

New York State Department of Health

NURSING HOME

RESIDENT ABUSE AND COMPLAINT

INVESTIGATION PROGRAM

REPORT

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Governor

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INTRODUCTION

The New York State Department of Health (DOH) 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 DOH 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 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 DOH. 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, 2010 to December 31, 2010. It also describes how the Department ensures that complaints are thoroughly investigated in a timely manner, and discusses steps the agency implemented during 2010 to further protect nursing home residents from potential abuse, neglect, or mistreatment. The Department of Health 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 of Health’s Division of Residential Services within the Office of Long Term Care, has surveillance responsibilities for long term care facilities. The DOH conducts complaint investigations through the DRS office in Delmar and four regional offices:

- Capital District Regional Office (CDRO) in Troy;
- 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 table 1). Throughout the year, the Department surveys 637 nursing homes on a surprise basis, and conducts 3,600 complaint surveys at nursing homes, and another 3,200 complaint investigations by trained nursing staff at the Delmar Office. Through their ongoing contact with providers, regional office staff 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.

Table 1. NYSDOH Regional Office Responsibilities

REGIONAL OFFICE	COUNTIES SERVED
Capital District (CDRO)	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington
Central New York (CNYRO)	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and 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

When the Department receives an allegation of an actual or potential adverse resident outcome, the submission is categorized by trained DOH 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 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, 2010 and December 31, 2010 the Department received 9,157 cases, 1 percent less than calendar year 2009. Of these **8,408 (92%)** were related to allegations of violations of federal or state regulations by the provider, and **749 (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.

THE COMPLAINT INVESTIGATION PROCESS

Complaints can be initiated in person, by mail or phone, or submitted using the online Nursing Home Complaint Form. Most complaints are received by phone through the Centralized Complaint Hotline (1-888-201-4563); however, many are now initiated using the online **Nursing Home Complaint Form**, which is available on the DOH Nursing Home Profile site. A large number of the complaints received – **about 41 percent in 2010** -- are incidents self-reported by the nursing homes. Public Health Law 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 DOH's jurisdiction and authority are investigated.

Each complaint is assigned to appropriate surveillance staff for investigation and a projected completion date is established during the triage process. The assignment of a completion date and the determination that an on-site investigation is required are based on the seriousness of the complaint, evaluation of safety measures in place, the current level of risk to all residents in the home, and the existing survey schedule. Those complaints outside DOH jurisdiction are promptly referred to the appropriate state or federal agency. Complaints fall into two categories: those that allege a violation of Public Health Law (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.

Public Health Law Section 2803-d Complaints of Abuse

These complaints describe an incident(s) of failing to protect persons receiving care or services in a nursing home from abuse, as required by Public Health Law 2803-d, and 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 4 of this report.

The Department's regional office staff investigation includes facility observation, review of records, and interviews, when possible, with all individuals, 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 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 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 Public Health Law.

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

All fair hearings or settlement conferences, in lieu of hearing, are scheduled and conducted by the Department's Division of Legal Affairs (DLA). The purpose of the hearing or conference 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 or meeting can determine whether a fine is warranted. Once all due process requirements have been met, the accused individual and complainant are advised, in writing, of the final outcome of the case.

In cases in which 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 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. The Department's regional offices are responsible for conducting onsite investigations for these types of complaints. When no harm is alleged and a review of the facility's investigation and other written information is sufficient to conduct an appropriate investigation, the Department's Case Resolution Unit (CRU) is responsible for the investigation. All investigations focus on the regulatory areas which were the basis of 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 Corrective Action (POC) be developed and implemented.

The POC must correct 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 state and/or federal regulations and a Statement of Deficiencies is issued to the provider as a result of the complaint.
- **Unsustained:** Insufficient evidence found to validate a complaint or, although sufficient evidence was collected to verify the complaint, a violation of a regulation by the provider did not occur.

Between January 1, 2010 and December 31, 2010, the Department received **9,157** cases. Eight (8) percent, or **749** cases, were related to allegations of violations of PHL section **2803-d**. The distribution of cases by DOH Regional Office is found below.

Table 2. Total Cases Received by Regional Office 2010

Region	Total Cases Received	General Cases Received	2803-d Cases Received	Percentage Cases 2803-d
CDRO	633	529	104	16
CNYRO	782	687	95	12
MARO	3,196	2,814	382	12
New Rochelle	750	662	88	12
NYC	1,695	1,481	214	13
Long Island	751	671	80	11
WRO	1,176	1,008	168	14
Buffalo	729	634	95	13
Rochester	447	374	73	16
CRU	3,370	3,370	0	0
NYS	9,157	8,408	749	8

In 2010, the Department implemented several initiatives to strengthen its complaint investigation effectiveness and timeliness. These actions are described in the next section, Complaint Program Initiatives.

The number of PHL section 2803-d cases reported to the Department of Health in 2010 is 6 percent fewer cases than the reported total in 2006. Department staff commences investigations immediately upon 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.

Table 3. Total Cases Received NYS by Year 2006-2010

Year	Total Cases Received	General Cases Received	2803-d Cases Received	Percent Cases 2803-d
2006	8,771	7,983	793	9
2007	8,594	7,813	782	9
2008	9,581	8,693	901	9
2009	9,243	8,384	859	9
2010	9,157	8,408	749	8

Tables 4 and 5 present information about the final disposition of cases related to violations of PHL section 2803-d. The Department closed **811** of these cases between January 1, 2010 and December 31, 2010 through on-site investigations by area office staff at facilities. This represents a 6 percent increase compared to the number of cases closed in 2006. The Department found **46 percent** of these cases were sustained. The outcome of the investigation found that an individual violated PHL section 2803-d by committing abuse against a resident or by not reporting an incident of abuse.

