

Northeast

The Northeast office uses the definitions from the statute. Examples of general complaints are billing problems and cold food. Sometimes there is a difference between classifications because one complaint grows out of systemic problems (general) while another is a complaint about a specific identified staff member (340).

Buffalo

Buffalo tends to define all complaints about a specific accused individual as a 340 and all complaints that might be systemic as a general complaint.

New York City

New York City uses the definitions from the statute. Many systemic issues are classified as 340s because they technically fall under the definitions in the statute. Examples of general complaints are: verbal abuse, lack of staff, lack of linen, discharge planning and resident rights.

Rochester

Rochester uses the definitions from the statute. Examples of general complaints are: misappropriation of property, understaffing, billing problems, transfer complaints and verbal abuse.

Syracuse

Syracuse classifies using the definitions in the statute. However, the director says that 90 percent of his 340s involve accused individuals. An example of a general would be a complaint of short staff.

New Rochelle

New Rochelle uses the definitions from the statute.

4. Investigation of Complaints

There are differences between the investigation of 340s and generals. By statute and regulation, the investigation for all complaints classified as 340s must follow very specific rules. Investigations of 340s must be initiated on-site within 48 hours of the complaint. An individual who is accused is notified. All 340s sustained at the area office level are sent to the central office for an official decision by a commissioner's designee, who is an individual senior staff member in Albany. Cases unsustained at the area office level or central office are, as required by statute, thrown out.

Investigation of a general complaint has no hard and fast rules and therefore much discretion is given each area office.

All long term care directors state that they send out an

investigator within 48 hours for a 340 unless there is a weather or distance problem (rare). However, some of the directors believe that this is not necessary for all 340 complaints. Some directors send investigators out within 48 hours for some general complaints and some general complaints are held and given to the survey team for the next official survey.

Northeast

While most complaints are investigated on-site, some general complaints such as short staffing without negative outcomes are handled by telephone. Upon arrival in the facility the investigator gives the administration a short written summary of the complaint.

The nature of the problem determines the length of time that elapses before sending out an investigator for a general complaint. It is possible for one or two months to pass.

Buffalo

Most complaints are investigated on-site. The investigator states the general nature of the complaint when s/he arrives at the facility and then goes to the specific unit. S/he tries to interview 3 to 5 residents so that the facility won't know who complained. Family will be interviewed if any member is present in the facility. The complainant, if not in the facility, might be interviewed if more information is needed.

Buffalo sends out staff within 48 hours for a general if it concerns residents not being fed or if residents seem to be in danger. If there is a survey planned for the near future, a general complaint is held and investigated by the team during that survey. Depending on the nature of the complaint, three months may elapse between the complaint call and the survey investigation.

New York City

While most complaints are investigated on-site, some billing and discharge planning complaints are not. When the investigator arrives at the facility s/he states the details of the allegation but does not give the name of the complainant. Family is interviewed most of the time by letter or telephone.

The time lapse between the initial complaint and the investigation of a general complaint depends on the past history of the facility and if the residents involved have been sent to a hospital. General complaints about environmental problems that are not resident specific and/or where no resident harm has been found may wait until the next survey. This decision is made by the survey team.

Rochester

Almost all complaints are investigated on-site. The investigator does not state the nature of the complaint to facility staff when

s/he goes on-site. The time between the initial complaint and the investigation of a general complaint depends on when surveyors or investigators were last in the facility and what they know about the facility. Some complaints can wait longer than others. The staff looks at any other complaints made about the facility. If a family member calls, the staff goes out more quickly and if a resident calls they go out the same day. If it is decided to send the general complaint to the survey team, three to six weeks may elapse between the complaint call and the survey team's investigation.

Syracuse

Although most complaints are investigated on-site, some minor general issues are not. The time between the initial complaint and the investigation of a general complaint depends on the nature of the problem. Syracuse tries to contact all complainants during the investigation.

The staff of Syracuse goes out within 48 hours for a general if a facility is threatening to discharge a resident; if a resident is threatening other residents; if there is no licensed nurse; and if financial trouble is affecting residents such as lack of food because bills have not been paid.

New Rochelle

Most complaints are investigated on-site. Upon arrival at the facility, the investigator states that s/he is there to investigate a problem and gives the general nature of the problem.

New Rochelle sends out staff within 48 hours for a general if it involves danger or everyone is sick. If a general complaint is not serious and the scheduled survey is close enough, it may be investigated at the time of survey. Depending on the nature of the complaint, two months may go by before investigation.

5. The Integration of the PCI Unit and the Survey Teams and Facility Enforcement Decisions

Northeast

After a 340 investigation, the PCI investigator meets with the survey team leader and makes a recommendation for action to be taken against a facility. If both agree, the recommendation is followed.

If a decision cannot be reached, the Director of Long Term Care makes the decision.

Since most general complaints are initially investigated by a surveyor, the team leader makes the decision on what action to take, if any, against the facility.

Buffalo

There is a formal and an informal system of integration in Buffalo. Informally, if an investigator needs more help, she can ask the survey team for additional people to do a focused survey

Formally, if the investigator believes action should be taken against the facility, she writes a draft of the negative finding or deficiency and the Director of Long Term Care reviews the case.

In order to use past investigations as a source of information, surveyors look at the facility file which lists complaints before going out on survey.

New York City

Integration of the PCI unit and the survey staff in the New York City office has long been a problem. A new liaison system has recently been put into place to help integrate the two areas. This system was not in place in 1990.

In 1990, there were only informal procedures for the head of the PCI unit to talk to the head of the long term care unit. The PCI investigations rarely led to any systemic findings.

Rochester

The PCI unit has been trained along with the surveyors and have been out with the survey team.

In order to use information gathered by PCI investigators, a complaint file is kept that is reviewed by the survey team. In addition, surveyors discuss specific issues with the PCI supervisor.

