

NURSING HOME
RESIDENT ABUSE AND
COMPLAINT
INVESTIGATION
PROGRAM REPORT

JANUARY 1, 2013 – DECEMBER 31, 2013

NEW YORK STATE DEPARTMENT OF HEALTH

March 24, 2014

Table of Contents

INTRODUCTION.....	1
NEW YORK STATE NURSING HOME SURVEILLANCE PROGRAM.....	2
<i>Figure 1 –Regional Office Counties Served.....</i>	<i>2</i>
<i>Figure 2 –Nursing Homes by Regional Office</i>	<i>3</i>
THE COMPLAINT INVESTIGATION PROCESS	3
<i>Figure 3 –Method of Reporting, Third Party Reported Complaints.....</i>	<i>4</i>
Public Health Law Section 2803-d Complaints of Abuse.....	5
Complaints about the Provider	6
Cases Received by the Department	7
<i>Figure 4 – Total Cases Received by Regional Office 2013</i>	<i>7</i>
<i>Figure 5 – Total Cases Received by Year 2009-2013.....</i>	<i>8</i>
Cases Closed by the Department.....	9
<i>Figure 6 – Total Cases Closed by Disposition 2013.....</i>	<i>9</i>
<i>Figure 7 – Total 2803-d Cases Closed by Regional Office 2013</i>	<i>10</i>
<i>Figure 8 – Total 2803-d Cases Closed by Year 2009-2013.....</i>	<i>11</i>
COMPLAINT PROGRAM INITIATIVES	11
ENFORCEMENT ACTIVITIES	12
<i>Figure 9 – Total Immediate Jeopardy Surveys by Year 2009-2013.....</i>	<i>13</i>
<i>Figure 10 – Total Immediate Jeopardy Citations by Year 2009-2013</i>	<i>13</i>
<i>Figure 11 – Section 12 Fines Assessed by Year 2009-2013</i>	<i>14</i>
CONCLUSION	14

INTRODUCTION

The New York State Department of Health (Department) protects and promotes the health of all New Yorkers through prevention, science and the assurance of quality health care delivery. Assuring high quality care and quality of life for all nursing home residents in New York State is an agency priority. Whether they are the elderly, young adults or children, nursing home residents are among the most vulnerable to abuse, neglect or mistreatment. They are often less able to defend themselves against harm.

To protect the health and safety of these residents, the Department aggressively and thoroughly investigates allegations of abuse, neglect, mistreatment and other negligent practices within our State's nursing homes, and takes appropriate action when these allegations are substantiated by evidence.

The Patient Abuse Reporting Law, Public Health Law (PHL) Section 2803-d, was enacted in 1977 to protect persons living in nursing homes from abuse, neglect and mistreatment. The law requires every nursing home employee -- including administrators and operators -- and all licensed professionals, whether or not employed by the nursing home, to report instances of alleged abuse, neglect or mistreatment to the Department. The statute requires the Department to investigate all such allegations, and also provides sanctions against individuals who are found guilty of these acts and against anyone required to report, but who fails to do so.

This report provides statistics and information about the Department's investigation of allegations of abuse, neglect and mistreatment from January 1, 2013 to December 31, 2013. It also describes how the Department ensures that complaints are thoroughly investigated in a timely manner, and discusses steps the agency implemented during 2013 to further protect nursing home residents from potential abuse, neglect or mistreatment. The Department remains committed to aggressively investigating all allegations of nursing home residents being harmed or in danger of harm.

NEW YORK STATE NURSING HOME SURVEILLANCE PROGRAM

The Department’s Nursing Home Surveillance Program, within the Office of Primary Care and Health Systems Management, Center for Health Care Quality and Surveillance, has surveillance responsibilities for long-term care facilities throughout New York State. The Nursing Home Surveillance Program conducts complaint investigations through the Central Office in Albany and four Regional Offices:

