

The Nursing Home Complaint System in New York State Does it Work?

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EXECUTIVE SUMMARY

Introduction

The New York State Department of Health is responsible for monitoring the care given to the state's 105,000 nursing home residents. It attempts to fulfill this function in two ways:

- (1) The Survey System. State inspectors are responsible for surveying facilities on a regular basis.
- (2) The Patient Care Investigation System (PCI). State investigators are responsible for investigating all complaints of abuse, neglect and mistreatment as they are reported.

The development of the PCI System to specifically investigate such complaints was crucial to enhancing the care monitoring capabilities of the state. In 1977, a statute was enacted to protect nursing home residents from abuse, mistreatment and neglect by requiring nursing home staff to report such incidents to the Department of Health.

The unique strength of the PCI system is that staff, residents and family members have immediate access on a daily basis to report problems in care to the Department of Health. There is no need to wait for the official survey, which may be as much as 15 months away. In addition, the surprise of the complaint investigation, as well as the ability of the investigator to enter facilities at odd times of the day and week, makes the monitoring of care more meaningful.

The Nursing Home Community Coalition of New York State (NHCC) evaluates in this report the PCI system's ability to investigate complaints and to evaluate the capability of the Department of Health to use the information received from the PCI system for the ongoing surveillance of the care in our state's nursing homes.

Organization of the State's Surveillance and Investigation system

The state inspectors and investigators are housed in six regional or area offices across the state: New Rochelle, Syracuse, Rochester, Buffalo, New York City and Northeast. Each regional office is responsible for monitoring the care in the nursing homes in its area and has discretion in the organization of its survey and investigation systems.

- - - Complaints Received by the PCI System

The PCI system receives two categories of complaints:

- (1) "340 Complaints." Abuse, mistreatment and neglect complaints as defined under legislation enacted to protect nursing home residents.

- (2) General complaints. All other complaints which do not fall under the statute's definitions.

Consumer Concerns

1. The long length of time it takes to make a determination for any complaint.
2. The low number of sustained complaints (complaints, that after investigation, are found to have merit).
3. The lack of meaningful integration of the complaint system with the state survey (surveillance and enforcement) systems.
4. The poor communication between the Department of Health and the complainant.

General Objective of the Project

To evaluate the effectiveness of the Patient Care Investigation system (PCI).

Specific Goals of the Project

1. Compare, by area office, the length of time it takes to resolve a general complaint.
2. Compare, by area office, the time spent on each general investigation.
3. Compare, by area office, the percentage of sustained vs unsustained general complaints.
4. Compare, by area office, the percentage of official facility citations of negative findings resulting from general complaint investigations.
5. Evaluate the reasons for the low sustained rate.
6. Evaluate, by area office, the state's ability to integrate its PCI investigation of general complaints with its surveillance and enforcement system.
7. Evaluate the ability of the state both to shorten the time it takes to close a 340 case and to integrate the PCI investigation of 340s with its survey system.
8. Analyze a sample of letters sent to complainants to see if the Department is responding fully and meaningfully to complainants.

Methodology

Analysis of the Residential Health Care Facility (RHCF) Complaint Survey and Investigation System

In order to meet the specific goals of this project, information from the uniform collection system was collected and analyzed for a random sample of 218 general cases from 1990.

Narrative Analysis

In order to make qualitative evaluations based upon the individual issues in each case, the author trained two people to join with her in evaluating each case in the random sample. The analysis of this qualitative information was completely independent of the quantitative analysis described above.

Interviews of Area Office Long Term Care Directors

Each director was interviewed in person with follow-ups by phone.

Analysis-of Statements of Deficiencies and Statements of Findings

In order to evaluate the extent of the integration of the PCI system with the Survey system, the Statement of Deficiency and/or finding (SOD and SOF: official citation of negative findings) written after a complaint investigation for each case in the random sample was analyzed for its relevance to the initial complaint.

Information on 340 Complaints

The statute covering 340 complaints allows public access to only closed and sustained cases. In the time frame covered by this report, February, 1990 to January, 1991, sixty 340 cases were closed and sustained, according to the Bureau of Administrative Hearings, the bureau responsible for the prosecution of parties guilty of abuse, mistreatment and neglect. The author read a random selection of 10 of these cases and interviewed the Director of the Bureau of Administrative Hearings.

Analysis of Letters to Complainants

In order to evaluate the Department of Health's ability to respond fully and meaningfully to complainants and thus, encourage the public to use the PCI system, a sample of letters sent to complainants were evaluated.

Major Findings

1. TOO FEW COMPLAINTS ARE BEING SUSTAINED

- * Less than one-third of all general complaints are sustained
- * New York City had the lowest sustained rate of the entire state: only 16 percent

- * Syracuse had the highest sustained rate of the entire state: 61 percent
- * 31 percent of the sample cases were evaluated to have been incorrectly resolved
- * 41 percent of the sample cases were evaluated not to have had all aspects of the case investigated

2. MANY FACILITIES ARE NOT BEING HELD ACCOUNTABLE FOR SUSTAINED COMPLAINTS THAT ARE FOUND TO HAVE MERIT

- * Statewide, no action was taken against nursing homes in 42 percent of the sustained general cases
- * Northeast took the least amount of action on sustained general cases, taking no action on 73 percent
- * Rochester took no action on 60 percent of its sustained general cases
- * Buffalo took the most action on sustained general cases, taking action on 69 percent
- * Even when the sustained complaint was deemed to be of a serious nature, i.e., causing harm warranting a physician's intervention, or causing harm that is physical and life-threatening, action was not always taken. Statewide, no action was taken against nursing homes in 27 percent of sustained general cases which were deemed to be of a serious nature

- * New York City never wrote a Statement of Deficiency (SOD), a serious official citation, for any sustained complaint

- * Only 31 percent of all sustained general cases led to an SOD

3. THERE IS LITTLE INTEGRATION BETWEEN THE PCI SYSTEM AND THE SURVEY SYSTEM

- * Investigators of general cases never suggested that a focus survey be conducted to investigate further any case evaluated
- * Only 9 out of 218 general cases indicated that investigators shared problems they observed with survey staff
- * Investigators recommended that survey staff follow-up at the next scheduled survey in only 2 out of the 218 cases analyzed

4. THE PCI SYSTEM IS NOT RESPONSIVE ENOUGH TO PROTECT NURSING HOME RESIDENTS FROM SYSTEMIC DEFECTS IN CARE WHICH COULD PRODUCE HARM

- * It takes an average of 18 days to initiate a general investigation

- * It takes an average of 72 days to complete a general investigation
- * It takes an average of another 47 days to respond to the complainant letting her/him know the determination
- * Northeast and Rochester take the least amount of time (11 to 12 days) to initiate a general investigation
- * New Rochelle takes the longest time (26 days) to initiate a general investigation and to complete the investigation and respond to the complainant (193 days)
- * Buffalo takes the least amount of time to complete the investigation and respond to the complainant (only 56 days)

Recommendations

1. Reducing the length of time it takes to initiate an investigation of a general complaint.
 - a. Develop clear and consistent statewide criteria for deciding when an investigation will be initiated. Reasonable limits must be set.
 - b. Develop clear and consistent statewide criteria for deciding when, in rare cases, an investigation may be conducted off-site.
 - c. Review the 340 statute. Decisions when to initiate an investigation should depend upon the nature of the complaint, not on whether an individual is accused. Regulations based upon the law require only complaints classified as 340s to be investigated within 48 hours; however, often complaints are classified as 340s only because an individual has been accused.
2. Reducing the length of time it takes to complete a general case.
 - a. Develop an uniform reporting system that all investigators must use when they write the narrative portion of the case. This system should include forms that reduce the amount of writing, yet include enough information to both prove a case and allow oversight by supervisors.
 - b. Mandate a specific time frame for a case to be complete. This time frame must encompass the time the complaint is received to the time the complainant is notified.
3. Reducing the length of time it takes to respond to complainants.

Set up a clerical routine that will send out letters within a few days of the completion of a case.

4. Focusing on methods to reduce the number of unsustained cases.
 - a. Review the 340 statute.
 1. The statute, with its focus on reporting and individual culpability, diverts attention from systemic problems and defects, which, if left uncorrected, threaten harm to all residents. The state needs a comprehensive, integrated complaint/surveillance system which must be oriented towards finding systemic problems as well as finding individual culpability.
 2. The requirement to destroy all information from a case where an individual has not been found guilty, limits the amount of oversight that can be conducted by both the Department of Health and by the public.
 - b. Form an independent committee, consisting of a majority of members representing consumer interests, to regularly review the operation of this complaint/survey system.
 - c. Conduct more meaningful training of investigators and survey staff.
 - d. Develop a strong internal quality assurance system with the computer support necessary to produce, in a timely fashion, area office findings similar to those in this study, to evaluate cases which are not sustained.
 - e. Mandate interviews of known family and/or friends of non-alert residents.
 - f. Lengthen the time that investigators are on-site. The average time on-site in this study was too short a time to accomplish all that needs to be done.
 - g. Require that each investigator interview the complainant during and at the end of the case to ask for more information and to ask for a response to other information the investigator has gathered. The complainant is the primary source of information. Require investigators to put more weight on the complainant's evidence.
 - h. Inform residents and relatives about the complaint process. Develop educational material that clearly explains the system. Meet with resident and relative councils.
5. Increasing the accountability of facilities for systemic problems in sustained cases.
 - a. Review all action taken on sustained cases to see if the action taken, or not taken, was appropriate. Collect and send to all area offices information similar to that gathered by this report for area office analysis. Make this a major part of the Department of Health's internal quality assurance system.

- b. Require investigators to give a written explanation if they recommend no action in a sustained case.
- c. Review the use of the DLI criteria, criteria used to determine seriousness of the complaint, with the complaint system.
 - 1. Mandate a SOD for any sustained complaint with a DLI of 4 or 5 (most serious).
 - 2. Consider the automatic triggering of a focused survey if a complaint sustains a certain number of DLIs of 3.
 - d. Require formal follow-up, for any sustained complaint, on the next scheduled survey. Require documentation by the survey team, demonstrating how the team reviewed the complaint.
 - e. Require 340 investigators start with the premise that facility administration is responsible for the actions of their staff.
 - f. Release publicly lists of all sustained complaints with and without action taken for public oversight.
- 6. Strengthening the integration of the complaint system with the survey system.
 - a. Create a formal structured system for the sharing of information that can be monitored by the Department of Health's internal quality assurance system.
 - b. Allow PCI investigators to write SOFs and SODs without getting agreement from the survey team.
 - c. Mandate clear and consistent statewide criteria for focused surveys or follow-up surveys and follow all complaint investigations.
 - d. Mandate that information gathered on complaint investigations be included in the formal preparation of a survey team before it goes into a facility.
- 7. Improving communication between the PCI unit and the complainant.
 - a. Develop a check system for letters written to complainants that includes:
 - 1. findings of all parts of the complaint.
 - 2. information that lets the complainant know what the findings are and what will be done about any sustained findings by the facility and by the Department of Health.

3. specificity about the complaints that were investigated.
- b. Develop a system that sends to the complainant a written acknowledgement of the complaint to ensure mutual agreement on the contents of the complaint.
- c. Require each area office to provide each complainant with a progress report near the end of the investigation with a request for any additional information having a bearing on the case. This report should also include a possible date for the completion of the case.
- d. Institute a system of rewarding complainants whose action led to the finding of systemic problems. This will encourage people to use the system more. They will begin to feel less like troublemakers and more like people who are helping to protect nursing home residents and who are helping to make systemic change.

SECTION ONE

INTRODUCTION

The New York State Department of Health is responsible for monitoring the care given to the state's 105,000 nursing home residents. It attempts to fulfill this function in two ways:

- (1) The Survey System. State inspectors are responsible for surveying facilities on a regular basis.
- (2) The Patient Care Investigation System (PCI). State investigators are responsible for investigating all complaints of abuse, neglect and mistreatment as they are reported.

The development of the PCI System to specifically investigate such complaints was crucial to enhancing the care monitoring capabilities of the state.

Nursing homes are regularly surveyed by the state on average only once a year. Although these surveys are supposed to be a surprise, because of the need to inspect at specific times related to past problems, facilities often have some idea when they will be surveyed. Thus, facilities spend much time "cleaning house," preparing for the state survey.

The unique strength of the PCI system is that staff, residents and family members have immediate access to the Department of Health on a daily basis to report problems in care. There is no need to wait for the official survey, which may be as much as 15 months away. In addition, the surprise of the complaint investigation, as well as the ability of the investigator to enter facilities at odd times of the day and week, makes the monitoring of care more meaningful.

The Nursing Home Community Coalition of New York State (NHCC) evaluates in this report the PCI system's ability to investigate complaints as well as the capability of the Department of Health to use the information from the PCI system for the ongoing surveillance of care in our state's nursing homes.

