Nursing Home Resident Abuse and Complaint Investigation Report

January 1, 2019 – December 31, 2019

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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, mistreatment or neglect. 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, mistreatment or neglect and other negligent practices within our State's nursing homes and takes appropriate action when these allegations are sustained 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, mistreatment or neglect. 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, mistreatment or neglect 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.

PHL Section 2803-d also requires the Department to issue an annual report on incidents of abuse, mistreatment, and neglect of persons receiving care in residential health care facilities. This report provides statistics and information about the Department's investigation of allegations of abuse, mistreatment or neglect from January 1, 2019 to December 31, 2019. The Department remains committed to aggressively investigating all allegations of nursing home residents being harmed or in danger of harm.

Executive Summary

In calendar year 2019, the Department surveyed 623 nursing homes, closed 13,475 complaint cases and received 13,154 complaints cases. Of the 13,475 complaints closed in 2019, 3,541 required no action, and of the remaining 9,934 cases closed, 866 involved allegations of resident abuse, mistreatment or neglect. The Department sustained 174 (20%) of the 866 closed cases which involved allegations of resident abuse, mistreatment or neglect. Of the 13,475 complaint cases received in 2019, 958 (7%) involved allegations of resident abuse, mistreatment or neglect. Not all the cases closed in 2019 were received in 2019.

NEW YORK STATE NURSING HOME SURVEILLANCE PROGRAM

The Department of Health is responsible for inspecting and investigating complaints against health care providers licensed under Article 28 of the Public Health Law. As the designated Single State Survey Agency for New York, the Department conducts inspections (known as surveys) and investigates complaints on behalf of the Federal Centers for Medicare and Medicaid Services (CMS) to ensure provider compliance with Federal regulations. Through its surveys and investigations, the Department also ensures compliance with New York State regulatory requirements.

The Department's Nursing Home Surveillance Program, within the Office of Primary Care and Health Systems Management, Center for Health Care Provider Services and Oversight, 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:

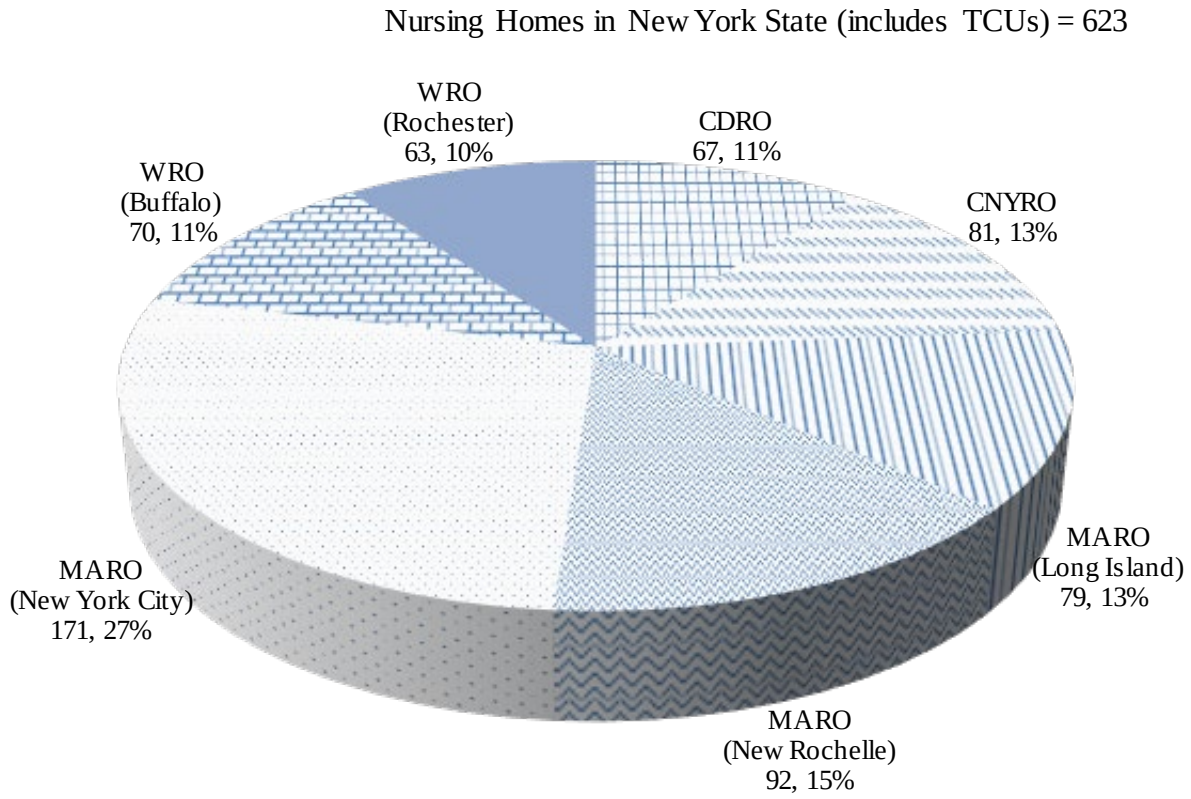
- Capital District Regional Office (CDRO) in Albany;
- Central New York Regional Office (CNYRO) in Syracuse;
- Metropolitan Area Regional Office (MARO) with offices in New York City, New Rochelle and Central Islip; and
- Western Regional Office (WRO) with offices in Buffalo and Rochester.