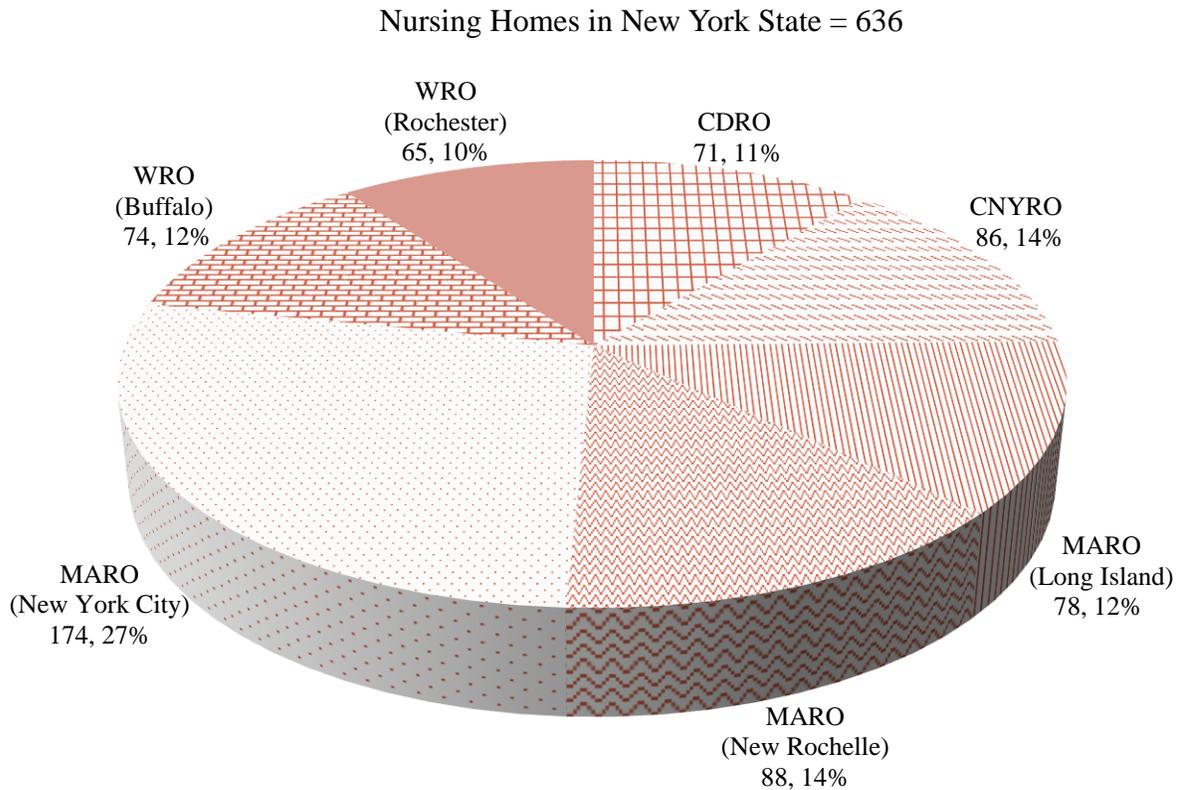
- ❖ Capital District Regional Office (CDRO) in Albany;
- ❖ Central New York Regional Office (CNYRO) in Syracuse;
- ❖ Metropolitan Area Regional Office (MARO) with offices in New York City, New Rochelle and Central Islip; and
- ❖ Western Regional Office (WRO) with offices in Buffalo and Rochester.

Each Regional Office is responsible for nursing home surveillance activities in specific counties (See Figure 1). In calendar year 2013, the Department surveyed 636 nursing homes (See Figure 2) and conducted 3,200 complaint surveys at nursing homes and another 3,000 complaint investigations at the Central Office. Through their ongoing contact with providers, Regional Office investigators acquires in-depth knowledge of the local long-term care system and the operations of its nursing homes, and can quickly respond to reports of nursing home deficient practices in their geographic area.

Figure 1 –Regional Office Counties Served

REGIONAL OFFICE	COUNTIES SERVED
Capital District (CDRO)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Central New York (CNYRO)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins
Metropolitan Area (MARO)	Bronx, Kings, New York, Queens, Richmond, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester, Nassau, Suffolk
Western (WRO)	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