ORGANIZATION OF THE STATE'S SURVEILLANCE AND INVESTIGATION SYSTEM

The state inspectors and investigators are housed in six regional or area offices across the state: New Rochelle, Syracuse, Rochester, Buffalo, New York City and Northeast. Each regional office is responsible for monitoring the care in the nursing homes in its area and has discretion in the organization of its survey and investigation systems.

COMPLAINTS RECEIVED BY THE PCI SYSTEM

The (PCI) system receives two categories of complaints:

- (1) "340 Complaints." Abuse, mistreatment and neglect complaints as defined under legislation enacted to protect nursing home residents. See Appendix G for a copy of this statute.
- (2) General complaints. All other complaints which do not fall under the statute's definitions.

340 Complaints: Abuse, Mistreatment and Neglect Complaints

Nursing home abuse reporting legislation was enacted in 1977 to protect nursing home residents from abuse, mistreatment and neglect by requiring anyone employed in a nursing home to report such incidents to the Department of Health.¹ Under this law, abuse is defined as: inappropriate physical contact such as hitting, pinching, kicking, and sexual molestation. Mistreatment is the inappropriate use of medications, isolation, physical or chemical restraints. Neglect includes the failure to provide timely, safe, consistent, adequate and appropriate treatment and care. The statute mandates immediate reporting to the Department of Health by all nursing home employees and licensed health care personnel of suspected nursing home abuse, mistreatment or neglect. Reporting by visitors, relatives and nursing home residents is encouraged. The statute describes the due process outlines complete confidentiality for the accused until a complaint is sustained or found to have merit. If a complaint is not sustained, the statute mandates the destruction of all written materials about the complaint and the accused. Department of Health regulations, interpreting the statute, protect the confidentiality of the complainant and require the Department to begin an on-site unannounced investigation into any statute violation within 48 hours of receipt. Although generally aimed at individual guilt, sustained 340s may lead to deficiency citation for the facility if it is also at fault, as well as punishment of the guilty staff person. It is also intended that non-sustained 340s against an individual might still lead to deficiencies for the facility if appropriate.

General Complaints

General complaints, lack clear definition by the Department of Health, but are those complaints that ostensibly do not fall under the statute's definitions as discussed above. In reality, since the statute focuses on individual guilt, it is sometimes difficult to discriminate between mistreatment and neglect as defined in the statute and mistreatment and neglect as a general issue. Classification of complaint reports is important because there are no regulations regarding the specific procedures for the investigation of general complaints. In addition, general complaints do not have to be destroyed if not sustained, thus, there is a greater opportunity for public oversight. Since some

of the general complaints are investigated by inspectors during their regularly scheduled surveys, the decision to investigate on-site and the estimated time for the start of the investigation depends upon the nature of the general complaint, the availability of the investigators and/or surveyors and the current survey schedule. Each area office has great discretion in how to investigate general complaints.

General complaints are subdivided into two distinct groups:

- (1) Resident Specific. Complaints that are specific to a resident such as issues involving: grooming, personal care, skin care, restraint use, resident rights, psychotropic drug use and proper diet at the appropriate temperature.
- (2) Facility specific. Complaints that are related to the entire facility such as issues involving: insect infestation, bed retention, financial issues, outdated drugs, competency of staff and equipment maintenance.

Sustained complaints may lead to deficiencies for the nursing home depending on the severity and scope of the finding.

DETERMINING SEVERITY OF THE NEGATIVE FINDING²

All area offices assign each 340 and general resident specific complaint a number indicating its potential seriousness in terms of its impact on the resident. Some area offices assign this number prior to an investigation and some assign it only to sustained cases after investigation. The impact on the resident may involve physical harm and/or quality of life issues. Severity is measured using a Deficit Level Index (DLI). There are two different scales. The severity scale related to physical harm ranges from 1 which means no negative outcome to 5 indicating that life threatening harm has occurred. The scale related to quality of life issues measures resident reaction and ranges from 1 which means that a reasonable person might just mention the occurrence to a staff person to 5 indicating that a reasonable person would request outside investigation of possible criminal conduct. The investigator assigns the highest DLI from either scale. When deciding whether to give a facility an official Statement of Findings (SOF)³ or Statement of Deficiencies (SOD), which cites it for violations of the minimum code of standards of care, the DLI score and the scope of the negative findings (number of times the event occurred) is used. SODs are the most serious penalty as this is the only action that requires a formal facility plan of correction that is followed up by the Department of Health with another survey. (See Appendix D for a detailed description of the deficiency writing process.)

CONSUMER CONCERNS WITH THE PCI SYSTEM

Information elicited from the PCI system is crucial to the state's monitoring of care in nursing homes. How well the state can respond in a timely fashion to systemic abuse, mistreatment and

neglect, how well it can encourage residents and families to use the system and report problems, and how well the state can integrate the PCI system with the Survey system are critical elements of the state's monitoring function.

Consumer groups who have been working with the Department of Health to improve the system have long been concerned about the effectiveness of the complaint process. Although there are differences among area offices, weaknesses in the present system are:

1. The length of time it takes to make a determination for any complaint. This delay contributes to the cynicism and frustration of residents, friends and relatives about the meaningfulness of the complaint system as a tool to correct poor care. Many decide not to file a complaint, because, "what's the use?"
2. The low number of sustained complaints. This contributes to the feelings of cynicism and frustration on the part of residents and relatives and indicates to consumers that the there are problems in the system.
3. The lack of meaningful integration of the complaint system with the state survey (surveillance and enforcement) systems. The low sustained rate for 340 complaints can be attributed to the difficulty in attaching blame to a single individual. Thus, although the investigator may believe that abuse, neglect or mistreatment has in fact occurred, there may be no one who can be proven guilty of the charge.

Consumers have long believed that many of the unsustained 340 complaints should have been sustained in relation to facility culpability and used as a basis for writing facility deficiencies for systemic problems. Unless an individual staff member commits a criminal act, the administration of the facility must also accept responsibility for employee behavior. We believe that many of the 340 mistreatment and neglect complaints are often caused by systemic problems at the nursing home and that the facility should be cited for violations of the code of care standards. For example, a nurse aide takes a frail resident to the bathroom; another resident calls the nurse aide for help; the first resident is left alone and falls; an investigation of a 340 neglect complaint is undertaken. Perhaps the investigation concludes that the resident calling the aide was in danger and thus, finds that an accusation of neglect cannot be proved. The case is then thrown out. However, it is possible that the facility is at fault because there may not be an appropriate number of staff members to care for the residents. If true, the complaint should be sustained, not against the aide, but against the facility and a deficiency should be written.

Consumers believe that the low number of negative citations, SOFs or SODs, generated by general complaints, is also due to the poor integration of the complaint system with the survey system. Do the inspectors use the information gathered by the

complaint investigators when they regularly survey facilities? Are investigators encouraged to expand their investigations to focused or full surveys if necessary?

4. The poor communication between the Department of Health and the complainant. Responses by the Department to complainants acknowledging receipt of the complaint, both during the investigation, and at its conclusion tend to be form letters that do not respond to the specific complaint or the actual findings and action taken by the state. Such letters, received after a long wait often bringing unsustained findings, lead to frustration and upset.

GENERAL OBJECTIVE OF THE PROJECT

To evaluate the effectiveness of the Patient Care Investigation system (PCI).

SPECIFIC GOALS OF THE PROJECT

1. Compare, by area office, the length of time it takes to resolve a general complaint.
2. Compare, by area office, the time spent on each general investigation.
3. Compare, by area office, the percentage of sustained vs unsustained general complaints.
4. Compare, by area office, the percentage of SOFs and SODs resulting from general complaint investigations.
5. Evaluate the reasons for the low sustained rate by interviewing the directors of long term care of each area office and by analyzing a random sample of 1990⁴ general complaints from each area office.
6. Evaluate, by area office, the state's ability to integrate its PCI investigation of general complaints with its surveillance and enforcement system by analyzing, by area office, the random sample of 1990 complaints with actual survey results to determine if the investigations are resulting in facility deficiencies.
7. Evaluate the ability of the state both to shorten the time it takes to close a 340 case and to integrate the PCI investigation of 340s by interviewing the Director of the Bureau of Administrative Hearings and by reading 10 randomly selected sustained 340 cases out of the 60 that are available.
8. Analyze a sample of letters sent to complainants to see if the Department is responding fully and meaningfully to complainants.

METHODOLOGY

ANALYSIS OF THE RESIDENTIAL HEALTH CARE FACILITY (RHCF) COMPLAINT SURVEY AND INVESTIGATION SYSTEM

In order to meet the specific goals of this project, information from the uniform collection system (see Appendix B for a sample copy of these forms) was collected and analyzed for a random sample of 218 general cases from 1990.⁵

Janet Buelow, Ph.D, senior research associate, Brookdale Center on Aging of Hunter College, selected the sample and conducted the analyses. A proportional stratified random sample of 218 general cases was determined to represent the total population of cases within the state area offices. This sample included a range of DLIs in each area office. See Appendix A for a detailed description of the sample selection and of the analysis.

NARRATIVE ANALYSIS

In order to make qualitative evaluations based upon the individual issues in each case, the author trained two people to join with her in evaluating each case in the random sample. This training involved a three hour workshop with sample cases. In addition to being trained to evaluate the investigation of each specific case, each evaluator was also trained to be able to assign a DLI to each complaint.

The narrative of each sample case was read by the trained evaluator. The evaluator was asked to answer questions about each case. See Appendix C for a copy of these questions. The author reviewed each case rated by the evaluators and was available for consultation on any questionable cases. The analysis of this qualitative information was completely independent of the quantitative analysis described above.

INTERVIEWS OF AREA OFFICE LONG TERM CARE DIRECTORS

Each director⁶ was interviewed in person with follow-ups by phone. Specific questions were asked about the complaint intake process, the classification of the complaint, the assignment of an investigator, the method of investigation, the in-office report writing and the determinations made and the action taken.

ANALYSIS OF STATEMENTS OF DEFICIENCIES AND STATEMENTS OF FINDINGS

In order to evaluate the extent of the integration of the PCI system with the Survey system, the Statement of Deficiency and/or Finding written after a complaint investigation for each case in the random sample was analyzed for its relevance to the initial complaint.

INFORMATION ON 340 COMPLAINTS

The statute covering 340 complaints allows public access to only closed sustained cases. In the time period covered by this report

(February, 1990 to January, 1991), according to the Bureau of Administrative Hearings, the bureau responsible for the prosecution of parties guilty of abuse, mistreatment and neglect, sixty 340 cases were closed and sustained. The author read a random selection of 10 of these cases and interviewed the Director of the Bureau of Administrative Hearings.

ANALYSIS OF LETTERS TO COMPLAINANTS

In order to evaluate the Department of Health's ability to respond fully and meaningfully to complainants and thus, encourage the public to use the PCI system, sample letters sent to complainants were evaluated.

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SECTION TWO

FINDINGS: ANALYSIS OF THE RHCF COMPLAINT SURVEY AND INVESTIGATION SYSTEM

Information for analyses were taken from the Department of Health's RHCF Complaint and Investigation System forms (see Appendix B for a sample copy of this uniform collection system). According to the information sent to this author, there were 1240 general complaint cases received and investigated by the Department of Health from February 1990 to January 1991. From this total, a random sample of 218 cases was selected.⁷ Each case may include more than one complaint. Table 1 shows the number of general cases and complaints analyzed from each area office.

DLIs of Sample Complaints

The DLI score indicates the severity of the complaints. The findings related to DLIs must be viewed with caution because some area offices assigned a DLI of 0 for cases found to be unsustainable after an investigation. Therefore, the findings do not tell us what the severity would have been if the complaint had been sustained. We do know however, that at least 24 percent of all the complaints in the sample were assigned a DLI of 4 or 5 meaning serious harm. DLIs of 3 accounted for at least 14 percent of the sample and at least 19 percent were assigned DLIs of 2. See table 2.

Methods of Investigation of General Complaints

When a complaint is received by the area office, it may be investigated on-site, i.e., actually at the nursing home involved, or off-site by telephone or letter or both on-site and off-site.

Statewide

Ninety (90) percent of all the general complaints in the random sample were investigated on-site. Of the 10 percent of the cases that were investigated off-site, 82 percent were investigated by telephone.

Area Office Differences

There were significant differences among area offices. The area offices of Buffalo, New Rochelle and New York City, investigated over 90 percent of their cases were on-site. However, only 78 percent of the cases in the Northeast and only 73 percent of the cases in Syracuse were investigated on-site. See table 3.

Timeliness of Investigation and Completion

Table 4 shows the number of days it takes from the initial report of the complaint to the initiation of the investigation, to the completion of the investigation and to the response to the complainant.

Table 1. Cases & Complaints per Area Office¹

	Total Sample	N.E.	Buf.	Roch.	Syr	N.R.	NYC
Number of Cases in Sample	218	37	34	18	23	50	56
Percent of Sample		17%	16%	8%	11%	23%	26%
Number of Complaints in Sample	455	100	83	27	33	120	92
Percent of Sample		22%	18%	6%	7%	26%	20%
Total cases reported to Health Dept: 1240 2/90 - 1/91 (Percent of total)		210 (17%)	183 (15%)	96 (8%)	145 (12%)	278 (22%)	328 (26%)

¹ Cases are the RHCF Complaint Survey and Investigation System documents completed by investigators for each initial report.
Each case may include more than one complaint.