Each Regional Office is responsible for nursing home surveillance activities in specific counties (See Figure 1). In calendar year 2019, the Department surveyed 623 nursing homes (See Figure 2), conducted 3,618 onsite investigations and 6,311 offsite investigations. Through their ongoing contact with providers, Regional Office investigators acquire 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



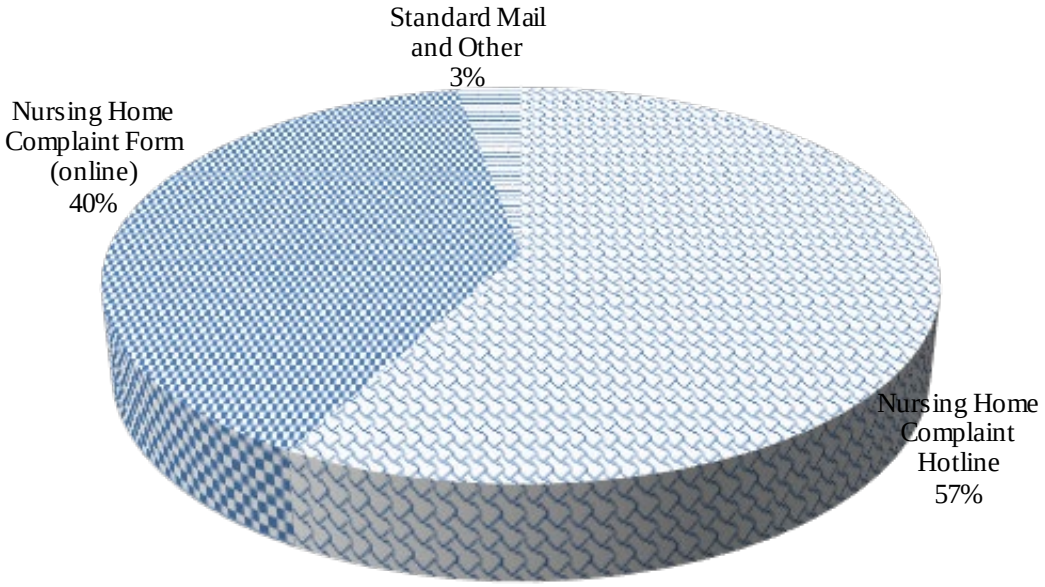
THE COMPLAINT INVESTIGATION PROCESS

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, mistreatment or neglect 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, 2019 and December 31, 2019, the Department received 13,154 complaint cases, slightly less than in calendar year 2018. This decrease can be attributed to the Department's process change with processing multiple complaints of the same issue on one complaint case. Of the cases received in 2019, 12,196 (93%) were related to allegations of violations of Federal or State regulation by the provider, and 958 (7%) were allegations of resident abuse, mistreatment or neglect by an individual. This data is consistent with the annual reporting in the past. 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 (3%), by calling the Department's Nursing Home Complaint Hotline (888-201-4563) (57%), or by submitting an online Nursing Home Complaint Form (40%). (See Figure 3.) A large number of the cases received -- about 63% in 2019 -- 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, mistreatment or neglect. 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, mistreatment or neglect 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, Mistreatment, or Neglect