Syracuse

The PCI staff and the survey staff are interchangeable. General complaints are always sent to one individual of the survey team familiar with the facility. S/he goes in separately or with the whole team. PCI staff are allowed to pursue other problems it sees on-site because they are also surveyors.

In addition, one-third of the hospital surveyors were once nursing home surveyors and work closely with nursing home surveyors if there is a connection with a hospital complaint

In order to use information gathered by PCI investigators, the survey team leader is given a list of all complaints against a facility to examine before going into that facility.

The PCI supervisor and the director of the long term care decide together on what action to take. They might decide to issue negative findings, trigger a full or focused survey or to issue a statement of deficiencies.

New Rochelle

General complaints are batched and given to the survey team.

The PCI supervisor reviews all investigation reports to see if action should be taken against a facility.

If a deficiency looks possible, the director of the long term care looks at it to see if it meets the criteria for a deficiency.

In order to use information gathered by the PCI investigators, surveyors look at a complaint file before going out on survey.

SECTION FIVE

FINDINGS:

ANALYSIS OF STATEMENTS OF DEFICIENCIES AND STATEMENTS OF FINDINGS

In order to find evidence of PCI integration with the survey system, each SOD or SOF written after the next survey following the complaints in the random sample were analyzed. Complaints which had directly led to SOFs or SODs were eliminated because these findings already indicated integration. The table below summarizes the findings. The SODs and/or SOFs written by surveyors generally do not refer to any previous complaint. In order to give the area offices the benefit of the doubt in terms of its integration of the PCI system and the survey process, an SOD or SOF was assumed to have been the result of the complaint if it seemed to have any relevance at all to the initial complaint.

TABLE 13
ANALYSIS OF SODS AND SOFS
WRITTEN AT THE NEXT SURVEY

| | NE | B | NYC | R | NR | S | TOTAL |
|-----------------|----|---|-----|---|----|---|-------|
| SODs or SOFs | 3 | 3 | 3 | 1 | 5 | 2 | 17 |

NE= Northeast; B= Buffalo; R=Rochester; NR= New Rochelle;
S= Syracuse.

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SECTION SIX

FINDINGS: INFORMATION ON 340 COMPLAINTS

Only sustained 340 cases that have been brought to conclusion are open to the public. The statute requires destruction of all information surrounding an unsustained 340 case.

Sixty (60) cases were sustained and closed during the time frame of this study (2/90 to 1/91). The author randomly selected 10 of these cases from a list supplied by the Bureau of Administrative Hearings, the office in central office responsible for the prosecution of all individuals accused of abuse, mistreatment and/or neglect, to read to gather information on the integration between 340 investigations and the survey process. There was no attempt to look at these cases by area office.

In addition, the author interviewed the director of the Bureau of Administrative Hearings in June, 1992.

Interview of the Bureau Director

Length of time to conclude a 340 case

According to the director, the length of time taken to investigate and conclude 340 cases is being reduced. Prior to November, 1991, if an area office, after investigating a 340 complaint, believed the case to have merit (be sustained), the case was sent to the Bureau of Long Term Care (BLTC) in the Albany headquarters of the Department of Health. Staff in this bureau would review the case checking to see that all needed information was included and that the case had credible evidence. It was then sent to the Bureau of Administrative Hearings where an attorney made a final check that the case was credible. If the case seemed credible, it was sent back to the BLTC for a decision by a commissioner's designee as to the guilt or innocence of the individual accused. If the designee sustained the case, the accused was offered the opportunity for a hearing.

In the past this procedure in the BLTC took 14 months. According to the director, in 1989, a study demonstrated that New York State took an average of 35 months to complete a 340 case. A new system, "direct referral," which is now used in the Northeast, Rochester and Buffalo area offices, cuts out the role of the BLTC entirely. The area office now sends all sustained cases directly to the Bureau of Administrative Hearings which reviews the case and acts as commissioner designees. The director of this bureau stated that the median time for the 20 cases conducted under this new system was 4 and one-half months. Other area offices will eventually also use the direct referral system.

Goal of a 340 investigation

The goal of a 340 investigation is to "make a case" against the individual accused. The investigators are told to "focus in" on

the case they are investigating and to put all their attention to making a credible case.

Reading Random Selection of 340 Cases

Although this sample is too small to make any generalizations, it does offer some insight into the integration of the information the investigator is gathering with the information gathered by the survey team.

It is clear from the cases read that the investigator's goal is not the same as the goal of a surveyor. Five (5) of the 10 cases alleged neglect by nurse aides. Four (4) of these neglect cases involved an aide who had either forgotten to apply a restraint with the result that a resident fell or did not use another staff member to help when two people were needed to move a resident. All cases involved minor injuries. In each of these cases, the aide admitted that s/he had been forgetful but stated that the facility was short-staffed; s/he was busy; s/he forgot to check the resident's record; s/he did not know the particular resident well. Most of the evidence collected included statements by witnesses and written records of staff training curriculums and attendance sheets, demonstrating that the accused was present at staff training sessions. This written information was collected to help "make the case," proving that the aide had been taught what to do. There is no evidence that the investigator was also trying to "make a case" against the facility. There is no evidence that the investigator makes the assumption that the facility is responsible for the behavior of all of its staff and must be prepared to deal with instances of staff shortage and must train its staff in meaningful ways. One case did include an administrator as a witness stating that s/he knew about the shortage; she said she told staff to change their routines, to forget about making beds; she said she rearranged baths; and she served lunch on each unit instead of in the main dining room. However, there is no indication that the investigator either elicited this information in her/his attempt to check on facility responsibility or checked the administrator's statements. The other cases read have no such information.

The last neglect case concerned an uncooperative resident who hurt himself while being cared for by an aide. Again, the entire focus is on the individual guilt of the aide and not on the facility's responsibility to help aides work with such residents. In addition, in one instance evidence included a copy of a bathing schedule, which happened to have written on it in large letters: *BIBS ON ALL PATIENTS DURING BREAKFAST! There is no note taken of this potential resident rights violation.