Table 2. DLIs of Complaints by Area Office¹

	Total n=306	N.E. n=56	Buff. n=65	Roch. n=26	Syr. n=22	N.R. n=67	NYC n=70
DLI = 0	33%	77%	---	42%	14%	57%	6%
DLI = 1	12%	4%	22%	19%	5%	3%	17%
DLI = 2	19%	7%	34%	8%	41%	13%	16%
DLI = 3	14%	4%	9%	15%	18%	16%	21%
DLI = 4 or 5	24%	9%	35%	15%	23%	10%	40%

Note: Deficit Level Index (DLI) rates the severity of each complaint:

- 0 = unsustained and no harm
- 1 = no harm
- 2 = no harm, but if continued over time will lead to harm
- 3 = no harm, but potential for harm from 1 incident or harm not needing physician intervention
- 4 = harm warranting physician intervention
- 5 = harm is physical and life threatening

Footnote: Comparisons of DLIs across area offices should be viewed with caution. Some area offices assigned a DLI of 0 only for cases found to be unsustained after a investigation; therefore, these figures do not tell us what the severity would have been if the complaint had been sustained.

Table 3. Methods of Investigation

	Total n=218	N.E. n=37	Buf. n=34	Roch. n=18	Syr. n=23	N.R. n=50	NYC n=56
*Onsite Visits 1	90%	78%	100%	89%	73%	98%	91%
*Offsite Visits 2	10%	22%	----	11%	27%	2%	9%
For Offsite Visits only:							
Phone Calls only	82%	100%	----	100%	50%	----	100%
Letter only	14%	----	----	----	50%	----	----
Both	4%	----	----	----	----	100%	----

1 This includes cases that have on-site visits with off-site visits.

2 This includes cases with only off-site visits.

* Significant differences found between area offices; ($p \leq 0.01$).

Table 4. Timeliness of Investigation & Response to Complainant (in days)
by Area Office

Mean Days From Initial Report To:	Total n=207	N.E. n=32	Buf. n=34	Roch. n=18	Syr. n=23	N.R. n=48	NYC n=54
Initial Contact (onsite or offsite)	18	11	17	12	14	26	19
Onsite Visit	19	11	17	13	15	26	21
Offsite visit only	11	8	---	1	8	2	20
Completion of Investigation	83	79	44	59	70	116	92
*Response to Complainant	130	137	56	90	169	193	115
Difference between com- pletion of investigation & response to complainant	47	58	12	31	99	77	23

*Significant differences found between: New Rochelle, Buffalo, Rochester and Syracuse; ($p \leq 0.05$).
Note: All numbers over 300 days were confirmed with the record.

Statewide

It takes the state an average of 18 days to begin an investigation of a general complaint and an average of 83 days to complete the investigation. It then takes another 47 days to respond to the complainant for an average total of 130 days.

Area Office Differences

The average number of days from the time the area office receives the case to the day it responds to the complainant differed significantly among area offices. The area offices that take the greatest number of days are New Rochelle and Syracuse and the areas with the smallest number of days are Buffalo and Rochester. New Rochelle and New York City, the area offices with the most complaints, take the longest time to initiate and to complete an investigation. Of the two, New Rochelle takes the longest time from the initial report to: begin the investigation (an average of 26 days); complete it (116 days); and to respond to the complainant (193 days). Although Northeast initiates the investigation more quickly than any other area office (11 days), it takes a long time to complete the investigation (79 days) and to respond to the complainant (137 days). Buffalo completes each investigation more quickly (44 days) and responds to the complainant in a shorter time frame than any other area office (56 days). Syracuse lets the most time pass between the completion of the investigation and the response to a complainant (99 days) bringing the total time it takes from the initial contact to the response to the complainant to 169 days.

DLI and Timeliness

Table 5 looks at this timeliness information by the severity of the complaint. It is clear that investigators tend to initiate an investigation more quickly if they perceive the complaint as serious. Thus, an average of 38 days will pass before the start of an investigation of a complaint with a DLI of 1; an average of 24 days will pass before the start of an investigation of a complaint with a DLI of 2; an average of 14 days will pass before the start of an investigation of a complaint with a DLI of 3; and an average of 12 days will pass before the start of an investigation of a complaint with a DLI of 4 or 5. It is important to note that this information is not complete. It does not include 77 percent of the Northeast's complaints because these complaints were given a DLI of 0. Thus, we cannot tell what DLI the complaint would have been given when it was first reported. In addition, as we will see in the next section, evaluators, after reading the cases, did not always agree with the DLI assigned.

Professional Time Spent on the Investigation of General Complaints

Table 6 shows the amount of time spent by the investigator on-site, interviewing by telephone, traveling, consulting and writing the final report.

Table 5. Timeliness of Investigation and Response to Complainant (in days)
by DLI

Mean Days From Initial Report To:	DLI= n=138	0	1 n=25	2 n=36	3 n=31	4+5 n=46
Initial Contact (Onsite or Offsite)		NOTE	38	24	14	12
Onsite Visit			39	24	15	12
Offsite Visit Only			4	11	33	5
Completion of Investigation			99	93	74	70
Response to Complainant			117	126	123	101

Footnote: Some area offices assigned a DLI of 0 only for cases found to be unsustained after an investigation; therefore, these figures do not tell us what the severity would have been if the complaint had been sustained. Comparisons of DLIs across area offices should be viewed with caution.

Table 6. Professional Time Spent on the Case Investigations (in hours) ¹

	Total n=218	N.E. n=37	Buf. n=34	Roch. n=18	Syr. n=23	N.R. n=50	NYC n=56
Mean Professional Time	9.8	7.5	10.1	8.2	14.0	11.0	8.9
Individual Professional Tasks							
Onsite Visits	3.4	3.3	4.6	2.2	3.6	3.5	3.0
* Telephone Interviews	0.5	0.4	0.1	0.1	1.1	0.3	0.9
Travel	1.6	1.0	1.4	1.1	1.6	2.0	1.6
Consultations	0.6	0.3	0.0	1.6	0.7	0.4	0.9
Write Report	4.0	3.0	4.1	3.2	6.8	4.8	2.8

¹ These numbers represent the average number of hours spent on each case. The hours are rounded to the nearest decimal. Hence, the sum of the individual professional tasks does not always equal the total mean professional time.

² Significant differences found between: Syracuse, Buffalo and Rochester; ($p \leq 0.01$).

Statewide

Across the state, on average, 9.8 hours is spent on each general case. Of that time, 3.4 hours are spent on-site and 4.0 hours are spent writing the report.

Area Office Differences

Syracuse spends the most professional time on a case (14 hours), almost one-half of which is spent writing the report (6.8 hours). In addition, Syracuse spends the most time on the telephone (1.1 hours) which makes sense considering that Syracuse uses telephone calls to investigate some complaints. However, Northeast which also uses telephone calls as a method of investigation, spends less than one-half the time that Syracuse spends on the telephone (.4 hours). Northeast spent the least amount of professional time on the investigations of the cases in the sample than any other area office (7.5 hours). Buffalo spends the most time on-site (4.6 hours), while Rochester spends the least amount of time on-site (2.2 hours). New York City spends only 8.9 hours of professional time on each case, the second lowest of all area offices.

Resolutions of Complaints

Each complaint within each case is resolved as sustained or unsustained.⁸ Table 7 demonstrates that only 31 percent of the complaints in the total sample were sustained. There were significant differences among area offices. New York City had the lowest sustained rate of all the area offices (16 percent). Syracuse's sustained rate was the highest at 61 percent.

Resolutions and Method of Investigation

Table 8 shows that all of the cases investigated off-site by Northeast and Rochester were unsustained. However, 42 percent of Syracuse's sustained cases were investigated off-site.

Actions Taken

After an investigation, a decision is made as to the action, if any, to be taken against the facility. The following actions may be taken: a SOF or a SOD may be written, the complaint may be followed up at the next scheduled survey, or a survey focused on specific issues may be immediately conducted. See table 9.

Statewide

Overall, no action was taken in 76 percent of the cases. Only 10 percent resulted in SOFs (22 cases) and only 11 percent (24 cases) led to SODs. Only two cases were recommended for follow-up at the next survey and none resulted in an immediate focused survey.

Area Office Differences

The most significant differences among area offices is in the number of cases where no action was taken. Both New York City and

Table 7. Complaint Resolutions per Area Office

	Total n=455	N.E. n=100	Buf. n=83	Roch. n=27	Syr. n=33	N.R. n=120	NYC n=92
Unsustained	68%	76%	54%	63%	39%	68%	80%
Sustained	31%	23%	46%	37%	61%	28%	16%

ie: There were a few complaints that were unsustained but actions were taken. Therefore all columns do not equal 100%.
The sustained complaints include those complaints where an SOF or SOD was done, but neither sustained or unsustained was checked.
Significant differences found between area offices; ($p \leq 0.001$).

Table 8. SUSTAINED Cases by Method of Investigation

	Total n=67	N.E. n=9	Buf. n=16	Roch. n=5	Syr. n=10	N.R. n=17	NYC n=10
*Onsite Visits	89%	100%	100%	100%	58%	94%	80%
*Offsite Visits Only	11%	-----	-----	-----	42%	6%	20%
For Offsite Visits only:							
Phone Calls only	56%	-----	-----	-----	43%	-----	100%
Letter only	13%	-----	-----	-----	29%	-----	-----
Both	31%	-----	-----	-----	29%	100%	-----

! A sustained case is one in which at least one complaint in the case was sustained
 * Significant differences were found between area offices; ($p \leq 0.05$).

Table 9. Actions Taken On Cases by Each Area Office ¹

	Total n=218	N.E. n=37	Buf. n=34	Roch. n=18	Syr. n=23	N.R. n=50	NYC n=56
** NONE	76%	89%	68%	83%	54%	66%	89%
* SUMMARY OF FINDINGS (SOF)	10%	3%	18%	----	26%	10%	7%
* STATEMENT OF DEFICIENCIES (SOD)	11%	8%	15%	6%	18%	20%	----
** FOLLOW-UP ON SURVEY (FUS)	1%	----	----	11%	----	----	----
FOCUSED-SURVEY	0%	----	----	----	----	----	----
OTHER (Primarily letters)	2%	----	----	----	----	4%	4%
2 SITE OBSERVATIONS MADE	4%	3%	----	6%	5%	8%	4%

1. The RHCf Complaint Survey and Investigation System documents gives the following choices for actions taken on a case: SOF, SOD, Follow-Up on Survey and Focused Survey. While in the facility, investigators observed other possible problems and referred these to survey staff by filling out a specific form for this purpose.

* These regions were significantly different; ($p < 0.01$).

* These regions were significantly different; ($p < 0.05$).

Northeast took no action for nearly 90 percent of their cases. This is in contrast to Syracuse, where a little over 50 percent of their cases led to no action. There were also significant differences among area offices in the number of SOFs and SODs written. Over one quarter of Syracuse's cases led to a SOF (6 cases) while only 3 percent of Northeast's cases (1) led to an SOF. Eighteen (18) percent of Syracuse's cases (4) led to a SOD where only 6 percent of Rochester's cases led to a SOD (1). New York City never wrote a SOD for any of its cases.

An additional action that can be taken by an investigator who observes problems not specific to the case s/he is investigating, is to fill out a form (Site Observation) outlining the problem observed with a suggestion for action. This form is given to the survey team for follow-up. Table 9 demonstrates that this form was used only 9 times throughout the state.

Actions Taken on Sustained Complaint Cases

Since the findings in table 9 relate to all cases, sustained or unsustained, it is interesting to look at what action was taken on sustained cases. We would expect, that when a complaint was found to have merit, it would lead to specific action. Table 10 demonstrates that this is not so.

Statewide

The state took no action on 42 percent of all of the sustained cases in the sample. Thus, no action was taken for 30 of the cases found to have merit after an investigation. Fifteen (15) SOFs were written and 22 SODs were written. Only one sustained case which did not lead to a SOF or a SOD was recommended for follow-up at the next survey. Letters were written to the facility in 3 sustained cases. No focused surveys were recommended.

Area Office Differences

Northeast, which had the second highest unsustained rate of all the area offices (tied with New Rochelle, see table 7), took no action on 73 percent of the cases it did sustain. Thus, Northeast sustained only 11 cases, and took action on only 3 of these. Rochester took no action on 60 percent of the cases it sustained. It sustained only 5, and took action on only 2. New York City sustained only 9 cases and took action on only 5 (2 of which led only to a letter to the nursing home administrator). Syracuse took action on 8 of the 12 cases it sustained. New Rochelle took action on 12 of the 18 cases it sustained (1 of which led only to a letter). Buffalo took the most action on its sustained cases, issuing an SOF or SOD in 69 percent of its sustained cases (6 SOFs and 5 SODs).

