# Nursing Home Residents at Risk

## Failure of the New York State Nursing Home Survey and Complaint Systems

Written by…

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# EXECUTIVE SUMMARY

## BACKGROUND

### Introduction

Many studies have indicated the need to improve the quality of care to our country's nursing home residents. Residents depend on the government to hold nursing home providers accountable for the care they receive by identifying problems accurately that need correction during regular inspections and when they perform investigations of complaints.

The ability of the surveyor to accurately identify problems is crucial for vulnerable nursing home residents. Unless such problems are identified, and rated accurately, they will not be corrected. If a surveyor determines that a facility does not meet certain criteria of care or safety, a deficiency or citation is given. The surveyor then rates the severity (seriousness) and scope of each citation. The accuracy of the determination of scope and severity is very important as it determines how serious the citation will be viewed by the facility, how quickly it needs to be corrected and the type of penalty that might be imposed. Unfortunately, recent studies have indicated nationwide problems related to the identification and ratings of nursing home problems.

### Purpose of this Study

Given the problems found nationwide, this study was conducted to analyze the effectiveness of New York State Department of Health's (DOH) nursing home inspection and complaint systems.

### Methodology

Project staff analyzed a number of different quantitative data. In addition, a random sample of 5 percent of the findings of the latest surveys in each region of New York State was analyzed for sources of findings and scope and severity of each citation.

## FINDINGS: NY STATE NURSING HOME RESIDENTS AT RISK

### NY STATE DOES NOT IDENTIFY NURSING HOME PROBLEMS VERY WELL

#### Findings demonstrate that federal surveyors write many more deficiencies when inspecting the same nursing homes.

In order to monitor DOH's survey competency, the federal government conducts a number of "comparative" surveys. These are surveys, conducted by federal surveyors, inspecting a facility a few weeks after DOH has inspected the same facility. Over a three-year span, ***Federal inspectors identified over four times the number of violations than did DOH for the same homes.***

#### NYS compares unfavorably to other states.

NYS writes fewer deficiencies per facility than 38 other states and finds more of its facilities deficiency-free than 36 other states.

#### Low staffing levels do not mean more staffing deficiencies in NYS.

The data indicate that although NYS staffing levels are below the national average, the percent of NYS facilities cited for insufficient staff is way below the national rate. While on average, 3 percent of the nation's facilities were cited for insufficient staff, NYS cited only 0.2 percent. In addition, project staff analyzed deficiency writing in a random sample of 5 percent of all surveyor findings in NYS for the most recent surveys. There were a number of examples where, in the opinion of the evaluators, a facility should have been cited for having insufficient staff in addition to another citation.

*An example…*

> One of the homes was cited for not providing sufficient supervision to prevent accidents. The resident involved had diagnoses which included dementia, swallowing difficulties, diabetes and congestive heart failure. The care plan required the resident to be sitting up when fed. The surveyor observed the resident, coughing, lying in bed with her knees leaning to the side while being fed. The aide said she did not get the resident up because there was not enough help to get all the work done. The charge nurse agreed and said that staffing was a concern and "that some days everything could not be done as it should." No deficiency was written for insufficient staffing.

**NYS's complaint substantiation rate is lower than 40 other states.**

NYS substantiates only 21.5 percent of the complaints it investigates while the national average is 30.9 percent. In addition, the percent of complaint cases in which nursing homes were actually cited for violations of federal and/or state regulations is only 5.9.

## • NYS DOES NOT RATE DEFICIENCIES IN TERMS OF SERIOUSNESS AND IMPACT ON RESIDENTS VERY WELL

After it is determined that a deficiency exists, an assessment of the effect the deficiency has on resident outcome (severity level) is made as well as a determination of the number of residents potentially or actually affected (scope level).

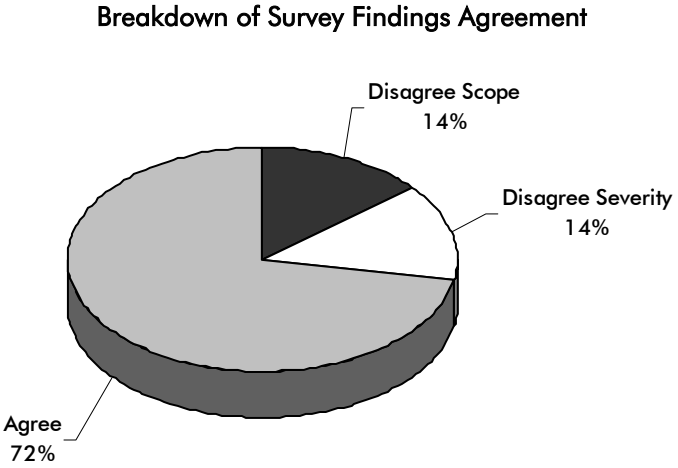
**Federal surveyors rate many more deficiencies as causing harm or putting residents in immediate jeopardy and rate many more deficiencies as being widespread or forming a pattern of problems than NYS surveyors inspecting the same nursing homes.**

**NYS compares unfavorably to other states when rating severity and scope.**

Although nationally surveyors are writing very few harm or immediate jeopardy deficiencies, NYS writes even fewer. NYS rates most of its deficiencies at the isolated potential for harm level of occurrence and severity and is way below the national average for citing deficiencies as widespread.

**NYS surveyors are underrating deficiencies in terms of severity and scope.**

Our analyses of deficiency writing disagreed with their ratings 28 percent of the time.



One of the areas where we had disagreement with the surveyor was related to psychosocial harm. Often, the surveyor did not seem to see this as harm, only the potential for harm.

*An example…*

> A competent resident was found to be hard of hearing and a hearing evaluation was ordered. The evaluation recommended a hearing aid. Ten months later the surveyor found that the resident had never received her hearing aid. The deficiency written was categorized as not causing harm.

## DISCUSSION

### DOH's Failure

The ability of NYS surveyors to identify issues that demonstrate violations of state and federal rules and to accurately categorize them in terms of their severity and scope is crucial to the state's vulnerable nursing home residents. The findings of this study indicate that NYS is failing in this job a significant amount of time and putting many nursing home residents at risk. The reasons for this are varied. Although this study did not specifically address the reasons below, we urge the state to examine and address these issues, which we believe could greatly improve the state's surveillance and complaint systems.

- There has long been a concern that there are not enough well trained surveyors and investigators to do the job. This may be part of the problem.
- Consumers have also been concerned that the message from "above" has been not to "burden" business owners such as nursing home operators. Thus, surveyors may tend to overlook certain things.
- DOH may not be conducting competent oversight and monitoring of its surveyors and inspectors.
- Facilities often figure out when they will be inspected and prepare for the survey.
- Surveyors do not inspect on "off-times" such as weekends, in the evenings and nights enough. It is during these times that many consumers see problems.

The study did find data raising two other issues that might account in part for NYS's failure to identify and appropriately rate deficiencies: lack of resident and family interviews used by surveyors to document deficiencies and surveyor intervention in situations where she/he felt it was necessary. While appropriate, intervention may have limited the number of cases where harm would have been found. What might have happened if the surveyor was not present?

### Federal Definitions of Severity and Scope

Appendix B details the definitions and guidelines for surveyors who must categorize each deficiency found. We found a number of problems using this information to categorize the deficiencies in our sample of NYS surveyor findings.

- Federal definitions of severity and scope are too vague.
- Federal guidelines are too broad and too many dissimilar types of deficiencies can fit into each category. This prevents proper identification of the problem and proper corrective action on the part of the facility. Project staff observed multiple scope inconsistencies by surveyors when determining "isolated," "pattern" or "widespread."