The other 5 cases involved 2 physical abuse cases and 3 mistreatment cases. Again, the focus is only on the individual accused.

The two patient abuse cases involved pinching, slapping and throwing covers over the head of the residents. These two cases were thoroughly investigated and clear and credible cases were

made against the staff involved. However, there is no evidence of investigation relating to the administration's role. Were there any other previous problems with the individuals accused? What did the administration do about them? When the individuals were hired, were their references checked? One of these cases does, however, state that other issues regarding other residents who were injured or who had complaints were discussed at the next survey.

The Director of the Bureau stated that he believed that the types of cases found by the author in this small sample was in fact representative of all the 340 complaints the Department of Health receives.

SECTION SEVEN

FINDINGS: ANALYSIS OF LETTERS TO COMPLAINANTS

Each complainant, unless anonymous, is supposed to receive information about the determination of the case s/he reported.

340 Complaints

Unsustained 340 complaint

The statute requires that all information about unsustained cases be expunged. Thus, letters written to complainants about unsustained 340 complaints rarely give any information.

Below is a sample response:

Dear :

In response to your complaint of _____, staff of the _____ Area Office conducted an on-site investigation at _____ on _____ pursuant to the provisions of Public Health Law Section 2803-d.

After careful review of the report of the investigation conducted, it has been determined that there is insufficient credible evidence that patient neglect has occurred regarding _____'s fall on _____.

I am notifying you of the decision to assure you that this office has conducted a thorough investigation into the matter, and carefully reviewed the circumstances surrounding this case. All information relating to any allegations not sustained regarding this report shall be expunged 120 days following this notification in accordance with Public Health Law Section 2803-d, a copy of which is enclosed for you information.

Should you wish more information or to discuss this matter further, please call _____.

Other letters demonstrate how long it takes for a 340 to be closed. Below is a letter from a complainant to the Department of Health:

Dear Health Department Staff

I am enclosing a copy of a letter you sent me back on March 14, 1989. I call to your attention the last paragraph stating that I will be apprised of the final results of the case. In a few days it will be a year since I got that letter. And 4 years since I filed with your department. Is this case still open? If not why was I not informed of the outcome?

The Department's response:

Dear _____:

Dr. Axelrod has asked me to respond to your letter dated March 1, 1990, regarding the above referenced patient abuse investigation.

You have asked for the results of the case and questioned why it has taken so long to fully resolve. As you know, the investigative phase of the case has been completed. The case remains open awaiting the resolution of the due process request. By law, we cannot release any information until the case has been fully resolved. I understand that there has been activity concerning the case, but it is not yet finished. Experience has shown that the disposition of medical cases is particularly time consuming.

Thank you for your letter and your continued patience. You will be contacted by letter once all due process provisions are completed.

What this letter does not say, however, is that if the case is unsustained, as most are, no information will ever be released.

Another letter dated August 8, 1989:

In response to your telephone call of April 27, 1988, the _____ Area Office/Office of Health Systems Management conducted an on-site investigation at the _____ nursing home, pursuant to provisions of Public Health Law Section 2803-d.

The Office of Health Systems Management has completed its investigation of the report. However, we are in the process of complying with additional statutory requirements and, therefore, cannot provide you with any further information at this time.

Once all requirements for due process, as afforded by the legislation have been met, you will be apprised of the final results of the case.

Sustained 340 complaint

Here is a letter informing the complainant that his complaint was sustained:

In response to your complaint, the _____ Area Office conducted an on-site investigation at the _____ nursing home on _____, pursuant to the provisions of Public Health Law Section 2803-d.

The Office of Health Systems Management has completed its investigation of the report and a sustained finding has been rendered by the Commissioner of Health's Designee. However, all persons charged by the Department of Health with violations of Public Health Law Section 2803-d, have the right to request amendment or expungement of the record and/or to request a fair hearing in the matter before an Administrative Law Judge. Therefore, we are in the process of complying with these additional statutory requirements and cannot provide you with any further information at this time.

Once all requirements for due process rights, as afforded by the legislation, have been met, you will be apprised of the final results of the case.

Even though the letter states the complainant will hear more, the complainant will not receive any more information unless s/he contacts the Department of Health.

If a sustained 340 complaint involves a resident abusing another resident or if it does not have an accused identified, the following letter is sent:

In response to your _____ of _____, the _____ Area Office conducted an on-site investigation at _____ nursing home.

The Office of Health Systems Management has completed its investigation of the report which resulted in a sustained determination. The facility has been informed of this determination.

There is no indication of what will be done now and how the same thing can be prevented in the future.

General Complaints

Even though the facts surrounding general complaints are not subject to any legislative rules, some letters to complainants reveal little, if anything, about the investigation of the case.

Unsustained general complaints

Here is an example of a response to a complainant about a unsustained general complaint:

On 7/10/90 the _____ Area Office of Health Systems Management received a complaint from you regarding _____ Nursing Home.

The complaint was investigated by a Nursing Services Consultant on 7/23/90.

Findings

Observations and interviews were conducted on-site with special attention given to the issues you mentioned in your complaint of 7/10/90.

There was no evidence found to support the allegations as stated.

If you have any questions in relation to the findings of the investigation, please contact _____.

Here is another, giving even less information, not even letting the complainant know if the case was sustained:

On 2/5/90 the _____ Area Office of Health Systems management received a complaint from you regarding _____.

The complaint was investigated by a Nursing Services Consultant on 4/10/90.

Findings

Your complaint was investigated and addressed with administrative staff at the facility.

Thank you for bringing this to our attention.

If you have any questions.....

Some give more information:

Dear _____:

On 10/22/90 the _____ Area Office of Health Systems Management received a complaint from you regarding _____.

The complaint was investigated by a Nursing Services Consultant on 10/24/90.