Figure 2 –Nursing Homes by Regional Office



THE COMPLAINT INVESTIGATION PROCESS

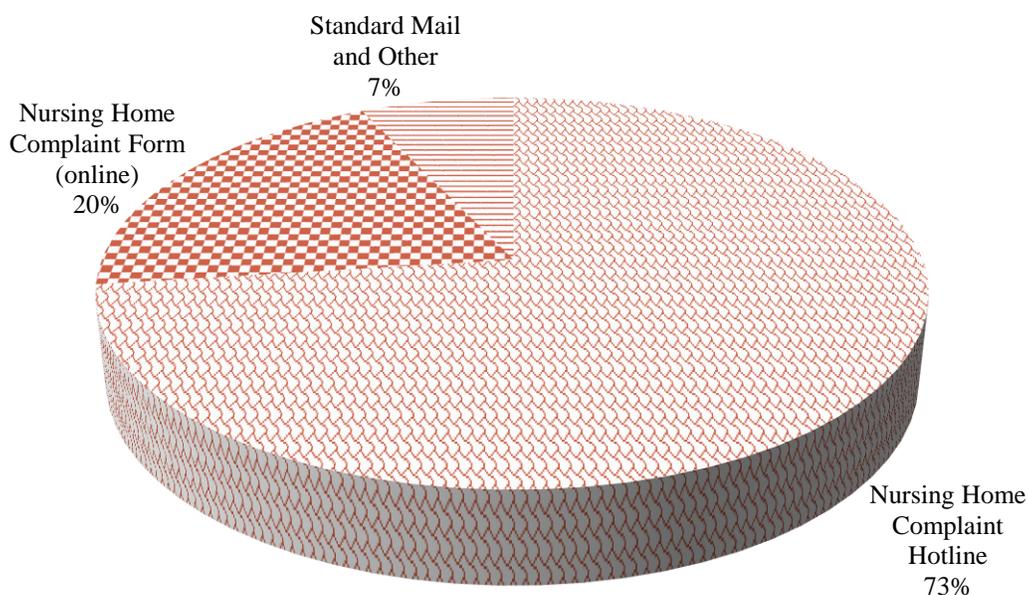
When the Department receives an allegation of an actual or potential adverse resident outcome, the submission is categorized by Nursing Home Complaint Hotline staff as an allegation of abuse, neglect or mistreatment against an individual, or as a general complaint against the provider that alleges a violation of Federal or State regulation. The allegation is opened as an investigation or “case.” A case may include more than one allegation. The case is then investigated by the appropriate Regional Office to determine whether the allegation occurred and if PHL Section 2803-d and/or Federal or State regulation has been violated.

Between January 1, 2013 and December 31, 2013, the Department received 10,696 allegations, 20% greater than in calendar year 2012. Of these, **9,829 (92%)** were related to allegations of violations of Federal or State regulation by the provider, and **867 (8%)** were allegations of resident abuse, neglect, or mistreatment by an individual. In

each case, the Department commenced its standard investigation, which thoroughly reviews the facts surrounding each allegation.

Third-party reported complaints (those from residents, family, friends, etc.) are initiated by complainants via standard mail (7%), by calling the Department’s Nursing Home Complaint Hotline (**888-201-4563**) (73%), or by submitting an online Nursing Home Complaint Form (20%). A large number of the cases received -- **about 56% in 2013** -- are self-reported incidents, which are submitted by nursing homes through an online Incident Reporting Form. PHL Section 2803-d requires designated persons in nursing homes to report any instance in which the facility has determined there is reasonable cause to suspect that a resident has suffered abuse, neglect, or mistreatment. All provider complaints received within the Department’s jurisdiction and authority are investigated.

Figure 3 –Method of Reporting, Third Party Reported Complaints



Each complaint is assigned to the Regional Office or Central Office for investigation and a projected completion date is established during a triage process, which determines the immediacy of the case. The assignment of a completion date and the determination that an onsite investigation is required are based on the seriousness of the complaint, evaluation of safety measures in place, current level of risk to all residents in the home and existing survey schedule. Complaints fall into two categories: those that allege a violation of PHL Section 2803-d related to resident abuse, neglect or mistreatment and those that allege a violation by the provider of Federal or State

regulation. Those complaints that are outside the Department's jurisdiction are promptly referred to the appropriate Federal or State agency.

Public Health Law Section 2803-d Complaints of Abuse

PHL Section 2803-d involves cases of abuse, mistreatment and neglect against an individual or individual(s) alleged to be responsible. It also describes complaints of failure to report such incidents by individuals required to do so. Department investigators also examine whether any systemic issues exist in the facility by conducting a concurrent Federal investigation, as defined on Page 6 of this report.

The investigation conducted by Regional Office investigators includes facility observation, review of records and interviews (when possible) with all individuals related to the case, including the resident, regarding the circumstances associated with the allegation. After completion of the investigation, the Regional Office issues a recommendation for the disposition of the case.

All completed PHL Section 2803-d investigations are reviewed by a Commissioner of Health's designee in each Regional Office. Substantiated cases are forwarded to the Central Office for final determination on the disposition of the case. Complaints are closed with one of the following three outcomes:

- ❖ **Sustained Resident Rights Violation:** There is sufficient evidence that a violation of PHL Section 2803-d occurred and individual culpability is established. Fines are assessed.
- ❖ **Sustained Abuse Violation:** There is sufficient evidence that the incident or event of abuse occurred, that it constitutes a violation of the regulation and individual culpability is established. Fines are assessed.
- ❖ **Unsustained Abuse Violation:** There is insufficient evidence that the event or incident occurred, or there is insufficient evidence that the incident or event of abuse constitutes a violation of the PHL Section 2803-d.

In all cases where it is determined that there is evidence that an abuse violation exists, the accused individual(s) is/are notified by the Department's Division of Legal Affairs of the violation and is/are apprised of his/her due process rights via certified mail. A request for a fair hearing may be made in writing within 30 days of receipt of the Department's letter. The administrator of the facility is concurrently notified of the determination.