- Federal guidelines require surveyors to cite deficiencies based upon the greatest severity case that occurred. We believe that this federal requirement misrepresents the true problem. Categorizing a deficiency at an isolated level because only one resident was harmed ignores the other residents whose severity rating was lower than harm. The categorization of pattern is as important as citing harm as it relates to correction.
- In the survey findings analyses there were some instances where surveyors noted a residence was receiving a "repeat deficiency," meaning they had been cited for the same deficient practice on a previous survey. Currently we believe that there is no federal instruction related to raising the level of severity or scope if a deficiency is a repeat. Thus, in a number of instances, repeat deficiencies were categorized at the same level of severity and scope.

## RECOMMENDATIONS

### DOH should:

- Develop a better quality assurance system to evaluate survey findings. DOH staff should:
  - Analyze samples of deficiencies on a regular basis. Are they appropriately cited?
  - Look specifically at numbers of widespread ratings.
  - Look specifically at deficiencies rated at the potential for harm category.
  - Evaluate each survey team and survey – are there any patterns?
  - Evaluate federal comparative surveys. Meet with state surveyors and discuss federal findings. Find out why state surveyors did not identify the deficiencies the federal surveyors did.
- Conduct better training specifically related to identifying deficiencies and appropriately rating severity and scope – give many examples in training workshops. Have surveyors do a number of different exercises.
- Focus on the need to cite insufficient staff.
- Help surveyors understand psychosocial and mental harm as well as physical harm.
- Require more resident and family interviews.

### Federal guidelines should be changed. CMS should:

- Define categories more narrowly. Federal guidelines need to either be separated into more distinctive categories and/or need to better define terms, such as "minimal harm" or "limited consequence." The current guidelines allow for too much variation across surveyors and make varied outcomes indistinguishable from one another. Better representation of deficiencies will aid in quality control methods because it will be easier to identify where surveyors are having assessment difficulties. Perhaps categories and definitions can be determined through an expert panel of providers, consumers, and government representatives.
- Require two different ratings if a pattern or widespread exists and only one or few residents are harmed or in immediate jeopardy, rather than require only one rating of isolated harm or jeopardy.
- Have a separate category for repeat violations and separate requirements for facilities to correct.

# NURSING HOME RESIDENTS AT RISK: FAILURE OF THE NEW YORK STATE NURSING HOME SURVEY AND COMPLAINT SYSTEMS

## BACKGROUND

Many studies have confirmed the need to improve the quality of care to our country's nursing home residents. Elderly and disabled nursing home residents are among the sickest and most vulnerable of long term care recipients. The US General Accounting Office (GAO, now known as the Government Accountability Office) has reported that 15 percent of the nation's approximately 17,000 nursing homes, which it believes is an unacceptably high proportion, had repeatedly caused actual harm to residents, such as worsening pressure sores or untreated weight loss, or had placed them at risk of death or serious injury. (See U.S. General Accounting Office, Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit, GAO/HEHS-99-157, Washington, D.C., June 30, 1999).

All nursing homes giving care to Medicare and/or Medicaid residents must be certified as meeting certain federal requirements. This certification is achieved through routine facility surveys, which the Federal Centers for Medicare & Medicaid Services (CMS) contracts with states to perform.

The New York State Department of Health (DOH) has the responsibility of monitoring the quality of care of the approximately 117,000 people residing in the state's nursing homes. Most nursing home residents are chronically ill, in their mid 80's and generally need extensive help with activities of daily living such as eating, walking and going to the bathroom. Nursing home residents in NYS include the frail elderly with chronic disabilities, infants with multiple impairments and young adults suffering from traumatic brain injury or other physical disabilities. DOH's surveyors, or inspectors, examine the quality of care in the homes once a year on average (within 9 to 15 month intervals) to determine whether facilities have met state and federal standards of care. In addition, they may investigate complaints they receive in between surveys.

The vulnerable residents in our state's nursing homes depend on the state to hold nursing home providers accountable for the care they receive by identifying problems that need correction during regular inspections and investigations of complaints.

The ability of the surveyor to accurately identify problems is crucial. Unless such problems are identified, and categorized or rated accurately, they may not be corrected. Deficiencies are written by a surveyor when he or she finds that a facility does not meet a standard of care. The surveyor then rates the severity (seriousness) and scope of each citation. The severity is the surveyor's assessment of the impact the deficiency might or does have on a resident and scope is his/her determination of the number of residents potentially or actually affected. Does the deficiency have the potential to cause more than minimal harm? Has it caused harm? Has it put residents into jeopardy? Is it isolated, a pattern or widespread? The accuracy of the determination of scope and severity is very important as it determines how serious the citation will be viewed by the facility, how quickly it needs to be corrected and the type of penalty that might be imposed.

### National Research

Recent studies have indicated nationwide problems related to the identification and ratings of nursing home problems. The US Government Accounting Office (GAO), referring to states across the country, stated in July, 2003:

> The continuing prevalence of and state surveyor understatement of actual harm deficiencies is disturbing. For example, 39 percent of 76 state surveys from homes with a

history of quality-of-care problems—but whose current survey found no actual harm deficiencies—had documented problems that should have been classified as actual harm or higher, such as serious, avoidable pressure sores.[1]

This report also stated that significant weaknesses in federal and state nursing home oversight that GAO has identified in a series of reports and testimonies since 1998 included periodic state inspections that understated the extent of serious care problems, and considerable state delays in investigating complaints alleging harm to residents. Most state agencies did not investigate serious complaints filed against nursing homes within required time frames, and practices for investigating complaints in many states may not be as effective as they could be. The report went on to discuss a CMS review of states' timeliness in investigating complaints alleging harm to residents. It revealed that most states did not investigate all such complaints within 10 days, as CMS requires. Additionally, a CMS-sponsored study of complaint practices in 47 states raised concerns about state approaches to accepting and investigating complaints.

Another study, conducted in 2004 detailed each state's deficiency record from 1997 through 2003. The data demonstrate a sharp drop in the percent of facilities that received one or more deficiencies that caused harm or immediate jeopardy from 2000 to 2003. (See, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003*. Harrington et al, Department of Social and Behavioral Sciences, University of California.) The authors point to other studies indicating an understatement of serious problems, rather than an improvement in care.

A recent study looked specifically at one state, Minnesota. A study by the Office of the Legislative Auditor, State of Minnesota (*Nursing Home Inspections* (Evaluation Report), Report No. 05-05 (Feb. 2005) 9) states that while state surveyors have cited more deficiencies, the severity of deficiencies has declined. As part of the study, a sample of 100 nursing home inspection reports was reviewed. The findings showed that inspectors were generally consistent in classifying the seriousness of the deficiencies that they identified. However, inspection teams tended to understate the seriousness of deficiencies more often than they overstated it—generally in respect to the number of residents or staff affected by a deficiency.

## PURPOSE OF THIS STUDY

Given the importance of identifying nursing home problems and the issues found nationwide, this study was conducted to analyze the effectiveness of New York State's inspection and complaint systems in comparison to other states as well as to evaluate our state's ability to identify problems, and appropriately rate the seriousness and scope of the impact of these problems.

## METHODOLOGY

Project staff analyzed a number of different quantitative data. We reviewed deficiency and complaint data for all states for the time period of October 1, 2003 to September 30, 2004 received from CMS. This included scope and severity findings, complaint substantiations and percent of deficiencies in selected standards. In addition, we reviewed CMS information illustrating differences in survey findings between federal surveyors and New York state surveyors inspecting the same facilities within a few weeks of each other. Data reported by Harrington, Carrillo and Crawford in, "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003" was also analyzed as well as information from CMS's website, *Nursing Home Compare* and DOH's website.

[1] See, GAO report: Nursing Home Quality: Prevalence of Serious Problems Remains Unacceptably High, Despite Some Decline.

In addition, a random sample of 5 percent of the findings of the latest surveys in each region of New York State was analyzed for sources of findings and scope and severity of each citation. See Appendix A for a detailed description of the methodology.