Findings

The investigation consisted of interviews and a thorough review of the medical record, including all PRIs that were done by _____ and by _____. The resident scored SNF level while at _____ Hospital and the nursing home had to acknowledge that PRI for determining placement. Although the resident quickly converted to HRF level, the admission to SNF was appropriate at the time. When the resident converted, she was immediately placed on a priority list for the first available HRF bed. There were no HRF beds vacated at _____ between 8/14/90 and 8/31/90.

A bed hold for 8/13/90 was agreed to and signed for by the family. There is no policy regarding partial payment for discharges prior to noon. The facility is within their rights charging SNF rates while a resident is residing in a skilled nursing bed.

This office was unable to substantiate any violations of the New York State Regulations regarding placement following a PRI done a certified assessor.

Some letters raise the question of whether the case was investigated well or at all.

Dear Mr. _____

May, 18, 1992

This letter is to inform you that we have completed our investigation of your complaint of February 27, 1992 regarding the facility's failure to communicate information on the incident of _____'s fall.

We did not find information to fully support your claim; however, this does not mean that what you reported to us did happen but rather that we were unable to find evidence of what you told us. Our investigation determined that the resident did sustain an injury due to the fall; however, it did not require suturing. On interview, the resident was able to say that she was already out of bed, the siderails were down and she wanted to go back to bed. While attempting to climb into the bed she slipped and fell; she did not call for help or use the call bell. She is generally alert and is independently ambulatory, however, she needs frequent reminding to request assistance.

Here is the complainant's response to this letter:

Dear State Health Department:

Thank you for your letter of _____ informing me of the results of your investigation of _____'s fall out of bed at the _____ nursing home resulting in facial bleeding.

Your report states that _____ is generally alert and is independently ambulatory. Ever since her stroke on July 12, 1991, my sister has been incoherent, cannot read or write and is not ambulatory.

As of this date _____ requires assistance to get in and out of bed. _____ is scheduled to return home the end of this month and requires a 24 hour attendant. Our friends who visit her regularly can attest that _____ is incoherent, and is not ambulatory.

Your report leaves question as to the extent of investigation and to whom you obtained your information.

Sustained general complaints

Here are responses to a sustained general complaint:

On 8/15/90 the _____ Area Office ... received a complaint from you regarding _____ nursing home.

The complaint was investigated by ...

Findings

All of the issues mentioned in your complaint were investigated and addressed with the current administrative staff at the facility.

There is ample evidence found regarding some personnel issues on the 11-7 shift and these issues are being corrected.

Thank you for bringing this to our attention.

If you have any questions in relation to the findings... please contact...

Dear _____:

On 11/16/90 the _____ Area Office ... received a complaint from you regarding _____ nursing home.

The complaint was investigated by ...

All of the issues mentioned in your complaint were thoroughly investigated and discussed with the administrative staff at the facility.

Thank you for bringing this to our attention.

If you have any questions related to the findings...

It is probable that this was a sustained case because the issues were "discussed with the administrative staff at the facility."

Some letters look like they give information when they really do not:

This letter is to inform you that we have completed our investigation of your complaint of patient rights violation. Your mother's right for decent and respectful care was being violated by the medical and nursing staff.

During this investigation we visited the facility, conducted interviews with persons familiar with the situation and reviewed the necessary records pertinent to the issues raised by you.

While we have kept your name confidential, we were able to find information to support your complaint. Our investigation determined that the facility had violated your rights to participate in the care plan for your mother. You should continue to work with the attending physician who is required to keep you informed and to explain the diagnosis which is causing your mother to be so ill. The patient has the right to have copies of his medical record; however, the law is unclear which family members also have this right. You would have to engage your own attorney.

In view of the above we have officially informed the Operator and the Administrator of our findings. We are, unable, however, to take any further action against the facility because these findings alone do not constitute a standard level violation of the State Hospital Code which gives the department the legal authority to take action against facilities which we license.

If you have any additional concerns...This agency has information about Ombudsman Programs and advocacy organizations in local areas of the State to which you can appeal for help in pursuing the issues involved in this complaint case. Enclosed please find a list of other advocacy groups available for assistance.

Even though the letter suggests that the complainant can call if s/he has any questions, the following letter from the complainant in response to the above letter, indicates that this may be a meaningless suggestion:

Enclosed is a letter from _____ of the Department of Health...

I spoke to _____, ..mentioned the letter she wrote me, as I believe it is much too vague. She refused to answer any of my questions, i.e.-

- (1) How was my mother's right for decent care and respectful care being violated by the medical and nursing staff?
- (2) What information was found to support my claim and what was the issues and situations determining the facility violated my rights to participate in the care plan. What are the violations? Who is involved? What are the specifics?
- (3) What about all my other more important complaints? Why weren't these issues addressed in the letter?

The investigation is inadequate....

You could also add that it is unclear what the facility has to do. The only thing the Department of Health has done is to "...officially inform the Operator and Administrator..."

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SECTION EIGHT

DISCUSSION

The ability of the PCI system to be able to investigate all complaints of poor care as they are reported is crucial to enhancing the care monitoring effectiveness of the state. Given the specific concerns raised by consumers, the major objective of this study was to evaluate this capability of the state.

1. The long length of time it takes to make a determination for any complaint.

The long delay in the time it takes to make a determination contributes to the cynicism and frustration of residents, friends and relatives about the meaningfulness of the complaint system as a tool to correct poor care. This may lead to fewer people using this system. If this happens, the state will lose a valuable source of information.

General Complaints

The time from the initial report to the initiation of the investigation is too long

The average statewide length of time taken to begin an investigation is 18 days. This varies from 11 days in Northeast to 26 days in New Rochelle. The PCI system is not responsive enough to protect nursing home residents from systemic harm. Many of the complaints involve issues that could cause serious harm if continued.