All fair hearings are scheduled and conducted by the Division of Legal Affairs. The purpose of the hearing is to determine whether the record should be amended or expunged on the grounds that the record is inaccurate or the evidence does not support the determination. The hearing can determine whether a fine is warranted. Once all due process requirements have been satisfied, the accused individual and complainant are advised, in writing, of the final outcome of the case.

In cases where there is insufficient evidence that an abuse violation exists, the accused individual and the complainant are notified that the complaint is unsubstantiated. All records related to the report are expunged in accordance with the statute.

Complaints about the Provider

Federal and State regulations require nursing homes to establish policies and procedures to ensure that each resident attains and maintains his/her highest practicable level of physical, mental and psychosocial well-being. When these policies and procedures are not followed and a breakdown occurs in the system, residents can be affected. In many cases, negative outcomes do occur.

General provider complaints are defined as alleged incidents or events that result from breakdowns of the policies and procedures instituted by the provider for the provision of care, services, treatments, medications, food, physical plant and maintenance. Unlike patient abuse allegations under PHL Section 2803-d, where the ultimate culpability rests with an individual(s) in an isolated situation or incident, the ultimate culpability in general provider complaints rests with the nursing home.

When the complaint alleges resident harm, Federal guidelines require an unannounced onsite investigation at the facility. Regional Offices investigators are responsible for conducting onsite investigations for this type of complaint. When no harm is alleged and a review of the facility's investigation and other written information is sufficient to conduct an appropriate investigation, Central Office investigators are responsible for the investigation. All investigations focus on the regulatory areas which were the basis for the allegations. An alleged deficient practice is examined against the nursing home regulatory requirements to determine whether a violation has occurred. When warranted, a Statement of Deficiencies (SOD) is issued to the nursing home requiring that a Plan of Correction (POC) be developed and implemented by the nursing home.

The POC submitted for Department approval must address the issues and identify preventive or proactive measures that will detect and monitor ongoing practices in the home to minimize reoccurrence. Additional sanctions, such as required staff training,

directed corrective action plans, fines and limitations on resident admissions are also imposed in more serious situations.

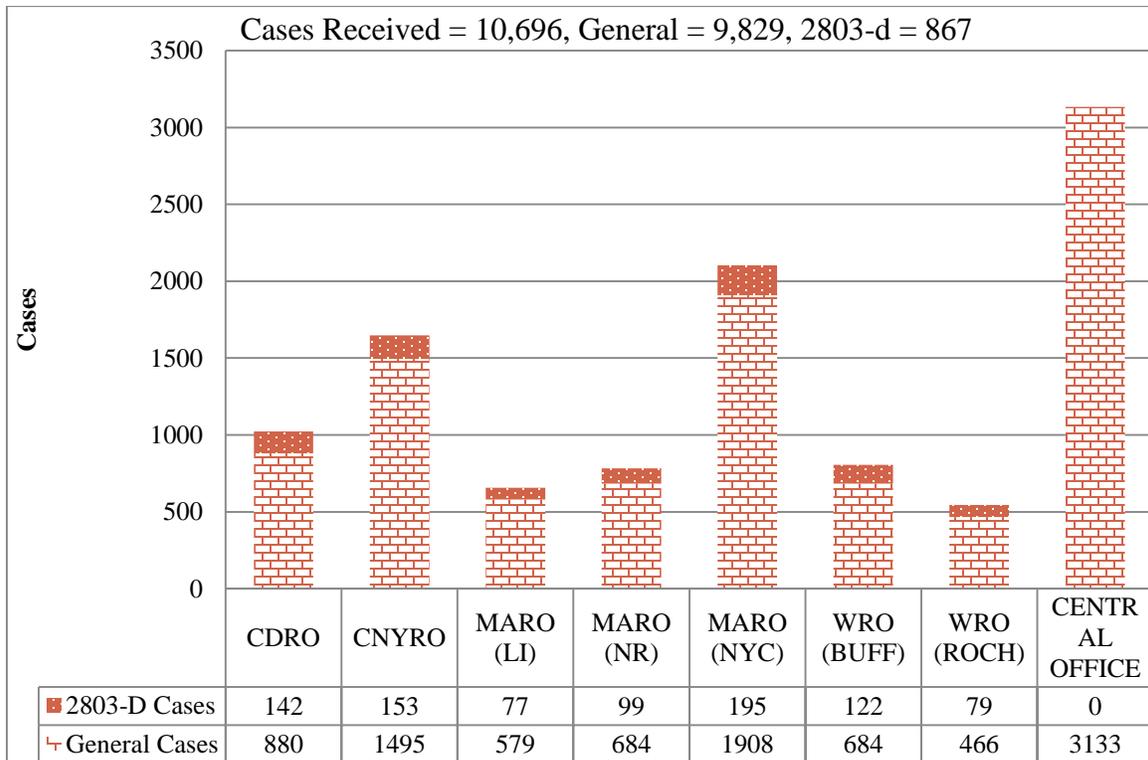
Complaints against providers are closed, per Federal guidelines, with one of the following two outcomes:

- ❖ **Sustained:** Deficient practices identified during a survey are operational violations of Federal and/or State regulations, and an SOD is issued to the provider as a result of the complaint.
- ❖ **Unsustained:** Insufficient evidence was found to validate the complaint, or sufficient evidence was collected to verify the complaint, but violation of a regulation by the provider did not occur.

