Safeguarding Residents & Program Integrity in New York State Nursing Homes

An Assessment of Government Agency Performance

by

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Executive Summary

Overview

LTCCC conducted this study to assess the efficacy of the state agencies responsible for (1) protecting nursing home residents and (2) ensuring appropriate use of the billions of tax-payer dollars spent on nursing home care each year. In New York, the Department of Health (DOH) is chiefly responsible for nursing home quality and program integrity and, thus, it is the principal focus of this report. In addition to DOH, we also assessed the state Medicaid Fraud Control Unit (housed in the NYS Attorney General's Office) and the state Office of Medicaid Inspector General. Last year we conducted an assessment of the state Long Term Care Ombudsman Program (LTCOP), which is not included in this report.[1] Though the LTCOP does not have regulatory authority, it plays a critical role in monitoring nursing home care and ensuring that residents are protected and their complaints addressed.

Fundamentally, our approach is predicated on the idea that it is the resident that is important….

In addition to providing an assessment of each agencies' oversight performance in respect to their respective missions, this report seeks, particularly in regard to DOH, to relate performance directly to the impact it has on individual nursing home residents. In our experience, quality and performance are most often viewed in respect to the provider. [For example, Nursing Home Compare provides information on the number of deficiencies per nursing home, individually and for state and national averages.] In this study, we sought to focus on the resident and to assess, wherever the data permitted, the extent to which enforcement actions are responsive to problems experienced by residents. Thus, for example, in the section on enforcement of pressure ulcer standards – a significant problem for nursing home residents in New York and nationally – we assess DOH's performance in terms of the number of citations for F-314 – failure to provide "proper treatment to prevent new bed (pressure) sores or heal existing bed sores" – against the number of residents in the state identified by their nursing homes as having a pressure ulcer (rather than citations per facility).

Fundamentally, our approach is predicated on the idea that it is the resident that is important, not the facility. The public, including (and especially) residents and families, does not generally care whether a facility is meeting a certain standard because they care about the facility but, rather, because they care about the safety and well-being of the people in the facility. Similarly, our approach presumes that the public – and our state leaders elected (or appointed) to protect the public interest – are principally interested in ensuring the integrity of public programs so that those programs are providing good value to our communities and

[1] *The New York State Long Term Care Ombudsman Program: An Assessment of Current Performance, Issues & Obstacles* (April 2014). Available at http://www.nursinghome411.org/?articleid=10080.

the state (i.e., are paying for the provision of decent and appropriate care to beneficiaries), not merely to provide a source of income to the nursing home business sector.

To that end, the report provides a comparative assessment of DOH's performance on several key criteria. First, we looked at states' citation rates as a whole, to identify the amounts of fines that each state has imposed in the last three years for deficiencies it uncovered and the rates at which the state agencies identified these deficient practices as causing resident harm. Then, in addition to pressure ulcers (mentioned above), we assessed performance in relation to nursing home staffing and antipsychotic drugging. While no data are perfect, we felt that assessing overall citation and penalty rates, as well as citations for three important indicators, would together provide valuable insights into State Survey Agency (SA) performance and the extent to which serious problems are being addressed.

Under-identification of harm is a national problem.

About Our Findings

Our findings are provided in the report in descriptive charts to allow for easy comparison between states as well as specific insights into DOH's performance in New York. The national charts include rankings of the states, so the reader can easily assess relative performance of the SAs. To facilitate easy access, the Table of Contents includes internal links to sections of interest. In addition, the tables are posted in Excel on our nursing home website at http://www.nursinghome411.org/articles/?category=lawgovernment. The Excel format allows for easy sorting of the state data, for instance to see how a state ranks on a given criteria. The various rankings enable one to get a useful snapshot of how any state is performing in terms of protecting its residents and how that performance compares against that of other states and the national average.

NYS Department of Health: Key Findings

We found that New York DOH ranks among the lowest SAs in terms of overall citations *per capita* (i.e., in respect to the size of our state's nursing home resident population). In addition, of the violations that DOH does identify, it rates about 97% of them as not having caused harm to residents. Though this is very low, DOH is about average in identifying harm among the states, indicating that the under-identification of harm is a national problem.

Antipsychotic Drugging: As the chart in the report shows, New York has a slightly lower average off-label AP drugging rate (18.04%) than the nation, but its F-329 citations are drastically lower: approximately 1/4 of the low national rate (0.08%). Of these citations, NY identifies resident harm 2.32% of the time. While miniscule, this is actually above the national average.

Pressure Ulcers: Pressure ulcers are a problem for almost one in 10 NYS nursing home residents. Though pressure ulcers are largely preventable, NY DOH cites nursing homes the equivalent of less than 1% of the time that a resident has a pressure ulcer (second lowest in

the country). Furthermore, when NY DOH does cite a facility for poor pressure ulcer care or prevention, it rarely finds that this failure has caused harm to the resident(s).

Staffing: Staffing levels have long been widely recognized as key to quality of care and quality of life for both residents and workers. Yet, as data in the report show, insufficient staffing is rarely cited in US nursing homes. Low staffing is an especially serious and longstanding problem in NY State nursing homes, with NY persistently ranking in the bottom quarter of the country in average staffing levels. Nevertheless, DOH only cites for insufficient care staff about 13 times each year. When considered on the resident level (*per capita*) DOH's citation rate for inadequate care staff is roughly equal to an individual's chances of dying in a plane crash. Furthermore, DOH has not identified inadequate staff as resulting in harm or immediate jeopardy to a resident's well-being in at least three years.

Recommendations for DOH

Following are our recommendations for DOH to improve safety and quality of care, as well as program integrity and value, in New York State nursing homes:

1. **Re-commit to its mission as an enforcement agency**. New York families depend on DOH to ensure that providers are meeting - or exceeding - standards of care. New York taxpayers depend on DOH to assure financial integrity of the billions of dollars spent each year on nursing home care. While other agencies do important and valuable work, DOH is ultimately responsible for oversight and enforcement and its dedication to its mission as a Survey Agency is essential.
2. **Comply with federal Survey Agency requirements**. DOH should focus on achieving both the *letter* and the *spirit* of the State Operations Manual. For example, it is not adequate to conduct 100% of the federally required surveys per year if those surveys are not effectively ensuring that standards are met and deficiencies are appropriately cited. Given that NYS nursing homes are twice as big as the national average, the state should identify and implement ways to overcome basic structural barriers to effectively identify and cite deficiencies. Simply put, how can it be possible to adequately survey a 200 or 700 bed facility with the same number of surveyors, in the same amount of time, as it takes to adequately survey a 70 or 100 bed facility? Nevertheless, this is the longstanding practice in New York State.
3. **Improve resource allocation**. DOH should dedicate its limited resources to fostering vigorous oversight, rather than training, engaging or otherwise trying to persuade providers to attain the minimum standards of care for which they are already being paid to achieve. Providers are professionals who are expected to provide services in accordance with professional standards. The public has the right to expect that providers have – and maintain – the skills and knowledge necessary to meet those standards.
4. **Improve performance assessment & integrity**.
    a. DOH should improve training and direction of surveyors. For instance, to reduce inappropriate and illegal antipsychotic drugging, survey teams should review all instances of off-label antipsychotic drugging. Is there a record of informed consent? Non-pharmacological interventions? Gradual dose reduction? When the answer is *no*,

surveyors must assess whether other relevant standards are being met (such as appropriate medical supervision, sufficient staffing and necessary care to achieve highest practicable well-being) and, if not, whether this has resulted in harm.

b. DOH should coordinate trainings with the state Medicaid Fraud Control Unit and other law enforcement entities to improve surveyor investigative techniques. In addition to the potential for improving surveyor practice, such coordinated trainings could have other benefits, such as improving law enforcement's understanding of its role in protecting residents, for instance in ensuring that the federal requirement on reporting any suspicion of crimes against residents is properly implemented.
c. DOH should collect and assess data on survey teams and regions relating to identification of deficiencies and identification of harm (when a deficiency is identified) and assess these data in relation to relevant measures (including, inter alia, antipsychotic drug use, staffing levels and pressure ulcer rates). For example, if staffing is not being cited when facilities have reported low staffing levels and/or problems that are likely to be staffing related, DOH should conduct a data-driven assessment to determine if there are deficiencies that are being missed or under-rated (in terms of scope and severity). These assessments should be conducted for a certain number of survey teams per year and for all of the state regional offices on at least an annual basis. The results of the regional office assessments should be made public in an annual report.

NYS Medicaid Fraud Control Unit: Key Findings

1. **Investigations Overall**: NY MFCU conducts approximately twice the number of investigations *per nursing home resident* than the national average for state MFCUs (one investigation per 71 residents for New York vs. one per 141 residents for US).
2. **Investigations of Abuse & Neglect**: NY MFCU conducts more than double the national average of investigations of resident abuse and neglect *per capita* than the national average (one investigation per 314 residents in NY, vs. one for every 822 residents nationally).
3. **Recovering Public Funds (Such as For Sub-Par & Fraudulent Services)**: NY MFCU's recovery of $378,434,543.00 in funds for fraud, abuse and neglect (etc…) in 2014 is by far the largest in the country. While this is to be expected, given the size of NY State's nursing home population, it is important to note that the NY MFCU's recoveries far outpace the national average. NYS MFCU recovered $3597 per resident in 2014, more than double the national average of $1708.
4. **Convictions**: NY MFCU's conviction rate is slightly above the national average, with an average of one conviction per 892 residents vs. the national average of one conviction for every 890 residents. Because the US OIG does not break down convictions in terms of occupation (for example, CNAs vs. RNs vs. owners), and given NY MFCU's strong performance in recovering funds, it is not possible to draw conclusions as to whether this is a positive or negative finding in terms of holding providers accountable for poor care. For instance, it is possible that these findings, together, indicate that NY MFCU is holding poorly performing nursing homes accountable at a higher level (by fining owners and operators, rather than convicting lower level employees).

Recommendations for MFCU

1. **Increase investigative capacity**. MFCU should continue and expand its nursing home work, which benefits both residents and taxpayers and delivers a significant "bang for the buck" in terms of resources allocated to the Unit.
2. **Redirect and expand outreach and trainings**.
   a. Expand outreach to the state LTC Ombudsman Program and the new managed LTC Independent Consumer Advocacy Network to learn about problems they are dealing with which may be related to fraud and abuse. This will become particularly important, we believe, as the state implements its transition to mandatory Medicaid LTC for nursing home residents.
   b. Conduct outreach and trainings to other relevant governmental and non-governmental entities to improve their knowledge and use of investigative skills and techniques employed by MFCU. As noted earlier in regard to DOH, MFCU dedicates resources to engaging and training providers. We do not believe that this is appropriate. Providers are already expected – and paid – to provide services that meet or exceed minimum standards. In addition, there are a plethora of both private pay and free, government-based services to help provider who have meeting longstanding minimum standards.[2] We believe that to the extent MFCU allocates staff time and other resources to trainings and outreach, this should be dedicated to improving monitoring and oversight in other state agencies, local agencies and organizations dedicated to helping individuals and families. At a minimum, these entities should be included in any trainings or programs that MFCU provides to the nursing home industry.

NYS Office of the Medicaid Inspector General: Key Findings

OMIG's mission is "…to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all State agencies responsible for services funded by Medicaid." These activities include:

1. Solicit, receive and investigate fraud and abuse complaints;
2. Pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, illegal or inappropriate acts or unacceptable practices perpetrated within the medical assistance program…; and
3. Investigate complaints of alleged failures of state and local officials to prevent, detect, and prosecute fraud and abuse in the medical assistance program.

[2] For examples, CMS provides services through the Quality Improvement Organizations (in New York, IPRO) and supports (financially and otherwise) Advancing Excellence, the provider industry based quality improvement organization. In addition, many organizations provide educational and other services to providers, including numerous companies that provide trainings focused on improving survey outcomes, avoiding litigation, etc…. **NOTE**: While nursing homes have a range of resources to help them when they fail to meet minimum standards it is important to note that, the vast majority of the time, they continue to receive full reimbursement while providing substandard or worthless services, even when doing so results in harm to residents.

Despite these requirements, and the fact that it specified addressing inappropriate antipsychotic drugging in nursing homes as one of its two "initiatives" for the last year (in its annual report), our findings indicate that OMIG has done little of substance to protect nursing home residents or to address the widespread and serious problem of inappropriate antispychotic drugging of nursing home residents. Almost five years ago, LTCCC met with OMIG staff, including investigators, and we were encourage by the depth of investigations about which we were told of nursing homes and, in particular, regarding the use (and misuse) of antipsychotic drugs. In late 2010, we were informed that OMIG had conducted a review of prescribing practices of atypical antipsychotics for the period 2007-8. This review found that 40% of nursing home residents on Medicaid who had been prescribed this drug "had no diagnosis of psychosis in the twelve months preceding the start of the atypical antipsychotic treatment."[3] Besides sending a joint letter (with the DOH Commisioner) to all nursing homes alerting them of longstanding standards and providing access to some resources on dementia care and antipsychotic drugging, OMIG has taken no action of which we are aware to address this serious and expensive problem.

> To our knowledge, OMIG has never conducted a single audit of antipsychotic drugging in nursing homes or other settings, despite the known, significant dangers to individuals and enormous public expense.

Recommendations for OMIG

1. **Overall monitoring and assessment**. OMIG should reinvigorate and strengthen its efforts to monitor and assess program integrity in nursing homes. Nursing home care is, increasingly, a highly sophisticated, profit-driven industry in New York. Numerous state and federal studies, including our own as well as those conducted by other researchers, the US Government Accountability Office and the US Inspector General have consistently indicated that substandard care is a pervasive problem for both Medicaid and Medicare beneficaries in nursing homes. In addition to protecting the welfare of these individuals through on-site investigations, OMIG is uniquely positioned to effectively use the available data to improve conditions for residents and the efficiency of public funds spent on nursing home care. In New York, 83% of nursing home care is paid for by the public. In 2013, this was approximately $10.8 billion.[4]

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[3] In conducting our assessment we repeatedly requested a copy of the "white paper" which OMIG staff told us they had written on the nursing home antipsychotic drugging problem and, repeatedly, our requests (including under the Freedom of Information Law) have been denied.

[4] Data on health spending are from the Kaiser Family Foundation, *State Health Facts,* and are for 2009; see note below for how we estimate current (2013) spending. Accessed February 2015 at http://kff.org/other/state-indicator/health-spending-by-service/#graph. Citing Centers for Medicare & Medicaid Services (2011), *Health Expenditures by State of Provider*. Retrieved (December 2011) at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. **Note**: The CMS website does not provide more recent data for individual states. The $13 billion figure is based on the Kaiser

2. **Crack down on inappropriate antipsychotic drugging**. OMIG should aggresively investigate and audit antipsychotic drugging practices in nursing homes (as well as in other settings) and hold providers accountable for appropriate prescribing of these medications and related requirements, including those related to medical supervision. To our knowledge, OMIG has never conducted a single audit of antipsychotic drugging in nursing homes or other settings, despite the known, significant dangers to individuals and enormous public expense.
3. **Increase accountability for failure to provide quality care**. In its 2007 annual report, OMIG stated that it "…is incorporating quality of care considerations in its detection and enforcement strategies. These efforts will include assessment of interventions and outcomes, pattern outcomes…, tracking of "never" events, detection of unreported adverse events/outcomes and unanticipated deaths." Seven years later, serious problems relating to so-called "never events" and "adverse events" have garnered significant national attention. For instance last year, the US Inspector General found that an astonishing one in three Medicare (rehab) beneficiaries were harmed in nursing homes within about a month of their arrival. Nevertheless, OMIG has not, to our knowledge, conducted substantive activities to reduce adverse events or, therefore, to hold providers accountable when such "events" are the result of substandard (or even wortheless) services. In fact, this provision from the 2007 annual report is absent from OMIG's most recent annual report.