Sustained Complaints, DLIs and Action Taken

The use of the DLI allows us to know the severity of the sustained complaint in terms of its impact on the nursing home resident. Table 11 shows us what action was taken on sustained complaints of

Table 10. Actions taken on SUSTAINED CASES by each Area Office¹

	Total n=71	N.E. n=11	Buf. n=16	Roch. n=5	Syr. n=12	N.R. n=18	NYC n=9
NONE	42%	73%	31%	60%	33%	33%	44%
SUMMARY OF FINDINGS (SOF)	21%	----	38%	----	33%	11%	33%
STATEMENT OF DEFICIENCIES (SOD)	31%	27%	31%	20%	33%	50%	----
FOLLOW-UP ON SURVEY (FUS)	1%	----	----	20%	----	----	----
FOCUSED SURVEY	---	----	----	----	----	----	----
OTHER	4%	----	----	----	----	6%	22%

A Sustained Case is one in which at least 1 complaint in the case was sustained.

Table 11. Sustained Complaints by DLI and Action Taken by Area Office¹

	Total n=130	N.E. n=15	Buff. n=40	Roch. n=9	Syr. n=14	N.R. n=35	NYC n=17
LI = 0 = 12 *	None= 92% SOF= ---- SOD= 8%	(8) 100% ---- ----	---- ---- ----	---- ---- ----	---- ---- ----	(2) 67% ---- (1) 33%	(1) 100% ---- ----
LI = 1 = 3	None= 100% SOF= ---- SOD= ----	(1) 100% ---- ----	(1) 100% ---- ----	---- ---- ----	(1) 100% ---- ----	---- ---- ----	---- ---- ----
LI = 2 = 37	None= 57% SOF= 11% SOD= 32%	(2) 100% ---- ----	(14) 78% ---- (4) 22%	(2) 100% ---- ----	(1) 25% (3) 75% ----	(2) 20% ---- (8) 80%	---- (1) 100% ----
LI = 3 = 29	None= 17% SOF= 17% SOD= 66%	---- ---- ----	---- ---- (8) 100%	(3) 100% ---- ----	---- (3) 75% (1) 25%	(2) 17% ---- (10) 83%	---- (2) 100% ----
LI = 4 or 5 = 49	None= 27% SOF= 20% SOD= 53%	---- ---- (4) 100%	(6) 46% ---- (7) 54%	---- ---- (4) 100%	(1) 20% ---- (4) 80%	(1) 10% (2) 20% (7) 70%	(5) 38% (8) 62% ----

¹ In this table the action taken is the resolution checked per complaint.
ne = sustained complaint, but SOF and SOD were not Checked.

Due to area office variations in the assignment of DLI = 0, it is unclear how the data should be interpreted for these figures.

varying seriousness. We would expect that, if all sustained complaints do not have specific actions taken against the facility responsible for the negative outcome, at least those sustained complaints of the most serious nature would have led to SOFs or SODs.

Statewide

Table 11 does not demonstrate this. Action was not taken in 27 percent of all the sustained complaints rated at a DLI of 4 or 5, meaning either that harm warranting a physician's intervention or harm that is physical or life-threatening had occurred, or psychosocial harm had occurred warranting a complaint to the Department of Health, Federal authorities or an investigation of possible criminal conduct should be begun. Of these serious sustained complaints, only 20 percent led to SOFs and only 53 percent led to SODs for the facility found to be responsible. Surprisingly, sustained complaints of DLIs of 3 led to more action than those of DLIs of 4 or 5. Only 17 percent of these complaints where there was either the potential for harm from the one incident or where there was harm that did not need a physician's intervention, led to no action, while 17 percent led to SOFs and 66 percent led to SODs.

Area Office Differences

The Northeast never wrote any SODs except for those sustained complaints that had DLIs of 4 or 5. Northeast took no action on any sustained complaints with DLIs of 2 or 3. Buffalo wrote SODs for 4 of its sustained complaints with DLIs of 2 and wrote SODs for all of its sustained complaints (8) with DLIs of 3. However, while Buffalo took action on 7 of its sustained complaints with DLIs of 4 or 5 (SODs), it took no action on 6 (46 percent) of these complaints. Rochester took action on only their sustained complaints with DLIs of 4 or 5, writing SODs. Syracuse took action on all of its sustained complaints with DLIs of 3 (3 SOFs and 1 SOD) and on 80 percent of its sustained complaints with DLIs of 4 or 5 (4 SODs). New Rochelle wrote SODs for 80 percent (8 complaints) of its sustained complaints with DLIs of 2, wrote SODs for 83 percent (10 complaints) of its sustained complaints with DLIs of 3, wrote SOFs for 20 percent (2 complaints) of its sustained complaints of DLIs of 4 or 5 and wrote SODs for 70 percent (7 complaints) of its sustained complaints of DLIs of 4 or 5. New York City wrote no SODs, no matter what the severity of its sustained complaints. Thus, it wrote 1 SOF for a sustained complaint with a DLI of 2, 2 SOFs for sustained complaints with DLIs of 3 and, while taking no action on 5 sustained complaints with DLIs of 4 or 5, wrote 8 SODs for sustained complaints with DLIs of 4 or 5.

SECTION THREE

FINDINGS: NARRATIVE ANALYSIS

The author and each trained evaluator reviewed a sample of cases from the six different area offices. Using the information available, which included all material on each case open to the public (see a sample case in Appendix B), they were asked to decide if:

- (1) the cases were investigated in a timely fashion;
- (2) the cases were investigated at an appropriate time of the day;
- (3) they agreed with the DLI score assigned by the investigator before investigating;
- (4) they agreed with the resolution;
- (5) all aspects of the case were investigated; and
- (6) residents, family members and staff were interviewed.

Appendix C includes a copy of the form filled out by the trained evaluators as they read each case. For all questions the evaluators had the following three choices: yes, no and DK (don't know)/NA (not appropriate). On the next page is a table summarizing the answers for the state as a whole and separately for the six area offices.

Statewide Findings

- (1) The evaluators judged that 78 percent of the cases in the sample (169) were investigated in a timely fashion; 22 percent were not (48 cases).
- (2) Of the cases where investigation at a specific time of day was important (31), only 48 percent were judged to have been investigated at the appropriate time.
- (3) In those cases where the evaluator could judge the assigned DLI, the evaluator agreed with 67 percent (73 cases) of these assigned DLIs and disagreed in 33 percent of these cases.
- (4) In cases where the evaluator could make a decision about the resolution (157), the evaluator agreed with the resolution reached in 69 percent of these cases and disagreed in 31 percent of these cases.
- (5) Residents were interviewed in only 59 percent of the cases where the evaluator believed they could have and should have been interviewed (103 cases). Family members were only interviewed in 28 percent of the cases where the evaluator believed they should have been interviewed (54 cases). Staff was interviewed in 96 percent of the cases.
- (6) In cases where the evaluator could judge whether all aspects were investigated (150), the evaluator agreed that all aspects were investigated in only 59 percent of the cases.

TABLE 12
NARRATIVE ANALYSIS

	NE		Buff		NYC		Roch		NR		Syr		Totals								
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N							
TIMELY	27	10	0	25	9	0	42	12	2	17	1	0	35	15	0	20	3	0	169	48	1
Total	73	27	0	74	26	0	78	22	4	94	6	0	70	30	0	87	13	0	78	22	-
%																					
PPROP																					
TIME	6	2	29	2	3	29	1	3	52	1	0	17	3	7	40	2	1	20	15	16	187
Total	75	25	78	40	60	85	25	75	93	100	0	94	30	70	80	67	33	87	48	52	86
%																					
LI	6	0	31	13	13	8	30	11	15	5	2	11	10	6	34	9	5	9	73	37	108
Total	100	0	84	50	50	24	73	27	27	71	28	6	63	37	68	64	36	39	67	33	50
%																					
ESOLU	20	13	4	11	4	19	24	7	25	8	5	5	29	16	5	16	4	3	108	49	61
Total	61	39	11	73	27	56	77	23	45	62	38	28	64	36	10	80	20	13	69	31	28
%																					
INTERV																					
RESID	3	9	25	6	0	28	17	8	31	6	5	7	22	11	17	7	10	6	60	43	115
Total	25	75	68	100	0	82	68	32	55	55	45	39	67	33	34	41	59	26	59	41	53
%																					
FAMIL	1	13	23	3	0	31	7	11	38	1	3	14	1	3	46	2	9	12	15	39	164
Total	7	93	62	100	0	91	39	61	68	25	75	78	25	75	92	18	82	52	28	72	75
%																					
STAFF	35	2	0	8	0	26	41	1	14	10	0	8	37	2	11	20	2	1	151	7	60
Total	95	5	0	100	0	76	98	2	25	100	0	44	95	5	22	91	9	4	96	4	28
%																					
ll																					
SPECT	19	15	3	6	2	26	20	14	22	5	7	6	24	20	6	14	4	5	88	62	68
Total	56	44	8	75	25	76	59	41	39	42	58	33	55	45	12	78	22	19	59	41	31
%																					
TOTALS	37			34			56			18			50			23			218		
%	17			16			26			8			23			11			100		

Y= Yes; N= No; NA= Not applicable or Do not know
The percentages of the Y and N = 100 %. The NA percentage is based upon the total number of cases in the sample.

Area Office Findings

Northeast: 37 cases

- (1) Of the cases read by the evaluator, 73 percent (27 cases) were thought to be investigated in a timely fashion and 27 percent (10 cases) were not.
- (2) Of the cases where investigation at a specific time of day was important (8), 75 percent were judged have been investigated at the appropriate time.
- (3) In this area office the investigators assigned a DLI of 0 to all cases not sustained. Since most of the cases were not sustained, only 6 were assigned a DLI of 1 or higher. Of these 6, the evaluator agreed with all the DLI scores given.
- (4) In cases where the evaluator could make a decision about the resolution (33), she agreed with the resolution reached in only 61 percent of the cases (20). This is the lowest rate for all area offices.
- (5) Residents were found to have been interviewed in only 25 percent of the cases (3) where the evaluator believed they could have and should have been interviewed (12 cases). In addition to the cases where a family member was the complainant, and thus already spoken to, the evaluator believed that an attempt should have been made to contact family in 38 percent of the remaining complaints (14). However, family were interviewed in only one such case. Staff were interviewed in 95 percent of the cases (35).
- (6) In cases where the evaluator could judge whether all aspects of the case had been investigated (34), she believed that in only 56 percent of the cases (19) were all aspects of the investigation covered.

Examples of Actual Cases in the Northeast Area Office

1. Timeliness of the Investigation.

Investigating in a timely fashion.

- * One case involving a resident who broke a foot was initiated in 3 days.
- * Another case involving an activities issue was investigated in 4 days.
- * One case a room change with an upset resident was started in 5 days.

Not investigating in a timely fashion.

- * One case involved a shortage of staff; staff yelling;

residents not getting to lunch; and staff not answering call bells. This investigation was not initiated for 2 months.

- * Another case involved non-release of restraints and other care issues. This was not investigated for 39 days.
- * Another case, alleging shortage of staff and resident care issues, was finally initiated after 20 days with a phone call to the facility.

2. Appropriateness of the Time of the Investigation.

Investigating at the appropriate time.

- * One case involved the allegation that the facility was getting residents up at 5:00 a.m., dressing them and then putting them back to bed so the Department of Health could not catch them leaving dressed residents in the dining room hours before breakfast. The investigator arrived at the facility at 5:30 am and verified by observation and by staff interviews that the allegations were true.

Investigating at an inappropriate time.

Of the 8 cases determined to have needed a specific time for an investigation, only 2 cases were judged to have been investigated at an inappropriate time and one case was investigated on an inappropriate day:

- * One case concerned short staff in the evening; the investigator arrived in the facility at 8:30 a.m.
- * One case concerned a complaint in the early evening (7:00 p.m.); the investigator arrived at 3:30 p.m.
- * One case involved a resident who was allegedly put in front of an air cooler without a sweater and was found to be cold; the investigator went into the facility on a cold, rainy day when the air cooler was not on.

3. The DLI Score

In order to determine the seriousness of the event, the investigator assigns each complaint a DLI score. The score, as described above and in Appendix D, runs from 1 - 5.

The evaluator agreed with the DLI scores of all the cases with DLIs of 1 or higher (6).

- * One case alleged that physical therapy services were not being provided. A DLI of 4, meaning harm had occurred warranting a physician's intervention, was assigned.

* In the case described above where residents were gotten out of bed at 5 a.m., washed, dressed and returned to bed, a DLI of 4, using the resident reaction scale, was assigned for grooming, choice and resident rights.

* Another case alleged that food trays were not distributed in a timely fashion and consequently the food was cold. A DLI of 2 was assigned.

4. Resolutions of the Cases.

In resolving each case, the investigator first decides if the complaint is sustained. If it is, the resolution involves the decision to take any action against the facility such as an SOF or SOD, referral to the next scheduled survey or an immediate focused survey.