Cases Received by the Department

Between January 1, 2013 and December 31, 2013, the Department received **10,696** cases. Of these cases, 8% (**867**) were related to allegations of violations of PHL Section 2803-d. The distribution of cases received by Regional Office is displayed in Figure 4.

Figure 4 – Total Cases Received by Regional Office 2013



The number of PHL Section 2803-d cases reported to the Department has fluctuated over the last five years, but remains at about the same level as that reported in 2009 (See Figure 5). Regional Office investigators commence investigations immediately on receipt of allegations of abuse, neglect or mistreatment of residents, and the agency takes swift and aggressive action against those that are found to have committed such acts.

Figure 5 – Total Cases Received by Year 2009-2013

Year	Total Cases Received	General Cases Received	2803-d Cases Received	% of 2803-d Cases
2009	9,242	8,384	866	9%
2010	9,155	8,408	760	8%
2011	8,572	7,946	637	7%
2012	8,909	8,039	870	10%
2013	10,696	9,829	867	8%

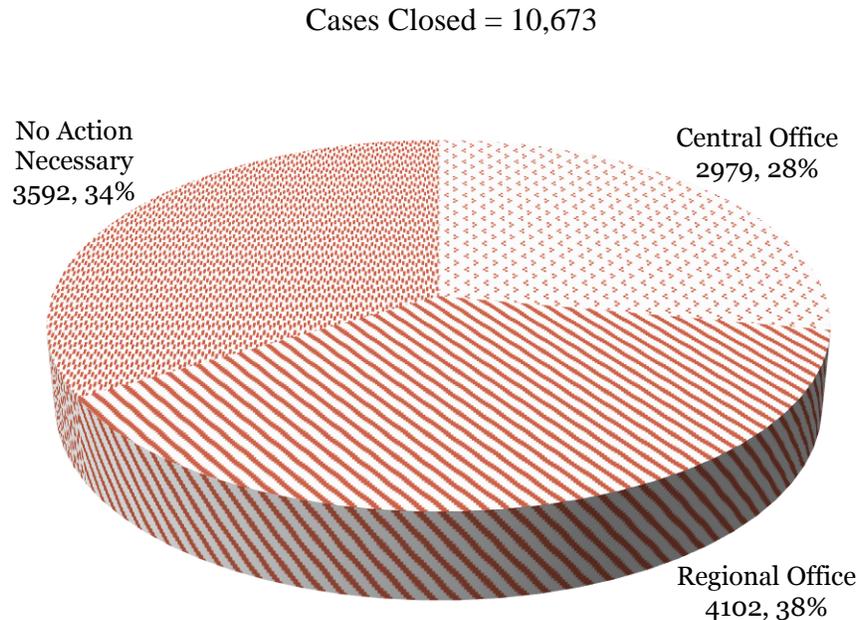
Any case reported to the Department that alleges abuse, neglect or mistreatment is referred to the Regional Attorney General’s Office. Case referrals include, but are not limited to, 2803-d cases, physical abuse unknown, suspected thefts of personal property, fraudulent billing, drug diversion, egregious cases, and any case that appears to be criminal in nature.

The Elder Justice Act requires reporting of any reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act, § 6703(b)(3). This requires certain individuals in long-term care facilities to report a reasonable suspicion of a crime committed against a resident. Those reports must be submitted to one law enforcement agency of jurisdiction, as well as the Department. Individuals who are required to report include the owner, operator, employee, manager, agent or contractor. The New York Attorney General’s Office, Medicaid Fraud Control Unit, which has jurisdiction to investigate and prosecute instances of abuse, mistreatment, neglect and misappropriation of resident funds, qualifies as a local law enforcement agency for these purposes. A serious bodily injury must be reported within two hours, whereas all others reports must be made within 24 hours. Individuals and facilities that fail to report may have a Civil Money Penalty imposed. Nursing homes must notify covered individuals annually of their need to report, and may not retaliate against an employee for reporting.