OMIG is uniquely positioned to effectively use the available data to improve conditions for residents and the efficiency of public funds spent on nursing home care. In New York, 83% of nursing home care is paid for by the public. In 2013, this was approximately $10.8 billion.

Family Foundation's 2009 number of $11.689 billion adjusted by 11.1%, which represents the increase in annual spending on nursing home care indicated in the CMS national data from 2009 to 2013.

Background

New York State nursing homes provide care, support services and home to over 105,000 people. This means that more than one in every 200 New Yorkers are living in a nursing home on any given day.[5] In addition to these individuals, their families and loved ones have a substantial personal stake in the quality of care and quality of life our nursing homes provide. And, with the advent of the aging "Baby Boomer" generations, these numbers are likely to rise. As reported in *U.S. News and World Report*, "[a] majority of people over age 65 will require some type of long-term care services during their lifetime, and over 40 percent of people will need a period of care in a nursing home."[6]

Over 40% of the population will need nursing home care at some point.

More than one in every 200 New Yorkers currently lives in a nursing home.

In addition to the personal stake New York's families have in nursing home care is the financial stake that we all share. New York's nursing home care costs approximately $13 billion per year.[7] The average rate for nursing home care in New York is well over $300 per day.[8]

Despite the significant need for both long-term and short-term nursing home care, and the billions of dollars spent on this care every year in New York, significant problems in resident care, quality of life and dignity are pervasive across the state. Our laws and regulatory standards are strong, providing that each resident be treated with dignity and receive the care and services that he or she needs to attain, and maintain, his or her highest practicable physical, emotional and social well-being. The fact that this level of care is the exception, rather than the rule, is a result of the failure (in fact multiple failures, every day) to adequately ensure that those standards and protections are being realized. For example, nursing homes often have inadequate care staff and fail to provide appropriate care with dignity because there is nothing stopping them from doing otherwise. As the findings in this report illustrate, there is often little or no penalty

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[5] New York has approximately 19.65 million residents. U.S. Census Bureau, *State & County QuickFacts* (2013 Estimate). Accessed February 2015 at http://quickfacts.census.gov/qfd/states/36000.html.

[6] Mullin, Emily, U.S. News and World Report, *How to Pay For Nursing Home Costs* (February 26, 2013). Accessed February 2015 at http://health.usnews.com/health-news/best-nursing-homes/articles/2013/02/26/how-to-pay-for-nursing-home-costs.

[7] The most recent state data on Kaiser Family Foundation, *State Health Facts,* are for 2009. Accessed February 2015 at http://kff.org/other/state-indicator/health-spending-by-service/#graph. Citing Centers for Medicare & Medicaid Services (2011), *Health Expenditures by State of Provider*. Retrieved (December 2011) at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. Note: The CMS website does not provide more recent data for individual states. The $13 billion figure is based on the Kaiser Family Foundation's 2009 number of $11.689B adjusted by 11.1%, which represents the increase in annual spending on nursing home care indicated in the CMS national data from 2009 to 2013.

[8] N.Y. State Department of Health, *Estimated Average New York State Nursing Home Rates*. Accessed February 2015 at https://www.health.ny.gov/facilities/nursing/estimated_average_rates.htm.

when nursing homes fail to achieve the standards for which they are paid, even, quite often, when that failure results in significant suffering.

The systemic acceptance of subpar care has a significant financial cost as well. Tax payers pay for the majority of nursing home care and we count on CMS and DOH to assure that public monies are spent appropriately. When care is poor it means we are not getting good value for the money we are spending. And when that poor care results in the need for additional care, whether it be medication to fight an unnecessary infection, or hospitalization due to a medication error, the public foots the bill for that too.

The purpose of this report is to present a current assessment of the nursing home quality assurance and oversight provided by the principal agencies responsible for ensuring that nursing homes meet or exceed government standards: the NYS Department of Health, the Medicaid Fraud Control Unit in the Office of the NYS Attorney General and the NYS Medicaid Inspector General. Since the Department of Health bears primary responsibility for protecting both residents and public funds (as a contractor for this purpose to the federal Centers for Medicare and Medicaid Services), it is the primary focus of this report.[9]

When care is poor it means we are not getting good value for the money we are spending. And when that poor care results in the need for additional care, whether it be medication to fight an unnecessary infection, or hospitalization due to a medication error, the public foots the bill for that too.

This report provides for the first time, to our knowledge, an assessment of nursing home quality assurance that is centered on nursing home residents as individual people. Typically, we look at oversight issues on a facility basis. For instance, the federal government's Nursing Home Compare[10] and non-governmental resources like ProPublica's Nursing Home Inspect[11] report citations on a per facility basis. However, because New York State's nursing homes are more than double the size of the national average (and frequently many times the size of the national average in the New York City metropolitan area), these resources are, in part, telling an incomplete "story" about the quality of care residents are receiving in facilities. For example, if a 70 bed facility and a 700 bed facility each have three survey findings of improper pressure ulcer care, this likely has very different implications about the quality of care in (and/or the oversight of) each facility.

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[9] The Centers for Medicare and Medicaid Services (CMS) contracts with DOH to enforce regulatory standards and ensure program integrity in all nursing homes in New York that participate in Medicare and/or Medicaid (virtually all nursing homes).

[10] Centers for Medicare and Medicaid Services, Nursing Home Compare. Accessed February 2015 at http://www.medicare.gov/nursinghomecompare/search.html.

[11] Ornstein, C. and Groeger, L., ProPublica, Nursing Home Inspect. Accessed February 2015 at http://projects.propublica.org/nursing-homes/.

Thus, Nursing Home Compare's Five Star rating (which is based, in large part, on the number of citations a facility has received as compared to other facilities) has a significant bias. Likewise, ProPublica's Nursing Home Inspect data tool, through which one can "…compare nursing homes in a state based on the deficiencies cited by regulators and the penalties imposed in the past three years," does not address the fact that three deficiencies in a 70 bed facility means something quite different than three deficiencies in a 700 bed facility (all other things being equal).

All things are not, of course, equal; there are variations in the efficacy of the states' Survey Agencies (which, due to widespread weaknesses in state oversight, overwhelmingly tend to favor the provider industry).[12] Nevertheless, while not perfect, these tools are valuable. In the present study, we endeavored to use these and other data sources to put the focus, wherever possible, on residents, and on how nursing home and state agency performance relates to residents' experiences and outcomes as individuals. Our goal, fundamentally, is to reflect the language and spirit of the requirements in the 1987 federal Nursing Home Reform Law, which are focused on the individual residents, not the individual businesses.

As the findings in this report illustrate, there is often little or no penalty when nursing homes fail to achieve the standards for which they are paid, even, quite often, when that failure results in significant suffering.

[12] Several U.S. Government Accountability Office (GAO) and other reports over the years have identified systemic under-identification of nursing home problems. See, for example, GAO, *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO-10-70: (November 2009). Accessed February 2015 at http://www.gao.gov/products/GAO-10-70.

New York State Department of Health

Introduction

The NY State Department of Health (DOH) is the principal agency responsible for overseeing care in nursing homes and responding to complaints about care. DOH is paid under a contract with the federal government to ensure that all nursing homes that are licensed under Medicare and/or Medicaid (virtually every facility in the state) meet or exceed federal standards of care for all of their residents. [This includes residents whose care is paid for by other sources.]

When resident neglect or abuse occurs, whenever a facility fails to ensure that each resident attains and maintains his or her highest practicable physical, emotional and social well-being, this is a failure to comply with the minimum legal and regulatory standards that DOH is charged with enforcing. Fundamentally, the persistent and widespread problems that exist in nursing homes across New York, including those that result in serious resident harm, are an outcome of failures to hold providers accountable for meeting minimum standards.[13]

In order to gain insights into DOH's ability to hold provider's accountable, we used data from the federal website, Nursing Home Compare, to assess the state's performance in identifying and citing problems.[14] Following are our findings on key criteria which we identified as important components of nursing home quality, including how the state compares to other states in its overall citation of deficiencies and the extent to which DOH, when it does identify a nursing home deficiency, cites it as causing harm to residents.

Essentially, a state's oversight of nursing home care boils down to two components: (1) its ability to identify when a failure to meet standards (i.e., a deficiency) exists and (2) its ability to appropriately rate deficiencies in terms of their "scope and severity." To help states *identify* deficiencies, CMS provides guidance on what surveyors are supposed to look for, the questions they are supposed to ask, etc…. To help them *rate* deficiencies, CMS provides both guidance and a scope and severity grid.[15]

The grid is crucial because it is used to signify how extensive the problem is in the facility (its 'scope') and its seriousness or 'severity'. Is it a minor problem that did not affect any residents or was it a serious problem that could or did cause harm? If there was harm, was it limited to one resident or more widespread?

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[13] Another serious outcome of this failure is the inappropriate use of public funds for poor care or worthless services.

[14] http://www.medicare.gov/nursinghomecompare/search.html. This is the official US government website with information on inspection results, staffing and quality measures for all nursing homes that are licensed under Medicare and/or Medicaid. These data are reported by all of the states to CMS, which in turn publishes the information on this website, which includes a five-star rating system for nursing homes based on these and other data that CMS collects.

[15] For more on certification and compliance, *see* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html. The scope and severity grid can be found in the Appendix of this report.

The rating of a deficiency in terms of its scope and severity is very important for two reasons: (1) it affects the star rating for that facility on Nursing Home Compare and individual states' nursing home information website (and, thus, public perceptions of the nursing home and the quality of care it provides) and (2) it is a determining factor in whether or not the nursing home is penalized for the deficiency.

Two Critical Questions for State & Federal Agencies:

1. Are neglect & other care problems being identified?
2. When problems are identified, is harm to the resident recognized?

Generally speaking, nursing homes are not penalized for deficiencies unless they are rated as having caused harm to one or more residents. Thus, deficiencies that are not rated at a harm level are virtually meaningless, from a public safety perspective, since they are extremely unlikely to have any negative repercussions for the facility. Furthermore, because fines tend to be low, especially for harm that is not rated as widespread and/or extremely egregious, it is not enough to just identify when there is harm; in order to be effective, the survey system must impose a penalty that is substantial enough to make preventing the abuse and neglect at issue worthwhile for the nursing home.

In the following figures and discussions, we use data from Nursing Home Compare as a basis for assessing DOH's performance in identifying nursing home deficiencies, rating them appropriately and levying fines that are meaningful enough to effectively penalize neglect and abuse and encourage good care. In addition to looking at DOH's performance on its own, we assess its performance as compared to other State Survey Agencies (SAs). First, we look at overall state citation rates, the amounts of fines that each state has imposed in the last three years and the rates at which the SAs identified deficiencies as causing resident harm. Then we focus on three specific criteria which we identified as key to quality of care.

Identifying Problems in Nursing Homes: NYS Compared to Other States

Chart: US States' Nursing Home Residents & Per Capita Citation Rates

State	Number of Residents	Number of Citations on NHC (3 yrs)	Annual Per Capita Citation Rate	Rank: Per Capita Citation Rate (Higher = More Citations)
RI	8012	624	3%	1
NH	6760	892	4%	2
MA	41302	5711	5%	3
NY	105200	15051	5%	4
NJ	45204	6939	5%	5
GA	33952	7097	7%	6
NC	37142	8301	7%	7
SC	16780	3791	8%	8
FL	73505	16783	8%	9
PA	79589	18916	8%	10
AL	22725	5777	8%	11
MS	16132	4304	9%	12
ME	6248	1694	9%	13
CT	24254	7009	10%	14
LA	25880	7600	10%	15
HI	3663	1080	10%	16
TN	28976	8880	10%	17
ND	5620	1738	10%	18
VA	28566	8864	10%	19
NM	5462	1702	10%	20
OH	76372	24219	11%	21
KY	22976	7507	11%	22
AR	17664	5911	11%	23
MN	26702	9175	11%	24
SD	6384	2201	11%	25
VT	2686	951	12%	26
MO	38273	14328	12%	27
MD	24408	9570	13%	28
AZ	11261	4530	13%	29
IL	72715	29593	14%	30
DC	2557	1080	14%	31
TX	93098	40937	15%	32
MI	39391	17597	15%	33
WA	17007	7727	15%	34
IN	38821	18092	16%	35
NV	4819	2317	16%	36
DE	4150	2045	16%	37
WI	27526	13668	17%	38
IA	24858	12447	17%	39
WV	9528	4958	17%	40
CA	102093	58129	19%	41
CO	16266	9633	20%	42
NE	12068	7165	20%	43
MT	4587	3084	22%	44
OR	7337	5213	24%	45
UT	5502	3918	24%	46
OK	19118	14128	25%	47
KS	18403	14241	26%	48
WY	2353	1894	27%	49
ID	3844	3197	28%	50
AK	608	615	34%	51
US Total	**1173476**	**482823**	**14%**	

To compare New York against other states in terms of its quality of oversight, we first looked at the citations per capita for each state. In other words, how many deficiencies are states identifying based not on the number of facilities in the state but, rather, on the state's nursing home resident population?

As the chart on the left shows, New York is among the very lowest in terms of per capita citations, with a rate of 5%. Only two states (out of the 50 states plus Washington, DC) have lower per capita citation rates. Looking at the nation as a whole, New York's citation rate is approximately one-third of the national average.

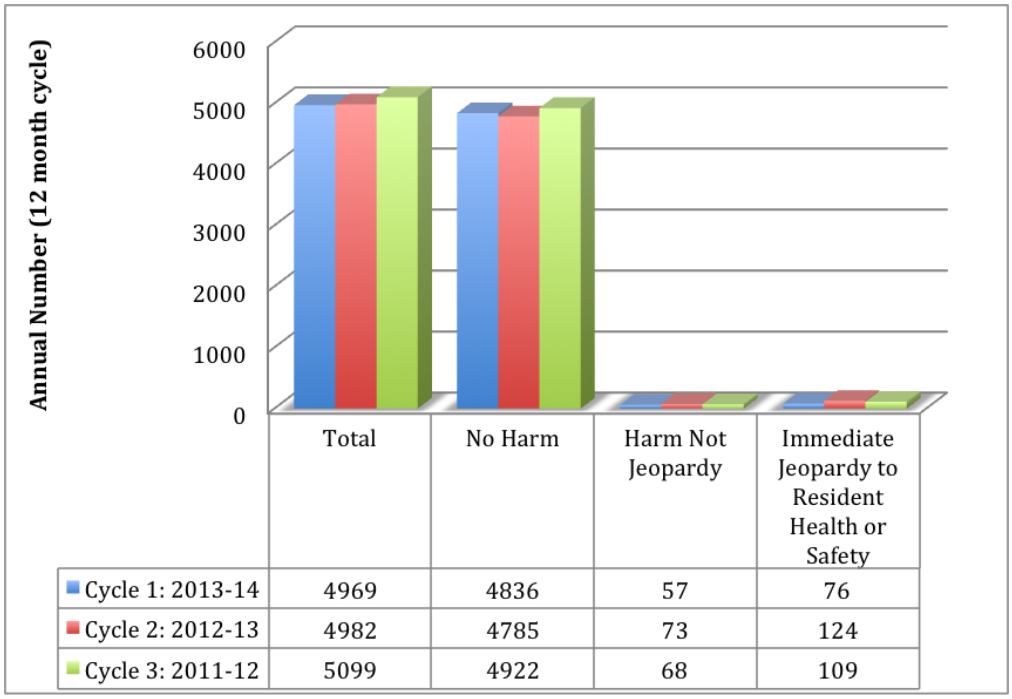
[Interestingly, the five states with the least number of citations per nursing home resident are in the northeastern United States, CMS Regions 1 and 2.]