PHL Section 2803-d governs the reporting of suspected abuse, mistreatment or neglect of a nursing home resident. It identifies mandated reporters, establishes the process that the Department must follow in investigating complaints, and identifies potential penalties the Department may impose.

The Department investigates every allegation of abuse, mistreatment, or neglect that it receives. The purpose of a PHL Section 2803-d investigation is to determine if the allegation is true, and if so, who is responsible. Department investigators also examine whether any systemic issues exist in the facility that may be noncompliant with regulations, by conducting a concurrent Federal investigation, as defined in the next section of this report.

The PHL Section 2803-d investigation conducted by Regional Office investigators includes observation of care and services provided in the facility, review of records and interviews (when possible) with all individuals potentially 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. Complaints are closed with one of the following three outcomes:

- **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, Mistreatment or Neglect 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, Mistreatment or Neglect 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, each accused individual is notified by the Department's Division of Legal Affairs of the violation and is apprised of his/her due process rights via certified mail. A request for an administrative 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 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 and if the determination will include a civil fine and be referred to a licensure board or Certified Nurse Assistant registry ("CNA") for further action.

In cases where there is insufficient evidence that an abuse violation exists, the accused individual and the complainant are notified that the complaint is unsustained. 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 operator.

When a complaint alleges resident harm, Federal guidelines require an unannounced onsite investigation at the facility. The Department's Regional Office investigators are responsible for conducting onsite investigations for this type of complaint. All investigations focus on the regulatory areas which are related to the allegations. An alleged deficient practice is examined against the nursing home regulatory requirements to determine whether a violation has occurred. If the Department investigation determines that a violation has occurred, a Statement of Deficiencies (SOD) is issued to the nursing home, describing the violation and 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.

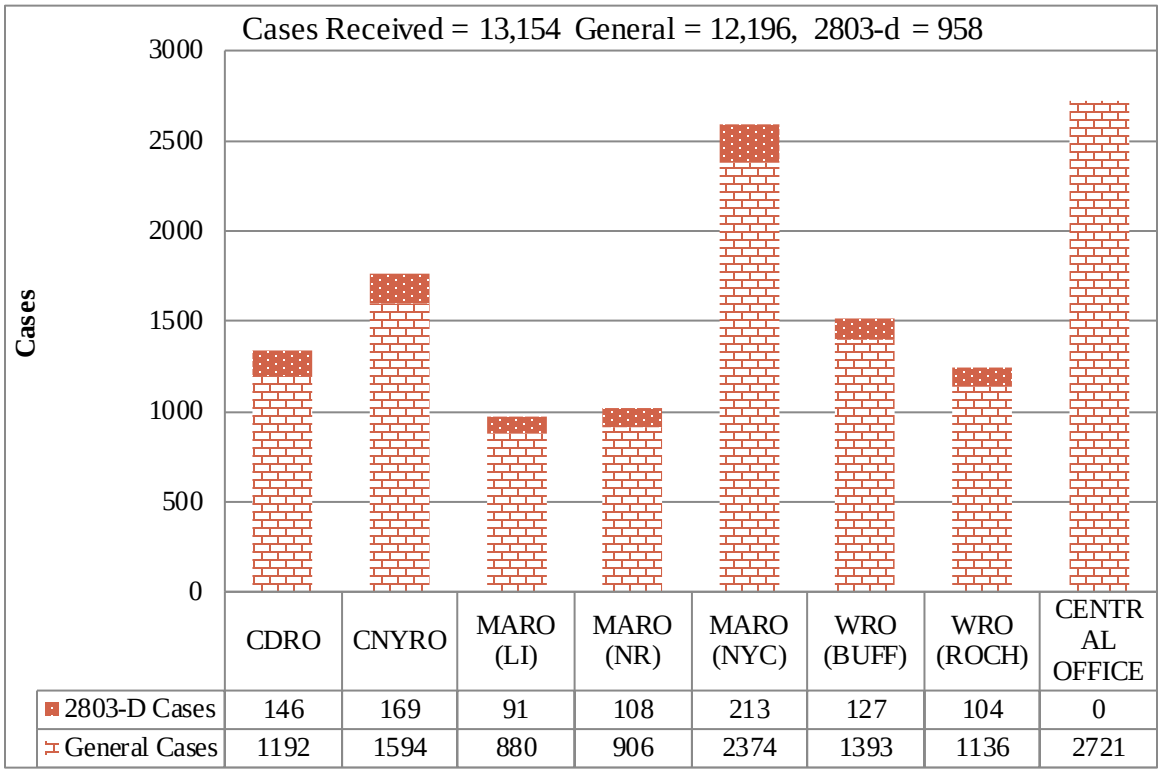
Complaints against providers are closed, per Federal guidelines, with one of the following two outcomes:

- **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:** Based on interviews, documents and record review, the care provided by the facility was found to be appropriate and timely and all relevant facility policies and procedures were in compliance with State and Federal requirements. As such, it was determined that there was insufficient credible evidence to sustain the allegations contained in the complaint.

Cases Received by the Department

Between January 1, 2019 and December 31, 2019, the Department received **13,154** cases. Of these cases, 7% **(958)** 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 2019



	CDRO	CNYRO	MARO (LI)	MARO (NR)	MARO (NYC)	WRO (BUFF)	WRO (ROCH)	CENTRAL OFFICE
2803-D Cases	146	169	91	108	213	127	104	0
General Cases	1192	1594	880	906	2374	1393	1136	2721

An average of 1,040 PHL Section 2803-d cases were reported annually to the Department over the last five years (See Figure 5). Regional Office investigators commence investigations immediately on receipt of allegations of abuse, mistreatment or neglect of residents, and the agency takes swift and aggressive action against those who are found to have committed such acts. Any case reported to the Department that alleges abuse, mistreatment or neglect is referred to the Regional Attorney General's Office.

Figure 5 – Total Cases Received by Year 2015-2019

Year	Total Cases Received	General Cases Received	2803-d Cases Received	% of 2803-d Cases
2015	11,443	10,344	1,099	10%
2016	12,341	11,263	1,078	9%
2017	13,440	12,315	1,125	8%
2018	13,234	12,295	939	7%
2019	13,154	12,196	958	7%