When complaints are called in, they generally involve either extremely serious issues or issues that have been unable to be solved at the facility level. Advocates who work with residents, family members and friends with complaints, urge them to speak first to facility staff, unless an issue is life-threatening. If that doesn't work, the advocate agency may call the administrator of the facility to discuss the issue. If that does not work, the complainant is urged to call the Department of Health. Thus, most of the time, when a complainant calls the PCI unit, it is after much time has already passed or an issue is serious enough to need a more immediate response time.

There are too few investigators

The poor response time may be due in part to the fact that the numbers of investigators and inspectors are shrinking as New York State continues to remove resources and public monies from the Department of Health. The number of investigators and inspectors has been reduced almost one-third since 1987. This puts our nursing home residents at risk.

Classifications of complaints make little sense

By regulation, investigations of 340 complaints must be

initiated within 48 hours of their receipt. There are no rules for the initiation of a general complaint. Often, when a complaint is classified, the only difference between a 340 and a general is whether an individual has been accused. The 340 statute focuses on individual culpability. Since content of the complaint and not whether it can be attributed to one individual should be more important, the strict requirement of 48 hours for 340s and no requirements for generals make no sense. Some general complaints are more serious in terms of resident harm than some 340s.

The effectiveness of triaging complaints
varies from area office to area office.

How different area offices set priorities for complaints, deciding which complaint investigations will be initiated before others and which ones will be investigated on- or off-site, varies from office to office.

DLIs. It is clear from our data on DLIs that the suspected DLI, or seriousness, of the reported complaint helps to determine how quickly an investigator will begin her/his investigation. Complaints with higher DLIs are investigated more quickly than complaints with lower DLIs. However, the shortest average time, 12 days, was still not timely for the most serious cases, those with DLIs of 4 or 5.

Poor management. Poor management, coordination and happenstance seems to explain some of the variation seen in different area offices. Some cases, which seem serious, wait weeks or even months and some cases, which do not seem to be as serious, are initiated the same day the complaint comes in.

The time from the on- or off-site investigation to the
completion of the case is too long

It takes the area offices an average of 72 days to complete an investigation. During this time the investigator might consult with other investigators, s/he might conduct one or two follow-up phone calls and write the report.

We might be tempted to blame the long period of time it takes to complete a case entirely on the fact that the Department has lost a large number of inspectors and that those who are left are too busy investigating complaints to sit down and complete a report. However, there are significant differences among area offices in regard to this time period that cannot be explained only by the available number of inspectors and numbers of cases to be investigated. For example, Buffalo, which had 3 investigators for 183 reported cases in 1990, takes, on average, only 27 days to complete each investigation, while New Rochelle, which used its 26 surveyors to act as investigators as well as surveyors for 278 cases, takes 90 days. Northeast, which had 3 PCI investigators for 210

cases, takes 68 days. New York City, which had 16 full and part-time investigators for 328 cases, takes 73 days. Rochester, which had 3 investigators for 96 cases, takes 47 days. Syracuse, which had 2 investigators (rotated from its surveyors) for 145 cases, takes 56 days. Management principles and procedures and organization of the PCI unit and the survey unit may be reasons why some offices are more timely than others.

The time from the completion of the case to the response to the complainant is too long

It takes an average of another 47 days to respond to the complainant to notify her/him of the determination of the case. The complainant, by this time, has been waiting an average of 130 days to learn the determination of the case.

Given the fact, as we have seen, that most of the letters responding to complainants are form letters and give little information, it is hard to understand why this step takes so long. The time for this step seems to have little to do with numbers of investigators or cases needing to be investigated. Syracuse, taking the longest time, waited an average of 99 more days from the completion of a case before responding to the complainant. Many will argue that it is more important to spend time on investigating than in responding to the complainant. That is true, however, the public will use this PCI system less and less, if complainants are not notified in a timely fashion. In addition, this step should be able to be taken in a more timely fashion without placing any undue burden on the investigator.

340 Complaints

This study was unable to examine most of the 340 complaints in order to analyze this issue. However, according to the director of the Bureau of Administrative Hearings at the central office in Albany, the time it takes to close a 340 case is being reduced by the new system of direct referral to legal staff.

2. The low number of sustained complaints.

General Complaints

The low number of complaints that were sustained (only 31 percent in the sample) leads to cynicism and frustration on the part of the public and indicates major problems in the system.

Possible reasons for low substantiation rate across the state

Inadequate investigations. Overall, the evaluators who read the sample cases, disagreed with the resolution reached in 31 percent of the cases they could judge. They believed that the evidence indicated a different decision than the one

reached. In addition, they believed that the investigator did not investigate all aspects of the case in 41 percent of the cases they could judge.

Not interviewing residents and family members. There were many cases in which the evaluators believed that residents and family members should have and could have been interviewed in order to gather the information necessary to make a decision. In addition, there is little indication that the system understands the importance of the primary evidence that a family member or resident, who are complainants, have. Investigators often did not call the complainant back to get further information, or to ask them to respond to other evidence being collected. It was almost as if the investigators ignored the evidence of the complainant, using it only as a starting place. In order for a complaint to be sustained, some other evidence had to be found, hopefully from a staff member of the facility.

Some area office differences and reasons for individual area office sustained rates

Looking at the 2 area offices with the lowest sustained rate and the 2 with the highest sustained rate demonstrates other factors for the low sustained rates.

New York City. New York City had the lowest sustained rate of all the area offices. Some of the causes why may relate to the reasons described above for the whole state. In addition, New York City's low rate may have been affected by the fact that New York City spent the least amount of professional time on each case of any other area office and spent less time on-site than 4 other area offices.

Northeast. Northeast had a sustained rate of only 23 percent. The cases read from the Northeast area office indicate additional reasons for this low sustained rate to those discussed above. These relate to the use of off-site investigations, the lack of resident interviews and not spending enough time on investigations.