Agreement with the Resolution

* A SOD was written directly from the complaint alleging that residents were gotten out of bed at 5 a.m. every day, washed, dressed and returned to bed.

Disagreement with Resolution

* One complaint alleged that a resident suffered an accident because the aides did not put slippers on her feet when the resident was pushed in her wheelchair, although the requirement for slippers had been written into the record because of a previous accident. No action was taken because the investigator found that the staff members were unable to find the slippers even after searching both the resident's room and the utility room. These particular aides usually worked on another floor and were unaware of the earlier accident and believed that sneakers would be better than no footwear at all. Thus, the investigator took no action. In the evaluator's opinion, the investigator should have investigated the facility's ability to deal with continuity of care when staff was unfamiliar with the resident.

* Another case alleged neglect due to poor staffing - residents were laying in excrement. This case was investigated by telephone to clarify the staff schedule with facility staff. No action was taken because "complainant failed to give specifics alleging the nature of the alleged neglects." The evaluator believed that "laying in excrement" is very specific and that the complaint should have been investigated on-site.

5. Interview of residents or family members.

Interviewing of residents and family.

* One complaint involved cold food at the evening meal. The investigator went into the facility at 5:30 p.m. and observed the meal. She interviewed all visitors (5 family members)

and all alert residents. She was able to find out that the facility had had a problem but that things had gotten better.

Not interviewing residents and family when they should have.

Whenever the investigators did not go on-site and used a telephone call as the only means of investigation, only staff were interviewed.

- * One complaint involved short staffing with the alleged consequence that call bells were not being answered. The investigator, who did conduct an on-site investigation, interviewed only staff and accepted staff assurances that call bells were being answered. There was no indication that the investigator tried to talk to residents.
- * Another case involving a lack of activities did not include interviews with residents. Only staff interviews and activities records were used.
- * Another complaint dealt with short staffing and the fact that residents were being taken to meals late. The investigator interviewed no one. The only evidence was observation.

4. Investigation of all Aspects of the Case.

Investigating all aspects of the case.

- * In one case the investigator spent two days in the facility to investigate a complaint about restraints. She observed all residents in restraints; she observed ambulation of residents; she observed more than one meal.
- * Another complaint involved a resident who had broken her hip, and seemed to be in pain. It was alleged that the facility was not helping alleviate her pain. The investigator tried to interview the resident but the resident could not be interviewed. The investigator spoke at length to the staff about the resident's treatment. She spoke to the nurse, the physical therapist and to the physician who was on the floor. She reviewed the medical record. She followed-up by calling the facility to make sure the facility was doing all it could.
- * One complainant alleged that the facility was lying when it said that a resident fell while trying to climb over her bedrails. Although the investigation did in fact conclude that the resident did fall trying to climb over the bedrails, the investigator continued to try to discover whether the facility had addressed the resident's frequent episodes of climbing over bedrails. Finding it had not, the facility was issued a SOF.

Not investigating all aspects of the case.

Staff interview and record reviews were often used as the only evidence that the complaint was not sustained. Even when residents and family could have been interviewed in person or by phone, they were not.

- * In one case involving a complaint of lack of activities, the investigator asked why there were no activities for the geriatric population in the evenings. A staff member stated that they go to sleep by 6:30 pm. The investigator found no evidence that there was a lack of activities. There was no investigation of other issues such as why the geriatric residents were asleep at 6:30 p.m. and whether the activities for them were meaningful.
- * In another case, two parts of the complaint, involving release of restraints and verbal abuse, was not even investigated. Only the issue of supplements and serving of bread, another part of the complaint, was addressed.
- * One complaint concerned a resident who was forced to give up her private room after 6 and one half years in the nursing home. Most of the investigator's report discussed the fact that there were no regulations prohibiting the facility from forcing such a move and devoted little, or no, time discussing how the facility helped the resident deal with the move and whether there were similar issues for other residents.
- * Another complaint involved stolen money and clothing. The investigator concluded that because the resident kept money in his pillowcase and some of his clothes were not clearly marked, the theft probably occurred but it was not the fault of the facility. There was no evidence of any investigation into the facility's required policy for dealing with lost items.

General Comments.

The evaluation of these 37 cases from the Northeast area office raise a number of critical issues.

1. Decisions to go on-site.

It is unclear what criteria is used for the decision to call the facility staff rather than to conduct an on-site investigation. The written documentation of each case does not make it easy to understand why one case is investigated on-site and another by telephone. For example, many of the staff shortage allegations mention serious negative resident outcomes. Most of these are handled only by a telephone call to staff; some are handled on-site. On April 5, 1990, a complainant called alleging neglect due to poor staffing at one facility. Nothing was done in response to this call until

20 days later when the investigator decided to telephone the facility and inquire about their staffing schedules. Yet, on May 3, 1990, another complaint about this same facility alleging stolen money and clothes was investigated, on-site, the very same day.

2. Lack of coordination.

There is no evidence that there are follow-ups to the complaint investigations at the next regular survey of the facility. At times the investigators do suggest a survey follow-up, within the narrative of the case, but an evaluation of subsequent survey findings reveals little evidence that this was done.

* One facility had a scheduled survey on April 26, 1990. Deficiencies were cited. During May, 1990, two additional complaints were received for this facility, concerning staff leaving, care "terrible," and smells of urine. The area office decided not to investigate these two complaints at the time, but to follow-up with a focused survey if warranted after the Post Certification Visit (PCV) that must be conducted for all facilities with deficiencies. Meanwhile, on August 20, 1990, another complaint came in alleging low staff rate, residents not being ambulated and staff eating residents' food. The investigator did not go on-site at this time. She did not call the director of nursing until October 24, 1990, two months after the complaint was made, to inquire about staffing levels. The PCV was finally conducted on September 9, 1990 to evaluate the deficiencies from the April survey. The conclusion of the visit was that the facility was back in compliance. There is no mention of the complaints of May or of August.

* At another facility a complaint alleging care issues such as restraint release and verbal abuse was received on May 18, 1990. The investigator did not start the investigation until June 6, 1990. However, on June 4, 1990, another complaint about this same facility was made alleging low staff rates and serious specific resident negative outcomes. The investigator went on-site for this complaint the next day. There is no indication that the investigator used this opportunity to investigate the May 18, 1990 complaint.

3. Role of the Investigator

Sometimes the investigator seems to be using her role to try to work things out between family, residents and the facility. While this may help matters in situations where family, residents and facilities have reached an impasse, it neglects the duty to hold the facility responsible for its obligations under the nursing home code.

4. Limiting the Investigation

Many times when a relative calls alleging care problems, naming a specific resident, the investigator spends a lot of

time looking into that specific case. If the investigator finds no evidence of any care issue for that particular resident, s/he ends her investigation and concludes that the complaint is unsustainable. For example, a complainant may allege poor grooming of a resident. It is possible that when the investigator saw the resident there was no sign of poor grooming. The complaint is unsustainable. It would be appropriate, however, for the investigator, before deciding that the complaint is not sustained, to see if other residents have similar problems. If none are found, there is more support for the conclusion of unsustainable. Individual cases really do not stand alone.

Buffalo: 34 cases

The cases from Buffalo included little or no documentation relating to the process of investigation. Therefore, the evaluator often had no way of assessing the investigation. Many of the evaluations of resolutions, interviewing and investigation are in the category of "don't know (kn)."

- (1) Of the cases reviewed, 74 percent (25) were judged to have been investigated in a timely fashion.
- (2) In the five (5) cases where the evaluator decided that the appropriate time of the day for the investigation was important, three (3) were investigated at an inappropriate time.
- (3) In those cases where the evaluator could judge the DLI (26), she agreed with the DLI assigned in only 50 percent of the cases (13). This is the lowest agreement rate of all the area offices.
- (4) Because of the lack of information, the evaluator could not make a judgement about the investigator's resolution in 56 percent of the cases (19). The evaluator agreed with the resolution in 73 percent of the cases (11) she could evaluate.
- (5) Data related to interviewing and investigation was so sparse that the evaluator could only judge the remaining issues in less than 10 to 25 percent of the cases, too small to be meaningful.

Examples of Actual Cases in the Buffalo Area Office

1. Timeliness of the Investigation.

Investigating in a timely fashion.

- * One complaint, although not investigated for two and one half months, at the time of the next survey, was determined by the evaluator to be timely because it related to a one time event that had already passed. It involved a "job switch" day where non-professional staff such as housekeepers and kitchen

help followed nurses around to watch how care was being given. The complaint involved privacy and confidentiality issues.

Not investigating in a timely fashion.

Of the nine (9) cases which the evaluator believed were not investigated in a timely fashion, most were situations where the office attempted to hold the complaint until the next scheduled survey. In those cases, the evaluator determined that the wait was too long to be justified, and given the substance of the complaint, not safe.

- * One case concerning serious care issues such as: residents waiting 2-3 hours to be toileted; call lights not responded to in a timely fashion; and facility reeking of urine, was not investigated for a month.
- * In another case where it was alleged that staff was verbally abusing residents who were afraid and crying, the office waited almost one month to start the investigation.
- * In a case involving a wheelchair-bound resident who had been left in the chair all day and had fallen over, the office waited more than two months to investigate.
- * Because a survey was scheduled for 20 days from the day of the complaint, the office decided to hold a case where the following was alleged: many residents with bedsores; poor hygiene; lack of proper positioning; and one resident with a huge bedsore on back.
- * A complaint about a "potty line" where staff lined up all residents, alert and confused, who needed help going to the bathroom, at the same time 3 times everyday, waited one and one half months to be investigated.
- * Another complaint involving major care issues on the night shift waited over two months to be investigated.

2. Appropriateness of the Time of the Investigation.

Investigating at the appropriate time.

In a number of cases, investigators went into the facility early enough to surprise staff and these investigations led to SODs.

Investigating at an inappropriate time.

Two of the 3 cases out of the 5 the evaluator judged needed a specific time of the day for investigation, were not investigated at night when the problem was said to exist. In the other one the investigators arrived at the facility two hours before the problem was alleged to occur, thus giving the facility time to change its procedures.

3. The DLI Score.

Agreement with the DLI Score.

- * One case involved the inappropriate use of Haldol, a psychotropic drug. The investigator assigned a DLI score of 4. By assigning such a high DLI, the investigator was able to cite the facility for deficiencies immediately when the complaint was substantiated.
- * Another case concerned the death of a resident and was given a DLI of 5.
- * One case involved an allegation that a resident's dentures were in with another resident's dentures. The evaluator agreed with the DLI of 2, meaning no harm but, if continued over time, harm could occur.

Disagreement with the DLI score.

- * In a case discussed above, where all residents were lined up in a "potty line" to go to the bathroom three times every day, a DLI of 2 was assigned. Alert residents found this undignified and some residents were becoming incontinent waiting for their turn. The assignment of a DLI of 2 means that that the investigator decided, using the physical harm scale, that no harm had occurred but that harm could result if continued. The investigator may have also used the resident reaction scale, meaning that a reasonable reaction to the event would have been to merely make a verbal objection to the staff person immediately responsible or to leave the situation. The evaluator believed that the continuous use, three times a day, of such a potty line should have been given a DLI higher than a 2 on the resident reaction scale. There is no indication that the investigator considered the effect of this potty line being used day after day. The evaluator believed that this would have led the investigator to agree that a reasonable reaction would have been to do more than that indicated by a DLI of 2.
- * Residents waiting 2 or 3 hours before being toileted and lack of timely response to call lights was also given a DLI of 2. Using the physical harm scale, call lights unanswered should have been at least a 3 because there is the potential for harm from a single occurrence. Again, using the reaction scale for the toileting issue, a DLI of 3 or 4 is not unreasonable since the complaint alleged patterns of waiting for toileting.
- * The complaint discussed above, under timeliness of the investigation, involving verbal abuse where the

residents were frightened and crying, was labeled with a DLI of 2 using the resident reaction scale. It would seem that in this case, a reasonable reaction would have had to have been at least a 3, meaning reporting to a supervisor or the administrator.

4. Resolution of Cases

Agreement with the resolution

- * The evaluator agreed that the case involving the "potty line" should have resulted in deficiencies for the facility.
- * Another case alleged that a resident needed a restraint because she fell and hurt herself. The investigator concluded, after interviewing the alert resident in question, that the fall was an accident and that the resident did want a restraint. No action was taken.
- * Inappropriate use of Haldol led to a deficiency.

Disagreement with the resolution

- * In one case the investigation revealed that the resident was not placed on the diet she had been on in the hospital and that she had developed severe diarrhea and vomiting and had to be sent back to the hospital. When she came back to the nursing home she was fine. Eight days later Mellaril, a psychotropic drug, was ordered for agitation. The resident began to demonstrate behavioral changes. The investigator concluded that there was no evidence of need for the ordering of Mellaril. However, although the conclusion was reached that the complaint was sustained, the investigator stated that there was, "no solid evidence of negative outcomes." The evaluator felt that the facility should have received an SOD. She does not agree that there was no negative outcome. Resident behavioral changes, as indicated in the report, are negative outcomes. However, even if there were no negative outcomes, the potential for serious harm was there and thus warranted at least an SOD. In addition, the investigator should have looked at a few other residents to see if the facility has a pattern of prescribing psychotropic drugs inappropriately and/or recommended a follow-up at the next scheduled survey.