## FINDINGS

### I. Identifying Deficiencies: How Well Does The State Identify Problems And Write Deficiencies?

Our analysis of the data indicates that NYS does not identify as many violations of federal and state rules as other states or as many as they should.

#### Federal "Comparative" Surveys

***Federal surveyors write many more deficiencies when inspecting the same nursing homes.***

In order to monitor DOH's survey competency, CMS conducts a number of "comparative" surveys. These are surveys, conducted by federal surveyors, inspecting a facility a few weeks after DOH has inspected the same facility. Table 1 shows the findings for these surveys for the years 2002, 2003 and 2004. CMS inspectors identified over four times the number of violations than did DOH for the same homes.

Federal surveyors do relatively few comparative surveys. Thus, they find the problems missed by the state in only a few cases. This raises the question: how many other problems are being missed by state inspectors? How many residents are at risk?

Table 1

| | DOH | | CMS | | |
|---|---|---|---|---|---|
| Residence | Date | Def | Date | Def | Days Between Surveys |
| 1 | 2/27/2002 | 5 | 3/15/2002 | 12 | 15 |
| 2 | 3/21/2002 | 0 | 4/19/2002 | 8 | 28 |
| 3 | 5/3/2002 | 2 | 6/14/2002 | 1 | 41 |
| 4 | 10/25/2002 | 3 | 11/18/2002 | 13 | 21 |
| 5 | 2/28/2003 | 3 | 3/31/2003 | 11 | 30 |
| 6 | 5/29/2003 | 3 | 6/20/2003 | 11 | 21 |
| 7 | 8/22/2003 | 1 | 9/22/2003 | 16 | 30 |
| 8 | 9/3/2003 | 2 | 10/31/2003 | 13 | 29 |
| 9 | 10/22/2003 | 5 | 11/21/2003 | 9 | 29 |
| 10 | 11/26/2003 | 0 | 1/2/2004 | 4 | 37 |
| 11 | 7/9/2004 | 2 | 7/30/2004 | 14 | 20 |
| 12 | 9/16/2004 | 2 | 11/19/2004 | 7 | 63 |
| Total (12 Homes) | | 28 | | 119 | |
| Avg. # of Def. Per Facility | | 2.33 | | 9.92 | Avg. Days Between Surveys = 30.33 |

#### National Research

***NYS compares unfavorably to other states.***

NYS writes fewer deficiencies per facility than 38 other states and finds more of its facilities deficiency-free than 36 other states. In addition, the trend in NYS over three years (2001, 2002 and 2003) was the opposite of the national trend. Over these years the average number of deficiencies per

facility written by NYS surveyors went **down** while the national average went **up**. A similar comparison can be made about facilities with no citations. The percent of facilities without any deficiencies identified by NYS surveyors went **up** while the national percentage went **down.** [2]

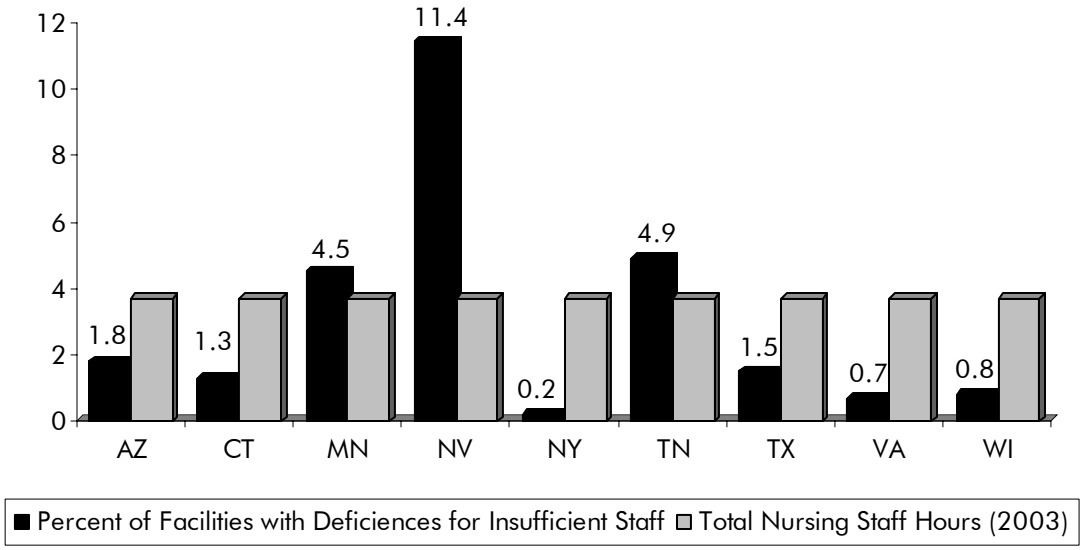
## Staffing Levels and Deficiencies

***Low staffing levels should lead to more deficiencies.***

When looking specifically at a characteristic such as staffing levels, the data indicates that although NYS staffing levels are below the national average, the percent of NYS facilities cited for insufficient staff is way below the national average. Identifying deficiencies in staffing is crucial. According to a CMS report, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (Phase II Final Report, December 2001), there is a clear relationship between quality and critical minimum staffing levels.

New York's average nursing staff levels is below the national average at 3.5 hours per resident per day.[3] The staffing standard called for by the National Citizens' Coalition for Nursing Home Reform, a consumer advocacy organization, in order to give "sufficient" care and validated by the CMS study is much higher at 4.13 hours per resident per day. Given the low staffing levels in NYS homes, one would expect more deficiencies related to insufficient staff to have been written. While on average, 3 percent of the nation's facilities were cited for insufficient staff, NYS cited only 0.2 percent.[4] We compared NYS's record of deficiency writing for insufficient staff with the eight other states with the same staffing level. In this group, NYS cited the fewest number of facilities.

Figure 1
Total Nursing Staff Hours and Percent of Facilities With Deficiency for Insufficient Staff




[2] Harrington, Charlene, Ph.D., Carrillo, Helen, M.S.& Crawford, Cassandra, M.A., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003, Department of Social and Behavioral Sciences, UCSF, August 2004. See Appendix C for a detailed table of this data.

[3] Ibid.

[4] Ibid.

Table 2 shows that the average percent of facilities cited for insufficient staffing for the eight states is 3.01, similar to the national average. NYS is far fewer at 0.2 percent.

Table 2

| | Total Nursing Home Hours | Percent of Facilities with Insufficient Staff Deficiencies |
|---|---|---|
| US Average | 3.6 | 3 |
| Group Average | 3.5 | 3.01 |
| NY | 3.5 | 0.2 |

## Evaluation of DOH Survey Findings

***NYS surveyors are not citing insufficient staff where appropriate.***

Project staff analyzed deficiency writing in a random[5] sample of 5 percent of all surveyor findings in each NYS region for the most recent surveys. There were a number of examples where, in the opinion of the evaluators, a facility should have been cited for having insufficient staff in addition to another citation. Below are some of these examples.

- One of the homes was cited for not providing sufficient supervision to prevent accidents. The resident involved had diagnoses which included dementia, swallowing difficulties, diabetes and congestive heart failure. The care plan required the resident to be sitting up when fed. The surveyor observed the resident, coughing, lying in bed with her knees leaning to the side while being fed. The aide said she did not get the resident up because there was not enough help to get all the work done. The charge nurse agreed and said that staffing was a concern and "that some days everything could not be done as it should." (See Appendix D, Buffalo Regional Office # 1, F324).
- A surveyor[6] cited a different facility for medication error rates. During her interview with the surveyor, the medication nurse stated, "the medication pass is very difficult to complete [on time], and is frequently late." Here too, no citation was given for insufficient staff. (See Appendix D, Syracuse Regional Office, #2, F332).