Twenty-two (22) percent of all the Northeast sample cases were investigated only by telephone. Of the 6 cases in the sample investigated by telephone to staff at the facility, 4 involved complaints of short staff with either poor care in evidence or with the potential for poor care. According to the cases read, Northeast investigators merely called each nursing home to ask for staffing schedules. Not one of these cases was sustained. The Northeast area office never sustained a complaint investigated off-site. One (1) of the other off-site cases was an allegation that an RN was drunk on duty. The administrator who was called said he would check on this issue. The matter ended there. The last off-site case concerned a resident rights problem. The investigator called both the facility and the relative who complained. S/he tried to work out a solution over the phone.

Northeast also had a lower average of interviewing residents when they could have and should have than any other area office.

Northeast also spent the least amount of professional time on each case than did any other area office. Although the Northeast used the phone to investigate some of its cases it spent much less of its professional time on the telephone than Syracuse, which also investigated some of its cases by telephone.

Buffalo. As noted under the narrative findings section, documentation for Buffalo cases were too sparse to allow for much meaningful qualitative analysis. However, the quantitative analysis of the time spent on the investigation and the method of the investigation indicates that Buffalo, with the second highest sustained rate of all the area offices, spent the most amount of time on-site (4.6 hours) of all the area offices. It also investigated all of its complaints on-site.

Syracuse. Syracuse had the highest sustained rate of all the area offices. Sixty-one (61) percent of all of its complaints were sustained compared to only 31 percent statewide. This rate may be a factor of the professional time spent on each investigation and an ability to use their resources effectively.

Syracuse spent the most professional time investigating the sample cases of all the area offices. Although many of its cases were conducted off-site, by telephone or by reading medical records sent to the office, many were sustained. In fact, 42 percent of its sustained complaints were investigated off-site. An examination of its off-site complaints demonstrates that Syracuse chooses cases to be investigated off-site differently than Northeast or Rochester. Of its 5 off-site cases, 1 involved a discharge because of non-payment and one alleged a unlicensed LPN. It would seem that these 2 cases could legitimately be investigated by telephone.¹ Another case involved the behavior of an individual aide. Syracuse asked the facility to conduct an internal investigation. The evaluator believed that this case should have been investigated on-site with interviews of staff and residents. This case was not sustained. The last 2 cases involved poor treatment decisions. These complaints were sustained through review of medical charts and in 1 of these 2, a telephone call was also made to the complainant for information. Although this method of investigation led to the sustaining of the complaints, the evaluator believed that, by not going on-site, the investigator lost the opportunity to see if the problems were systemic.

340 Complaints

Unsustained 340 complaints were not available for this study. However, even the small sample of sustained cases read demonstrate the lack of the ability of the investigators of

340 complaints to simultaneously make a case against both the facility and the individual accused. If the investigators had been able to do this, some of the unsustained cases where the investigator was unable to attach blame to an individual or where it was found that the circumstances were beyond the control of the individual accused, may have been sustained against the facility.

3. The lack of meaningful integration of the complaint system with the state survey system.

Conditions in nursing homes will not change for the better unless the state takes strong action against facilities found to be responsible for poor care. However, little action is being taken on complaints being investigated statewide.

Investigators can take specific action against facilities directly by writing SOFs or SODs or they can integrate their information with the information gathered by surveyors so that, taken together, this information can eventually generate SOFs and SODs.

General Complaints

Actions Taken by Investigators

Unsustained complaints and complaints that were unable to be sustained at the time of the investigation.

Although investigators can recommend that surveyors follow-up on unsustained cases or complaints that were unable to be sustained at the time of the investigation at a focused survey or at the next scheduled survey, investigators rarely suggested this action. Investigators did not take the opportunity to integrate their information with information gathered by surveyors and missed an opportunity to have any further investigation on almost all of the complaints. Although almost all of the area office directors of long term care at their interview said that surveyors were asked to read files discussing complaints at the facilities they were about to survey, there is no documentation that this is being done. This system of just putting complaints into a file to be read may be too informal a system.

Sustained complaints.

Investigators can write SOFs or SODs for sustained complaints. However, little such action was taken on sustained complaints in the sample. Only 21 percent of the sustained complaints led to SOFs and only 31 percent of the sustained complaints led to SODs. The state took no action, not even a focused survey or a follow-up on the next scheduled survey, on 42 percent of the sustained complaints.

Writing an SOD is crucial to holding facilities accountable. Only if an SOD is written does a facility have to develop a plan of correction and submit it to the area office. Only if a

SOD is written does the area office have to conduct a follow-up visit to monitor correction. However, an investigator can write a SOD directly from a complaint investigation only if the severity (DLI) and/or frequency is high enough. It is possible that the low number of SODs written in the state from complaint investigations is due to the fact that the criteria, using severity and frequency, for writing a deficiency is not appropriate for a complaint investigation. By its very nature and by the constrained amount of time an investigator has to spend on each case, the investigator generally focuses on one event or one resident. Thus, unless the event rates a DLI of 4 or 5, the investigator could not write a SOD. Given this criteria, it is understandable why some of the sustained complaints did not lead to a SOD, however, it is hard to understand why 27 percent of the sustained complaints with a DLI of 4 or 5, meaning harm needing a physician or a harm that is life-threatening, led to no action at all.

In addition, while criteria for writing an SOD is very strict, criteria for writing an SOF in 1990 was very vague. An SOF could be written if an investigator believed that the findings warranted a written record. However, few SOFs were written for sustained complaints, even those with a high DLI.

If an investigator believes that s/he does not have enough information or that her/his sustained findings do not reach the level of an SOF or SOD, s/he could recommend that a focused survey by the survey inspectors take place in the near future or that the survey team should follow-up at the next scheduled survey by looking into the original complaint to see if the problem persists or is systemic. These actions seem to have the best potential for integrating the PCI data with the survey data. However, as noted above, there was little use of any of these actions. Only 2 cases, from Rochester, indicated actual recommendations from investigators to follow-up on the next scheduled survey. There were no recommendations for a focused survey for any of the investigated complaints.