- * Another investigation sustained a complaint that the third floor residents were not receiving care and looked messy. No SOD or SOD was issued.

5. Interviews of residents and family members

Interviewing of residents and family members

- * When investigating the "potty line," the investigator interviewed residents.

- * When investigating a fall of an unrestrained resident, the resident was interviewed and her wishes determined the resolution of the case.
- * When investigating the misuse of Haldol, the investigator observed/interviewed the resident.
- * When investigating a complaint from a family member that the facility wants to get rid of a "nasty, disruptive" resident, the investigator interviewed the resident.

Not interviewing of residents and family members

Because of a lack of documentation, it was impossible to evaluate cases where the investigator should have interviewed residents and family members and did not.

6. Investigation of All Aspects of the Case.

Investigating all aspects of the case.

- * One complainant charged that the facility was trumping up charges of bizarre behavior and falsifying medical records in order to put her family member on Haldol. She also alleged that the administrator was lying to her. The investigator went into the facility to investigate this complaint. When the investigator concluded that the charges were false, she did not stop the investigation there. She examined the reasons for the use of Haldol and found that there seemed to be no medical reason for its use. She reviewed the record and spoke to the nurses. She found that excessive amounts of Haldol were used and that the negative outcomes for the resident were serious.

- * In another complaint where it was alleged that a resident was not cared for and died, the investigator conducted an investigation on-site in the nursing home and in the hospital where the resident was transferred. She interviewed the administrator, nursing staff, the social worker and the attending physician.

Not investigating all aspects of the case

- * A family member called to complain that a resident was not restrained and fell and that the resident should be restrained. The investigator concluded after the investigation that the facility was acting in the best interests of the resident when they removed the restraint.

The case ended there. The investigator should have gone further and looked to see what plan the facility had for removing the restraint while trying to prevent falls. Restraints cannot just be removed without the substitution of other intervention techniques. Often, family members are concerned about the removal of restraints because the facility does not deal with the problem of safety in other ways.

General Issues

1. Decisions: When to initiate the investigation.

Although the evaluator concluded that many complaints waited too long for the investigation to start, one case, which did not seem to need a speedy investigation, was investigated within two days. This case involved a billing complaint, after the resident had already been discharged from the facility. It is unclear what criteria is used to decide that some complaints can wait until the next survey to be investigated and some cannot.

2. Lack of Documentation.

The lack of documented information is a serious problem. The Department of Health must conduct internal quality assurance to evaluate how well its investigators are performing. Without documentation, it will be unable to conduct this crucial task and will be unable to suggest changes to better the system.

3. Use of the DLI.

When applying the scale rating physical harm, the investigators' DLI assignment generally was found to be appropriate by the evaluator. However, the evaluator disagreed with many of the assignments of the resident reaction scale of the DLI. This area office, in the opinion of the evaluator, tended to put low DLIs on resident rights and psychosocial issues.

New York City: 55 cases

- (1) New York City was judged to have investigated 78 percent of its cases (42) in a timely fashion.
- (2) Of the 4 cases in which the evaluator determined that a specific time of the day for the investigation was important, most (3) were thought to have been investigated at the wrong time of the day.
- (3) In those cases where the evaluator could judge the DLI (41), she agreed with the assigned DLI score in 73 percent of the cases (30) and disagreed in 27 percent (11).
- (4) In those cases where the evaluator could make a decision about the resolution (27), she agreed with the final resolution of the case in 77 percent of the cases (24) and disagreed in 23 percent (7).
- (5) In the 44 percent of the cases (25) where the evaluator believed that residents should have or could have been interviewed, residents were interviewed 68 percent of the time (in 17 cases). Not counting Buffalo, where documentation was scarce, this is the highest percentage of all the area offices. In the 18 cases where the evaluator believed that the family should have been interviewed, in only 7 cases were

family members in fact interviewed. Staff was interviewed in 98 percent of the cases where the there was enough information to judge this issue.

- (6) In cases where the evaluator could judge whether all aspects of the investigation were covered (34), she concluded that in 59 percent of these cases (20) did the investigator evaluate all aspects of the case. In 41 percent of these cases (14) the evaluator decided that the investigator did not investigate all aspects of the case.

Examples of Actual Cases in the New York City Area Office

1. Timeliness of Investigation

Investigating in a timely fashion.

- * One complaint alleged that residents were losing weight because they were not getting enough food and that the facility was dirty. The investigation began the next day.
- * Another case concerning a general deterioration of care was investigated in 2 days.
- * Another case involved a helpless resident not getting food. The investigation was initiated in 1 day.

Not investigating in a timely fashion.

- * A complaint concerned no blankets in a facility. The investigation began one month later.
- * A complaint was made in April, 1990. It alleged that residents were cold and there were no blankets. The investigator went on-site one month and 4 days later in May and could not verify the complaint.
- * Another complaint alleged urine odor, no supervision, use of restraints without orders and neglect. The investigation did not begin for one and one half months.
- * A complaint about decubitus did not begin for two months.
- * Another complaint alleging low staff, neglect and dangerous situations was not investigated for 18 days.

2. Appropriateness of Time of the Investigation

Investigating at the appropriate time.

- * One complaint, from an alert resident, alleged that s/he was not being helped to eat. The investigator observed at meal time.

Investigating at an inappropriate time.

- * One case alleged that the floor is always left unattended;

the nurse aides hang around in their own lounge room all evening and talk nastily to the residents. The investigator went on-site at 9:30 a.m.

- * Another case involved residents not being fed. The investigator went on-site at 2:00 p.m. after lunch and left at 4:00 p.m. before meal time.

3. The DLI score.

Agreement with the DLI score.

- * One case involved two residents fighting. The fight led to black eyes. The assigned DLI was 4.
- * Another case involved poor grooming and lack of cleanliness of a resident's room. The assigned DLI was 2.
- * A resident alleged that he was not getting therapy, although he was admitted for rehabilitation. The assigned DLI was 3.
- * Another complaint alleged that a patient died and his widow was not notified of the death for one and one half hours and that the body was sent to the morgue before her arrival. The DLI score was 3 on the reaction scale.
- * One case alleged that the social worker was not helping a resident to be discharged to her own apartment. The DLI given was 3 for care planning and for resident choice.

Disagreement with the DLI score.

- * A case alleging that an orderly kicked a resident's wheelchair, was given a DLI of 2. The evaluator judged this to be too low as even one incident such as this could cause harm or that a reasonable reaction would have been to report this to a supervisor, the administrator or to the Department of Health (DLIs of 3 or 4).
- * Another case alleged that residents were being intimidated by a physician who does not examine them and that the staff was abusive. The nurses were alleged to have parties with loud music and drink alcohol. A DLI of 1 was assigned.

4. Resolution of the Cases

Agreement with the Resolution

- * One case alleged that the facility was not helping a resident transfer to another facility with a younger population. After investigation, an SOF was issued indicating the resident's need for a transfer and for more therapy. This conclusion was based upon interviews with the resident and the social worker.

Disagreement with the Resolution

* In one case the investigator documented 17 residents with decubitus. Of these, 14 had developed the decubitus in the facility. The investigator recommended sending an SOF and conducting an off-cycle focused survey. The area office followed neither of these recommendations. The evaluator believed that these negative findings should have led to an SOD which would have required a follow-up visit, or, if there was no evidence at this time that the development of the decubitus was the result of poor care by the facility, a focused survey should have been conducted. There was no evidence presented that the large number of decubitus was not the fault of the facility.

* In another case involving a resident who fell and was left on the bathroom floor while his call bell was not answered for one hour, the investigator suggested that the facility be given a SOF requiring them to develop a plan to attempt to resolve the problem as the resident's continuous falls could lead to serious injury. The investigator believed that the complaint of neglect was sustained and that the facility had failed to address the problem prior to the complaint. The area office did not take the investigator's recommendation and took no action.

5. Interviews of residents and family members

Interviewing of residents or family members

* In a case alleging general deterioration of care, as well as residents forced to do things against their will, a number of residents were interviewed.

* In another case alleging that residents were being continuously abused verbally by a member of the professional staff, the resident who was said to be abused was interviewed.

Not interviewing residents and family when they should have

* The investigator did not interview residents and/or family members in a case that alleged diapers were not changed and residents were restrained without orders.

* In another case, alleging not enough staff at meal times to feed residents and that consequently helpless residents were hungry, the investigator did not observe a meal and did not interview residents.

* In a case alleging residents not being fed, no residents or family members were interviewed.

* In a another case alleging that residents were being neglected and that there was not enough staff, no residents or family were interviewed.

- * In another case alleging residents not being ambulated, restraints not released and residents not toileted, no residents or family members were interviewed.

6. Investigation of all aspects of the Case

Investigating all aspects of the case

- * One case alleged that the toilets on the third floor were not clean, that walls and furniture were dirty and that residents were not given enough food and were therefore losing weight. The investigator went on-site; interviewed the assistant to the administrator, the director of nursing and a number of residents. S/he took a walking tour of the third floor, inspecting shower and bathrooms. S/he observed residents eating and reviewed monthly weight charts.
- * A resident complained that he was not given blankets when he was cold. When the investigator arrived and interviewed the resident, he said that his complaint had been resolved. However, the investigator continued the investigation by taking a tour of the facility noting that every bed did have a blanket and that the linen closet had extra blankets available.

Not investigating all aspects of the case

- * In a case involving a resident who was physically and verbally abusive to other residents and staff, the investigation was ended because the resident had been removed to a psychiatric facility. There was no evidence that any investigation of the facility's plan to deal with this resident's or other residents' similar problems was undertaken.
- * In a case dealing with a resident who was missing for 3 days, most of the investigation dealt with how the resident was able to leave the facility and whether continual attempts to leave had been noted. This resident was known to be a wanderer, alert and oriented with times of forgetfulness. According to the material, the investigation spent no time on why the resident wanted to leave and how the facility planned to find out what his reasons were or how the problem could be resolved. There was mention that the facility decided to keep clothing away from the resident in order to keep him in the facility. The investigation should have gone beyond the methods the facility used to keep him from leaving.
- * Two cases dealt with residents complaining of no rehabilitation. The investigators looked only at each individual case and found no problems. They should have looked at a few other residents on rehabilitation.

General Issues

1. Lack of Coordination between PCI unit and Survey unit.

* One case demonstrated the problem of integration between the PCI unit and the regular survey unit. During an investigation, an investigator called a facility, asking for the supervisory nurse and was told that there was no supervisor on that day or on weekends. The investigator noted that this was a serious deficiency and should be investigated. That was the only mention of this matter.

* In another case, the investigator sustained a complaint involving a facility which did not want to readmit a patient from the hospital. The investigator convinced the facility to readmit the resident but no other action was taken. This would have been a good opportunity to follow-up during a regular survey to find out if the facility had similar problems.

2. Not following investigator's recommendations

In a number of cases the area office did not follow the investigator's recommendation to sustain a case, generally recommending little or no action.

3. Unsubstantiated staff statements

A number of cases demonstrated the investigator's willingness to accept staff statements at face value.

4. Limiting the Investigation

Many times when a relative called alleging care problems, naming a specific resident, the investigator spend a lot of time looking into that specific case. If the investigator found no evidence of care issues for that particular resident, s/he ended her investigation and concluded that the complaint was unsubstantiated. It would have been appropriate for the investigator, before deciding that the complaint was not sustained, to investigate similar problems among a few other residents. If no similar problems were found, there would have more support for the conclusion of unsubstantiated.

5. Documentation of cases

Written notes are very hard to read. It is difficult for the Department of Health to conduct adequate internal quality assurance if the written documentation cannot be read.

6. Decisions: When to initiate the investigation

It is unclear what criteria is used in the New York City area office. Although in general New York City began its investigations in a timely fashion, there were a number of cases needing more immediate action, that waited for 5 or 10

days to be investigated while others, not needing an immediate response, were investigated the same or the next day.

For example, one complainant alleged that the facility was keeping his deceased brother's money. The investigator went on-site in 2 days. However, other cases alleging that residents were dirty and had serious care issues were not investigated for 5 or 10 days.

Rochester: 18 cases

- (1) Of the cases read by the evaluator, 94 percent (17 cases) were thought to be investigated in a timely fashion. This is the highest percentage of all the area offices.
- (2) In only one case was a specific time of day for the investigation important, and that case was investigated at the appropriate time.
- (3) In this area office the investigators assigned a DLI of 0 to all cases not sustained. Only 7 cases have an assigned DLI of 1 or higher. Of those 7 cases, the evaluator agreed with the DLI score in 71 percent of the cases (5).
- (4) In those cases where the evaluator could make a decision about the resolution (13), she agreed with the resolutions reached in only 62 percent of these cases (8). This percentage is among the 3 lowest of all the area offices.
- (5) Residents were found to have been interviewed in 55 percent of the cases (6) where the evaluator believed they should have been interviewed. The evaluator believed that family members should have been interviewed more than they were. Family members were interviewed in only one case. Staff were interviewed in 100 percent of the cases where the evaluator believed they could have been interviewed.