Why Are Citations Per Capita Important?

Because it puts the focus on whether (or not) residents are being protected.

Identifying When A Resident Is Harmed: NYS Stats

Chart: NY DOH Citations at No Harm, Harm and Immediate Jeopardy



	Total	No Harm	Harm Not Jeopardy	Immediate Jeopardy to Resident Health or Safety
Cycle 1: 2013-14	4969	4836	57	76
Cycle 2: 2012-13	4982	4785	73	124
Cycle 3: 2011-12	5099	4922	68	109

This chart shows the total number of deficiencies for each of the last three years ("cycles") on Nursing Home Compare (NH Compare). As the table indicates, the overwhelming majority of citations are at no harm, meaning that there are likely to be no repercussions whatsoever for the facility for its failure to meet minimum standards. In addition, the chart shows that overall citations have dropped slightly over the last three years and that deficiencies cited at harm or immediate jeopardy increased by 11% in 2013 but then dropped significantly (32%) in 2014.

Earlier studies have shown that the State Agencies, in general, significantly and systematically under identify deficiencies and under rate them in terms of the harm caused to residents.[16] In a 2005 study, LTCCC found that that New York lagged behind the majority of states in citing deficiencies and, for nursing homes in our own state, fell sharply behind what federal inspectors uncovered when they went into facilities.[17] Now, ten years later, current data indicate an enormous gap between the total number of deficiencies cited and those that are identified as causing harm to residents.

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[16] See, for examples, numerous studies by the US Government Accountability Office (GAO), including: *Nursing Homes: Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear*, GAO-10-434R: Published: Apr 28, 2010. Available at http://www.gao.gov/products/GAO-10-434R and *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO-10-70: Published: Nov 24, 2009. Available at http://www.gao.gov/products/GAO-10-70. Henceforth, *GAO Studies*.

[17] LTCCC's 2005 study, *Nursing Home Residents at Risk: Failure of the New York State Nursing Home Survey and Complaint Systems*, reported that from 2002-2004 "CMS inspectors identified over four times the number of violations than did DOH for the same homes." *Nursing Home Residents at Risk* at p. 9. The report is available at http://www.nursinghome411.org/?articleid=10075.

Identifying When a Resident is Harmed: NY Compared to Other States

Chart: US Citations and Percentages Identified as Causing Resident Harm

State	Number of Citations on NHC (3 yrs)	Number Cited as Harm+ (3 yrs)	Percent Deficiencies Cited as Harm	Rank: % Citations Harm+ (Higher = More I.D. of Harm)
CA	58129	663	1.14%	1
AL	5777	66	1.14%	2
PA	18916	246	1.30%	3
MD	9570	137	1.43%	4
WY	1894	36	1.90%	5
MT	3084	59	1.91%	6
MN	9175	183	1.99%	7
OH	24219	493	2.04%	8
NE	7165	148	2.07%	9
MO	14328	330	2.30%	10
HI	1080	25	2.31%	11
VA	8864	228	2.57%	12
FL	16783	452	2.69%	13
ME	1694	47	2.77%	14
CO	9633	276	2.87%	15
AZ	4530	136	3.00%	16
NH	892	27	3.03%	17
DE	2045	63	3.08%	18
NV	2317	72	3.11%	19
IL	29593	927	3.13%	20
IN	18092	581	3.21%	21
UT	3918	127	3.24%	22
NY	15051	501	3.33%	23
KS	14241	478	3.36%	24
WV	4958	186	3.75%	25
NC	8301	313	3.77%	26
GA	7097	269	3.79%	27
DC	1080	43	3.98%	28
OK	14128	572	4.05%	29
WI	13668	571	4.18%	30
OR	5213	218	4.18%	31
IA	12447	522	4.19%	32
AK	615	26	4.23%	33
TX	40937	1732	4.23%	34
AR	5911	259	4.38%	35
TN	8880	398	4.48%	36
NJ	6939	312	4.50%	37
LA	7600	383	5.04%	38
ID	3197	168	5.25%	39
ND	1738	95	5.47%	40
MI	17597	991	5.63%	41
CT	7009	412	5.88%	42
RI	624	37	5.93%	43
SD	2201	131	5.95%	44
WA	7727	471	6.10%	45
VT	951	61	6.41%	46
MS	4304	313	7.27%	47
KY	7507	646	8.61%	48
MA	5711	499	8.74%	49
SC	3791	364	9.60%	50
NM	1702	184	10.81%	51
US Total	**482823**	**16477**	**3.41%**	

As discussed earlier, when a nursing home is cited, it is rated in terms of the scope and severity of the deficiency. The chart on this page provides information on the rate at which each state identifies that a deficiency has caused harm (or greater injury) to a resident. [18]

As the chart indicates, states rarely find that a deficiency has caused harm to a resident. Because, generally speaking, only findings of harm result in a penalty against the nursing home, this means that penalties for deficiencies in care or services are exceedingly rare.

Fast Facts:

(1) DOH cites 96.6% of deficiencies as ***not*** having caused any harm to residents.
(2) Though very low, DOH is about average in identifying harm among the states, indicating that this is a widespread problem.
(3) Penalties for deficiencies in care or services are exceedingly rare.

[18] Specifically, we excluded findings of "no actual harm" and counted the number of citations in which the surveyor found "actual harm that is not immediate jeopardy" or "immediate jeopardy to resident health or safety" (i.e., "G" or higher in the Scope and Severity Matrix).

Following are two examples of survey findings of "no harm." One is an example of a finding of no harm which we believe, based solely on the findings in the Statement of Deficiency (SoD), is incorrect. The second is an example of a no harm finding which appears (also based on the SoD) to be appropriate.

These examples were identified by conducting a search of non-harm deficiencies (F and below) on ProPublica's Nursing Home Inspect website and reviewing a number of them to find two that we felt were illustrative. Since we were looking only for illustrative examples, it is important to note that this is an informal sampling of SoDs and not meant to be considered representative. That being said, we found it difficult to identify a no harm finding which we did not think was, in fact, harm. These included failure to provide medication, providing the wrong medication, failure to provide a privacy curtain (so that the resident was constantly exposed to others, including during her treatment), etc….[19]

Example of finding of "no harm" that appears inappropriate

In November 2014, surveyors at Medford Multicare Center for Living on Long Island found that it violated several federal minimum standards related to unnecessary drugging of residents. The SoD states that the violation

> …was **evident for three of five residents reviewed for Unnecessary Drugs** in a total Stage 2 sample of 38 residents. Specifically, 1) Resident # 30 was administered an Antipsychotic medication without a documented adequate clinical indication/justification/diagnosis its use 2) Resident # 187 was being administered Antianxiety and Antipsychotic medications without an adequate clinical indication for use or that appropriate gradual dose reductions were attempted 3) Resident # 234 was administered Antipsychotic and Antianxiety medications without adequate indication for use and no attempts at gradual dose reduction.
>
> [Emphasis added.]

In addition to being cited at no harm the survey identified the violation as "isolated." Following are the findings for one of the three residents.

> 1) **Resident #30 was admitted with diagnose including Senile Dementia, Alzheimer's Disease, Diabetes Mellitus and Depression**.
>
> A Comprehensive Care Plan (CCP) dated 6/30/13 - 11/2014 titled Psychotropic Medication use documented a diagnosis of Dementia.
>
> The Admission Minimum Data Set (MDS) dated 9/9/14 documented a Brief Interview For Mental Status (BIMS) score of 3 (cognition impaired). The

[19] Numerous previous studies have identified the under-identification of serious problems. *See*, for examples, the *GAO Studies* and *Nursing Home Residents at Risk,* referenced earlier.

MDS also had **no documented evidence of mood disorder, Psychosis or behavior concerns**. The MDS also (under section I active diagnoses) no documented Psychosis, mood disorder or behavior concerns.

A POFs [**Physician's Order Form] dated 11/12/14 documented Haldol 0.5 mg for a diagnosis of Personality Disorder**.

A **Psychiatry Consultation Report** (PCR) dated 12/2/13 documented that the consultation was for a follow up for Dementia with behaviors. The PCR also **documented that the resident has diagnosis of Dementia with behavior and to start Haldol** 0.5 milligrams (mg) two times a day for Paranoia.

A **Physician's Order Form (POF) dated 12/23/13 documented Haldol 0.5 mg two times a day for a diagnosis of Dementia. Haldol (Haldol has a black box warning and not Federal Drug Administration (FDA) approved for elderly residents with a diagnosis of Alzheimer's Disease/Dementia because there is a higher risk for death**.)

A POFs dated 12/30/13 **documented a diagnosis of Dementia with behavior for the Haldol use**.

A PCR dated 12/30/13 documented a diagnosis of Dementia with behaviors and to continue the Haldol for Paranoia.

A POF dated 1/13/14, 5/28/14, 7/21/14, and 11/12/14 documented a diagnosis of personality disorder for the use of Haldol.

Summary of this "No Harm" Citation:

(1) DOH finds three out of five residents being given antipsychotic drugs "without adequate clinical indication."
(2) FDA Black-Box Warning notes increased risk of falls, stroke, death, etc… with antipsychotic drugging.
(3) DOH finds "no actual harm."
(4) Facility has no penalties in three years, according to NH Compare (as of Apr. 13, 2015).

A **Pharmacy Consultant Review Form** (PCRF) dated 1/17/14 **documented that the resident is receiving Haldol for a diagnosis of Dementia. The PCRF documented to please change the diagnosis to an appropriate Federal Drug Administration (FDA) approved diagnosis for Haldol** (schizophrenia/Tourett's Syndrome). **The PCRF also documented that this is the focus of the Department of Health and the change to an appropriate diagnosis will keep the facility in compliance**.

A PCR dated 1/27/14 documented that the staff report that the resident can be easily redirected and has diagnosis of Dementia Senile type.

A PCR dated 4/22/14 documented to continue Haldol for a diagnosis of Psychosis.

A POF dated 4/28/14, 6/25/14, 9/17/14 and 10/16/14 documented a diagnosis of Psychosis for the Haldol use.

A PCR dated 5/9/14 documented that the resident is followed for her sad mood, periods of restlessness and wandering and to continue Haldol for Psychosis

A POF dated 5/28/14, 7/21/14, and 11/12/14 documented a diagnosis of Personality Disorder for the Haldol use.

A PCR dated 10/6/14 documented that the consultation was for restlessness and that the resident is followed for sad mood, periods of restlessness and wandering and to continue Haldol for Psychosis.

Physician's Assessment and Plan of Care (PAAPOC) dated 12/2013 through 11/2014 **documented that the resident was receiving Psychotropic medication for the diagnosis of Dementia**.

There is **no documented evidence in the medical record that the resident had symptoms of Psychosis Paranoia or Personality Disorder or a clinical indication for the use of an antipsycotic medication (Haldol**).

An **interview was held with the Licensed Practical Nurse (LPN) Charge Nurse** on 11/18/14 at 10:30 AM. **The LPN stated that Resident # 30 does not exhibit any behavior symptoms**.

An interview was held with the Medical Director on 11/18/14 at 2:30 PM. The **Medical Director reviewed the medical record and stated that he would expect that if the resident was not exhibiting any behavioral symptoms that she should not be on the antipsycotic medication Haldol**.

An interview was held with the Psychiatrist on 11/18/14 at 2:45 PM. The **Psychiatrist stated that the resident stated that she did not belong here and was trying to pack her bags to go home that is why the resident was started on Haldol**.[20, 21]

[Emphases added.]

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[20] Statement of Deficiency for Medford Multicare, survey date November 18, 2014. Accessed at http://www.nursinghomes.nyhealth.gov/nursing_homes/deficiency/637/2YQK.

[21] Antipsychotic drugs carry an FDA black box warning against use on elderly individuals with dementia due to their increased risk of serious harm and death. For more information, *see* Antipsychotic Drugs & Dementia Care: Resources and Information at http://www.nursinghome411.org/articles/?category=antipsychotic.

Example of finding of "no harm" that appears appropriate

Many deficiencies identified by surveyors are, of course, appropriately cited. For example, in May 2013, Schuyler Hospital Inc. and Long Term Care Unit in Montour Falls for failing to "[m]aintain drug records and properly mark/label drugs and other similar products according to accepted professional standards." The facility was found to be storing controlled medications in a narcotics box that was not secured with a double lock. Since the drugs were in a medication room, away from where residents are likely to be or have easy access, it appears from the record that residents were neither harmed nor in immediate jeopardy of being harmed.

Penalizing Facilities When Substandard Care & Services are Uncovered

Chart: US State Fines Under Federal Standards, Comparison of Number & Dollar Amount

State	Total # Fines on NHC	Total Amount of Fines on NHC	Average Fine on NHC	Rank: Average Fine (Higher = Larger Per Deficiency)
AK	7	$44,591.00	$6,370	15
AL	40	$1,056,475.00	$26,412	35
AR	169	$1,925,912.00	$11,396	23
AZ	25	$604,406.00	$24,176	33
CA	155	$3,811,287.00	$24,589	34
CO	90	$610,663.00	$6,785	16
CT	139	$679,310.00	$4,887	9
DC	9	$577,912.00	$64,212	49
DE	24	$908,154.00	$37,840	44
FL	263	$7,771,290.00	$29,549	39
GA	63	$3,128,563.00	$49,660	47
HI	9	$26,980.00	$2,998	5
IA	102	$957,191.00	$9,384	19
ID	45	$224,526.00	$4,989	10
IL	265	$3,870,354.00	$14,605	27
IN	152	$1,476,631.00	$9,715	21
KS	62	$541,330.00	$8,731	18
KY	141	$9,701,492.00	$68,805	50
LA	136	$3,928,831.00	$28,888	38
MA	213	$2,744,327.00	$12,884	26
MD	19	$1,146,978.00	$60,367	48
ME	15	$69,228.00	$4,615	7
MI	448	$6,627,851.00	$14,794	28
MN	80	$431,508.00	$5,394	12
MO	88	$673,146.00	$7,649	17
MS	54	$2,488,529.00	$46,084	46
MT	6	$18,949.00	$3,158	6
NC	181	$6,692,132.00	$36,973	43
ND	0	$0.00	$0	1
NE	12	$113,348.00	$9,446	20
NH	19	$90,219.00	$4,748	8
NJ	35	$636,952.00	$18,199	31
NM	48	$244,521.00	$5,094	11
NV	13	$243,097.00	$18,700	32
NY	**73**	**$888,675.00**	**$12,174**	**24**
OH	346	$3,408,537.00	$9,851	22
OK	197	$3,548,541.00	$18,013	30
OR	121	$234,718.00	$1,940	4
PA	48	$1,274,948.00	$26,561	36
RI	6	$190,925.00	$31,821	40
SC	94	$4,272,573.00	$45,453	45
SD	0	$0.00	$0	2
TN	64	$6,126,700.00	$95,730	51
TX	693	$8,853,146.00	$12,775	25
UT	54	$319,402.00	$5,915	14
VA	35	$1,174,309.00	$33,552	41
VT	14	$479,233.00	$34,231	42
WA	74	$400,391.00	$5,411	13
WI	188	$2,858,156.00	$15,203	29
WV	28	$799,576.00	$28,556	37
WY	0	$0.00	$0	3
US Total	**5162**	**$98,896,513.00**	**$19,159**	

This chart provides information on several important points regarding the extent to which states fine facilities when they are found to be failing to achieve federal minimum standards. As noted earlier, we believe that fining is critical, since providers are generally unlikely to change practices unless there is a financial incentive for them to do so.

