough to have an impact on the facility and result in sustained compliance. In fact, CMS's State Operations Manual, Chapter 7, gives states guidance on imposing CMPs with the example that if failure to spend money is the root cause of the facility's noncompliance, then any civil money penalty imposed should at least exceed the amount saved by the facility. When poor care costs the facility more than good care, an incentive for compliance is created.

CMS has the ability to tailor remedies to the specific problems found in a facility. Yet a study that looked at enforcement cases found that enforcement actions are selected in a routine way and with little differentiation between the needs or problems of facilities.[10]

Lastly, we know of at least one instance of a sanction that "disappeared." In Kansas, a serious instance of abuse had been cited at an Immediate Jeopardy level and a fine of $9,000 issued in January 2012. Both the deficiency and the fine were deleted, with no public explanation. With no corrective action required, the abuse continued and escalated: within 20 months the same facility was cited for actual harm, abuse, and failure to report abuse and fined $150,000.

Enforcement Replaced by Consultation and Collaboration

A key reason for inadequate and decreased enforcement actions is that CMS enforcement, as required by the federal law, has been supplanted by consultation and collaboration with the nursing home industry. This is strikingly evident in CMS's response to the shocking failures in nursing home care (primarily related to nurse staffing) that were revealed by the OIG Report. CMS's formal response to the report made clear it planned to rely on facilities' own self-directed Quality Assessment and Performance Improvement (QAPI) programs to eliminate serious quality and safety

[9] Connecticut I-Health Team, August 5, 2014

[10] Improving Nursing Home Enforcement: Findings from Enforcement Case Studies, March 22, 2007

problems, rather than addressing other studies' findings that states frequently fail to cite deficiencies for harm like that described by the OIG, or if they cite them, fail to impose meaningful penalties. It is not surprising that John O'Connor, editorial director of *McKnight's* Long Term Care News, wrote an article about the OIG report under the headline, "Federal regulators say they will back off nursing homes—at least for now" (McKnight's 03/10/14). Mr. O'Connor noted that "[r]ather than promising a crackdown featuring tougher inspections, the agency is saying that the Quality Assessment and Performance Improvement [QAPI] program will take care of the mess." While it is understandable for a publication that caters to the nursing home industry to support CMS's reliance on self-correction, it is not acceptable for the federal agency tasked with enforcement to put forth QAPI as the solution to the serious problems found by the OIG.

Consumer Voice believes that facilities should engage in quality assurance and performance improvement efforts. However, QAPI is no substitute for meaningful enforcement, as prescribed by law – statutes that Congress passed in order to protect the health, safety, welfare and rights of nursing home residents. Furthermore, the nation's Quality Improvement Organizations (QIOs) are tasked to work with the industry to educate nursing homes and promote best practices. Survey and Certification is charged with regulatory responsibilities to enforce the provisions of the Nursing Home Reform Law. Both are essential but have very different roles and responsibilities. Nursing homes have many options available to them for technical assistance and consultation; nursing home residents, their families and the public have only one place to turn for enforcement of federal regulations – CMS. CMS is the sole federal entity specifically charged with ensuring that facilities comply with the federal requirements designed to protect dependent and vulnerable nursing home residents.

In 1986, the Institute of Medicine (IoM) identified four primary problems with enforcement: 1) federal and state attitudes toward enforcement, 2) federal rules and procedures, 3) state variations in enforcement authority, policies and procedures, and 4) inadequate federal and state resources committed to enforcement. The IoM found that "federal procedures for dealing with facilities found to be out of compliance are oriented toward helping facilities to improve rather than enforcing the certification standards," with the result that the federal approach "allows states to continue certifying facilities that provide poor or marginal care."[11] The IoM noted that "[c]urrent federal policies requiring consultation undermine state agency efforts to eliminate substandard providers and deter marginal facilities from repeating violations."[12]

The IoM recommended modifying federal and state enforcement procedures "to reorient the program toward enforcement rather than consultation and to encourage states to adopt a stronger enforcement posture" by "(1) separating the consultant and surveyor roles, (2)

[11] Improving the Quality of Nursing Home Care, p. 147. Institute of Medicine, 1986.
[12] Ibid.

making survey follow-up procedures more specific, (3) making federal and state sanctions more comprehensive and applying them more rigorously, and (4) increasing both federal oversight and federal support of state enforcement activities."[13] The 1986 IoM Report could be reprinted with today's date, identifying the same problems, and recommending the same solutions. It is hard to imagine how many people depending on nursing homes for quality care have been adversely affected by this enforcement failure.

More than a decade ago, William Scanlon, then director of Health Financing and Public Health Issues at GAO, testified before the U.S. Senate Finance Committee. Looking back over more than six years in his position at GAO, Dr. Scanlon objected to "quality initiatives" as a substitute for strengthening the survey and enforcement process, and he rejected a consultative role for surveyors: "The nursing home industry is a $100 billion a year industry, employing tens of thousands of health professionals. It is incongruous to me to think that it needs the consultative assistance of a government surveyor to correct problems that every non-health professional in this room would instantly agree involved care that was simply and woefully lacking."[14] Dr. Scanlon concluded by dismissing the contention that the enforcement process is unable to ensure quality of care for residents:

> "My perspective is different. I do not believe we have adequately implemented the survey and enforcement process as envisioned in OBRA 1987, and further defined by HFCA [now CMS]. The execution of surveys and enforcement actions that should follow them have been so lacking, we do not know how effective the process can be."[15]

Dr. Scanlon's testimony is as applicable and his conclusions are as true today as they were when he appeared before Congress in July 2003.