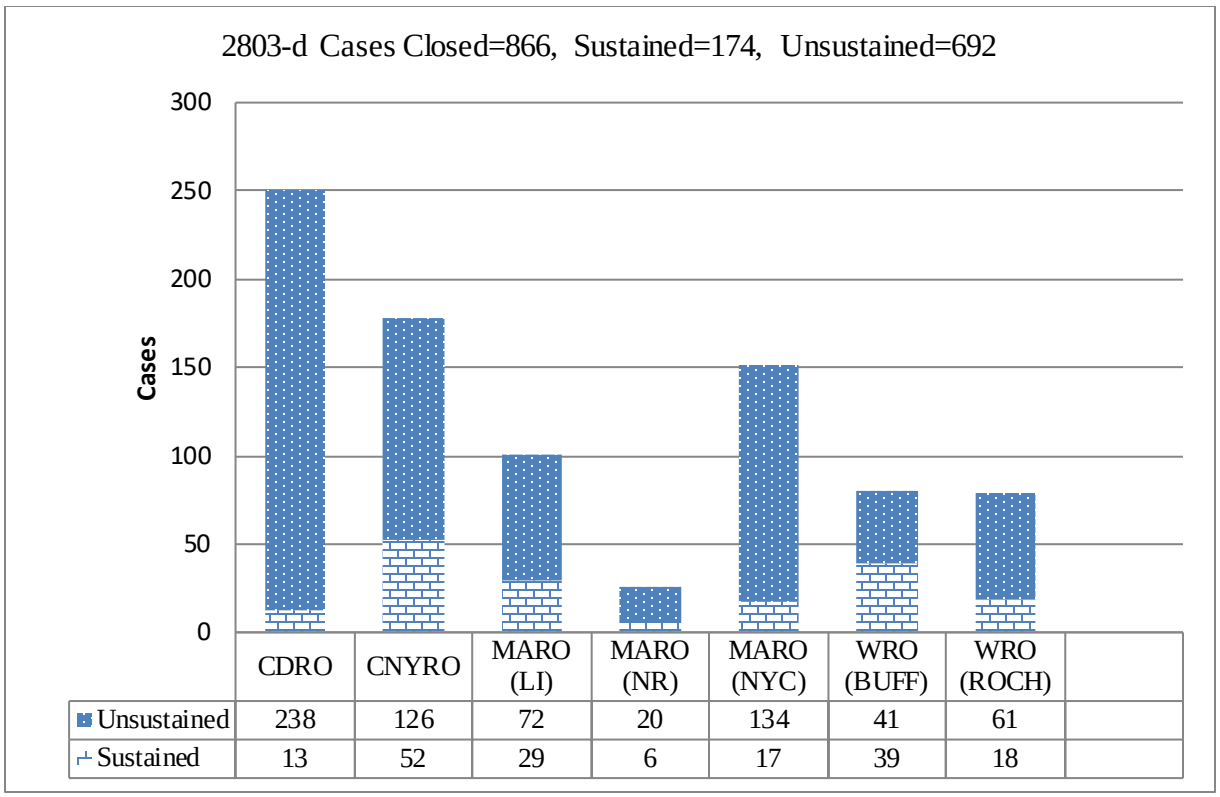
The Elder Justice Act requires reporting of any reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act, Section 6703(b)(3). This requires certain individuals in long-term care facilities to report a reasonable suspicion 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 other 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 13,475 cases during calendar year 2019. Of those, 3,541 cases did not require an investigation because they neither alleged abuse, mistreatment or neglect, nor contained a violation of Federal or State regulations. Of the remaining 9,934 closed complaint cases, 866 cases were related to allegations of abuse, mistreatment and neglect.

Regional Office investigators closed 866 cases in calendar year 2019 that include alleged violations of PHL Section 2803-d. The Department sustained 20% 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. The reason for the decrease in substantiated cases is due to high turnover of facility staff that often results in the Department's inability to locate perpetrators and witnesses of alleged incidents, a critical component to all investigations. Absent a witness and/or medical record evidence to corroborate the allegation of abuse, substantiating complaint cases becomes exceedingly difficult. Figures 6 and 7 present information about the final disposition of cases related to alleged violations of PHL Section 2803-d.

Figure 6 – Total 2803-d Cases Closed by Regional Office 2019



	CDRO	CNYRO	MARO (LI)	MARO (NR)	MARO (NYC)	WRO (BUFF)	WRO (ROCH)	
Unsustained	238	126	72	20	134	41	61	
Sustained	13	52	29	6	17	39	18	

Figure 7 – Total 2803-d Cases Closed by Year 2015-2019

Year	2803-d Cases Closed	2803-d Cases Sustained	% of Cases Sustained
2015	770	305	40%
2016	746	277	37%
2017	782	273	35%
2018	695	171	25%
2019	866	174	20%

CONCLUSION

The Department is committed to ensuring the health and safety of individuals residing in New York State's nursing homes.

The Department continues to ensure that all allegations of resident abuse, neglect, or mistreatment are aggressively and thoroughly investigated, and that those who commit abuse, mistreatment, or neglect are held responsible and are appropriately penalized.

The Department's efforts will continue. Those who call New York's skilled nursing facilities their home deserves 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 practices that ensure that residents of New York State's nursing homes receive the care and services they deserve.