Cases Closed by the Department

The complaint program closed 10,673 cases during calendar year 2013, based on cases received and triaged by the Nursing Home Complaint Hotline staff. Central Office investigators closed 2,979 intakes (28%) within an average of 12 days. For 4,102 intakes (38%), an onsite investigation was required at a nursing home by Regional Office investigators to determine compliance with Federal and State requirements. The remaining 3,592 intakes (34%) were processed immediately, as no action necessary by Nursing Home Complaint Hotline staff, since these cases did not involve statutory or regulatory compliance. The Department has been working to reduce complaint processing time. Almost all cases triaged at the Immediate Jeopardy level (which is described below) were started within two working days, as required by the Centers for Medicare and Medicaid Services (CMS), thus focusing on the most egregious cases in a timely manner. These actions are described in the next section, Complaint Program Initiatives (Page 11).

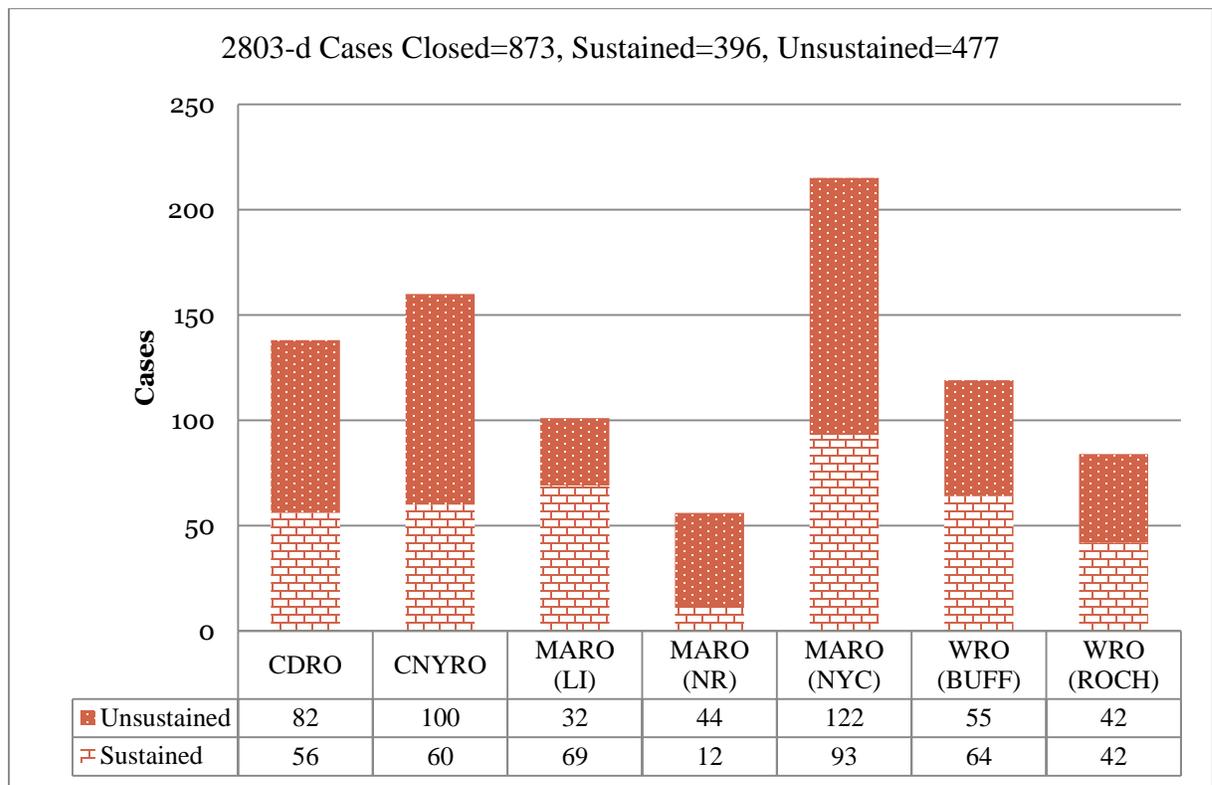
Figure 6 – Total Cases Closed by Disposition 2013



Regional Office investigators closed **873** of these cases related to violations of PHL Section 2803-d cases between January 1, 2013 and December 31, 2013 through onsite investigations at facilities. Tracking of 2803-d cases over a five-year period shows the number of 2803-d cases closed in 2013 is consistent with the number of cases closed

in 2009. The Department sustained **45%** of the cases against an individual in violation of PHL Section 2803-d, which involved abuse against a resident, or a responsible individual not reporting an incident of abuse. Figures 7 and 8 present information about the final disposition of cases related to violations of PHL Section 2803-d.

Figure 7 – Total 2803-d Cases Closed by Regional Office 2013



The Department continues to aggressively pursue all cases alleging abuse, neglect or mistreatment, and to take appropriate measures when individuals are found to have violated the law. There has been a **25%** increase in the 2803-d cases sustained over the last five years. The initiatives implemented by the Department during the report period have made a significant impact on nursing home service delivery. These are described in the following section.