Some area office differences

Some area offices took even less action than others. Northeast took action on only 27 percent of its sustained cases. As noted by the evaluator who read the Northeast sample cases, Northeast investigators seem to believe that their role is to mediate conflicts among residents, relatives and facility staff. It is possible that is why Northeast wrote few SODs and SOFs. This use of mediation may at times be helpful, but it is not appropriate for a regulator. It is the job of the regulator to hold facilities accountable; by acting as a go-between, s/he loses credibility with the public.

New York City took action on 55 percent of its sustained cases. However, no SODs were written for any complaint, even complaints with DLIs of 4 or 5 and only 33 percent of New York City's sustained cases led to SOFs. Much of the other action involved writing letters to the facility.

Buffalo, Syracuse and New Rochelle took the most action on sustained complaints. Buffalo's action on its sustained complaints with DLIs of 4 or 5, however, was difficult to understand. Buffalo wrote 7 SODs and took no action at all for 6 sustained complaints with DLIs of 4 or 5.

Other Types of Integration

Survey findings indicate little integration. Even when the findings of the next scheduled survey were examined to see if the survey team wrote any SOFs or SODs related to the previous complaint investigation, little additional action was seen.

Few indications that investigators are observing other problems. The Department of Health developed a form that an investigator was to fill out and give to the survey unit if s/he observed other possible problems unrelated to the event being investigated. This is an excellent way to make the time the investigator spends in the facility more valuable. However, this form was rarely filled out; only 9 such forms were filled out for our sample of 218 cases. While it is possible that informal sharing is going on, informal sharing is often lost; and, only a formal system can be monitored.

340 Complaints

The investigator may not see systemic problems. The small sample of complaints read does not allow any generalizations. However, some findings, which need further study, can be cited. According to the Director of the Bureau of Administrative Hearings, the goal of an investigator is to "make a case" against an individual. The investigator is told to focus in on the case s/he is investigating. While appropriate for the important job of protecting nursing home residents from individual abuse, neglect and mistreatment, this goal is very different from the surveyor's goal which is make a case against a facility. In addition, by focusing only on the case being investigated, the investigator may miss systemic problems both connected with the case being investigated and unrelated to the case being investigated.

The system of integration is informal. Most of the area office Directors of Long Term Care that were interviewed, indicated an informal system of integrating the information gathered by the investigator of a 340 with the survey team. Investigators meet with a survey team leader to recommend that action be taken to hold the facility responsible. Buffalo seemed to be the only area office which, in 1990, required the investigator to write a draft of any negative finding s/he believed should be written as a deficiency. The Director would then review the case. New York City, in 1991, instituted a new formal structured liaison system between the PCI unit and the survey section. Although advocates believe this is a positive step, many questions have been raised about its implementation. There is a need to study this new process to see if it will help integrate the two parts of the state's monitoring system.

The statute governing 340s may be hampering the entire complaint system. As we have seen, that although the statute defines the types of abuse, neglect and treatment that is covered by law, some area offices classify complaints as 340s, not upon the definitions, but only if an individual is accused. Many of the examples given as general complaints in Section Three seem to fit the definitions of 340s as described in the law. To the extent that the statute narrows the focus of the complaint to individual culpability, it ignores the existence of systemic problems. The statute encourages correction on a case by case basis rather than correcting facility-wide issues by holding the nursing home provider accountable. In addition, by its requirement to destroy all information from unsustained cases, the law removes both oversight by the Department of Health and by the public of systemic issues.

- (4) The poor communication between the Department of Health and the complainant.

The sample 340 and general complaint letters indicate that most complainants wait a long time to get little information and often that information is that no evidence of a problem was found.

SECTION NINE

RECOMMENDATIONS

1. Reducing the length of time it takes to initiate an investigation of a general complaint.
 - a. Develop clear and consistent statewide criteria for deciding when an investigation will be initiated. Reasonable limits must be set. The open-ended system, where no limits are set, does not seem to work. Some investigations are not being initiated in a timely fashion. Setting workable limits will also aid supervisors conducting oversight.
 - b. Develop clear and consistent statewide criteria for deciding when, in rare cases, an investigation may be conducted off-site.
 - c. Review the 340 statute. Decisions when to initiate an investigation should depend upon the nature of the complaint, not on whether a complaint accuses an individual. The 340 statute is a reporting law. It requires reporting of certain types of incidents. It has little to say about how the investigation system should work. Regulations based upon the law require only complaints classified as 340s to be investigated within 48 hours; however, often complaints are classified as 340s only because an individual has been accused. An attempt should be made to set priorities of how quickly to initiate an investigation based upon the harm or potential harm to residents regardless of whether it is a systemic problem or a situation where an individual is accused.
2. Reducing the length of time it takes to complete a general case.
 - a. Develop an uniform reporting system that all investigators must use when they write the narrative portion of the case. This system should include forms that reduce the amount of writing, yet include enough information to both prove a case and allow oversight by supervisors.
 - b. Mandate a specific time frame for a case to be complete. This time frame must encompass the time the complaint is received to the time the complainant is notified.
3. Reducing the length of time it takes to respond to complainants.

Set up a clerical routine that will send out letters within a few days of the completion of a case.
4. Focusing on methods to reduce the number of unsustained cases.

a. Review the 340 statute.

1. The statute, with its focus on reporting and individual culpability, diverts attention from systemic problems and defects, which, if left uncorrected, threaten harm to all residents. The state needs a comprehensive, integrated complaint/surveillance system which must be oriented towards finding systemic problems as well as finding individual culpability. Unless an individual staff member has committed a criminal act, the facility is responsible for her/his behavior. If the approach to sustaining complaints is not broadened to look at systemic issues as well as issues relating to individual acts, the system is reduced to solving problems on a case by case basis without helping to protect all the residents in the facility.