The second and third columns provide the number and total amount of fines imposed by each state over the last three years.[22] NY falls roughly in the middle, with $888,675 in fines. However, it is important to note that NY is the state with the largest nursing home population, meaning that the amount of fines are not in line with the number of nursing home residents. In fact, Delaware, the state with the next highest amount of fines, has 4,150 residents, less than four percent of New York's (105,200).

Though it fines at about two-thirds of the national average, as the fifth column shows NY ranks in the median (24th) in average dollar amount (indicating significant variation nationwide). NY's relatively low total in dollars is also, to a large extent, reflective of the fact that it fines nursing homes far less frequently than the average state (no matter one its size). NY has a total of 73 fines on NH Compare, which equals, on average, fewer than 25 facilities per year. The average state (including those with no fines: WY, ND and SD) fines just fewer than 34 facilities per year.[23]

[22] NH Compare provides information on nursing homes for the previous three years, or "cycles." Data were accessed end of January 2015. **Important Note**: These are the fines posted on NH Compare and do not include state fines.

[23] US total of 5162 divided by 51 (US States + DC) divided by three (years captured on NH Compare) equals 33.74.

Beyond Overall Citations & Fines: Assessing Performance on Three Critical Indicators

The above comparisons of performance in overall citation rates, identification of harm and imposition of penalties provides a number of valuable insights into how New York compares against other states (and how they compare with each other). However, these insights are limited by the fact that they do not take into account variations that may exist in quality between states. For example, if State A's nursing homes are better, overall, than State B's, it would be unfair to use the number of penalties each imposes as a basis for comparison of the efficacy of their survey agencies.

To address possible variations in quality, in this and the following sections we assess New York DOH's performance in terms of three indicators which we believe address important aspects of nursing home quality: antipsychotic drugging, pressure ulcers (also known as bed sores or decubitus ulcers) and direct care staffing levels.

Inappropriate Antipsychotic Drugging: Background

Inappropriate antipsychotic drugging is a serious and widespread problem in nursing homes across the United States. As the example discussed earlier of a "no harm" citation that appears inappropriate indicates, residents who do not have a diagnoses of a psychotic condition may be given antipsychotics to make them easier to care for or for other reasons for which there are not clinical indications. In addition, being diagnosed with a psychotic condition does not – or at least should not – mean that an individual can be given these drugs with impunity. Frequently, these drugs are administered as a form of chemical restraint, and as a substitute for good care.

As discussed earlier, federal standards have long prohibited inappropriate drugging and chemical restraint use. Since March 2012, the federal government has had a national campaign, focusing specifically on reducing the inappropriate and dangerous use of antipsychotics on residents with dementia. Last year, we conducted two evaluations of the campaign. One examined New York State's record in reducing and holding providers accountable for inappropriate drugging.[24] The other assessed the impact on residents of the failure of the federal campaign to meet its self-identified goal.[25]

In the following sections, we look at antipsychotic drugging rates and citations for unnecessary drugging, which are coded in the federal system as F-329. While F-329 is imprecise, in that it is not limited to antipsychotics (it includes inappropriate administration of other drugs), one would expect, given that this is a drugging problem and F-329 has been a focus of the federal campaign, that we would find robust citing of this F-tag.

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[24] Mollot, R., Long Term Care Community Coalition, Antipsychotic Drug Use in NY State Nursing Homes: An Assessment of New York's Progress in the National Campaign to Reduce Drugs and Improve Dementia Care (April 2014). Available at http://www.nursinghome411.org/?articleid=10082.

[25] Mollot, R., Long Term Care Community Coalition, *Left Behind: The Impact Of The Failure To Fulfill The Promise of The National Campaign To Improve Dementia Care* (December 2014). Available at http://www.nursinghome411.org/?articleid=10091.

Inappropriate Antipsychotic Drugging: NYS DOH

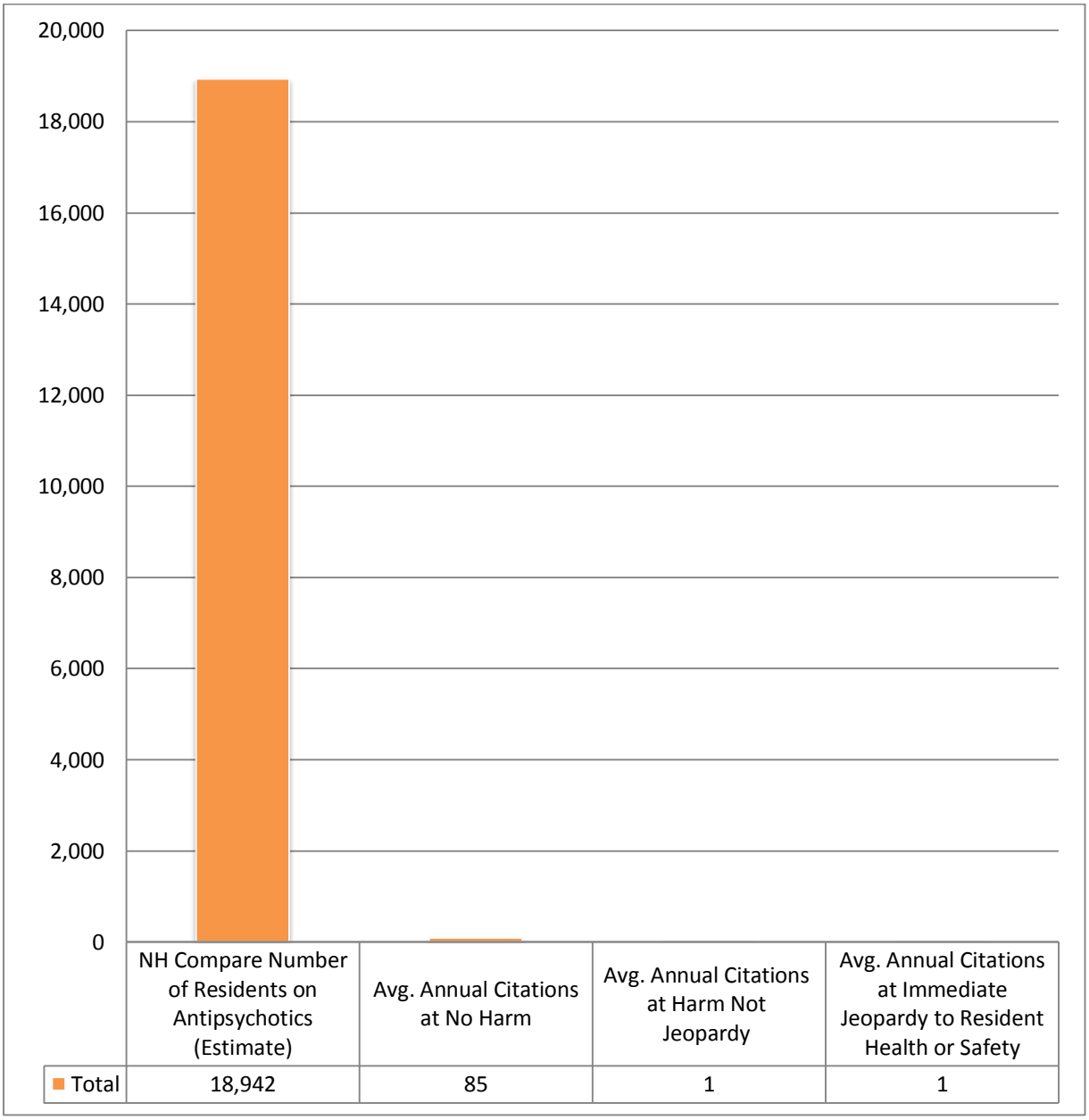
Data on antipsychotic (AP) drugging are published in two ways. The rates published on Nursing Home Compare are risk-adjusted. Specifically, they are risk-adjusted to exclude individuals who are given AP drugs in the nursing home and who have a diagnosis of schizophrenia, Tourette's syndrome or Huntington's disease. This is a blanket exclusion, meaning that it does not distinguish whether or not these individuals received the drug appropriately or even whether or not their diagnoses are appropriate. Nursing home AP drugging rates are also recorded in the MDS Frequency Report, which are the actual percentages of residents who are given antipsychotics (i.e., not risk-adjusted), as reported by the facility.[26]

According to the MDS data, 21.36% of New York's nursing home residents receive antipsychotic drugs. The NH Compare (risk-adjusted) rate is 18.04%. Given that New York has roughly 105,000 nursing home residents, this means that about 22,428 residents are currently being administered antipsychotics. The NH Compare drugging figures (which exclude resident with the aforementioned conditions) equals 18,942. Approximately two percent (2%) of the population suffers from a psychotic disorder. Two percent of the NYS nursing home population would be 2,100 people.

The following chart presents the number of NYS nursing home residents receiving antipsychotic drugs according to NH Compare as compared to the number of citations for inappropriate drugging imposed by the state at no harm, harm but not jeopardy and immediate jeopardy to one or more resident's health or safety.

[26] CMS describes the Minimum Data Set (MDS) as "… a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility." For more information see the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/LongTermCareMinimumDataSetMDS.html.

Chart: NY Antipsychotic Drugging Rates & Citations for Unnecessary Drugs



	NH Compare Number of Residents on Antipsychotics (Estimate)	Avg. Annual Citations at No Harm	Avg. Annual Citations at Harm Not Jeopardy	Avg. Annual Citations at Immediate Jeopardy to Resident Health or Safety
Total	18,942	85	1	1

As the chart indicates, close to 19,000 New York nursing home residents are receiving AP drugs for off-label (and likely inappropriate) purposes. Yet DOH makes an average of 87 findings per year of inappropriate drugging.[27] Only two of those, in the entire state, are cited as having caused either resident harm or immediate jeopardy to resident health or safety.

[27] Furthermore, as noted earlier, these citations relate to *any* inappropriate drugging, including (but not limited to) antipsychotics. Thus, this figure likely includes other drugging problems, such as giving residents the wrong drug or the wrong dosage of a drug.

Identifying Inappropriate Antipsychotic Drugging: NY vs. Other States

We collected data on each states' average antipsychotic drugging rates (both risk-adjusted on NH Compare and the more "raw" data in the MDS Frequency Reports), states' citations for F-329 on NH Compare and the numbers of state citations identified as having caused harm or higher (G or higher on the scope and severity matrix).

We ranked states in respect to their average drugging on both NH Compare and the MDS. Variations between the MDS and NH Compare data (particularly when they are significant) should, we believe, raise questions about the appropriateness of diagnostic and medical supervision practices. Essentially, the gap between the NH Compare number and the MDS number reflect the number of residents receiving antipsychotic drugs who have a diagnosis of Huntington's disease, Schizophrenia or Bipolar Disorder.[28] If that number is significantly larger than the percentage of the population that legitimately has those conditions, it might indicate that individuals are being given these diagnoses *in order* to give them the drugs with impunity.[29] While not dispositive, this can (and should, we believe) signal to policymakers and program integrity agencies that further investigation is called for.

Nationally, average drugging rates are 18.95% on NH Compare and 22.42% on the MDS, indicating that the MDS drugging rate is 18.3% higher than the NH Compare rate.[30] New York's rates are slightly lower (NH Compare rate of 18.04 and MDS rate of 21.36) and its rate of disparity is roughly the same (18.4% difference between what is reported on NH Compare and what is reported on MDS).

[28] Approximately one percent (1%) of the population is estimated to have schizophrenia, according to the National Institute of Mental Health (http://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml) and .01% of the population is estimated to have Huntington's Disease, according to the Huntington's Disease Society of America (*HDSA Fast Facts*, http://www.hdsa.org/new-to-hd-1/new-to-hd.html). The adult and senior populations with Tourette's syndrome are more difficult to quantify. According to the National Tourette Syndrome Association, "The best estimate for the prevalence of TS is 6 cases per 1,000 (0.6%) children…. There are currently no reliable prevalence estimates of TS and other Tic Disorders in adults, but are expected to be substantially less than in children as tics often decline with aging." *The Spectrum of Tourette Syndrome and Tic Disorders*, downloaded from http://www.tsa-usa.org/Medical/whatists_cov.html in February 2015).

[29] It is important to note, again, that a diagnosis of one of these conditions, even when appropriate, does not mean that antipsychotic drugs are necessarily being given appropriately.

[30] 22.42 - 18.95 = 3.47. 3.47 is 18.31% of 18.95.

Chart: State Antipsychotic Drugging Rates, NH Compare vs. MDS Frequency Reports

Interestingly, as the following chart shows, New York ranks higher (better) among the states in its NH Compare average than its MDS average, which raises questions as to the prevalence of cases in which residents are being given diagnoses of psychotic conditions inappropriately, i.e., in order to evade being cited for inappropriate drugging. This appeared to be the case in the citation discussed earlier (the example of finding of "no harm" that appears inappropriate). It was also a problem identified as potentially significant by the NYS Office of Medicaid Inspector General (OMIG) several years ago. However, to date and to our knowledge, OMIG has failed to follow through on its plans to investigate it further.

Note: All of the national charts in this report are available as interactive Excel files on our website, www.nursinghome411.org.

The Excel files allow one to easily view and compare states' rates and rankings.