## Complaints

***NYS's substantiation rate is lower than 40 other states.***

DOH investigates any allegation it receives that suggests a nursing home has violated federal or state regulations, or has provided inadequate care to its residents. Data from CMS on complaints clearly illustrates NYS's difficulty in substantiating and citing facilities for violations. NYS substantiates only 21.5 percent of the complaints it investigates while the national average is 30.9 percent.[7] And, according to the DOH website (March, 2005) the percent of complaint cases in which nursing homes were actually cited for violations of federal and/or state regulations is only 5.9. This would seem to indicate that many homes where complaints have been substantiated were not cited for any violations.

[5] In 7 cases, no deficiencies were written. Seven new findings were substituted. These findings were chosen by the number of deficiencies. See Appendix A for documentation that the both the random sample and the replacement sample is similar to CMS data for all findings in NYS.

[6] Findings are written by a survey team. We will use the term "surveyor" to mean the entire team.

[7] CMS data. See Appendix C for the table showing substantiation rate for complaints by state.

## II. Rating Deficiencies: How Well Does NYS Rate Seriousness And Impact On Residents?

After it is determined that a deficiency exists, an assessment of the effect the deficiency has on resident outcome (severity level) is made as well as a determination of the number of residents potentially or actually affected (scope level). Our analysis of the data indicates that NYS does not categorize deficiencies as well as other states or as well as they should.

### Severity

Surveyors are required to rate each deficiency they write in terms of its severity. They follow a grid (see Appendix B). There are four levels of severity: (1) no harm or minimal harm, (2) potential for more than minimal harm, (3) actual harm, and (4) immediate jeopardy.

### Federal Comparative Surveys

***Federal surveyors rate many more deficiencies as causing harm or putting residents in immediate jeopardy.***

CMS's comparative surveys also rated the severity of the 119 deficiencies identified by federal surveyors. Table 3 demonstrates that NYS not only missed the problems found by CMS, but also tended to rate the deficiencies it found as less serious and having impact on fewer residents than the federal surveyors. For the 28 deficiencies identified, NYS only rated 1 as causing harm or jeopardy. Fifteen (15) of the 119 or 13 percent of CMS's citations were categorized as causing harm or jeopardy.

Table 3

| | DOH | | CMS | | |
|---|---|---|---|---|---|
| Residence | Date | Harm and Above | Date | Harm and Above | Days Between Surveys |
| 1 | 2/27/2002 | 0 | 3/15/2002 | 3 | 15 |
| 2 | 3/21/2002 | 0 | 4/19/2002 | 1 | 28 |
| 3 | 5/3/2002 | 1 | 6/14/2002 | 1 | 41 |
| 4 | 10/25/2002 | 0 | 11/18/2002 | 1 | 21 |
| 5 | 2/28/2003 | 0 | 3/31/2003 | 1 | 30 |
| 6 | 5/29/2003 | 0 | 6/20/2003 | 0 | 21 |
| 7 | 8/22/2003 | 0 | 9/22/2003 | 0 | 30 |
| 8 | 9/3/2003 | 0 | 10/31/2003 | 0 | 29 |
| 9 | 10/22/2003 | 0 | 11/21/2003 | 0 | 29 |
| 10 | 11/26/2003 | 0 | 1/2/2004 | 4 | 37 |
| 11 | 7/9/2004 | 0 | 7/30/2004 | 3 | 20 |
| 12 | 9/16/2004 | 0 | 11/19/2004 | 1 | 63 |
| Total (12 Homes) | | 1 | | 15 | |
| Avg. # of Harm and Above Per Facility | | 0.08 | | 1.25 | Avg. Days Between Surveys = 30.33 |

### National Research

***NYS compares unfavorably to other states when rating severity.***

While the percent of facilities receiving a deficiency for causing actual harm or putting their residents in jeopardy nationwide is extremely low and had dropped over a three year span, NYS dropped even lower. NYS's percent of facilities receiving a deficiency for actual harm or jeopardy was

33.2 percent in 2001. It dropped to only 11 percent in 2003, less than the national average of 16.6 percent.[8]

Figure 2 compares NYS and the US trend in actual harm/jeopardy deficiency writing. It reveals that NYS dropped more sharply.

Figure 2
Trend in Deficiency Writing: Harm and Immediate Jeopardy, NY vs. US

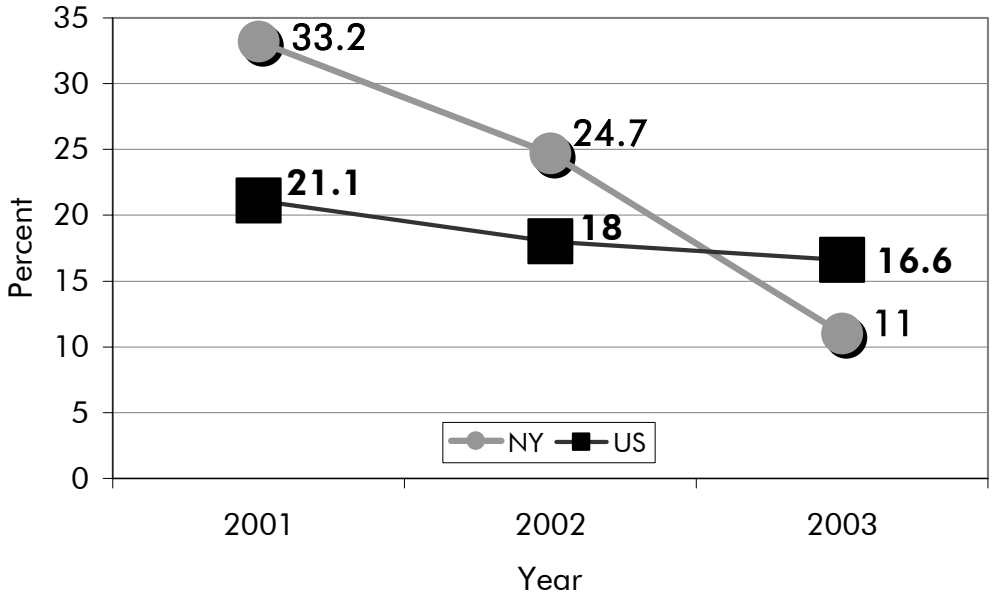
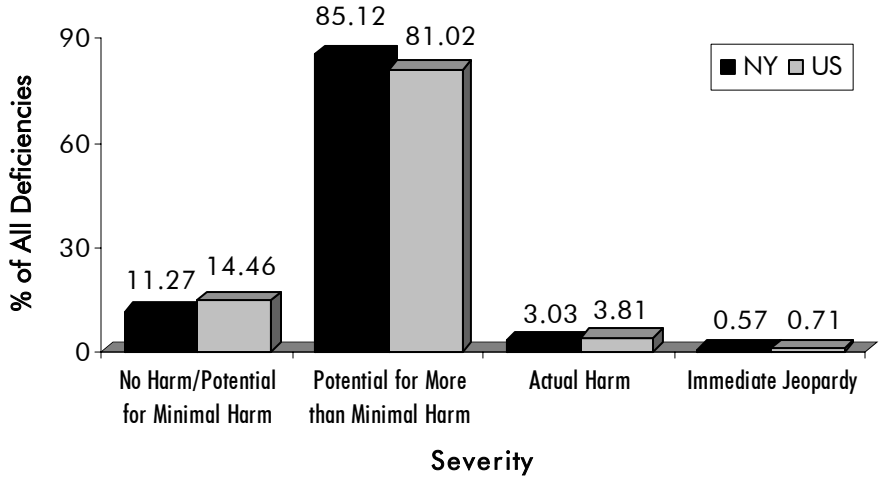



Figure 3[9] compares NYS to national data for each level of severity rating. Although nationally surveyors are writing very few harm or immediate jeopardy deficiencies, NYS writes even fewer.