Figure 8 – Total 2803-d Cases Closed by Year 2009-2013

Year	2803-d Cases Closed	2803-d Cases Sustained with SOD	% of Cases Sustained with SOD
2009	868	318	37%
2010	750	351	47%
2011	731	310	42%
2012	912	448	49%
2013	873	396	45%

COMPLAINT PROGRAM INITIATIVES

Described below are the major initiatives initiated in calendar year 2013 to assist with complaint activities:

- ❖ A new system for nursing homes to electronically report incidents was implemented in October 2011. Enhancements to the system in calendar year 2013 improved the Department’s ability to manage facility-reported incidents. Of the 5,553 incidents closed last year, 55% were designated as no action necessary by the Central Office, since these cases did not need further resolution. This is due in large part to clear reporting requirements and more thorough information submitted on behalf of nursing home providers, which allows most incidents to be reviewed initially and closed by the Central Office. As a result, both Central and Regional Office investigators can focus on more egregious allegations.
- ❖ The Statewide Call Center Consolidation Project was implemented in September 2013, allowing citizens across the State to access information and interact with State agencies. The Statewide Call Center provides a consistent, accurate, high quality service. Call Center staff have been trained to handle low-level calls and inquiries (Level 1 complexity calls), field all calls, and forward all issues that rise to the level of regulatory oversight/complaints to the Nursing Home Complaint Hotline. This project provides operational efficiencies, improves business processes and improves customer service.
- ❖ An Electronic Plan of Correction (ePOC) Program was implemented in August 2013. As planned, other surveillance programs will implement ePOC in 2014 and 2015. The ePOC system leverages the Health Commerce System to optimize the time needed to exchange SODs and

POCs, and eliminates the need to send hard copy documents by conventional postal mail and/or fax, thus reducing the expense of mailings, storage space and staff time. Feedback from providers thus far on this cutting edge application has been extremely positive.

- ❖ The Nursing Home Surveillance Program employs an effective quality assurance program to ensure a consistent statewide complaint investigative process. Monitoring reports displaying program metrics and milestones are reviewed weekly, focusing on complaint processing timeframes and backlogs encountered by Regional Offices. The data are used by Central and Regional Office leadership to identify potential issues and implement actions to ensure acceptable performance.

ENFORCEMENT ACTIVITIES

In addition to the initiatives noted in the prior section, the Department issued State fines and applied Federal remedies against nursing homes cited for the most egregious types of deficient practice. The two most serious categories of deficiencies against a provider are Immediate Jeopardy and Substandard Quality of Care.

Immediate Jeopardy (or “IJ”) is a situation in which the provider’s noncompliance with one or more requirements has caused or is likely to cause in the immediate future, serious injury, harm or death to a resident if corrective action is not implemented immediately. Substandard Quality of Care (or “SQC”) reflects serious deficiencies in the specific regulatory areas of quality of life, quality of care or resident behavior and facility practices. Deficiencies cited at the Substandard Quality of Care level may represent system failures that could or did potentially affect more than one resident.

Between 2009 and 2013, the Department had 34 to 42 surveys per year involving Immediate Jeopardy. There were 104 to 150 citations issued per year at the Immediate Jeopardy level. Most Immediate Jeopardy citations involve Substandard Quality of Care, but they can be mutually exclusive of each other. Fifty-six percent of all surveys resulted from a complaint investigation; the remainder of the surveys were a result of annual recertification surveys. Figure 9 and Figure 10 display detailed information on the number of surveys and citations issued per year involving Immediate Jeopardy.