State	Number of Residents	Average AP Drugging on NHC (Q1-3) (Higher = More Drugging)	RANK: AP Drugging on NHC (Higher = More Drugging)	MDS % of Residents Given AP Drugs	RANK: AP Drugs on MDS (Higher = More Drugging)
AK	608	13.34%	2	15.11%	2
AL	22725	22.38%	45	25.57%	45
AR	17664	21.70%	40	21.19%	32
AZ	11261	19.11%	29	21.06%	31
CA	102093	15.41%	8	20.76%	27
CO	16266	16.63%	13	19.61%	15
CT	24254	20.55%	34	23.98%	39
DC	2557	14.83%	5	19.51%	13
DE	4150	15.56%	9	17.83%	9
FL	73505	21.16%	37	22.87%	35
GA	33952	20.81%	36	24.23%	40
HI	3663	10.87%	1	9.76%	1
IA	24858	19.43%	31	19.93%	20
ID	3844	18.80%	25	19.45%	11
IL	72715	24.02%	49	30.04%	51
IN	38821	20.03%	33	20.59%	24
KS	18403	21.98%	42	25.29%	44
KY	22976	21.52%	38	23.35%	37
LA	25880	26.07%	51	29.66%	50
MA	41302	20.61%	35	23.26%	36
MD	24408	16.24%	12	18.20%	10
ME	6248	18.97%	28	20.82%	28
MI	39391	13.89%	3	16.66%	5
MN	26702	15.56%	10	17.00%	6
MO	38273	22.33%	44	25.75%	46
MS	16132	23.89%	48	26.34%	49
MT	4587	16.79%	15	19.99%	22
NC	37142	15.22%	7	17.59%	7
ND	5620	18.31%	22	20.59%	25
NE	12068	22.24%	43	23.63%	38
NH	6760	19.38%	30	20.85%	29
NJ	45204	14.81%	4	19.48%	12
NM	5462	18.80%	26	19.74%	16
NV	4819	19.77%	32	19.96%	21
NY	**105200**	**18.04%**	**19**	**21.36%**	**33**
OH	76372	21.76%	41	26.13%	48
OK	19118	21.54%	39	24.56%	42
OR	7337	17.57%	18	19.75%	17
PA	79589	18.40%	24	20.59%	26
RI	8012	17.00%	17	19.75%	18
SC	16780	15.67%	11	17.65%	8
SD	6384	18.21%	20	19.99%	23
TN	28976	23.39%	46	24.51%	41
TX	93098	25.97%	50	25.94%	47
UT	5502	23.55%	47	24.68%	43
VA	28566	18.81%	27	20.89%	30
VT	2686	18.34%	23	21.62%	34
WA	17007	18.25%	21	19.55%	14
WI	27526	15.08%	6	16.19%	3
WV	9528	16.75%	14	19.90%	19
WY	2353	16.97%	16	16.51%	4
US	**1173476**	**18.95%**		**22.42%**	

Chart: US AP Drugging Rates on NH Compare vs. MDS

Chart: US Antipsychotic Drugging Rates and Citations for F-329

The following chart provides information on enforcement of the federal standard prohibiting inappropriate drugging, F-329. As noted earlier, this standard applies to any drug that is given inappropriately or unnecessarily. Thus, the numbers include any citation for unnecessary antipsychotic drug use as well as for other drugs given unnecessarily. However, given especially that F-329 has been a major focus of the national campaign to reduce inappropriate AP drugging, we believe that citations to it are a good measure of a state's enforcement in regard to this important criteria.

To facilitate understanding of state performance, we included in the chart the Nursing Home Compare antipsychotic drugging rate for each state. This essentially gives nursing homes the "benefit of the doubt" in terms of appropriate use of the drugs for people with a condition that might merit its use. Comparing these drugging rates with the rate of citation for F-329, one can see that, overall, the states do a very poor job in citing for F-329. The average risk-adjusted state drugging rate is 18.95% while the average state citation rate is 0.31%. This indicates that there is a significant amount of inappropriate antipsychotic drugging that is not being cited by the states.

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Next we looked at state citations for F-329 that were cited as having caused some kind of harm to one or more residents (G or higher on the scope and severity matrix). The data indicate that, on average, states only find two percent (2%) of all F-329 violations as having caused any harm to residents. Given the known significant dangers of these drugs, widely publicized since the FDA's "Black Box Warning" ten years ago, we believe this is a striking and troublesome finding. If giving residents drugs that are both highly dangerous and not clinically indicated is not harm, what is?

New York State does particularly poorly in citing for F-329; as the chart shows, its rate is roughly one-fourth of the national rate (which is, as discussed above, very poor). There are only six states that perform more poorly: Tennessee, Georgia, Missouri, New Hampshire, Kentucky and Alabama.

State	Average AP Drugging on NHC (Q1-3) (Higher = More Drugging)	F-329 Deficiencies on NHC (3 yrs)	Annual Per Resident F-329 Citation Rate	RANK: Citations Per Resident (Higher = More Citations)	F-329 Deficiencies on NHC at G+ (3 yrs)	Percent F-329 Deficiencies G+	RANK: Percent Citations at G+ (Higher = Greater % Deficiencies Cited as Causing Harm)
AK	13.34%	4	0.22%	18	0	0.00%	1
AL	22.38%	24	0.04%	1	1	4.17%	41
AR	21.70%	73	0.14%	13	1	1.37%	19
AZ	19.11%	186	0.55%	45	1	0.54%	12
CA	15.41%	1201	0.39%	35	19	1.58%	23
CO	16.63%	257	0.53%	43	2	0.78%	13
CT	20.55%	200	0.27%	24	1	0.50%	11
DC	14.83%	29	0.38%	33	0	0.00%	3
DE	15.56%	73	0.59%	48	1	1.37%	18
FL	21.16%	511	0.23%	20	9	1.76%	26
GA	20.81%	61	0.06%	5	2	3.28%	38
HI	10.87%	34	0.31%	28	1	2.94%	36
IA	19.43%	217	0.29%	25	13	5.99%	47
ID	18.80%	130	1.13%	50	2	1.54%	22
IL	24.02%	469	0.21%	17	6	1.28%	17
IN	20.03%	533	0.46%	38	23	4.32%	42
KS	21.98%	631	1.14%	51	5	0.79%	14
KY	21.52%	36	0.05%	4	2	5.56%	46
LA	26.07%	212	0.27%	23	3	1.42%	21
MA	20.61%	109	0.09%	8	2	1.83%	27
MD	16.24%	277	0.38%	34	6	2.17%	33
ME	18.97%	50	0.27%	22	1	2.00%	30
MI	13.89%	432	0.37%	32	8	1.85%	28
MN	15.56%	405	0.51%	42	2	0.49%	10
MO	22.33%	177	0.15%	15	2	1.13%	15
MS	23.89%	25	0.05%	3	**0**	0.00%	9
MT	16.79%	57	0.41%	36	3	5.26%	45
NC	15.22%	163	0.15%	14	13	7.98%	51
ND	18.31%	41	0.24%	21	2	4.88%	44
NE	22.24%	182	0.50%	40	0	0.00%	8
NH	19.38%	9	0.04%	2	0	0.00%	7
NJ	14.81%	155	0.11%	11	0	0.00%	2
NM	18.80%	49	0.30%	27	2	4.08%	40
NV	19.77%	60	0.42%	37	1	1.67%	25
NY	**18.04%**	**259**	**0.08%**	**7**	**6**	**2.32%**	**34**
OH	21.76%	815	0.36%	31	13	1.60%	24
OK	21.54%	333	0.58%	47	4	1.20%	16
OR	17.57%	118	0.54%	44	3	2.54%	35
PA	18.40%	396	0.17%	16	0	0.00%	6
RI	17.00%	24	0.10%	9	0	0.00%	4
SC	15.67%	54	0.11%	10	1	1.85%	29
SD	18.21%	42	0.22%	19	3	7.14%	49
TN	23.39%	62	0.07%	6	3	4.84%	43
TX	25.97%	348	0.12%	12	22	6.32%	48
UT	23.55%	132	0.80%	49	10	7.58%	50
VA	18.81%	254	0.30%	26	8	3.15%	37
VT	18.34%	28	0.35%	29	0	0.00%	5
WA	18.25%	282	0.55%	46	6	2.13%	32
WI	15.08%	390	0.47%	39	8	2.05%	31
WV	16.75%	144	0.50%	41	2	1.39%	20
WY	16.97%	25	0.35%	30	1	4.00%	39
US	**18.95%**	**10778**	**0.31%**		**224**	**2.08%**	

Chart: US AP Drugging Rates & Inappropriate Drugging Citation Rates

Citing for Failure to Prevent and Treat Pressure Ulcers

The following two charts provide information for (1) All states and (2) New York on rates of unhealed pressure ulcers among nursing home residents alongside citations for failing to appropriately treat and prevent pressure ulcers. We selected pressure ulcers (PUs) as a key criteria on which to focus in this report because it is an important indicator of a nursing home's quality of care.

According to the Centers for Disease Control and Prevention,

> Pressure ulcers, also known as bed sores, pressure sores, or decubitus ulcers, are wounds caused by unrelieved pressure on the skin. They usually develop over bony prominences, such as the elbow, heel, hip, shoulder, back, and back of the head. Pressure ulcers are serious medical conditions and one of the important measures of the quality of clinical care in nursing homes.[31] [Endnotes deleted from original.]

While some pressure ulcers are unavoidable, research and experience indicate that,"[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."[32] In fact, the need to reduce pressure ulcers in nursing homes has been one of the key areas identified for quality improvement by the nursing home industry's quality improvement campaign, Advancing Excellence.[33]

The first chart uses data from MDS reports and NH Compare to compare states' rates of nursing home PUs and rates of citations against nursing homes for failing to provide adequate services to prevent and treat PUs. We found that the average rates for PUs among the states vary considerably: from a low of 4.2% in New Hampshire to a high of 11.09% in Nevada. The national average was 7.38%. It should be noted that, given the seriousness of this problem, the rates overall should be much lower and would be, we believe, if appropriate care was more consistently provided in nursing homes. For instance, regular monitoring and evaluation of all residents, and pro-active care for residents identified as "high-risk," would undoubtedly result in a substantial reduction in the PU rates across the nation.

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[31] NCHS Data Brief, No. 14 (February 2009), which incorporates *Pressure Ulcers Among Nursing Home Residents: United States*, *2004*. Accessed in March 2015 from www.cdc.gov/nchs/data/databriefs/db14.pdf (PDF).

[32] Edsberg, Laura E.; Langemo, Diane; Baharestani, Mona Mylene; Posthauer, Mary Ellen; and Goldberg, Margaret, "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313–334. Abstract accessed in March 2015 at http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable_Pressure_Injury__State_of_the_Science.6.aspx. Henceforth *Unavoidable Pressure Injury*.

[33] Advancing Excellence in America's Nursing Homes, https://www.nhqualitycampaign.org/default.aspx.

Chart: US Unhealed Pressure Ulcer Rates and F-314 Citations

The following chart provides information on states' citations for inadequate pressure ulcer care (F-314) in two important ways:

1. Annual rates of citations have been computed for each state based on the number of nursing home residents with PUs. We thought that this was critical in order to gain insights into a fundamental question: what are the states doing in response to the pressure ulcers suffered by their citizens? Our findings indicate that, nationally, the citation rates are very low, averaging only 2.96%. This means that there is only about one F-314 citation for every 33 cases of a resident with pressure ulcers. From an advocate's perspective, this is a long way from the idea that in the "vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."[34]
   Though the average is low overall, we found significant variation among the states. In addition to providing each state's percentages, we have ranked the states.
2. Numbers of citations at harm or above (G+ on the scope and severity matrix) are provided for each state. As noted earlier, a facility is unlikely to be penalized unless a deficiency is cited as having caused harm or immediate jeopardy to one or more residents. Since pressure ulcers are, by definition, a wound and are well-recognized as a serious problem, one might consider that *any* case of a pressure ulcer developing is harmful to the individual. Nevertheless, our findings indicate that states cite at a level of harm less than 25% of the time. Here, too, we found a wide disparity among the states, ranging from 0% citing of harm to over 80%.

Fast Facts:

(1) Pressure ulcers are a problem for almost one in 10 NYS nursing home residents.
(2) Though pressure ulcers are largely preventable, NY DOH cites nursing homes the equivalent of less than 1% of the time that a resident has a pressure ulcer.
(3) When NY DOH does cite a facility for poor pressure ulcer care or prevention, it rarely finds that this failure has caused harm to the resident(s).

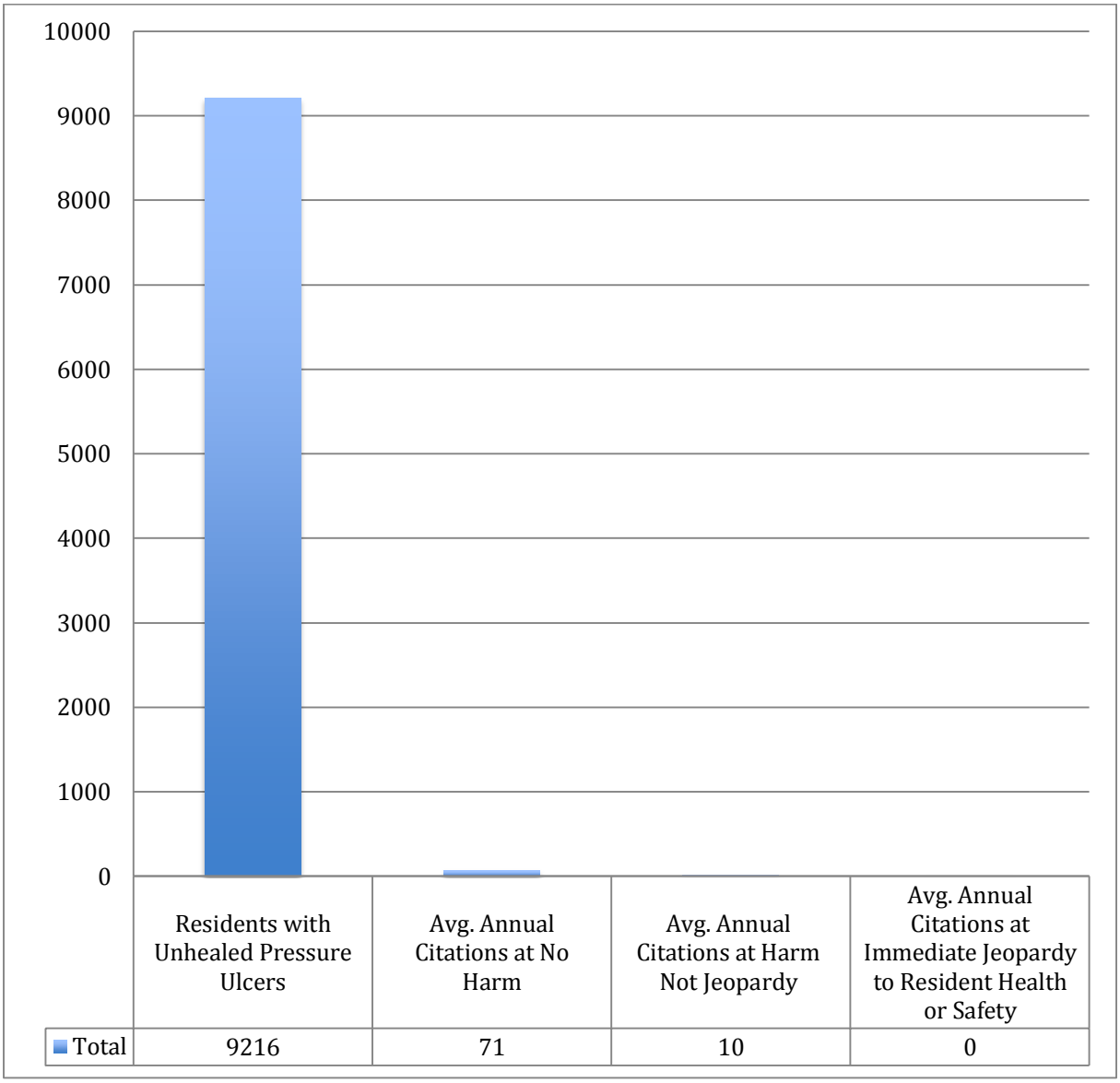
Though close to one in ten NY State nursing home residents (8.76%) suffer with pressure ulcers, our findings indicate that New York DOH is particularly weak in holding providers accountable, rarely citing facilities when residents have PUs and, when it does cite, being much less likely than most other states to identify the PU as having resulted in harm or immediate jeopardy to a resident's well-being. Our findings indicate that NY is ranked 2nd lowest in the country in terms of citing pressure ulcers. Furthermore, only 12.35% of the deficiencies that DOH does cite are identified as having caused harm and none are cited as causing immediate jeopardy to resident health or safety. New York DOH ranks 8th lowest in the country in terms of identifying harm when it cites for poor PU care.