- (6) In those cases where the evaluator could judge whether all aspects of the case were investigated (12), she believed that in only 42 percent of the cases (5) were all aspects of the cases covered. This is the lowest percentage of all the area offices.

Examples of Actual Cases in the Rochester Area Office

1. Timeliness of the Investigation

Most of the investigations were timely.

Not investigating in a timely fashion.

* Although a facility had been cited for problems with the kitchen and food services in December, 1989, a complaint alleging that the facility ran out of food and that the resident could not go out on Easter Sunday because the facility wouldn't give medication was not investigated for almost 2 months until the time of the next survey.

2. Appropriateness of the Time of the Investigation
Only one case was determined to need a specific time of the day for the investigation and the investigator conducted the visit at an appropriate time.

* However, one case alleging that a resident was seen lying on the corridor floor while a nurse paid no attention, was investigated over the phone. The evaluator believed that this complaint should have been investigated on-site.

3. The DLI Score

Agreement with the DLI

* One complaint alleged that a resident developed blisters, on her hands and feet, that became large open areas. There had been no diagnosis or treatment and the staff did not know how to handle the problem. A DLI of 4 was assigned.

* Another complaint alleged that an aide was verbally abusive. A score of 3 was assigned.

Disagreement with the DLI Score

* A resident complained that she could not get to the bathroom by herself and waited over a half hour for help. In addition, she did not have her weekly shower. A DLI of 2 was assigned. Using the resident reaction scale, the evaluator believed that a 3 should have been given, meaning a reasonable person would report the occurrence to the supervisor or the administrator.

* Another complaint alleged that the resident was not well groomed and developed a urinary tract infection but was never given needed medication. This was assigned a DLI of 1.

(4) Resolution of the Cases

Agreement with the Resolution

* One case involved a resident who had fallen twice since admission. Even though it was found that she had indeed fallen, the investigator concluded that the facility was doing all it could to deal with the problem. Care conferences were held with the family and the resident and the facility seemed to be dealing very well with the issues.

* Another case dealt with verbal abuse by an aide. The investigation determined that the complaint was valid. The facility received no negative findings or deficiencies because the facility had already counseled this aide and had written three warnings for poor performance and irritability with residents. She was also referred to a remedial program. This aide resigned right after the investigation.

Disagreement with the Resolution of the Case

- * One case involved the broken bone of a resident, who became combative and fell when being taken to the bathroom. The record indicated that the facility knew that the resident was combative at times. The resolution was to do nothing because the investigator did not believe that inadequate care was given. The evaluator believed that the investigator should have looked at the facility's ability to deal with combative residents to prevent injury.
- * Another case alleged that the facility social worker was not allowing a couple to be discharged to go back home. During the investigation, it became clear that the social worker did not believe it was in their best interest for this couple to go home and therefore did not help them develop an appropriate discharge plan. The investigator helped and the couple was discharged to their home with home health care aides. No further action was taken. The evaluator believed that some findings should have been written about the social worker's refusal to allow these alert residents the right to make their own decisions.
- * Another case involved a resident who was given a cushion as an alternative to a physical restraint. She fell and required stitches. Although the facility is to be commended for attempting to remove restraints, this case indicated that the facility did not plan adequately for removing restraints. The investigator took no action even though s/he found the facility needed to do better care planning.

(5) Interviews of Residents and Family

Interviewing of residents

- * One case alleged that a resident had fallen twice and that the facility was not taking care of her. The resident was interviewed at length.
- * Another case involved a confused and disoriented resident. The investigator tried to converse with her. She was able to see that at first the resident seemed to be afraid but was able to shake hands with her/him. When it became clear that the resident could not answer questions, the investigator observed the resident.

Not interviewing residents or family

- * One case alleging bruises did not include a resident interview.
- * In another case discussed above involving a combative resident, no attempt was made to interview the resident.

* Another case alleged dirty bathrooms and that incontinent residents lay in wet beds. Although the investigator checked bathrooms and the supply of sheets and rubber sheets, there was no indication of any attempt to interview residents.

* Another case alleged poor grooming and lack of activities for the resident as well as a lack of medication. Only the medication issue was investigated and that was done entirely by reviewing the medical record.

(6) Investigation of all Aspects of the Case

Investigation of all aspects

* In a case described above a resident alleged that she was not receiving good care. She also claimed that the facility was short-staffed. The complainant also stated that she had to wait for her call bell to be answered and that she had not gotten her weekly shower. The investigator made an unannounced visit; s/he met with the administrator and toured the facility. The resident who made the complaint was interviewed. Even though the resident stated that things had improved, her medical record was reviewed. A third resident was observed during the visit which led to another investigation. Another resident asked for an interview with the investigator. With all of this information, the investigator found, that although the original complaint was not substantiated on the visit, other care issues needed to be addressed.

Not investigating all aspects

* The case described above dealing with a couple who wanted to leave the facility and receive care at home, demonstrated a case that the evaluator did not believe was investigated fully. A more intensive investigation of the social work services should have been conducted to see if there were other cases where the social worker did not respect the rights of the residents.

* Another case alleged that the facility ran out of food and that one resident who wanted to go out on Easter could not because the facility would not give her her medication. Only the food complaint was investigated.

General Issues

Coordination between PCI unit and Survey unit.

In a number of cases, the investigator urged a follow-up at the next survey. There is no indication that this was done.⁹ It is possible that information is kept and followed and is available in other facility files. The idea of survey follow-up is a good one if in fact there is clear follow-up.

Syracuse: 23 cases reviewed

- (1) Of the cases read by the evaluator, 87 percent (20 cases) were thought to be investigated in a timely fashion and 13 percent (3 cases) were not.
- (2) Of the cases where a specific time of day for the investigation was important (3), two cases were investigated at the appropriate time.
- (3) In those cases where the evaluator could judge the DLI (14), she agreed with the assigned DLI in 64 percent of the cases (9) and disagreed in 36 percent.
- (4) In those cases where the evaluator could make a decision about the resolution (20), she agreed with the resolution reached in 80 percent (16) of these cases. This is the highest agreement rate of all the area offices.
- (5) Residents were found to have been interviewed in only 41 percent of the cases (7) in which the evaluator believed they should have been. Family members were interviewed in only 18 percent of the cases (2) in which the evaluator believed they should have been. Staff was interviewed in 91 percent of the cases (20).
- (6) In those cases where the evaluator could judge whether all aspects of the case were investigated (18), she believed that the investigator investigated all aspects of the case in 78 percent of these cases (14). This is the highest percentage of all the area offices.

Examples of Actual Cases in the Syracuse Area Office

1. Timeliness of the Investigation

Most of the cases (20) were investigated in a timely fashion. However, some were investigated merely by requesting the medical records for review at the area office

- * One of these timely cases was investigated by telephone. This complaint involved a threatened discharge as well as complaints about food and laundry. The telephone investigation covered only the discharge issue.

Only 2 were not investigated in a timely fashion.

- * One complaint alleged that the facility had been short-staffed resulting in unanswered call bells and wandering residents. This complaint was not investigated for 2 months.
- * Another case alleged inadequate nursing assessment and intervention. This investigation was not only not timely but was investigated by a telephone call requesting medical records.

2. Appropriateness of the Time of the Investigation

Only 3 cases were judged to need a specific time for investigation.

Investigating at the appropriate time.

- * One case alleged short staff on the 3 to 11 shift. The investigator went on-site at 3:00 pm.
- * Another case alleged short staff on the 7 to 3 and 3 to 11 shift. The investigator went on-site at 9:30 am and stayed on-site for almost 8 hours.

Investigating at an inappropriate time

Only 1 case fell into this category.

- * This complaint involved verbal abuse on the 3 to 11 shift. The investigator went on-site at 10:00 am.

3. The DLI Score

Agreement with the DLI Score

- * One case was assigned a DLI of 4 because a wandering resident had apparently fallen out of her wheelchair and broken her hip in another resident's room.
- * Another case alleged that when a resident was taken to the bathroom, the aides stood there affording him no privacy. The DLI was 3.

Disagreement with the DLI Score

- * A DLI of 1 was assigned to a case alleging short staff resulting in unanswered call bells. The evaluator believed the DLI should have been a 3.
- * Another case was assigned a DLI of 2. The evaluator believed the DLI should have been 3 to 4 because the complaint alleged that staff did not know how to hook up a oxygen regulator; the resident did not get help, had to walk to the bathroom alone and suffered a massive stroke; the staff did not respond in time and the resident fell, suffering bruises on arm and shoulder.

4. Resolution of the Cases

Agreement with the resolution

- * One case alleging verbal abuse led to a SOF after a very detailed investigation. It was concluded that the facility did not assure that the residents were free from mental abuse and were treated with consideration, respect and dignity.

* No action was taken after a full investigation indicated that the facility had been experiencing a shortage in staffing but that they were attempting to alleviate the problem by increased compensation and recruitment efforts. The investigator observed the evening meal and found adequate staff and observed no other problems. During a recertification survey the surveyor investigated this complaint again by interviewing residents and family members and found no problems.

* Another case alleged that the facility was not allowing an alert resident to endorse his retirement checks; was intercepting his mail; and was allowing him only \$5 per month. After an on-site visit and interviews with the resident and the nursing home staff, and a number of telephone follow-up interviews, the allegations were sustained. An SOD was issued.

* An alert resident complained that when he was taken to the bathroom the aides stood there and did not afford him privacy. He had already spoken to the director of nurses and nothing was done. Staff interviews indicated that the staff was concerned about the resident and did not want to leave him alone. The investigator concluded that although most of the staff believed the resident to be unrealistic and uncooperative in his expectations about his abilities and his disease, "...in the absence of good supporting evidence, indicating a mental impairment rendering him incapable of making choices about his care, (that) the facility must allow him the freedom to choose what manner of toileting he will use. The resident needs to be informed of all the options and all the risks." He must be allowed to make the decision. The facility was issued a SOF.

Disagreement with the resolution

* In one case, although negative outcomes were found due to a staff shortage, the investigator recommended that no action be taken because the facility was acting appropriately in the recruitment and training endeavors. Negative outcomes, in the evaluator's judgement warrant action.

* In another case an SOF was issued. The evaluator believed that an SOD should have been issued because many problems involving short-staffing were found. Staff interviews indicated that staff rounds were often not done because only one aide was on duty. Staff also stated that they find it almost impossible to keep track of the wandering residents and can render care only when an aide is on duty.

5. Interviews of Residents and Family Members

Interviewing of residents and family

* In the case involving the resident taken to the bathroom while aides stood by, the resident was interviewed in a sensitive manner.

* In another case alleging that call bells were not answered, the investigator interviewed as many alert and oriented residents as she could find.

Not interviewing of residents and family members

In a number of cases alleging short-staffing and unanswered call bells and lack of care, no residents or family members were interviewed.

* In another case alleging a mean and nasty caregiver, the investigator called the facility, asking it to conduct an internal investigation and report back to the area office. This was the end of the investigation.

* In another case involving major care problems with a specific resident, the only investigation conducted was a request for the medical records and a review of the records.

6. Investigation of All Aspects of the Case

Investigating all aspects of the case

* In the case involving verbal abuse, a concurrent 340 investigation was also conducted. Staff and residents were interviewed. The case did not end with an individual aide sustained finding. The investigator believed that the facility did not do all it could to protect the residents.

* Another case involved a nursing home and two hospitals. The investigator went on-site to all 3 locations. She went into depth on all the issues stating problems found even if she was not recommending any action be taken.

Not investigating all aspects of the case

A few cases merely asked the facility to send medical records.

In a number of cases only part of the complaint seemed to be investigated.

* In a case alleging care problems, the investigator discovered through an interview with the supervisor that the supervisor had asked the complainant why she didn't take her mother home or to another facility if she wasn't happy. Although the investigator states that this response may have been inappropriate and the allegation of rudeness was partially sustained, no action was taken and there was no evidence of any additional investigation on this point.

General Issues

1. Decision to not make an on-site visit

In 5 cases, this area office decided not to go on-site. In 2 of these, serious care allegations were handled by merely

reviewing medical records in the area office. In another 2 of these, one involving short staffing with unanswered call bells and one involving a "mean and nasty" staff person, the facility was asked to undertake an internal investigation and report back. Another case, alleging inappropriate discharge, unhappiness with food quality and quantity and ripped clothes, a telephone call to the administrator was the sum total of the investigation.

2. Integration with survey teams

Two cases indicate that the investigator urged follow-up at a survey and this was in fact done.