Figure 3
NY vs. US Deficiencies Based on Severity



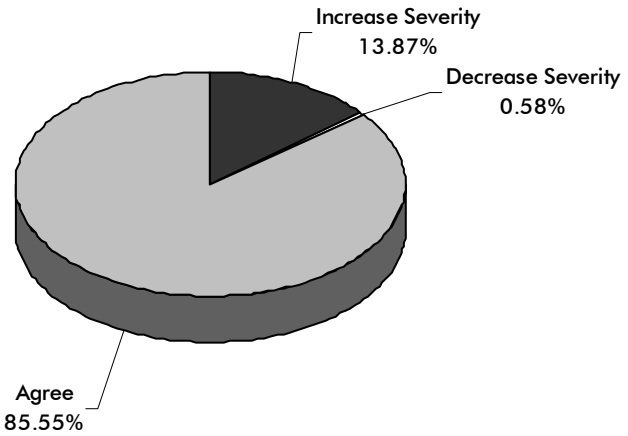

[8] Harrington, et.al. August, 2004. See Appendix C for a table of all the states.
[9] Based upon CMS data.

## Evaluation of DOH Survey Findings

***NYS surveyors are underrating deficiencies in terms of severity.***

Project staff analyzed (see Appendix D for full tables showing all evaluations) the categorization of the deficiency writing in the random sample of all surveyor findings in NYS for the most recent surveys. Figure 4 indicates the number of times our evaluators disagreed with surveyor ratings of severity. While we agreed[10] with surveyor severity ratings almost 86 percent of the time (note: project evaluators agreed only 72 percent of the time when looking both at scope and severity), we felt that the severity ratings should have been increased almost 14 percent (24 deficiencies) of the time. One of the areas where we had disagreement with the surveyor was related to psychosocial harm. Often, the surveyor did not seem to see this as harm, only the potential for harm. See below.

Figure 4
Severity Agree/Disagree




Following are some of the examples where the evaluators believed the rating of the deficiency should have been increased.

- A competent resident was found to be hard of hearing and a hearing evaluation was ordered. The evaluation recommended a hearing aid. Ten months later the surveyor found that the resident had never received her hearing aid. The deficiency written was categorized as not causing harm. The project evaluators believe that this psychosocial issue had to have caused actual harm for the resident and should have been categorized as such. (Buffalo, #3, F309).
- A facility was cited (as isolated, not causing harm) for not ensuring that open and necrotic wounds were assessed and monitored. The resident, who had impaired short-term memory and moderately impaired decision-making skills, required total care. A nursing note documented a black scab on his toe. After the facility failed to make sure he received a visit with the nurse practitioner and a few weeks had passed, the toe was now open and warm to the touch with pus drainage. Within a few days, the toe became worse and is now in early stages of gangrene, possibly requiring amputation. Project staff questioned the surveyor's rating of no harm. (Albany, #4, F309).
- A resident's mental status was documented as declining (she became verbally abusive towards staff, repeatedly shouted "help me, kill me," refused medication, refused to eat and preferred to die which would be "better than living like this"). The care plan included monitoring the resident for depression, including the resident in decision-making about care and giving

[10] While evaluating severity and scope, we followed the federal guidelines for assessing severity and scope. At times, we disagreed with the guidelines or felt they were unclear. However, if the surveyor followed the guidelines, we did not disagree. Please see Discussion section below for a discussion of the problem we see with federal guidelines.

counseling support to help vent feelings. Yet, over the following three to four months the surveyor documented that there was no visit from a social worker or counseling support. In addition, during this time, the physician stated that the resident is apparently refusing to eat and drink to gradually die by his own decision. The surveyor determined the facility's actions resulted in no actual harm. (Rochester, #1, F250).

### Scope

Surveyors are also required to rate each deficiency they write in terms of scope or how many residents are affected. They follow a grid (see Appendix B). There are three levels of scope: (1) isolated, (2) pattern, and (3) widespread.

### Federal Comparative Surveys

***Federal surveyors rate many more deficiencies as a pattern or widespread.***

Table 4, based on CMS data, reveals that DOH did not rate any of its 28 deficiencies as widespread and only 7 (25%) as a pattern, while CMS rated 21 (18%) of its 119 as widespread and 25 (21%) as a pattern.

Table 4

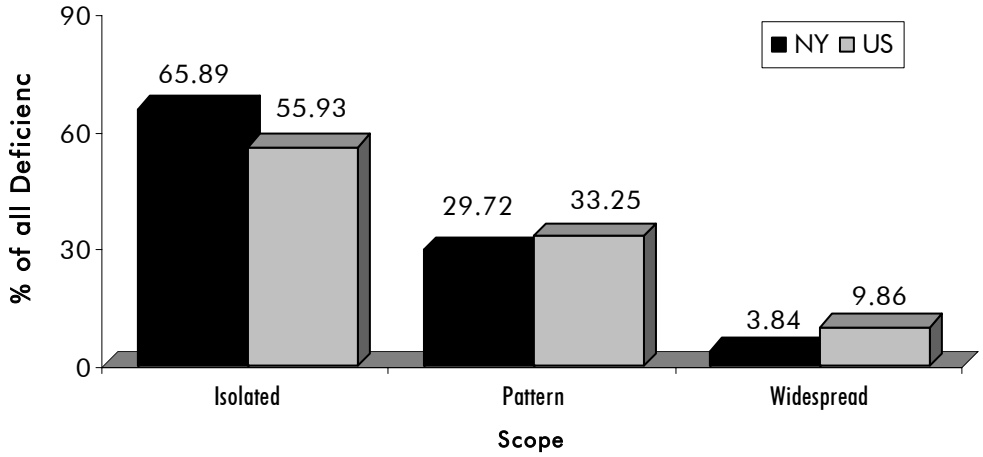
| | DOH | | | CMS | | | |
|---|---|---|---|---|---|---|---|
| Residence | Date | Pattern | Widespread | Date | Pattern | Widespread | Days Between Surveys |
| 1 | 2/27/2002 | 3 | 0 | 3/15/2002 | 2 | 0 | 15 |
| 2 | 3/21/2002 | 0 | 0 | 4/19/2002 | 1 | 0 | 28 |
| 3 | 5/3/2002 | 1 | 0 | 6/14/2002 | 0 | 0 | 41 |
| 4 | 10/25/2002 | 0 | 0 | 11/18/2002 | 7 | 1 | 21 |
| 5 | 2/28/2003 | 1 | 0 | 3/31/2003 | 1 | 1 | 30 |
| 6 | 5/29/2003 | 0 | 0 | 6/20/2003 | 1 | 4 | 21 |
| 7 | 8/22/2003 | 1 | 0 | 9/22/2003 | 4 | 5 | 30 |
| 8 | 9/3/2003 | 0 | 0 | 10/31/2003 | 6 | 5 | 29 |
| 9 | 10/22/2003 | 0 | 0 | 11/21/2003 | 1 | 2 | 29 |
| 10 | 11/26/2003 | 0 | 0 | 1/2/2004 | 0 | 0 | 37 |
| 11 | 7/9/2004 | 0 | 0 | 7/30/2004 | 0 | 2 | 20 |
| 12 | 9/16/2004 | 1 | 0 | 11/19/2004 | 2 | 1 | 63 |
| Total (12 Homes) | | 7 | 0 | | 25 | 21 | Total Days = 364 |
| Avg. Scope Per Facility | | 0.58 | 0.00 | | 2.08 | 1.75 | Avg. Days = 30.33 |

### National Research

***NYS compares unfavorably to other states in rating scope.***

Figure 5, based upon CMS data, compares NYS and US scope ratings. NYS rates most of its deficiencies at the isolated level and is way below the national average in identifying widespread deficiencies.