Figure 9 – Total Immediate Jeopardy Surveys by Year 2009-2013

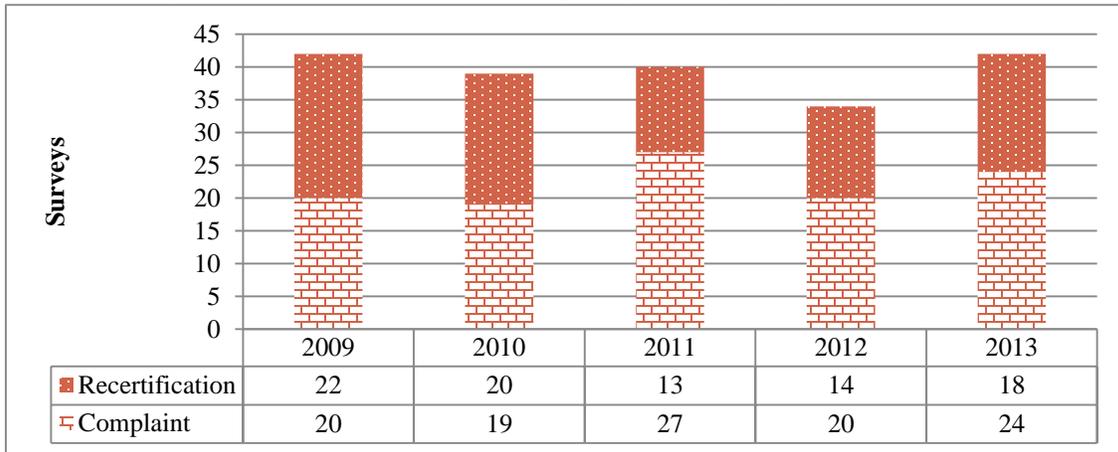
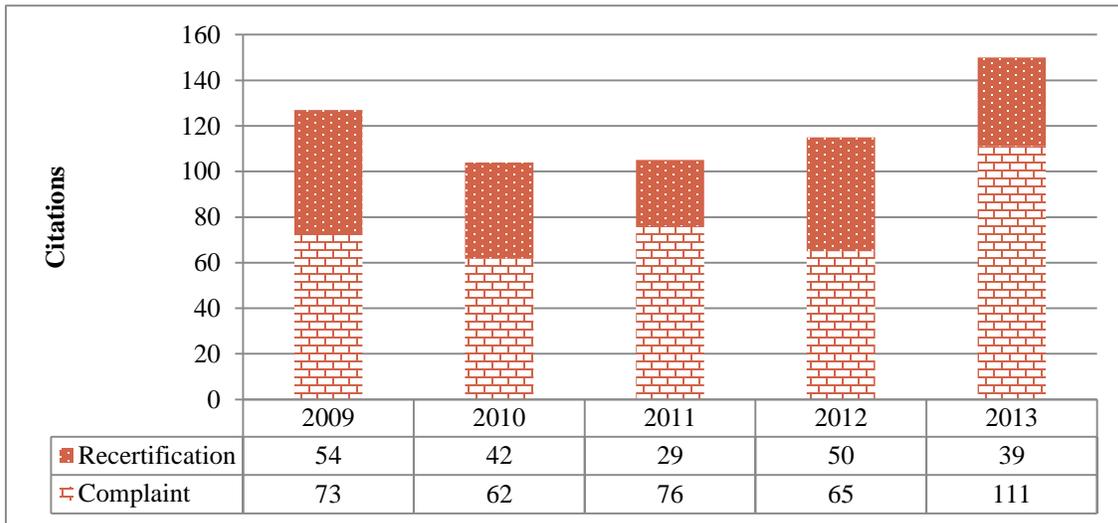


Figure 10 – Total Immediate Jeopardy Citations by Year 2009-2013



The Department also imposes fines on nursing homes under Section 12 of the PHL based on violations of the New York State Medical Facilities Code. The Department imposed \$2.1 million in fines from 2009 through 2013, as displayed in Figure 11.

Figure 11 – Section 12 Fines Assessed by Year 2009-2013

Year	Number of Facilities Fined	Total Fines Assessed
2009	49	\$241,000
2010	64	\$499,000
2011	61	\$620,000
2012	46	\$480,000
2013	20	\$238,000

In 2006, the Department received approval to participate in the Federal Civil Money Penalties Program. This Program allows State survey agencies to recommend that CMS impose Federal fines of up to \$10,000 per day in cases where Immediate Jeopardy is present. Almost \$1 million per year is collected as a result of these federally imposed fines.

In 2013, the Department experienced delays in the assessment of State fines. The Department addressed this issue by dedicating additional resources and by revising its process. As of October 2015, the Division's backlog in enforcements was eliminated and State fines are assessed more expeditiously.

The Department will continue its aggressive approach to enforcing remedies against providers that are found to endanger residents. This is another component of a comprehensive surveillance program that will ensure the health and safety of our State's nursing home residents.

CONCLUSION

The Department is committed to ensuring the health and safety of individuals residing in New York State's nursing homes. The agency continues to implement initiatives to strengthen its long-term care surveillance program.

The Department has enhanced policies, procedures and standards to improve the effectiveness, quality and timeliness of its complaint investigation program. The actions taken by the agency have been successful in ensuring that all allegations of resident abuse, neglect or mistreatment, or any other allegation of practices administered by nursing homes that violate Federal or State regulation, are aggressively and thoroughly investigated.

The Department's efforts will continue. Those who call New York's skilled nursing facilities their home deserve high quality, appropriate and timely health care and other services. They deserve to receive services in a manner that recognizes their dignity and ensures a high quality of life. The Department will continue to seek and implement innovative quality improvement assurance practices that ensure that residents of New York State's nursing homes receive the care and services they deserve.