New Rochelle: 48 cases

- (1) Of the cases reviewed, 70 percent (35) were thought to be investigated in a timely fashion and 30 percent (15) were not.
- (2) Of the 10 cases in which the evaluator determined that a specific time of the day for the investigation was important, 7 were not investigated at the right time.
- (3) In those cases where the evaluator could judge the DLI (16), she agreed with the assigned DLI score in 63 percent of the cases (10) and disagreed in 37 percent of the cases (6).
- (4) In those cases where the evaluator could make a decision about the resolution (45), she agreed with the final resolution of the case in 64 percent of the cases (29) and disagreed in 36 percent (16).
- (5) In the 66 percent of the cases (33) where the evaluator believed that residents should have or could have been interviewed, residents were interviewed in only 67 percent of the cases (22). In cases where a family member did not complain, a family member was interviewed in only one case. Staff were interviewed in 95 percent of the cases.
- (6) In cases where the evaluator could judge whether all aspects of the case were investigated (44), she concluded that in 55 percent of these cases (24) the investigator did evaluate all aspects of the case. In 45 percent of these cases (20), the evaluator decided that the investigator did not investigate all aspects.

Examples of Actual Cases in the New Rochelle Area Office

1. Timeliness of the Investigation

Investigating in a timely fashion.

- * One case involving a scabies outbreak was investigated in 1 day.
- * Another case alleging urine odor and lack of help in the evenings was investigated in 3 days.

- * One case alleging verbal abuse and a filthy day room was investigated in 4 days.

Not investigating in a timely fashion

A number of cases were, according to the evaluator, were inappropriately kept until the next regularly scheduled survey.

- * One, that waited for 6 weeks, alleged thin blankets and cold water in baths.
- * Another, that waited for almost 2 months, alleged poor staffing, residents put to bed too late at 11 pm, no turning of residents and not enough diapers.
- * One case, not investigated for 7 weeks, alleged major care problems such as residents sitting in feces.
- * Another case, not investigated for 20 days, involved an immediate bed hold issue and inappropriate discharge planning.
- * Another case, called in by a relative alleging poor toileting, waited 6 weeks even after the relative called back after 2 weeks to add to her complaint.
- * Another case, not investigated for over 2 months, was called in by a relative alleging that a resident could not feed himself and no one was helping him.

2. Appropriateness of Time of the Investigation

Investigating at the appropriate time

- * The complaint alleging that no one was helping a resident feed himself, was investigated at mealtime.
- * A complaint alleging verbal abuse by an aide was investigated when that aide was on duty.

Investigating at the inappropriate time

- * A complaint about the evening shift was investigated at 9:30 a.m.
- * Another complaint alleging short staff on the 11 to 7 a.m. shift was investigated after 7 a.m.
- * A complaint alleging that residents were brought to meals 2 hours before the food was served was investigated at 9:15 a.m.
- * Another complaint alleging that residents awakened at 3:30 a.m. for morning care was investigated at 10 a.m.

3. The DLI score

Agreement with the DLI score

- * A complaint alleging that the facility did not notify the family about a serious accident was given a DLI of 3.
- * Another complaint alleged problems between a resident and his roommate. One of the residents was sent to a private room for a week just to sleep for the night to solve the problem. This case was assigned a DLI of 4 for psychosocial issues, after the investigator discovered that the facility had not worked on a plan for dealing with major behavior problems.

Disagreement with the DLI score

- * A complaint alleging verbal abuse (the staff member yelled at a resident saying that she was ugly and her clothes were ugly) was given a DLI of 2. The evaluator believes this should have been at least a 3.
- * Another case involving a resident who was prevented from going home by the facility, was given a DLI of 1 for violations of resident choice.
- * Another case alleging few activities in the nursing home was given a DLI of 2. The evaluator believed this should have risen to the level of a 3.
- * Another complaint alleged verbal and physical abuse such as swearing and shoving. The caller alleged that all the residents are fearful. The DLI assigned was a 3. The evaluator believes that this should rate a 4 on the resident reaction scale.

4. Resolution of the Cases

Agreement with the Resolution

- * In the case described just above, the investigator recommended no action be taken against the facility because she had verified that the facility had already terminated the staff member involved.
- * An investigation of a complaint about lack of activities found that, although the activity calendar and schedules indicated a variety of activities, on 5 out of 16 days, the facility did not provide the activities scheduled and that there were no meaningful activities offered. An SOD was written.
- * In the case of problems between a resident and his roommate, the investigator concluded that the facility had failed to develop and implement an appropriate care plan to deal with major care and psychosocial issues. The facility was issued a SOD.

- * In another case alleging wheelchairs needing repair, residents brought to the dining room 2 hours before mealtime, and slow response to call bells, the investigator, after touring the facility, interviewing residents and staff, decided that the complaint was unfounded.

Disagreement with the Resolution

- * In a case alleging that residents were gotten up at 3:30 a.m. in order for morning care and preparation for breakfast, the investigator decided the complaint was unsubstantiated. The evaluator disagreed with this conclusion because the investigator arrived in the facility at 10 a.m., long after the alleged event might have taken place. In addition, the investigator accepted what staff told her without question and did not interview residents.
- * Another case found that a facility did not notify the family member when a resident sustained an injury and was transferred to the hospital. In addition, it was found that, although the resident had a history of dehydration, the care plan was not implemented as it related to nutrition. The resident became dehydrated. A SOF was issued. The evaluator believed that this should have been an SOD.
- * In another case alleging short staff, the investigator decided the complaint was not sustained. The investigation included only inspecting records of staff schedules.
- * A resident called to complain that her doctor took her off her insulin for a long-standing diabetes problem and put her on another medication. She wants to be put back on insulin. The investigator concluded that no action should be taken against the facility stating that there was no problem with medical care. However, it was also clear that the resident's right to refuse and decide treatment after being fully informed was being violated.

5. Interview of residents and family members

Interviewing of residents or family members

- * Residents were interviewed on a complaint about activities.
- * A resident was interviewed concerning a complaint about housekeeping and odor.
- * Although the investigator interviewed residents regarding a complaint about unanswered call bells and verbal abuse, the residents interviewed were chosen by the facility staff.

Not interviewing residents and family when they should have

- * In a complaint made by staff from a transitional day care program on behalf of a retarded nursing home resident who seemed very upset about returning to the facility, an effort should have been made to speak to the aunt of the

resident. Although the day care staff member, knowing the resident for 4 months, believed that the resident was telling the truth, the investigator essentially relied upon the facility staff for information.

- * In a complaint alleging medication not being given, no residents were interviewed.
- * In another case alleging that dangerous material used to clean floors was affecting the residents, the investigator agreed that the material used could affect staff. However, s/he believed that it presented no problem to residents. This conclusion was reached without interviewing any resident.
- * Another case alleged lack of restraint release and cold food on weekends. No residents were interviewed even though a specific resident was named in the complaint.
- * Another case alleging that the facility was no longer offering snacks, led to a conclusion that the complaint was not sustained because when the investigator was on-site, the snacks were being offered. No residents were interviewed.
- * Another case alleged poor staffing. The investigator concluded that this complaint was strictly a labor/management issue because she stated that there was no evidence of negative outcomes. No residents were interviewed. Even though the investigator, through observation and staff interviews, found that the facility resolved its post 3:00 p.m. staffing problems by putting residents to bed before 3:00 p.m. and having all showers and baths completed by the day staff, no action or additional investigation was undertaken.

6. Investigation of all aspects of the Case

Investigating all aspects of the case

- * Investigating a complaint alleging verbal abuse and a dirty day room, the investigator spoke privately to 4 residents about the complaints; she reviewed resident council minutes and executive board minutes.
- * While investigating a complaint, an investigator noticed that two residents were in bed fully dressed. They stated they were cold. The investigator spent time looking into the matter. Although the original complaint was not sustained, the facility was given an SOF for inadequate heating.
- * In a case discussed above concerning the psychosocial and care problems of a resident and his roommate, the investigator did a thorough job of looking into the complaints. S/he interviewed the resident; s/he interviewed staff including the social worker; and s/he reviewed the resident's medical record.

- * The investigator for one complaint could not find the resident referred to in the complaint. Rather than just leave and close the case, s/he selected three other residents with potentially the same problem and reviewed their care.

Not investigating all aspects of the case

- * A case alleging serious care problems including residents sitting in feces, was investigated long after the fact. In addition, the investigator was accompanied on her/his tour by the director of nursing. No family or residents were interviewed.
- * The case involving the diabetic who wanted to change her medicine should have involved the investigation of a few more residents to find out if they believe their rights are being protected. The investigator could either look for a pattern and/or suggest that the survey team look into the matter at the next survey.
- * In a case concerning the turning of one resident, the investigator looked only at that one resident. It would make sense to use the on-site time in a more valuable way by looking at a few other residents to see if the problem is pervasive.
- * In the case involving the facility's not notifying a family member, the investigator did not try to see if there was a pattern for this violation.
- * In another case involving the use of Haldol, the investigator did not investigate if alternative treatments were tried prior to Haldol use.

General Issues

Decisions to go on-site

In the opinion of the evaluator, there were two cases where the area office could have used a telephone call instead of an on-site visit if there was a backlog of serious complaints. One involved a question of staff certification which could have been handled by the facility sending verification of certification and another involved the lack of milk at one meal. This last complaint could have started with a telephone call and the complainant could have been told that the area office would handle it by a phone call but that if the problem persists to call back.

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SECTION FOUR

FINDINGS: INTERVIEWS OF THE DIRECTORS OF LONG TERM CARE OF EACH OF THE 6 AREA OFFICES

Each area office has a Director of Long Term Care who oversees the surveillance and investigation procedures of each region. Each area office Director was sent a series of questions in preparation for a personal interview during 1991. All interviews were followed up by telephone. See Appendix E for a copy of the questions asked. Below is a summary of the answers given.

1. The Organization of the PCI Unit Within the Long Term Care Area Office

According to the interviews, the six area offices vary in the way they organize the PCI unit within their long term care section.

Northeast

Northeast has 3 PCI investigators who are separate from its survey staff. All the PCI staff are nurses. If another discipline is needed for the investigation, survey staff fill in. In addition, if needed, the physician in the office, who may be involved in hospital work or monitoring physician conduct, is consulted. Ninety (90) percent of all general complaints are sent to the survey team to investigate. The team may initiate the investigation immediately or may wait until the next scheduled survey. The PCI staff deals almost entirely with 340 complaints.

Buffalo

Buffalo has 3 nurse investigators who are separate from its survey staff to investigate 340s and general complaints. However, all surveyors are trained to be investigators. If a physician is needed, the case is brought back to the office or the Director of the Bureau of Long Term Care at the central office in Albany, who is a physician, is called.

New York City

New York City's PCI unit is separate from its survey staff. Its 16 full and part-time investigators include nutritionists, nurses and a physician. This unit investigates all 340s and general complaints.

Rochester

Rochester has 3 PCI investigators separate from its survey staff. The PCI staff include nurses, sanitarians and administrators. At times, they take survey staff with them and at times, survey staff is used to investigate general complaints.

Syracuse

Syracuse has 16 full-time surveyors, organized into three teams, who conduct inspections of the nursing homes. These teams consist of nurses, nutritionists, sanitarians and, in one case, a social worker. Two of these 16 surveyors (with at least one nurse), on a rotation basis, investigate 340 complaints and general complaints where an immediate investigation is needed. If the PCI supervisor or the Director of Long Term Care decides that a general complaint can wait, the survey team that usually inspects the specific nursing home to be investigated will include the investigation with its next survey. If a specific discipline is needed, a hospital or home care surveyor may be called in.

New Rochelle

New Rochelle uses its 26 surveyors as investigators. Its survey staff includes nurses, sanitarians and social workers. A particular surveyor is chosen as an investigator according to the discipline needed for the nature of the complaint and the facility being investigated. If a physician is needed, the case is brought back to the office for review.

2. Responding to the Complainant

Generally in all area offices a professional or a trained support person take the initial call.

All directors say they explain the law and its confidentiality requirements to all callers. Directors in Buffalo, Northeast and Rochester say that they explain the procedure to callers, letting them know that a 340 case will take a long time to investigate (in Buffalo the caller is told that a general complaint will be resolved in ten days from the start of the investigation) and that they will be notified of the resolution. New Rochelle tells callers that their complaint will be investigated and that they will be notified. If the caller has anything additional to add she/he is asked to call back.

All area offices say they send letters to all identified complainants at the end of the investigation. Rochester states that it also calls each complainant at the end of the investigation to discuss the findings.

3. Classification of Complaints into 340s and Generals

All decisions on classification are made by professionals. In New York City, supervisory staff make the decision; in Rochester, the PCI coordinator and the Long Term Care Director review; in the Northeast office, the survey team leader or the supervisor reviews the decision; in New Rochelle the investigator makes the decision; and in Buffalo, the director makes the decision.

There are many difficulties in the classification of complaints. Although most directors of long term care state that they follow the statute's definitions, they admit that it is not easy to classify complaints.