[34] As previously cited from *Unavoidable Pressure Injury*.

State	Number of Residents	MDS % Residents Unhealed Pressure Ulcers	Number of Residents with Pressure Ulcers	RANK: Percent of Residents with Pressure Ulcers (Higher = Greater % PUs)	F-314 Deficiencies on NHC (3 yrs)	Annual F-314 Citation Rate Per Resident with Pressure Ulcers	RANK: F-314 Citations (Higher = More Citations Per Res. w/PU)	Number F-314 Deficiencies Cited as Harm (G+)	Percent F-314 Deficiencies Cited as Harm (G+)	RANK: Percent Citations at G+ (Higher = Greater % Deficiencies Cited as Causing Harm)
AK	608	7.06%	43	30	5	3.88%	31	1	20.00%	17
AL	22725	6.48%	1473	24	95	2.15%	20	3	3.16%	2
AR	17664	5.34%	943	11	267	9.44%	49	18	6.74%	5
AZ	11261	8.61%	970	43	81	2.78%	27	38	46.91%	44
CA	102093	9.75%	9954	50	645	2.16%	21	48	7.44%	6
CO	16266	5.08%	826	7	127	5.12%	41	36	28.35%	28
CT	24254	5.48%	1329	13	189	4.74%	38	60	31.75%	32
DC	2557	9.34%	239	48	20	2.79%	28	12	60.00%	48
DE	4150	5.44%	226	12	44	6.50%	46	12	27.27%	24
FL	73505	9.07%	6667	47	200	1.00%	4	13	6.50%	4
GA	33952	7.98%	2709	37	109	1.34%	11	12	11.01%	7
HI	3663	5.75%	211	15	16	2.53%	25	2	12.50%	9
IA	24858	4.21%	1047	2	163	5.19%	42	57	34.97%	36
ID	3844	5.85%	225	18	111	16.45%	51	71	63.96%	49
IL	72715	6.42%	4668	22	626	4.47%	36	109	17.41%	15
IN	38821	6.67%	2589	26	325	4.18%	34	89	27.38%	25
KS	18403	5.69%	1047	14	291	9.26%	48	115	39.52%	42
KY	22976	7.38%	1696	34	64	1.26%	10	10	15.63%	12
LA	25880	7.19%	1861	32	84	1.50%	13	13	15.48%	11
MA	41302	6.17%	2548	19	72	0.94%	3	36	50.00%	46
MD	24408	9.00%	2197	46	77	1.17%	7	5	6.49%	3
ME	6248	5.79%	362	16	26	2.40%	23	0	0.00%	1
MI	39391	7.17%	2824	31	407	4.80%	39	135	33.17%	34
MN	26702	5.27%	1407	9	226	5.35%	44	39	17.26%	14
MO	38273	5.05%	1933	6	349	6.02%	45	72	20.63%	18
MS	16132	7.41%	1195	35	40	1.12%	6	16	40.00%	43
MT	4587	6.39%	293	21	18	2.05%	19	9	50.00%	45
NC	37142	8.47%	3146	41	113	1.20%	8	17	15.04%	10
ND	5620	4.79%	269	5	41	5.08%	40	15	36.59%	39
NE	12068	4.39%	530	3	85	5.35%	43	26	30.59%	31
NH	6760	4.20%	284	1	14	1.64%	15	5	35.71%	37
NJ	45204	9.36%	4231	49	105	0.83%	1	22	20.95%	19
NM	5462	6.49%	354	25	11	1.03%	5	9	81.82%	51
NV	4819	11.09%	534	51	29	1.81%	17	5	17.24%	13
NY	**105200**	**8.76%**	**9216**	**44**	**243**	**0.88%**	**2**	**30**	**12.35%**	**8**
OH	76372	6.89%	5262	28	391	2.48%	24	118	30.18%	30
OK	19118	6.80%	1300	27	159	4.08%	33	54	33.96%	35
OR	7337	8.85%	649	45	61	3.13%	30	18	29.51%	29
PA	79589	6.90%	5492	29	206	1.25%	9	49	23.79%	22
RI	8012	6.18%	495	20	23	1.55%	14	5	21.74%	20
SC	16780	8.55%	1435	42	62	1.44%	12	17	27.42%	26
SD	6384	5.14%	328	8	43	4.37%	35	33	76.74%	50
TN	28976	8.31%	2408	38	119	1.65%	16	38	31.93%	33
TX	93098	7.34%	6833	33	377	1.84%	18	106	28.12%	27
UT	5502	6.45%	355	23	48	4.51%	37	12	25.00%	23
VA	28566	8.37%	2391	39	195	2.72%	26	44	22.56%	21
VT	2686	5.28%	142	10	17	4.00%	32	10	58.82%	47
WA	17007	7.70%	1310	36	119	3.03%	29	47	39.50%	41
WI	27526	5.81%	1599	17	484	10.09%	50	95	19.63%	16
WV	9528	8.45%	805	40	56	2.32%	22	22	39.29%	40
WY	2353	4.72%	111	4	25	7.50%	47	9	36.00%	38
US	**1173476**	**7.38%**	**86603**		**7703**	**2.96%**		**1837**	**23.85%**	

Chart: US Unhealed Pressure Ulcer Rates & F-314 Citations

Chart: NYS Pressure Ulcers Rates and Annual F-314 Citations



Over 9000 NY nursing home residents are documented to be suffering with unhealed pressure ulcers though (as noted above), in "the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."[35] As this chart indicates, DOH cites nursing homes less than 100 times per year (overall) for inadequate PU care, and the large majority of these are cited as not having caused harm to the residents. As noted above, no citations have been made, in at least the last three years, at a finding of immediate jeopardy to resident health or safety.

[35] As previously cited from *Unavoidable Pressure Injury*.

Citing When There is Insufficient Care Staff

Staffing levels are one of the most (if not the most) important indicators of a nursing home's quality and safety. A landmark federal study in 2001 found that 97% of facilities failed to meet one or more staffing requirements and 52% failed to meet all staffing requirements necessary to prevent avoidable harm to residents.[36] The analysis determined that 91% lacked sufficient staff to provide decent care. Unfortunately, this situation continues today. A March 2014 study by the US Inspector General found that an astonishing one-third of the people who go to nursing homes for short-term Medicare rehab services are harmed and that 59% of the time that harm is "clearly or likely preventable."[37]

Fast Facts:

(1) Though sufficient staff has been identified as critical to good care, and insufficient staffing is known to be a widespread problem, insufficient staffing is rarely cited in US nursing homes.
(2) Low staffing is an especially serious and persistent problem in NY State nursing homes, yet DOH only cites for insufficient care staff about 13 times each year in total.
(3) DOH's citation rate for inadequate care staff, per nursing home resident, is equal to an individual's chances of dying in a plane crash.
(4) DOH has not identified inadequate staff as resulting in harm or immediate jeopardy to a resident's well-being in at least three years.

Low staffing in New York State nursing homes is a longstanding problem. While staffing nationwide is inadequate, overall, New York's nursing home staffing rates are particularly low. As the national chart below indicates, New York ranks as the 13th lowest in the country in average staffing levels, placing it between Missouri and Tennessee. Perhaps uncoincidentally, New York is also among the minority of states without minimum staffing standards for nursing homes.

Despite the widespread – and widely acknowledged – insufficiency of care staff in US nursing homes, and the known correlation between low staffing and poor outcomes for both residents and staff, insufficient staff is rarely cited in the US. As the national chart below indicates, only 1478 staffing deficiencies have been cited in the last three years in the entire country.[38] With a national total of 15,465 nursing homes, this means that about one in 31 nursing homes in the entire country are cited for insufficient staffing each year.[39]

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[36] Abt Associates (Prepared for the Centers for Medicare and Medicaid Services), *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report To Congress: Phase II Final (December 2001).
[37] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014).
[38] Nursing Home Compare F-353 deficiencies for last three cycles downloaded in January 2015.
[39] NH Compare total deficiencies were 1478 for three years or roughly 493 per year for the entire US. There are 15,465 nursing homes in the country (Kaiser Commission on Medicaid and the Uninsured analysis of 2011 Online

More importantly, from a resident perspective, is the fact that despite our knowledge that insufficient staffing is a widespread problem with serious repercussions for resident care, quality of life and dignity, the annual percentage of staffing deficiencies per resident is infinitesimal: 0.042%.

New York, in the bottom quarter of states in the country in terms of staffing levels, is also among the states least likely to cite a facility for insufficient staffing. With over 600 facilities and over 100,000 residents, DOH only cites for insufficient staff about 13 times a year in total. That means that there is roughly a two percent (2%) chance of a facility receiving a staffing citation in the course of the year. On a per resident basis, the annual per capita rate for staffing deficiencies in New York is 0.012%. This is about the same as the likelihood of dying in an airplane crash.[40]

While citing deficiencies is important, appropriately identifying when residents are harmed or put in immediate danger is critical, since (in general, as discussed earlier) facilities are only penalized when a deficiency is cited as having caused harm or immediate jeopardy. Here, our findings indicate that, nationally, less than five percent of staffing deficiencies are cited as having caused harm. These rates vary widely, from zero to fifty percent.

For the three year period covered on Nursing Home Compare, New York DOH *never* cited insufficient staffing as having resulted in harm or immediate jeopardy to any resident. In this respect it was joined by 21 other states. It ranks number two on our chart ("Rank: Percent Deficiencies Cited at Harm+") because it has the second lowest number of care staff per resident per day of the 22 states with no harm deficiencies.

Survey, Certification, and Reporting system (OSCAR) data. Accessed at http://kff.org/other/state-indicator/number-of-nursing-facilities/.)

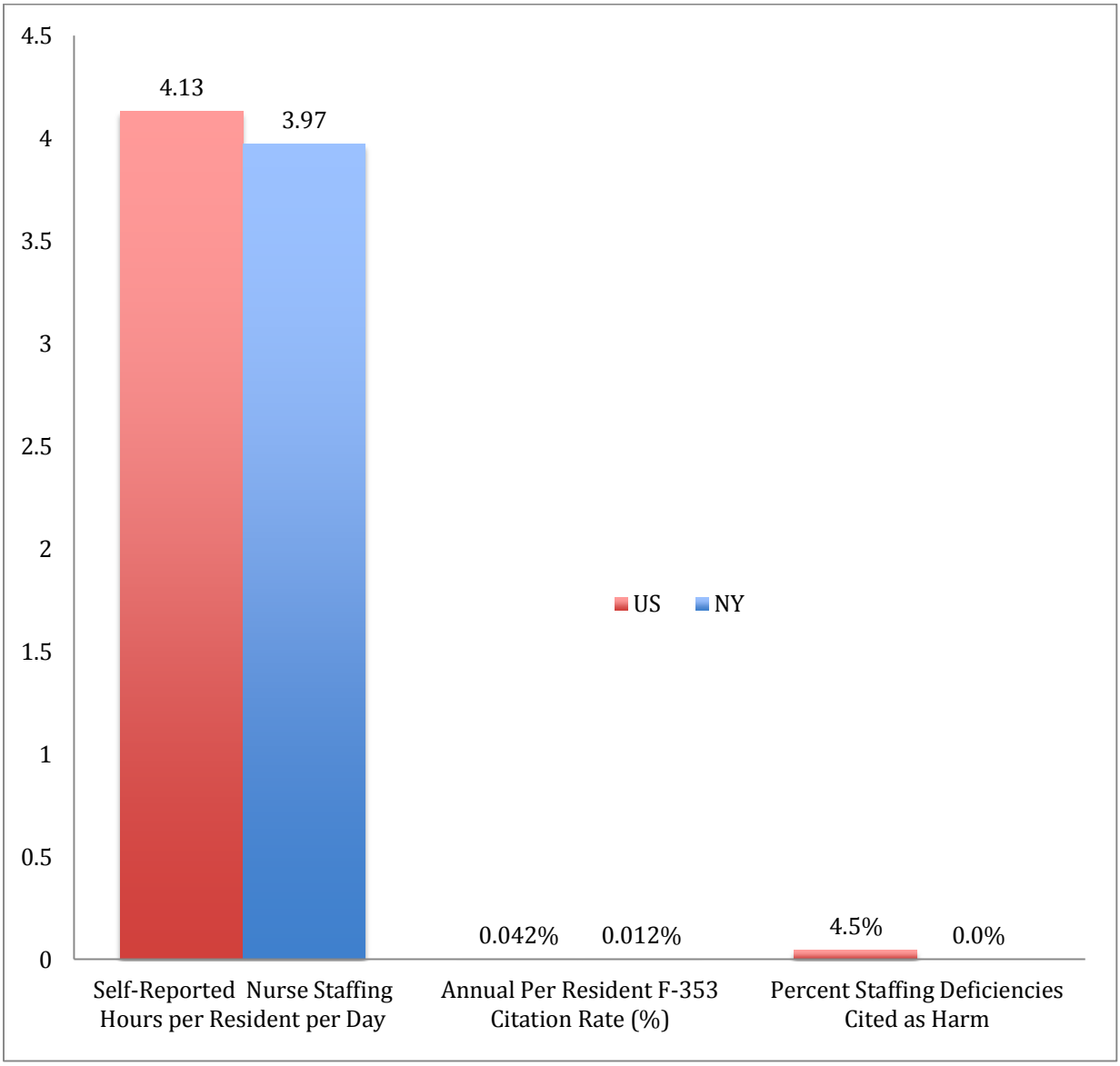
[40] According to the National Safety Council, the odds of dying from "Air and Space Transport Incidents" are 1:8,357 which is 0.012%. Statistical data accessed in April 2015 at http://www.nsc.org/learn/safety-knowledge/Pages/injury-facts-chart.aspx.