Failed enforcement has consequences for people, for our citizens. The human costs attributable to the harm and even death of residents nationwide are unconscionable; the monetary costs of failed care are staggering. The OIG report must serve as a call to action.

To that end, we request that CMS take the following actions:

1. **Create an Office of Enforcement headed by an "Enforcement Czar" and staffed with qualified enforcement experts.** The current system within CMS fails to provide adequate oversight of enforcement actions, and a separate office outside of the existing structure is necessary to adequately address and remedy

[13] Ibid.
[14] Nursing Home Quality Revisited: The Good, the Bad, and the Ugly. 108th Cong., 1st Sess, S.Hrg. 108-325, July 17, 2003.
[15] Ibid.

these shortcomings. The purpose of this action is to achieve an independent office solely dedicated to enforcing established laws and regulations in order to protect nursing home residents and to ensure quality care. This Office would be located outside of the Survey and Certification Group (S&C) and the Center for Clinical Standards and Quality (CCSQ) and report directly to the CMS Administrator. While survey and enforcement authority would remain within S&C, the Office of Enforcement would monitor enforcement actions to ensure strong, consistent and appropriate enforcement. This would include 1) review of survey results, including scope and severity, 2) review and analysis of enforcement remedies to see that the best and strongest measures are being imposed, and 3) monitoring of survey and enforcement trends. The Office would serve as a "watchdog," making recommendations to CMS and Congress about ways in which the enforcement system could be improved in order for nursing homes to achieve compliance with the Nursing Home Reform Act. It must be led and staffed by qualified professionals dedicated to enforcement of the law.

2. **Require an entity outside of CMS to conduct periodic, independent audits of surveys from across the country.** These reviews would be separate from those conducted by the Office of Enforcement and would have to be structured to ensure objectivity and greatly reduce conflicts of interest. Such audits are essential for revealing issues related to deletion and downgrading of deficiencies. The necessity of these audits is evidenced by a recent article in the *Los Angeles Times* which reported that an audit revealed supervisors had downgraded findings in 40% of closed nursing home inspection cases, "meaning that the nursing home got a less serious citation or a smaller fine."[16]

3. **Change State Operations Manual guidance and state standard performance guidance to hold states more accountable for their survey and enforcement duties.** Current language in the SOM permits states to dispute citations for poor performance and requires CMS to consider circumstances beyond the control of the state governor when assessing a state's poor performance and must be eliminated. Such language permits states to escape accountability and responsibility for failure to effectively perform their duties, weakening the overall enforcement process. Additional measures relating to the quality of survey and enforcement should be added to State Performance standards as well.

[16] Los Angeles Times, Audit Finds Some LA County Nursing Home Cases Prematurely Closed. August 28, 2014. Kaiser Health News. Another Audit Finds Fault with Nursing Home Inspections in Los Angeles County. August 29, 2014.

4. **Significantly increase transparency and disclosure of enforcement information**. The public has little or no access to enforcement data, despite the fact that knowing what sanctions have been imposed against a facility is important when choosing a nursing home. Only information about fines and denial of payment is posted on Nursing Home Compare. Consumers need data about the full range of enforcement remedies in order to get a better understanding of a facility's performance. Publicly posting all sanctions against a nursing home creates pressure on facilities to improve.

   For each state, CMS should post online the annual number of deficiencies cited and where they fall within each level of scope and severity. This information is available, but it is difficult to find. Easy access to these data would allow consumers, advocates and the public to know how their state compares with other states.

   Finally, nursing home residents and their families should be notified of enforcement actions at the time the facility is notified. Far too often, residents - the ones most affected - and their families are the last to know about any penalties, even in cases when termination is the potential certain outcome of a survey. Residents should know what is happening in their home: it affects their daily lives and like any other citizen, they should have the information necessary to ensure they are living in a place that can meet their physical and emotional needs.

There are many more recommendations we could provide, and we would be happy to do so. However, these four actions represent a major step toward a stronger, more effective enforcement system - one that, in Director Scanlon's words, "implements the enforcement process as envisioned in OBRA 1987."

Conclusion

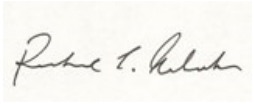
Ineffective enforcement sends a message to nursing home operators and providers that they can *get away with* poor care. As a voice for consumers, however, we must add an additional perspective, a common reaction that has occurred as a result of the current enforcement system and its failure to achieve quality care in nursing homes consistent with existing law, regulations and resident rights: Across America, consumers fear nursing homes, and many people will do anything to avoid them. While many consumers have access to other long-term care options, in an aging population in which the fastest growing segment is the very aged who are often frail and suffering from disability or chronic and progressive health conditions, there are millions of people for whom nursing home care will be the most appropriate or only long term care option for their circumstances (medical, familial, and financial). It is unacceptable that they feel they

must avoid their best option because they fear their health, welfare, safety, and rights will not be protected.