2. The requirement to destroy all information from a case where an individual has not been found guilty, limits the amount of oversight that can be conducted by both the Department of Health and by the public. If such information, without reference to the individual found innocent, was allowed to be kept, the Department of Health would be able to build a system for tracking all complaints (sustained and unsustained) and would be able to integrate such a system into the surveillance system.

b. An independent committee should be formed, consisting of a majority of members representing consumer interests to regularly review the operation of this complaint/survey system.

c. Conduct more meaningful training of investigators and survey staff.

1. Surveyors and investigators should be trained to both investigate individual cases and to survey care for systemic problems.
2. Training should make use of outside resources such as relatives and residents.
3. Training should include direction on how to interview alert residents and how to gather information from confused residents.
4. Train investigators and surveyors in their role as regulators. They are to hold facilities accountable.
5. The goals of the investigation of 340s must include making a case against the facility as well as the individual.
6. Supervisors should be available to help train on-site.

- d. Interviews of known family and/or friends of non-alert residents must be mandatory. This interview can be conducted over the telephone if necessary.
 - e. Lengthen the time that investigators are on-site. The average time on-site in this study was too short a time to accomplish all that needs to be done.
 - f. Develop a strong internal quality assurance system, with the computer support necessary to generate timely area office findings similar to those used in this study, to evaluate cases which are not sustained. To date, most review of investigator work is done on cases that have been sustained. Cases that are unsustained at the area office level are not reviewed toward an eye to evaluate the investigation and to decide whether the complaint should have been sustained. With such low rates of sustaining, this must be done by both the Bureau of Long Term Care for general complaints and the Bureau of Administrative Hearings for 340s.
 - g. Require that each investigator interview complainants who are residents or family members, during and at the end of the case to ask for more information and to ask for a response to other information the investigator has gathered. This complainant is the primary source of information. Require investigators to put more weight on this complainant's evidence.
 - h. Inform residents and relatives about the complaint process. Develop educational material that clearly explains the system. Meet with resident and relative councils.
5. Increasing the accountability of facilities for systemic problems in sustained cases.
- a. Review all action taken on sustained cases to see if the action taken, or not taken, was appropriate. Make this a major part of the newly developed internal quality assurance system. Collect and send out information similar to that gathered by this report for area office analysis.
 - b. Require investigators to give a written explanation if they recommend no action in a sustained case.
 - c. Review the use of the DLI criteria with the complaint system.

Unless investigators are trained and are given more time on-site to expand their focus from one specific case to systemic problems, the use of the DLI criteria is inappropriate. New criteria should be:

- 1. Mandate a SOD for any sustained complaint with a DLI of 4 or 5.

2. Consider the automatic triggering of a focused survey if a complaint sustains a certain number of DLIs of 3.
3. Review the use of the DLI of 2. Compare various complaints which received a DLI of 2 to see if they are comparable. Often this classification does not seem to discriminate between types of complaints very well. This is especially true when used with resident rights and quality of life complaints.
- d. Require formal follow-up, for any sustained complaint, on the next scheduled survey. Require documentation by the survey team, demonstrating how the team reviewed the complaint.
- e. Require that 340 investigators start with the premise that facility administration is responsible for the actions of their staff. They must gather information relating to facility accountability as they gather information against an individual.
- f. Release publicly lists of all sustained complaints with and without action taken for public oversight.
6. Strengthening the integration of the complaint system with the survey system.
 - a. Create a formal structured system for the sharing of information that can be monitored by the internal assurance system.
 - b. Allow PCI investigators to write SOFs and SODs without getting agreement with the survey team.
 - c. Mandate clear and consistent statewide criteria for focused surveys or follow-up surveys and follow all complaint investigations.
 - d. Mandate that information gathered on complaint investigations be included in the formal preparation of a survey team before it goes into a facility.
7. Improving communication between the PCI unit and the complainant.
 - a. Develop a check system for letters written to complainants that includes:
 1. relates findings of all parts of the complaint.
 2. lets the complainant know what the findings are and what will be done about any sustained findings by the facility and by the Department of Health.

3. specificity about the complaints that were investigated.

Parts of this letter can still be a "form letter," but other parts must be individualized.

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

FOOTNOTES

- 1 Public Health Law Section 2803-d. See Appendix G for a copy of the law.
- 2 A negative finding is a sustained complaint. This means that the investigator had determined that an individual and/or a facility has done something wrong.
- 3 SOFs are no longer being used in the survey and investigation systems. Surveyors are told to write a negative finding sheet (NFS) listing every negative finding with its assigned DLI. Although investigators are supposed to follow the same procedures, it is unclear at this time if this rule is being followed. However, theoretically, all findings will now be listed for each investigation.
- 4 The sample includes cases initiated no earlier than February, 1990. A uniform system of collecting information was not started by the Health Department until February, 1990. Since, by law, all information from unsustained 340 complaints must be destroyed, the only cases open to the public include sustained 340 cases. There were only 60 closed and sustained cases during the time period being studied. It was decided to generally limit this analysis to general complaints. A discussion related to 10 randomly selected 340 closed and sustained cases will be discussed in a later section.
- 5 This random sample was drawn from a list of 1240 general complaints received from the Department of Health listing all the general cases reported from February, 1990 to January, 1991.
- 6 Due to an impending vacancy in the director's position, the head of the PCI unit was substituted for the director in New York City.
- 7 Some tables will refer to cases and some will refer to complaints. Cases are made up of complaints. Each case may contain more than one complaint.
- 8 Investigators have the following choices on the forms for a resolution of a complaint: sustained, unsustained, SOF, SOD and Trigger Survey. The investigators are instructed to mark a complaint, "sustained" without marking any other choice, if the complaint has merit from the complainant's perspective, but does not meet the criteria for an SOF or SOD. The investigators are instructed to mark SOF or SOD only for a complaint that does meet the criteria for an SOF or SOD.
- 9 Findings related to SODs discussed in the next section, demonstrates little integration.