Chart: US States' Staffing Levels and F-353 Citations

State	Number of Residents	Reported Total Nurse Staffing Hours per Resident per Day	F-353 Deficiencies on NHC (3 yrs)	Annual Per Resident F-353 Citation Rate	Number Cited as Harm	Percent Staffing Deficiencies Cited as Harm	Rank: Reported Staffing (Higher = More Staff)	Rank: Staffing Deficiencies Per Resident (Higher = More Deficiencies)	Rank: Percent Deficiencies Cited at Harm+ (Higher = Gtr ID at Harm+)
AK	608	6.69	0	0.000%	0	0.0%	51	1	21
AL	22725	4.30	3	0.004%	0	0.0%	34	5	11
AR	17664	4.33	3	0.006%	0	0.0%	35	10	12
AZ	11261	4.55	6	0.018%	0	0.0%	44	18	16
CA	102093	4.53	53	0.017%	1	1.9%	43	17	25
CO	16266	4.25	46	0.094%	4	8.7%	29	43	36
CT	24254	4.10	19	0.026%	0	0.0%	20	29	7
DC	2557	5.09	2	0.026%	1	50.0%	50	28	51
DE	4150	4.62	1	0.008%	0	0.0%	46	11	18
FL	73505	4.50	55	0.025%	3	5.5%	42	26	30
GA	33952	3.78	3	0.003%	1	33.3%	3	4	46
HI	3663	4.87	10	0.091%	1	10.0%	49	42	39
IA	24858	3.78	145	0.194%	3	2.1%	2	48	26
ID	3844	4.87	20	0.173%	0	0.0%	48	47	20
IL	72715	3.79	56	0.026%	1	1.8%	4	27	24
IN	38821	4.18	72	0.062%	2	2.8%	27	35	27
KS	18403	4.08	111	0.201%	0	0.0%	19	50	6
KY	22976	4.36	16	0.023%	1	6.3%	36	23	32
LA	25880	3.79	29	0.037%	6	20.7%	5	32	43
MA	41302	4.12	7	0.006%	1	14.3%	23	9	41
MD	24408	4.27	10	0.014%	0	0.0%	32	16	10
ME	6248	4.62	4	0.021%	0	0.0%	45	20	17
MI	39391	4.26	124	0.105%	2	1.6%	31	44	22
MN	26702	4.06	64	0.080%	0	0.0%	17	39	5
MO	38273	3.92	41	0.036%	0	0.0%	11	30	1
MS	16132	4.26	10	0.021%	3	30.0%	30	19	45
MT	4587	4.14	3	0.022%	1	33.3%	24	21	47
NC	37142	4.07	11	0.010%	1	9.1%	18	13	37
ND	5620	4.40	4	0.024%	0	0.0%	39	24	15
NE	12068	4.11	30	0.083%	1	3.3%	22	40	28
NH	6760	4.21	1	0.005%	0	0.0%	28	8	9
NJ	45204	4.10	2	0.001%	0	0.0%	21	2	8
NM	5462	3.79	4	0.024%	1	25.0%	7	25	44
NV	4819	4.36	8	0.055%	0	0.0%	37	34	13
NY	**105200**	**3.97**	**37**	**0.012%**	**0**	**0.0%**	**12**	**14**	**2**
OH	76372	4.04	96	0.042%	0	0.0%	15	33	3
OK	19118	3.87	75	0.131%	8	10.7%	9	45	40
OR	7337	4.79	16	0.073%	0	0.0%	47	37	19
PA	79589	4.05	11	0.005%	0	0.0%	16	7	4
RI	8012	3.84	2	0.008%	1	50.0%	8	12	49
SC	16780	4.37	1	0.002%	0	0.0%	38	3	14
SD	6384	3.66	7	0.037%	3	42.9%	1	31	48
TN	28976	3.99	4	0.005%	2	50.0%	13	6	50
TX	93098	3.79	64	0.023%	3	4.7%	6	22	29
UT	5502	4.49	28	0.170%	2	7.1%	41	46	34
VA	28566	4.17	11	0.013%	1	9.1%	26	15	38
VT	2686	4.30	16	0.199%	1	6.3%	33	49	31
WA	17007	4.48	37	0.073%	7	18.9%	40	36	42
WI	27526	4.16	61	0.074%	1	1.6%	25	38	23
WV	9528	3.87	24	0.084%	2	8.3%	10	41	35
WY	2353	4.04	15	0.212%	1	6.7%	14	51	33
US Total	**1173476**	**4.13**	**1478**	0.042%	**66**	**4.5%**			

Note: This and all US States' charts are posted in Excel at www.nursinghome411.org. The Excel format allows for easy sorting and comparison of the state rates and rankings.

Chart: New York vs. US Staffing Levels, F-353 Citations & Identification of Harm



As discussed above, inadequate staffing is widely recognized as one of the most – if not the most – significant determinants of poor care, including resident neglect and abuse. There are no specific federal requirements for staffing levels, though about two-thirds of the states have requirements in their laws. New York is not one of them.

This chart provides a specific comparison between New York and national rates. As the chart indicates, New York has lower staffing than the national average. While overall national citation rates for inadequate staffing are extremely low (.042% nationally per resident), NY DOH's citation rate is a fraction of the national average. Furthermore, while nationally State Agencies identify only 4.5% of these violations as causing harm to residents, in New York the number is far less: zero. As noted earlier, New York is one of the minority of states that never identifies insufficient staffing as causing harm to residents.

NY DOH: Discussion & Recommendations

As with all of the state enforcement agencies, and CMS itself, DOH has a history of under-identifying nursing home deficiencies and, for those deficiencies that it does cite, too often failing to adequately identify when residents are harmed or endangered. The nursing home industry has historically complained that the resulting system of uneven enforcement hurts them because it makes for an inconsistent environment in which to do business; the argument being that facilities do not know for what they are – or are not – going to be cited. However, given that the federal regulations implementing the Nursing Home Reform Law have been in effect for over two decades, we would argue that providers are – or should be – well aware of minimum requirements and should be held accountable (in meaningful ways) for meeting them. When standards are not evenly and vigorously enforced, allowing too many nursing homes to provide substandard care to their residents, it is principally the residents who suffer and the public who pays the price. Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?

Recommendations for DOH:

We have long called on DOH to strengthen its oversight of nursing homes. Our main concern, as consumer advocates, has been the thousands of nursing home residents who are abused or neglected every day, with impunity, in nursing homes across the state. In addition, the persistence of substandard care in the nursing home industry (including services that are often worthless, if not harmful) is also extremely costly to tax-payers, who too often foot the bill for care that falls below that which facilities agree to provide as Medicare and Medicaid contractors.

Fundamentally, we believe that there is a strong body of knowledge regarding how to effectively identify and cite deficiencies; the problem is, generally, due to three things: (1) lack of will, (2) lack of knowledge among survey staff and/or (3) lack of resources. To address these issues, we recommend that DOH:

1. **Re-commit to its mission as an enforcement agency**. New York families depend on DOH to ensure that providers are meeting - or exceeding - standards of care. New York taxpayers depend on DOH to assure financial integrity of the billions of dollars spent each year on nursing home care. While other agencies do important and valuable work, DOH is ultimately responsible for oversight and enforcement and its dedication to its mission as a Survey Agency is essential.
2. **Comply with federal Survey Agency requirements**. DOH should focus on achieving both the *letter* and the *spirit* of the State Operations Manual. For example, it is not adequate to conduct 100% of the federally required surveys per year if those surveys are not effectively ensuring that standards are met and deficiencies are appropriately cited. Given that NYS nursing homes are twice as big as the national average, the state should identify and implement ways to overcome basic structural barriers to effectively identify and cite deficiencies. Simply put, how can it be possible to adequately survey a 200 or 700 bed facility with the same number of surveyors, in the

same amount of time, as it takes to adequately survey a 70 or 100 bed facility? Nevertheless, this is the longstanding practice in New York State.

3. **Improve resource allocation**. DOH should dedicate its limited resources to fostering vigorous oversight, rather than training, engaging or otherwise trying to persuade providers to attain the minimum standards of care for which they are already being paid to achieve. Providers are professionals who are expected to provide services in accordance with professional standards. The public has the right to expect that providers have – and maintain – the skills and knowledge necessary to meet those standards.
4. **Improve surveyor training & performance assessment**.
    a. DOH should improve training and direction of surveyors, so that knowledge is not only acquired but also *consistently utilized* to effectuate better care (and greater accountability for substandard care). For instance, to reduce inappropriate and illegal antipsychotic drugging, survey teams should review all instances of off-label antipsychotic drugging. Is there a record of informed consent? Non-pharmacological interventions? Gradual dose reduction? When the answer is *no*, surveyors must assess whether other relevant standards are being met (such as appropriate medical supervision, sufficient staffing and necessary care to achieve highest practicable well-being) and, if not, whether this has resulted in harm.
    b. DOH should coordinate trainings with the state Medicaid Fraud Control Unit and other law enforcement entities to improve surveyor investigative techniques. In addition to the potential for improving surveyor practice, such coordinated trainings could have other benefits, such as improving law enforcement's understanding of *its* role in protecting residents, for instance in ensuring that the federal requirement to report any suspicion of crimes against residents is properly implemented.
    c. DOH should collect and assess data on survey teams and regions relating to identification of deficiencies and identification of harm (when a deficiency is identified) and assess these data in relation to relevant measures (including, *inter alia*, antipsychotic drug use, staffing levels and pressure ulcer rates). For example, if staffing is not being cited when facilities have reported low staffing levels and/or problems that are likely to be staffing related, DOH should conduct a data-driven assessment to determine if there are deficiencies that are being missed or under-rated (in terms of scope and severity). These assessments should be conducted for a certain number of survey teams per year and for all of the state regional offices on at least an annual basis. The results of the regional office assessments should be made public in an annual report on agency effectiveness, similar to what other state and federal agencies do.

New York State Medicaid Fraud Control Unit (MFCU)

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. Every state (except for North Dakota) has an MFCU. The MFCU in NY State is housed in the Office of the NYS Attorney General (as is the case for the majority of units).

According to federal regulations,

> (a) The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan. (b) (1) The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities. (2) If the initial review indicates substantial potential for criminal prosecution, the unit will investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.[41]

Every year, each MFCU is required to submit an annual report to the federal government on its activities and accomplishments relating to:

> (a) The number of investigations initiated and the number completed or closed, categorized by type of provider; (b) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence; (c) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies; (d) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total amount of overpayments actually collected by the unit; (e) The number of recovery actions initiated by the Medicaid agency under its agreement with the unit, and the total amount of overpayments actually collected by the Medicaid agency under

[41] 42 CFR § 1007.11, Duties and responsibilities of the unit. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

> this agreement; (f) Projections for the succeeding 12 months for items listed in paragraphs (a) through (e) of this section; (g) The costs incurred by the unit; and (h) A narrative that evaluates the unit's performance….[42]

MFCU Stats for 2014

The following chart provides information for all of the state MFCUs. New York's nursing home population is the largest in the country and, as the last column indicates, its MFCU is also the largest.[43] It is, in fact, proportionally much larger than the next biggest state (California) in terms of staff size relative to nursing home population. As with our analysis of NY DOH, our assessment of MFCU focuses on the actions taken and accomplishment in terms of the state's nursing home population.

Key findings:

1. **Investigations Overall**: NY MFCU conducts approximately twice the number of investigations per nursing home resident than the national average for state MFCUs (one investigation per 71 residents for New York vs. one per 141 residents for US).
2. **Investigations of Abuse & Neglect**: NY MFCU conducts more than double the national average of investigations of resident abuse and neglect per capita than the national average (one investigation per 314 residents in NY, vs. one for every 822 residents nationally).
3. **Recovering Public Funds (Such as For Sub-Par & Fraudulent Services)**: NY MFCU's recovery of $378,434,543 in funds for fraud, abuse and neglect (etc…) in 2014 is by far the largest in the country. While this is to be expected, given the size of NY State's nursing home population, it is important to note that the NY MFCU's recoveries far outpace the national average. NYS MFCU recovered $3,597 per resident in 2014, more than double the national average of $1,708.[44]
4. **Convictions**: NY MFCU's conviction rate is slightly above the national average, with an average of one conviction per 892 residents vs. the national average of one conviction for every 890 residents. Because the US OIG does not break down convictions in terms of occupation (for example, CNAs vs. RNs vs. owners), and given NY MFCU's strong performance in recovering funds, it is not possible to draw conclusions as to whether this is a positive or negative finding in terms of holding providers accountable for poor care. For instance, it is possible that these findings, together, indicate that NY MFCU is holding poorly performing nursing homes accountable at a higher level (by fining owners and operators, rather than convicting lower level employees).

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[42] *Id*. at § 1007.17.

[43] Office of Inspector General, U.S. Department of Health and Human Services, Medicaid Fraud Control Units Statistical Data for Fiscal Year 2014 (February 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2014.asp.

[44] All computations are based on numbers of residents on Nursing Home Compare, as detailed earlier in this report. The precise per capita recoveries are $3597.29 per nursing home resident in NY and $1707.96 per resident in the US (including NY).