It is unacceptable that the laws designed to protect nursing home residents who are generally highly dependent on others for the quality of care they receive are not being enforced by the federal government and the agency charged with that responsibility.

Consumer Voice is committed to taking actions that support and achieve effective enforcement of the Nation's nursing home laws and regulations. Our first steps are to share this review and to meet with you as CMS Administrator. In that regard, we look forward to meeting with you in October and hearing your plan to adopt these recommendations or others, as we all work to further support effective enforcement of nursing home resident protections.

Sincerely,



Richard L. Gelula
Executive Director

Robyn Grant
Director of Public Policy and Advocacy

Addendum to Letter to CMS Administrator Marilyn Tavenner
September 16, 2014

Numerous OIG, Government Accountability Office (GAO) and other reports validate the conclusion that the Nursing Home Reform Act, OBRA '87, an enforcement statute, has been largely abandoned/ignored by the Centers for Medicare and Medicaid Services (CMS). The following are but a few examples of CMS's longstanding, continual reported failings.

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries (OEI-06-11-00370): February 2014; https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf

Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040): Nov. 18, 2013
https://oig.hhs.gov/oei/reports/oei-06-11-00040.asp

CMS Should Improve Efforts to Monitor Implementation of the Quality Indicator Survey [Reissued on March 9, 2012]
GAO-12-214: Feb 1, 2012.

More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations
GAO-11-280: Apr 7, 2011.

Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear. GAO-10-434R: Apr 28, 2010.

Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment GAO-10-70: Nov 24, 2009.

Opportunities Exist to Facilitate the Use of the Temporary Management Sanction. GAO-10-37R: Nov 20, 2009.

Responses from Two Web-based questionnaires to *Nursing Home* Surveyors and State Agency Directors (GAO-10-74SP), an e-supplement to GAO-10-70 GAO-10-74SP: Nov 24, 2009.

CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing *Homes*, Which Tended to Be Chain Affiliated and For-Profit GAO-09-689: Aug 28, 2009.

CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities. GAO-09-64: Feb 13, 2009

Memorandum Report: Trends in Nursing Home Deficiencies and Complaints (OEI-02-08-00140): September 2008 http://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf

Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses GAO-08-517: May 9, 2008

Nursing Home Enforcement: Processing Denials of Medicare Payment. (OEI-06-03-00390): May 2008 http://oig.hhs.gov/oei/reports/oei-06-03-00390.pdf

Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes. GAO-07-794T: May 2, 2007

Efforts to Strengthen Federal Enforcement Have Not Deterred Some *Homes* from Repeatedly Harming Residents. GAO-07-241: Mar 26, 2007

Nursing Home Complaint Investigations (OEI-01-04-00340): July 2006 http://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf

Nursing Home Enforcement: Application of Mandatory Remedies (OEI-06-03-00410): May 2006 http://oig.hhs.gov/oei/reports/oei-06-03-00410.pdf

Nursing Home Enforcement: The Use of Civil Money Penalties (OEI-06-02-00720): April 2005 http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf

Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety. GAO-06-117: Dec 28, 2005

STATE REFERRAL OF NURSING HOME ENFORCEMENT CASES (OEI-06-03-00400): December 2005 http://oig.hhs.gov/oei/reports/oei-06-03-00400.pdf

Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care. GAO-05-78: Nov 12, 2004

Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline.
GAO-03-1016T: Jul 17, 2003

Nursing Home Deficiency Trends and Survey and Certification Process Consistency (OEI-02-01-00600): MARCH 2003 https://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

More Can Be Done to Protect Residents from Abuse. GAO-02-312: Mar 1, 2002

Many Shortcomings Exist in Efforts to Protect Residents from Abuse. GAO-02-448T: Mar 4, 2002

Nursing Home Deficiency Trends and Survey and Certification Process Consistency. http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. HEHS-00-6: Nov 4, 1999

HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care. T-HEHS-00-27: Nov 4, 1999

Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. HEHS-99-154: Aug 13, 1999

Abuse Complaints of Nursing Home Patients (OEI-06-98-00340): May 1999. https://oig.hhs.gov/oei/reports/oei-06-98-00340.pdf

Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care. T-HEHS-99-89: Published: Mar 22, 1999. Publicly Released: Mar 22, 1999

Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. HEHS-99-46: Mar 18, 1999

Federal and State Oversight Inadequate to Protect Residents in *Homes* With Serious Care Violations. T-HEHS-98-219: Jul 28, 1998

Nursing Home Survey and Certification: Deficiency Trends http://oig.hhs.gov/oei/reports/oei-02-98-00331.pdf

Nursing Home Survey and Certification: Overall Capacity http://oig.hhs.gov/oei/reports/oei-02-98-00330.pdf