Figure 5
NY vs. US Deficiencies Based on Scope

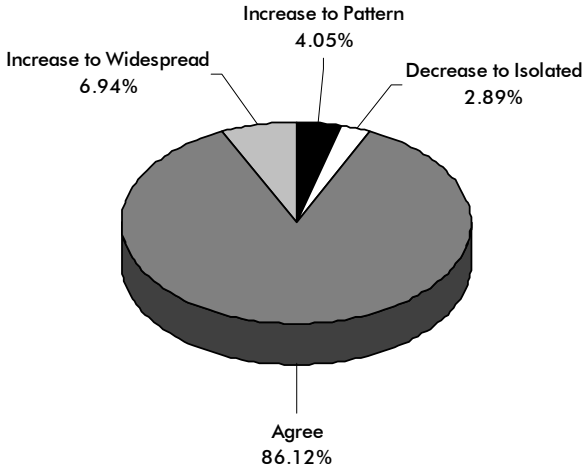



**Evaluation of DOH Survey Findings**

***NYS surveyors are underrating deficiencies in terms of scope.***

Figure 6 shows results of our evaluation of the sample of survey findings in terms of disagreement with NYS surveyor ratings on scope. Although our evaluators agreed in over 86 percent of the ratings of scope, in almost 11 percent of the time, they believed the scope ratings should have been higher.

Figure 6
Scope Agree/Disagree




Below are some of the examples where the evaluators believed the rating of the deficiency should have been increased in terms of scope.

- A facility was cited for being unsanitary in food preparation, storage, and service. There were issues related to the cleanliness of food surfaces and the cleanliness and proper maintenance of floors (ex. food debris, standing water, and soil buildup), walls (deteriorating grout and missing tiles), and equipment. While, the surveyor rated the scope as a pattern, we felt that the scope should be widespread because the federal guidelines require widespread be cited if a deficiency has the potential to affect all residents. (Rochester, #3, F371).

- A resident with dementia and organic brain syndrome developed chills and a low grade fever late one afternoon. The resident's physician was notified and prescribed various treatments. The following morning, the resident was observed eating breakfast in the dining room on the unit with the other residents. The resident was later observed sitting in the hallway next to another resident. During separate interviews, both the licensed nursing staff and infection control nurse agreed "that the current policies and procedures lacked guidelines for the nursing staff to follow, or implement, when a resident developed signs and symptoms of an infection." The surveyor rated the deficiency as isolated, possibly because the deficiency was related to one resident. However, we concluded that the surveyor did not follow the federal guidelines. The lack of protocols was a systemic failure, with the potential to affect all residents and thus should have been cited as widespread. (Syracuse, #1, F441).

## DISCUSSION

### Identifying and Categorizing Deficiencies

The ability of New York State surveyors to identify issues that demonstrate violations of state and federal rules and regulations and to accurately categorize them in terms of their severity and scope is crucial to the state's vulnerable nursing home residents.

The findings of this study indicate that NYS is failing in this job a significant amount of time and putting nursing home residents at risk. Our findings demonstrate that when federal surveyors inspect a nursing home a few weeks after NYS surveyors, many more serious and widespread problems are found. National data indicate that NYS compares unfavorably with other states in terms of identifying, categorizing problems and substantiating complaints. In addition, our analyses of a sample of NYS survey findings indicate that deficiencies are being underrated 28 percent of the time.

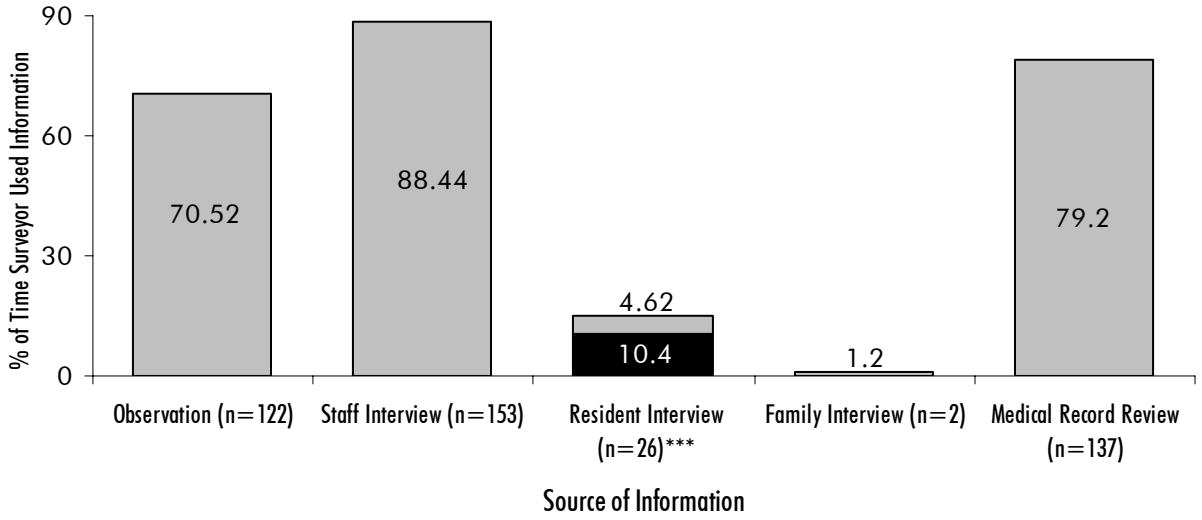
The reasons for this are varied. Although this study did not look into the reasons listed below, we believe the state should examine them.

- There has long been a concern that there are not enough well trained surveyors and investigators to do the job. This may be part of the problem.
- Consumers have also been concerned that the message from "above" has been not to "burden" business owners such as nursing home operators. Thus, surveyors may tend to overlook certain things. Our analysis of survey findings showed we most often disagreed in cases where we thought the severity should be harm instead of a potential for harm. Perhaps, because of messages from "above," surveyors may have been more likely to assign a potential for harm rather than harm, and they may have also been more likely to assign no harm and no potential for serious harm rather than even a potential for harm. As such, this may explain variance with the rest of the nation as well as variance with the federal surveys. We were unable to measure this theory because surveyors do not report no harm or potential to cause serious harm deficiencies on the survey findings.
- DOH may not be conducting competent oversight and monitoring of its surveyors and inspectors.
- Facilities often figure out when they will be inspected and prepare for the survey.
- Surveyors do not inspect on "off-times," such as weekends and in the evenings and nights, often enough. It is during these times that many consumers see problems.

The study did find data raising two other issues that might account in part for NYS's failure to identify and appropriately rate deficiencies: lack of resident and family interviews used by surveyors to document deficiencies and surveyor intervention. Figure 8 below indicates the percentage of time

record review, staff interviews, observation, resident interviews and family interviews that were used for documentation of deficiencies in the sample reviewed by project staff. Surveyor use of resident and family interview is very low for such documentation. Resident interviews were used only 15 percent of the time. Use of family interviews is almost non-existent. In addition, less than half of the facility findings (15 out of 34) indicate any use of a resident or family member interview. It is possible that if such interviews were used as documentation, the deficiencies may have been rated differently.

Figure 8
DOH Surveyor's Documentation of Deficiencies




***Resident Interviews were used as documentation 15.02% of the time: 10.40% Individually; 4.62% As a Group.

Below is an example of a situation where project staff felt that resident and family interviews should have been conducted to help determine severity.

- A facility was cited for not meeting a resident's needs based upon the plan of care. The resident was assessed as having problems with communication. The care plan stated that the facility would establish communication by using hand gestures, ask yes and no questions and provide tactile stimulation. When the surveyor observed treatment, the aide did not speak to the resident or provide tactile stimulation. When asked why, she said she forgot. The deficiency was rated as isolated and not causing harm. The evaluators felt that before the surveyor could categorize this deficiency as not causing harm, information should have been solicited from family. There was no indication that this was done. (NYC, #5, F282)

Another reason for NYS's failures may be because surveyors sometimes intervene. Project staff found that sometimes, when a surveyor observes possible harm, she/he may intercede. While appropriate, by intervening she/he may be stopping a deficiency from being identified or from being more severe. What might have happened if the surveyor was not present?

