

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 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, 2012 to December 31, 2012. It also describes how the Department ensures that complaints are thoroughly investigated in a timely manner, and discusses steps the agency implemented during 2012 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 Division of Nursing Homes and ICF/IID Surveillance, within the Center for Healthcare Quality and Surveillance has surveillance responsibilities for long term care facilities. The Division of Nursing Homes and ICF/IID Surveillance conducts complaint investigations through the Albany Central Office, 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 636 nursing homes on a unannounced basis, and conducts 3,400 complaint surveys at nursing homes, and another 2,400 complaint investigations at the Central Office. Through their ongoing contact with providers, the 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. Department of Health, 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 Department 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, 2012 and December 31, 2012 the Department received 8,909 cases, 4 percent less than calendar year 2011. Of these **8,039 (90%)** cases were related to allegations of violations of federal or state regulations by the provider, and **870 (10%)** cases 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

Third-party reported complaints are initiated by complainants via standard mail (5%), calling the Centralized Complaint Hotline **1-888-201-4563** (75%), or submitting an online Nursing Home Complaint Form (20%). A large number of the cases received – **about 42 percent in 2012** -- are self-reported incidents, which are submitted by nursing homes through a new online Incident Reporting form established in 2012. 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.

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 onsite 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 the Department's jurisdiction are promptly referred to the appropriate state or federal agency. 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.

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 PHL section 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 investigation conducted by the Department regional office staff 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 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 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 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. 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 by the nursing home.

The POC submitted for Department approval 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, 2012 and December 31, 2012, the Department received **8,909** cases. Ten (10) percent, or **870** cases, were related to allegations of violations of PHL section 2803-d. The distribution of cases by the Department’s Regional Office is found below.

Table 2. Total Cases Received by Regional Office 2012

Region	Total Cases Received	General Cases Received	2803-d Cases Received	% of Cases 2803-d
CDRO	803	671	132	16%
CNYRO	959	806	153	16%
MARO	3,083	2,699	384	12%
Long Island	734	637	97	13%
New Rochelle	659	585	74	11%
NYC	1,690	1,477	213	13%
WRO	1,104	903	201	18%
Buffalo	665	558	107	16%
Rochester	439	345	94	21%
CRU	2,960	2,960	0	0%
NYS	8,909	8,039	870	10%

In 2012, the Department implemented several initiatives to strengthen its complaint investigation effectiveness and timeliness. These actions are described in the next section, Complaint Program Initiatives (Page 8).

The number of PHL section 2803-d cases reported to the Department in 2012 is 3.5 percent fewer than the reported total in 2008. Department staff commence 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 2008-2012

Year	Total Cases Received	General Cases Received	2803-d Cases Received	Percent Cases 2803-d
2008	9,581	8,693	902	9
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

Tables 4 and 5 present information about the final disposition of cases related to violations of PHL section 2803-d. The Department closed **912** of these cases between January 1, 2012 and December 31, 2012 through onsite investigations by regional office staff at facilities. This represents an 11 percent increase compared to the number of cases closed in 2008, and the highest number closed in the last five years. The Department found **49 percent** of these cases were sustained, also the highest during the five-year period. 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 2012

Region	2803-d Cases Closed	2803-d Cases Sustained	% of Cases Sustained
CDRO	126	63	50%
CNYRO	134	58	43%
MARO	437	210	48%
Long Island	82	45	55%
New Rochelle	75	24	32%
NYC	280	141	50%
WRO	215	117	54%
Buffalo	120	63	53%
Rochester	95	54	57%
NYS	912	448	49%

Table 5. Final Department Disposition of Abuse, Neglect, Mistreatment Cases by Year 2008-2012

Year	2803-d Cases Closed	2803-d Cases Sustained w. SOD	Percent Cases Sustained w. SOD
2008	822	307	37
2009	868	318	37
2010	750	351	47
2011	731	310	42
2012	912	448	49

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. As a result there has been a **46 percent** 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.

COMPLAINT PROGRAM INITIATIVES

The complaint program closed 9,100 intakes during calendar year 2012, based on cases triaged by the Centralized Complaint Intake Unit (CCIU). The Complaint Resolution Unit (CRU) was able to investigate 2,387 intakes (26%) within an average of 11 days with trained clinical staff from the central office. For 4,461 intakes (49%), an onsite investigation was required at a nursing home to determine compliance with federal and state requirements. The remaining 2,252 intakes (25%) were processed immediately, as no action necessary by the CCIU, since these cases did not 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 2012 to assist with complaint activities:

- The program further enhanced its online process for nursing homes to electronically report incidents. This process has greatly improved the complaint program's ability to manage facility-reported incidents. The new system was implemented effective October 17, 2011, and further enhanced in calendar year 2012. Forty-three percent of the 4,410 incidents closed last year were made no action necessary by central office staff, since these cases didn't need further resolution. This is in large part due to clear reporting requirements, and more thorough information submitted on behalf of nursing home providers, which allows most incidents to be reviewed initially by central office staff. This allows both central office and regional office staff to focus on more egregious allegations.
- The Incident Reporting Manual was updated in response to discussions with providers, the NYS Office of the Attorney General and patient advocacy groups, clarifying requirements for nursing homes to report incidents as specified by federal and state law.
- Policies and procedures were revised to make better use of investigative resources. Most facility-reported incidents are initiated by Central Office complaint program staff. This also allows regional office staff to focus their efforts on more egregious allegations.
- The Nursing Home Complaint hotline was expanded to include a call center to track resident during Hurricane Sandy, to assist with repatriation efforts. The tracking program was implemented for several months after the disaster to assist residents and providers with repatriation efforts. Hurricane Sandy resulted in 25 nursing homes being evacuated on 10/28/2012 with 3,683 residents evacuated, who later needed to be repatriated. Complaint staff assisted in repatriation efforts and nursing homes reopening. Complaint staff also investigated any complaints, due to the evacuation and repatriation efforts from Hurricane Sandy.
- The Division employs an effective quality assurance program to ensure a consistent statewide complaint investigative process. Monitoring reports and grids 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 (IJ) and Substandard Quality of Care (SQC).

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

Between 2008 and 2012, the Department has issued 564 IJ or SQC citations. Most IJ citations involve SQC, but they can be mutually exclusive of each other. Sixty (60) percent of these citations resulted from 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 2008-2012

Year	Immediate Jeopardy (IJ) Citations	IJ Citations Resulting from Complaint Investigation	Substandard Quality of Care (SQC) Citations	SQC Citations Resulting from Complaint Investigation
2008	102	60	46	31
2009	127	73	55	34
2010	104	62	50	28
2011	105	76	46	33
2012	115	65	52	31

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. The Department imposed \$2.1 million in fines from 2008 through 2012. Fines have doubled since 2008 as a result of higher fines imposed under Section 12 (See chart below).

Table 7. Civil Penalties for Violations and Fines Assessed by Year 2008-2012

Year	Number of Facilities Fined	Total Fines Assessed
2008	65	\$241,000
2009	49	\$241,000
2010	64	\$499,000
2011	61	\$620,000
2012	46	\$480,000

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. Almost \$1 million per year is collected as a result of these 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 is committed to ensuring the health and safety of individuals residing in the 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 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 improvement assurance practices that ensure that residents of New York's nursing homes receive the care and services they deserve.