MFCU STATISTICAL DATA FOR FISCAL YEAR 2014

State	Investigations[1]			Indicted/Charged			Convictions			Civil Settlements and Judgments	Recoveries[2]			Expenditures		Staff on Board
	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect		Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Alabama	44	16	28	11	7	4	6	4	2	10	$17,988,911.38	$249,298.54	$17,739,612.84	$1,253,192.56	$5,454,050,260.00	10
Alaska	173	160	13	35	35	0	44	44	0	4	$644,325.57	$535,433.49	$108,892.08	$1,105,990.03	$1,546,569,264.00	8
Arizona	309	228	81	54	36	18	40	28	12	4	$538,729.34	$209,276.83	$329,452.51	$2,316,273.90	$9,452,683,998.00	20
Arkansas	108	24	84	15	6	9	22	5	17	15	$2,228,764.66	$127,656.00	$2,101,108.66	$2,454,099.72	$5,154,278,818.00	22
California	1,194	671	523	114	53	61	97	59	38	20	$77,622,974.52	$22,713,170.28	$54,909,804.24	$26,158,835.03	$68,248,444,914.00	193
Colorado	260	255	5	6	6	0	10	9	1	26	$9,999,945.37	$84,090.00	$9,915,855.37	$1,615,524.84	$6,265,152,763.00	17
Connecticut	62	59	3	12	12	0	8	8	0	18	$3,030,886.46	$17,599.12	$3,013,287.34	$1,989,924.12	$7,167,946,629.00	13
Delaware	624	538	86	16	1	15	11	0	11	21	$1,949,633.53	$106,816.07	$1,842,817.46	$1,944,099.15	$1,805,108,123.00	17
D.C.	248	170	78	27	25	2	3	2	1	12	$3,973,338.22	$7,672.48	$3,965,665.74	$2,708,823.90	$2,524,458,778.00	21
Florida	665	600	65	81	55	26	60	42	18	34	$91,867,057.44	$3,989,921.37	$87,877,136.07	$15,506,673.66	$20,818,233,200.00	161
Georgia	414	410	4	4	4	0	9	9	0	23	$48,703,251.01	$7,776,456.19	$40,926,794.82	$4,523,319.47	$9,858,134,878.00	46
Hawaii	68	20	48	9	0	9	10	4	6	8	$3,079,615.23	$61,241.26	$3,018,373.97	$1,301,425.29	$2,049,769,576.00	13
Idaho	124	118	6	9	7	2	11	11	0	10	$801,857.53	$104,933.38	$696,924.15	$656,936.78	$1,692,361,521.00	8
Illinois	311	230	81	56	42	14	76	53	23	23	$90,872,897.09	$1,202,159.97	$89,670,737.12	$7,719,034.17	$17,726,308,920.00	45
Indiana	1,272	941	331	66	55	11	29	22	7	30	$54,591,556.99	$2,324,000.85	$52,267,556.14	$6,119,574.00	$9,600,134,668.00	55
Iowa	270	249	21	48	33	15	44	28	16	16	$24,403,657.64	$987,348.24	$23,416,309.40	$1,020,053.20	$4,110,153,654.00	8
Kansas	101	95	6	28	25	3	16	13	3	22	$27,437,135.25	$150,269.17	$27,286,866.08	$1,330,521.73	$2,933,837,600.00	14
Kentucky	145	118	27	27	14	13	18	14	4	18	$66,222,772.25	$1,141,643.13	$65,081,129.12	$2,989,940.10	$8,017,227,454.00	28
Louisiana	425	366	59	132	118	14	76	65	11	40	$245,305,060.00	$118,815,109.00	$126,489,951.00	$5,134,743.68	$7,337,796,633.00	52
Maine	39	31	8	10	6	4	7	5	2	12	$9,776,295.20	$19,168.00	$9,757,127.20	$728,261.61	$2,528,826,380.00	8
Maryland	314	283	31	13	6	7	12	6	6	22	$41,493,941.04	$48,049.37	$41,445,891.67	$3,510,342.00	$9,625,821,402.00	31
Massachusetts	612	500	112	7	7	0	22	19	3	21	$59,771,098.02	$4,658,134.34	$55,112,963.68	$5,470,721.00	$14,952,760,958.00	41
Michigan	531	483	48	39	32	7	25	17	8	16	$46,562,340.96	$116,478.70	$46,445,862.26	$5,392,508.51	$14,147,522,772.00	33
Minnesota	173	170	3	25	23	2	20	20	0	19	$18,518,275.21	$806,716.32	$17,711,558.89	$1,539,616.87	$10,429,856,324.00	16
Mississippi	668	79	589	34	3	31	41	5	36	11	$17,314,765.90	$299,775.38	$17,014,990.52	$3,318,064.00	$5,016,224,369.00	33
Missouri	230	207	23	10	9	1	8	8	0	23	$8,224,673.47	$176,420.80	$8,048,252.67	$2,047,671.44	$9,238,680,706.00	21
Montana	28	26	2	7	5	2	1	1	0	12	$438,209.11	$26,746.15	$411,462.96	$721,553.25	$1,146,046,567.00	8
Nebraska	130	104	26	16	8	8	7	4	3	15	$10,058,619.95	$19,542.16	$10,039,077.79	$881,048.80	$1,907,477,721.00	9
Nevada	23	21	2	8	8	0	14	12	2	15	$11,292,356.58	$1,080,006.72	$10,212,349.86	$1,887,577.46	$2,431,932,881.00	18
New Hampshire	40	33	7	2	1	1	3	0	3	4	$4,409,810.30	$22,780.47	$4,387,029.83	$724,113.05	$1,420,746,975.00	7
New Jersey	418	395	23	20	15	5	10	7	3	13	$45,632,565.79	$1,105,245.00	$44,527,320.79	$4,442,399.61	$13,193,930,655.00	31
New Mexico	195	192	3	4	4	0	4	4	0	21	$9,389,207.60	$29,693.02	$9,359,514.58	$1,851,072.67	$4,349,892,086.00	18
New York	746	618	128	142	62	80	118	53	65	66	$378,434,543.00	$2,452,239.00	$375,982,304.00	$45,814,464.43	$53,915,930,694.00	294
North Carolina	455	439	16	8	5	3	10	8	2	8	$72,432,176.86	$20,362,132.81	$52,070,044.05	$5,190,480.80	$12,655,046,228.00	44
Ohio	1,190	903	287	149	124	25	102	88	14	32	$71,166,458.65	$4,777,299.91	$66,389,158.74	$8,830,152.53	$20,223,303,745.00	89
Oklahoma	253	186	67	22	14	8	17	9	8	15	$18,368,761.23	$395,659.16	$17,973,102.07	$2,391,463.00	$4,925,190,754.00	22
Oregon	82	69	13	34	29	5	28	26	2	13	$17,025,308.47	$710,316.73	$16,314,991.74	$2,067,043.64	$7,291,147,501.00	15.5
Pennsylvania	328	315	13	66	66	0	46	46	0	12	$5,707,431.30	$1,354,491.20	$4,352,940.10	$5,352,554.37	$24,414,853,435.00	44
Rhode Island	51	32	19	12	5	7	20	13	7	7	$3,677,355.38	$18,417.41	$3,658,937.97	$1,192,427.99	$2,566,378,392.00	11
South Carolina	180	146	34	11	8	3	18	11	7	16	$27,403,805.39	$519,381.02	$26,884,424.37	$1,426,802.68	$5,596,632,601.00	16
South Dakota	49	46	3	1	1	0	1	1	0	6	$3,853,755.60	$566.00	$3,853,189.60	$409,564.00	$840,849,947.00	5
Tennessee	241	198	43	31	15	16	19	14	5	22	$62,298,836.50	$3,979,297.78	$58,319,538.72	$4,053,210.93	$9,654,242,145.00	35
Texas	1,303	1,177	126	122	100	22	90	85	5	17	$106,075,376.19	$82,758,688.05	$23,316,688.14	$16,502,689.27	$32,831,310,090.00	175
Utah	132	115	17	5	3	2	5	3	2	18	$23,725,403.00	$116,355.00	$23,609,048.00	$1,830,431.32	$2,234,539,587.00	13
Vermont	100	82	18	18	18	0	12	12	0	10	$976,625.85	$145,457.00	$831,168.85	$850,205.92	$1,570,053,514.00	7
Virginia	389	373	16	51	45	6	34	30	4	23	$64,755,506.27	$1,758,644.80	$62,996,861.47	$11,757,417.96	$7,980,183,305.00	93
Washington	175	167	8	14	13	1	11	10	1	14	$24,063,857.53	$245,904.04	$23,817,953.49	$3,905,815.00	$7,522,374,478.00	32
West Virginia	125	96	29	20	8	12	9	7	2	17	$19,608,914.14	$4,160,695.44	$15,448,218.70	$1,267,131.57	$3,488,266,696.00	21
Wisconsin	390	383	7	5	5	0	8	7	1	10	$49,010,312.00	$550,803.00	$48,459,509.00	$1,359,678.77	$7,783,215,463.00	12
Wyoming	57	55	2	3	3	0	6	5	1	10	$1,516,673.20	$46,988.59	$1,469,684.61	$485,828.73	$594,519,949.00	4
Grand Total	**16,464**	**13,192**	**3,272**	**1,659**	**1,185**	**474**	**1,318**	**956**	**362**	**874**	**$2,004,245,629.17**	**$293,366,188.74**	**$1,710,879,440.43**	**$235,051,298.51**	**$488,240,409,971.00**	**1957.5**

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Chart: US MFCU Action & Recoveries

MFCU: Discussion and Recommendations

Though it does not provide the level of ongoing oversight for which the Department of Health is responsible, NY MFCU's work is an important and formidable component of the nursing home quality, oversight and accountability "landscape." The Unit's individual nursing home investigations, including hidden camera investigations that have uncovered serious cases of abuse and neglect, have long provided commendable examples of government's ability to protect both residents, who are generally frail and vulnerable, as well as public funds.

Recommendations for MFCU:

1. **Increase investigative capacity**. MFCU should continue and expand its nursing home work, which benefits both residents and taxpayers and delivers a significant "bang for the buck" in terms of resources allocated to the Unit.
2. **Redirect and expand outreach and trainings**.
    a. Expand outreach to the state LTC Ombudsman Program and the new managed LTC Independent Consumer Advocacy Network to learn about problems they are dealing with which may be related to fraud and abuse. This will become particularly important, we believe, as the state implements its transition to mandatory Medicaid LTC for nursing home residents.
    b. Conduct outreach and trainings to other relevant governmental and non-governmental entities to improve their knowledge and use of investigative skills and techniques employed by MFCU. As noted earlier in regard to DOH, MFCU dedicates resources to engaging and training providers. We do not believe that this is appropriate. Providers are already expected – and paid – to provide services that meet or exceed minimum standards. In addition, there are a plethora of both private pay and free, government-based services to help provider who have difficulty meeting standards.[45] We believe that to the extent MFCU allocates staff time and other resources to trainings and outreach, this should be dedicated to improving monitoring and oversight in other state agencies, local agencies and organizations dedicated to helping individuals and families. At a minimum, these entities should be included in any trainings or programs that MFCU provides to the nursing home industry.

[45] For examples, CMS provides services through the Quality Improvement Organizations (in New York, IPRO) and supports (financially and otherwise) Advancing Excellence, the provider industry based quality improvement organization. In addition, many organizations provide educational and other services to providers, including numerous companies that provide trainings focused on improving survey outcomes, avoiding litigation, etc…. **NOTE**: While nursing homes have a range of resources to help them when they fail to meet minimum standards it is important to note that, the vast majority of the time, they continue to receive full reimbursement while providing substandard or worthless services, even when doing so results in harm to residents.

New York State Office of the Medicaid Inspector General (OMIG)

OMIG Activities and Annual Report

According to the mission statement on its website, OMIG is "…an independent entity created within the New York State Department of Health to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste, and abuse control activities for all State agencies responsible for services funded by Medicaid."[46] These activities include:

1. To solicit, receive and investigate fraud and abuse complaints;
2. To pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, illegal or inappropriate acts or unacceptable practices perpetrated within the medical assistance program…;
3. To review and audit contracts, cost reports, claims, bills, and all other expenditures of medical assistance funds to determine compliance with applicable federal and state laws and regulations and take such actions as are authorized by federal or state laws and regulations;
4. To receive and to investigate complaints of alleged failures of state and local officials to prevent, detect, and prosecute fraud and abuse in the medical assistance program; [and]
5. To conduct, in the context of the investigation of fraud and abuse, on-site facility and office inspections….[47]

In its latest annual report[48] for 2013 (issued October 2014), OMIG reported as one of its two "initiatives" for the year that it had issued a warning letter to nursing homes about antipsychotic drug use (jointly with the DOH). "The purpose of the letter was to provide resources to nursing homes that may assist in ensuring appropriate care for residents and compliance with federal regulation 42 CFR §483.25(l), and specifically highlight antipsychotic medications."[49]

It is important to note that the federal standard about which OMIG & DOH issued its "warning letter" has been in place since 1991.[50] The "activities" components of OMIG's 2013 report did not discuss any substantive activities relating to nursing home resident abuse or the fraud that occurs when nursing homes take funds to provide care and fail to provide that care, or provide it at substandard levels. The report *does* include the proceeds from audits conducted of nursing homes and other providers relating to rate issues such as capital costs and bed

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[46] OMIG Vision Plan, Responsibilities of the Office of the Medicaid Inspector General. Accessed March 2015 at http://www.omig.ny.gov/index.php/information/about-omig.
[47] *Id*.
[48] New York State Office of the Medicaid Inspector General, *2013 Annual Report*. Accessed March 2015 at http://www.omig.ny.gov/latest-news/816-nys-office-of-the-medicaid-inspector-general-issues-2013-annual-report.
[49] *Id*. at p.4.
[50] 42 CFR 483.25 - Quality of care, 56 FR 48873, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992; 70 FR 58851, Oct. 7, 2005. Accessed at http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-sec483-25/content-detail.html.

hold payments. The rate audit recoveries by OMIG in 2013 were $39,819,797. The substantial majority of this amount came from nursing home providers.[51] It also discusses auditing that it is performing on the accuracy of nursing homes' MDS (Minimum Data Set) submissions. The MDS is used to evaluate residents' needs and as a basis for nursing homes' rates. OMIG reported that it had "initiated 496 MDS reviews covering both the January and July 2012 census dates." It plans to complete these audits in 2014.[52]

In addition to these activities, OMIG has the authority to exclude individuals from providing care in the Medicaid program (which includes all licensed nursing homes in the country). OMIG can exclude individuals based on its own investigations or those of other agencies, such as the Medicaid Fraud Control Unit (MFCU). During the course of each year, OMIG does exclude many nursing home caregivers, typically nurse aides and licensed nurses who have been found guilty of abuse or fraud by the MFCU.[53]

Fast Facts:

1. 2007: NY OMIG states it will be addressing "adverse events/outcomes and unanticipated deaths."
2. 2014: US OIG studies adverse events; finds that an astounding one in three rehab patients are harmed in nursing homes within about a month of their arrival.
3. 2014: NY OMIG: No known action to address this outrageous and costly problem to date. Addressing "adverse events" no longer in OMIG annual report as of 2013.

OMIG: Discussion and Recommendations

Based on the the important and unique tools that OMIG can "bring to the table" (such as its data-mining and auditing capabilities) and its stated interest in holding providers accountable for providing good care, the output of this agency is disappointing. Almost five years ago, LTCCC met with OMIG staff, including investigators, and were encourage by the depth of investigations about which we were told of nursing homes and, in particular, the use (and mis-use) of antipsychotic drugs. In late 2010, we were informed that OMIG had conducted a review of prescribing practices of atypical antipsychotics for the period 2007-8. This review found that 40% of nursing home residents on Medicaid who had been prescribed this drug "had no diagnosis of psychosis in the twelve months preceding the start of the atypical antipsychotic treatment.[54] Subsequently, we were told that further investigations into antipsychotic prescribing practices were being conducted and that OMIG staff had written a white paper on the

[51] *Id*. at p. 49.
[52] *Id*. at p. 54.
[53] OMIG provides a database of exclusions on its website at http://www.omig.ny.gov/fraud/medicaid-terminations-and-exclusions. LTCCC publishes a selection of these exclusions relating to nursing home caregivers in its quarterly newsletter and on-line at http://www.ltccc.org/enforcements/archives.shtml.
[54] Letter to LTCCC's executive director from OMIG's Deputy Medicaid Inspector General.

problem. However, as noted above, the only output to date relating to this problem (of which we are aware) is the joint letter issued to nursing home providers.

Recommendations:

1. **Overall monitoring and assessment**. OMIG should reinvigorate and strengthen its efforts to monitor and assess program integrity in nursing homes. Nursing home care is, increasingly, a highly sophisticated, profit-driven industry in New York. Numerous state and federal studies, including our own as well as those conducted by other researchers, the US Government Accountability Office and the US Inspector General have consistently indicated that substandard care is a pervasive problem for both Medicaid and Medicare beneficaries in nursing homes. In addition to protecting the welfare of these individuals through on-site investigations, OMIG is uniquely positioned to effectively use data to improve conditions for residents and the efficiency of public funds spent on their care. In New York, 83% of nursing home care is paid for by the public. In 2013, this was approximately $10.8 billion.[55]
2. **Crack down on inappropriate antipsychotic drugging**. OMIG should aggresively investigate and audit antipsychotic drugging practices and hold providers accountable for appropriate prescribing of these medications and related requirements, including those related to medical supervision. To our knowledge, OMIG has never conducted a single audit of antipsychotic drugging in nursing homes or other settings, despite the known, significant dangers to individuals and enormous public expense.
3. **Increase accountability for failure to provide quality care**. In its 2007 annual report, OMIG stated that it "…is incorporating quality of care considerations in its detection and enforcement strategies. These efforts will include assessment of interventions and outcomes, pattern outcomes…, tracking of "never" events, detection of unreported adverse events/outcomes and unanticipated deaths." Seven years later, serious problems relating to so-called "never events" and "adverse events" have garnered significant national attention. For instance last year, the US Inspector General found that an astonishing one in three Medicare (rehab) beneficiaries were harmed in nursing homes within about 30 days. Nevertheless, OMIG has not, to our knowledge, conducted any substantive activities to address the problem in NY State, such as by holding providers accountable when such "events" are the result of substandard (or even wortheless) services. In fact, this provision from the 2007 annual report is absent from OMIG's most recent annual report.

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[55] Data on health spending are from the Kaiser Family Foundation, *State Health Facts,* and are for 2009; see note below for how we estimate current (2013) spending. Accessed February 2015 at http://kff.org/other/state-indicator/health-spending-by-service/#graph. Citing Centers for Medicare & Medicaid Services (2011), *Health Expenditures by State of Provider*. Retrieved (December 2011) at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. **Note**: The CMS website does not provide more recent data for individual states. The $13 billion figure is based on the Kaiser Family Foundation's 2009 number of $11.689 billion adjusted by 11.1%, which represents the increase in annual spending on nursing home care indicated in the CMS national data from 2009 to 2013.

Appendix: Scope and Severity Matrix