Below is an example of a case where there was surveyor intervention and a low severity rating:

A facility was cited for not giving proper nutrition, grooming and personal and oral hygiene. This was a repeat deficiency from the last survey. A diabetic resident was found to have ten long fingernails. The resident asked the nursing staff to cut his fingernails but guessed that staff was too busy. After the surveyor intervened, the fingernails were cut. The deficiency was categorized as not causing harm. However the

surveyor intervened and perhaps stopped harm. How can one cite such a deficiency that is a repeat but has been intervened with before harm occurred? Are residents, who are not reviewed by survey teams, being harmed? How will the surveyor know? (Rochester, #2, F312)

### Federal Definitions of Severity and Scope

Appendix B details the definitions and guidelines for surveyors who must categorize each deficiency found. We found a number of problems using this information to categorize the deficiencies in our sample of NYS surveyor findings. We can only assume that surveyors may be having the same issues. In a number of cases, we disagreed with the surveyor rating but did not list it as a disagreement because it was clear that the surveyor was following federal guidelines. If we had included these, our rate of disagreement would have been much higher.

First, we believe that federal definitions of severity are too vague. Severity level 2 (see Appendix B) states that the deficiency results in no more than minimal "discomfort" to the resident or has "limited consequence" and/or has the potential to compromise the resident's ability to maintain or reach his/her well-being. It is difficult to tell whether a resident who has fallen numerous times resulting in bruises and abrasions should be rated level 2 or 3 (harm). There is little direction defining "discomfort" and "limited consequence."

Second, definitions of scope are too vague. Project staff observed multiple scope inconsistencies by surveyors when determining "isolated", "pattern" or "widespread." For example, two residences exhibited deficient practices in relation to infection control. In one case, 2 of 9 residents experienced a deficient practice, one time each only. (NYC, #1, F441) In another case, 2 of 3 residents experienced a deficient practice, also one time each only. Yet, in the first case, the surveyor rated the deficiency a "pattern" and in the second case the surveyor rated it "isolated." (Albany, #2, F441) In another facility, an environmental deficiency was categorized as "widespread" because the deficient practice was evident in 3 of 3 resident units in a building. (New Rochelle, #1, F156) However, in another case in the same region, a deficiency was categorized as "pattern" even though the deficient practice was evident in 7 of 7 resident units. (New Rochelle, #2, F252). Both deficiencies were noted to occur at multiple times.

Third, we believe that the federal guidelines are too broad and too many dissimilar types of deficiencies can fit into each category. This prevents proper identification of the problem and proper corrective action on the part of the facility. For example, according to federal guidelines, a D deficiency (isolated and potential for harm) can be described in 18 different ways, once a D deficiency is assigned, there can be varied interpretations of the deficiency. For example, one person minimally harmed psychosocially is the same as one person with a potential for actual physical harm. Another example, one person affected numerous times is treated the same as multiple residents (more than a limited number) affected once.

Fourth, federal guidelines require surveyors to cite deficiencies based upon the greatest severity case that occurred. For example, if a residence (New Rochelle, #1, F314) was cited for problems for 6 residents, only one of whom was harmed, the surveyor is instructed to label the deficiency a "G" – isolated, actual harm. This is the highest severity level of the 6 residents. We believe that this federal requirement misrepresents the true problem. Categorizing the deficiency at an isolated level ignores the other 5 residents whose severity rating was lower than harm. Without the federal requirement, project staff believes a "pattern" would have been assigned. The categorization of pattern is as important as citing harm as it relates to correction.

Finally, in the survey findings analyses there were some instances where surveyors noted a residence was receiving a "repeat deficiency," meaning they had been cited for the same deficient practice on a previous survey. (For example, Syracuse, #4, F492). Currently we believe that there is no federal instruction related to raising the level of severity or scope if a deficiency is a repeat. Thus, in a number of instances, repeat deficiencies were categorized at the same level of severity and scope.

## RECOMMENDATIONS

### DOH should:

- Develop a better quality assurance system to evaluate survey findings. DOH staff should:
  - Analyze samples of deficiencies on a regular basis. Are they appropriately cited?
  - Look specifically at numbers of widespread ratings.
  - Look specifically at deficiencies rated at the D category.
  - Evaluate each survey team and survey – are there any patterns?
  - Evaluate federal comparative surveys. Meet with state surveyors and discuss federal findings. Find out why state surveyors did not identify the deficiencies the federal surveyors did.
- Conduct better training specifically related to identifying deficiencies and appropriately rating severity and scope – give many examples in training workshops. Have surveyors do a number of different exercises.
- Focus on the need to cite insufficient staff.
- Help surveyors understand psychosocial and mental harm as well as physical harm.
- Require more resident and family interviews.

### CMS should:

- Define categories more narrowly. Federal guidelines need to either be separated into more distinctive categories and/or need to better define terms, such as "minimal harm" or "limited consequence." The current guidelines allow for too much variation across surveyors and make varied outcomes indistinguishable from one another. Better representation of deficiencies will aid in quality control methods because it will be easier to identify where surveyors are having assessment difficulties. Perhaps categories and definitions can be determined through an expert panel of providers, consumers, and government representatives.
- Require two different ratings if a pattern or widespread exists and only one or few residents are harmed or in immediate jeopardy, rather than require only one rating of isolated harm or jeopardy.
- Have a separate category for repeat violations and separate requirements for facilities to correct.

# APPENDIX A

## METHODOLOGY

1. Analysis of Research
   a. Project staff reviewed research conducted by others. This research is detailed in the report.
   b. Project staff reviewed data received from CMS.
   c. Project staff used information from the New York State Department of Health's website and the Medicare Compare site.

2. Analysis of Statement of Deficiencies
   a. A random sample of 5 percent of the latest surveyor findings from each region in the state: Albany, Rochester, Buffalo, NYC and environs, Syracuse and New Rochelle were received from DOH.
   b. If the findings indicated no deficiencies, another was put in its place. Seven findings were replaced. These were not randomly selected. To make sure that the replacements had identified deficiencies that could be evaluated, replacements were chosen if they had a sufficient number of deficiencies to be rated.
   c. The table below demonstrates that the final sample did not differ notably in terms of scope and severity findings from CMS data on all NYS findings. See the table below.

| Category | CMS Data for NY | Our Sample Data for NY |
|---|---|---|
| B | 8.60% | 4.62% |
| C | 2.60% | 2.89% |
| D | 63.00% | 63.01% |
| E | 21.10% | 25.43% |
| F | 0.10% | 1.16% |
| G | 2.90% | 2.89% |
| H | 0.10% | 0.00% |
| I | 0.10% | 0.00% |
| J | 0.20% | 0.00% |
| K | 0.40% | 0.00% |
| L | 0.00% | 0.00% |
| H, I, J, K, L | 0.80% | 0.00% |

   d. Two project staff (evaluators) read each survey finding (statement of deficiency-(SOD), gathering information on sources of documentation for each deficiency and scope and severity ratings. Based upon the surveyor's findings, each evaluator rated the severity and scope of each deficiency. A final determination on the evaluator's scope and severity for each deficiency was made only when both evaluators agreed.
   e. The table below shows that the replacement sample did not lend itself to more disagreement with surveyor findings on scope and severity. In fact, the evaluators agreed more with the replacement findings than the original random sample.

| | Scope & Severity | O | I-S | I-R | I-F | R | Agree | Disagree |
|---|---|---|---|---|---|---|---|---|
| Replacement | 53 | 45<br>84.91% | 49<br>92.45% | 9<br>16.98% | 1<br>1.89% | 41<br>77.36% | 42<br>79.25% | 11<br>20.75% |
| Original | 120 | 77<br>64.17% | 104<br>86.67% | 17<br>14.17% | 1<br>0.83% | 96<br>80.00% | 86<br>71.67% | 34<br>28.33% |
| Total | 173 | 122<br>70.52% | 153<br>88.44% | 26<br>15.03% | 2<br>1.16% | 137<br>79.19% | 128<br>73.99% | 45<br>26.01% |

O=observations, I-S=staff interviews, I-R=resident interviews, I-F=family interviews.