Table 4. Final Department Disposition Abuse, Neglect, Mistreatment Cases by Region 2010

Region	2803-d Cases Closed	2803-d Cases Sustained	Percent Cases Sustained
CDRO	111	42	38
CNYRO	84	37	44
MARO	451	213	47
New Rochelle	88	25	28
NYC	278	134	48
Long Island	85	54	64
WRO	165	80	48
Buffalo	106	49	46
Rochester	59	31	53
NYS TOTAL	811	372	46

Table 5. Final Department Disposition of Abuse, Neglect, Mistreatment Cases by Year 2006-2010

Year	2803-d Cases Closed	2803-d Cases Sustained w. SOD	Percent Cases Sustained w. SOD
2006	761	264	35
2007	772	291	38
2008	827	311	38
2009	893	332	37
2010	811	372	46

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. 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.

COMPLAINT PROGRAM INITIATIVES

The complaint program processed 9,194 intakes during calendar year 2010, based on cases received and triaged by the Centralized Complaint Intake Unit (CCIU). The Complaint Resolution Unit (CRU) was able to investigate 3,225 intakes (35%) within an average of 13 days with trained clinical staff from the central office. 4,498 intakes (49%) required an onsite investigation at a nursing home to determine compliance with federal and state requirements. The remaining 1,471 intakes (16%) were processed immediately, as no action necessary by the Centralized Complaint Intake Unit (CCIU) during the intake process, since these cases didn't involve statutory or regulatory compliance. Staff focused on reducing processing timeframes and increasing timeliness of processing complaints. 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. Described below are the major initiatives initiated in calendar year 2010 to assist with complaint activities.

- A written complaints process was implemented that allows complainants to submit their complaints online, which helps supplement complaints received via the nursing home helpline. The Nursing Home Complaint Form is available through the Nursing Home Profile website. The nursing home helpline message was updated to inform consumers about the online option. About 10% to 20% of complaints are being submitted online.
- Policies and procedures continue to be developed that reduce the onsite workload volume, through the use of Central Office complaint program staff. This has further decreased the number of cases required onsite. The process of triaging provider reported incidents was enhanced to fully review all cases by CRU staff before initiating an onsite review. This enhancement further alleviated area office workload, and ensured timely processing of complaints through CRU staff, which assisted in the reduction of the complaint backlog.
- Policies and procedures were implemented to expand the sample of residents reviewed, when additional facts are needed for the investigation. Central Office performed a quality review of this process and found accuracy and time savings.
- Data entry processes were improved to document cases entered into the federal Aspen Complaint Tracking System (ACTS). Area office staff uses standard templates to enter all cases including 2803-d abuse reports providing a uniform approach across the seven area offices.
- Complaint staff developed a plan for improving the management of facility reported incidents. This process is in development, and will result in cost savings by helping to further reduce the number of onsite investigations. Staff is developing policies and procedures, and an online form for the new reportable incident system, which will be implemented in 2011.
- The on-call process for the weekends/holidays was redesigned to further optimize cost savings. Program needs were analyzed, and the on-call process was redesigned to have a Registered Nurse triage calls once on Saturday, once on Sunday and once on holidays. The area office weekend on-call process to investigate cases also was restructured to further ensure cost savings.
- Staff standardized policies and procedures to only substantiate those cases that result in Statement of Deficiencies, which is in compliance with the State Operations Manual. The process of substantiating complaints was aligned with federal requirements to only substantiate a complaint when a regulatory violation occurred.

ENFORCEMENT ACTIVITIES

In addition to the initiatives noted above, 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 (IJ) and Substandard Quality of Care (SQC).

Immediate Jeopardy 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 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 SQC level may represent system failures that could or did potentially affect more than one resident.

Between 2006 and 2010, the Department has issued 578 IJ or SQC citations. More than 50 percent of these citations were related to complaint investigations; the remainder of the citations was a result of annual recertification surveys. The table below provides detailed information on the number of these citations.

Table 6. Total Number of Immediate Jeopardy Citations by Year 2006-2010

Year	Immediate Jeopardy (IJ) Citations	IJ Citations Resulting from Complaint Investigation	Substandard Quality of Care (SQC) Citations	SQC Citations Resulting from Complaint Investigation
2006	136	85	77	48
2007	101	55	49	28
2008	105	58	48	27
2009	132	57	58	27
2010	104	54	47	22

New York State also imposes fines on nursing homes under Section 12 of the NYS Public Health Law. In addition, the facility is liable for civil penalties for violations of Article 28 of the Public Health Law and the New York State Medical Facilities Code. Since 2006, the Department has imposed more than \$1.4 million in fines. Fines have tripled since 2006 as a result of higher fines imposed under Section 12 (See chart below).

Table 7. Civil Penalties for Violations and Fines Assessed by Year 2006-2010

Year	Number of Facilities Fined	Total Fines Assessed
2006	57	\$145,000
2007	93	\$264,500
2008	73	\$286,000
2009	52	\$249,000
2010	58	\$467,000

In 2006, the Department received approval to participate in the federal Civil Money Penalty (CMP) 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. In 2010, as a result of DOH recommendations, CMS imposed \$754,000 in CMP fines.

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 of Health is committed to ensuring the health and safety of individuals residing in the state's nursing homes. The agency has implemented several initiatives since 1999 to strengthen the long term care surveillance program, including adding significant resources necessary to maintain an effective program in light of new federal mandates and increasing challenges in nursing home care.

Specifically, the Department made several improvements to 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 nursing facilities their home deserve high quality, appropriate and timely health care and other services. They deserve to receive those 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 assurance practices that ensure that residents of New York's nursing homes receive the care and services they deserve.