# APPENDIX B

## SCOPE AND SEVERITY GRID

Surveyors categorize each deficiency by its severity and scope and use both the grid and federal guidelines.

| SEVERITY | | | | |
|---|---|---|---|---|
| | J | K | L | Immediate jeopardy to resident health and safety |
| | G | H | I | Actual harm that is not immediate jeopardy |
| | D | E | F | No actual harm with the potential for more than minimal harm |
| | A | B | C | Substantial compliance - no actual harm with the potential for no more than minimal harm |
| | isolated | pattern | widespread | |
| | SCOPE | | | |

## Federal Guidelines

### Severity

- Severity is Level 1 if a deficiency that has the potential for causing no more than a minor negative impact on the resident(s).
- Severity is Level 2 if noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Severity is Level 3 if noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.

- Severity is Level 4 if immediate jeopardy, a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.

**Scope**

- Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations. If the deficiency affects or has the potential to affect one or a very limited number of residents, then the scope is isolated.
- Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility. If an adequate system/policy is in place but is being inadequately implemented in certain instances, or if there is an inadequate system with the potential to impact only a subset of the facility's population, then the deficient practice is likely to be pattern.
- Scope is widespread when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility. If the facility lacks a system/policy (or has an inadequate system) to meet the requirements and this failure has the potential to affect a large number of residents in the facility, then the deficient practice is likely to be widespread.

*Note.* If the evidence gathered during the survey for a particular requirement includes examples of various severity or scope levels, surveyors should generally classify the deficiency at the highest level of severity, even if most of the evidence corresponds to a lower severity level. For example, if there is a deficiency in which one resident suffered a severity 3 while there were widespread findings of the same deficiency at severity 2, then the deficiency would be generally classified as severity 3, isolated.

# APPENDIX C

## TABLES SHOWING ALL STATES -- SELECTED DATA

SUBSTANTIATED COMPLAINTS*

| State | Total Complaints | Total Substantiated | Percent |
|---|---|---|---|
| AK | 17 | 3 | 17.6% |
| AL | 334 | 206 | 61.7% |
| AR | 442 | 248 | 56.1% |
| AZ | 270 | 117 | 43.3% |
| CA | 5,084 | 722 | 14.2% |
| CO | 325 | 165 | 50.8% |
| CT | 274 | 217 | 79.2% |
| DC | 46 | 9 | 19.6% |
| DE | 83 | 52 | 62.7% |
| FL | 1,790 | 365 | 20.4% |
| GA | 1,060 | 529 | 49.9% |
| HI | 47 | 8 | 17.0% |
| IA | 997 | 267 | 26.8% |
| ID | 112 | 46 | 41.1% |
| IL | 3,034 | 922 | 30.4% |
| IN | 1,402 | 873 | 62.3% |
| KS | 785 | 238 | 30.3% |
| KY | 745 | 92 | 12.3% |
| LA | 392 | 135 | 34.4% |
| MA | 994 | 291 | 29.3% |
| MD | 493 | 235 | 47.7% |
| ME | 435 | 99 | 22.8% |
| MI | 888 | 343 | 38.6% |
| MN | 358 | 70 | 19.6% |
| MO | 2,248 | 389 | 17.3% |
| MS | 170 | 54 | 31.8% |
| MT | 41 | 13 | 31.7% |
| NC | 1,229 | 397 | 32.3% |
| ND | 35 | 11 | 31.4% |
| NE | 360 | 113 | 31.4% |
| NH | 101 | 49 | 48.5% |
| NJ | 1,315 | 441 | 33.5% |
| NM | 75 | 31 | 41.3% |
| NV | 399 | 179 | 44.9% |
| **NY** | **3,375** | **726** | **21.5%** |
| OH | 2,110 | 695 | 32.9% |
| OK | 979 | 277 | 28.3% |
| OR | 266 | 140 | 52.6% |
| PA | 1,751 | 893 | 51.0% |
| RI | 164 | 84 | 51.2% |
| SC | 316 | 53 | 16.8% |
| SD | 0 | 0 | 0.0% |
| TN | 939 | 276 | 29.4% |
| TX | 5,413 | 1,723 | 31.8% |
| UT | 224 | 74 | 33.0% |
| VA | 205 | 131 | 63.9% |
| VT | 95 | 21 | 22.1% |
| WA | 1,855 | 484 | 26.1% |
| WI | 802 | 274 | 34.2% |
| WV | 326 | 167 | 51.2% |
| WY | 56 | 21 | 37.5% |
| **US** | **45,256** | **13,968** | **30.9%** |

* CMS DATA Surveys conducted during fiscal year: 10/01/2003 to 9/30/2004

## AVERAGE NUMBER OF DEFICIENCIES AND PERCENT OF FACILITIES WITH NO DEFICIENCIES*

| State | Average Number of Deficiencies Per Facility | | | | Percent of Facilities with No Deficiencies | | |
|---|---|---|---|---|---|---|---|
| | 2003 | 2002 | 2001 | | 2003 | 2002 | 2001 |
| AK | 3.8 | 4.4 | 6.1 | | 7.1 | 8.3 | 7.1 |
| AL | 7 | 6.2 | 6.5 | | 8.3 | 8.3 | 8.2 |
| AR | 9.7 | 6.8 | 7.9 | | 2.2 | 3.4 | 4.7 |
| AZ | 9 | 7.5 | 10.2 | | 5.4 | 0.8 | 3.9 |
| CA | 10.8 | 9.9 | 11.3 | | 2.8 | 2.5 | 1.8 |
| CO | 7.8 | 5.6 | 5.3 | | 6.3 | 6.1 | 12.5 |
| CT | 7.4 | 5.8 | 5.7 | | 4.9 | 3.8 | 6.2 |
| DC | 12.8 | 9.5 | 11.5 | | 0 | 10 | 0 |
| DE | 7.7 | 4.2 | 6.6 | | 2.7 | 30.3 | 15.8 |
| FL | 9.2 | 7.3 | 7.9 | | 2.9 | 2.9 | 3 |
| GA | 9.9 | 8.1 | 5.7 | | 4.1 | 4.6 | 9.6 |
| HI | 9.9 | 9.5 | 10.4 | | 3.1 | 0 | 5.7 |
| IA | 4.6 | 4.1 | 4.2 | | 17 | 13.8 | 13.4 |
| ID | 7.8 | 9.4 | 6.6 | | 4 | 2.8 | 8.2 |
| IL | 5 | 4.3 | 5.2 | | 13 | 12.9 | 12.8 |
| IN | 5.3 | 5.4 | 6.2 | | 18.5 | 16 | 12.4 |
| KS | 8.3 | 7.3 | 6.9 | | 9.4 | 9.2 | 11.1 |
| KY | 9 | 7.4 | 8.4 | | 5.4 | 7.7 | 3.7 |
| LA | 8.6 | 10.7 | 6.9 | | 8.9 | 5.8 | 10.9 |
| MA | 5.2 | 4.8 | 4.7 | | 22.9 | 25.4 | 27.8 |
| MD | 7.6 | 6.5 | 4.4 | | 12.7 | 12.2 | 12.4 |
| ME | 10.5 | 7.5 | 5.1 | | 1.9 | 3.5 | 3.6 |
| MI | 9.9 | 9.2 | 8.4 | | 3.8 | 2.4 | 3.1 |
| MN | 10.1 | 5.8 | 4.6 | | 2.9 | 12.8 | 13.8 |
| MO | 7 | 6.3 | 5.5 | | 11.2 | 10.7 | 12.2 |
| MS | 5.9 | 4.8 | 6.4 | | 10.1 | 7.9 | 4.3 |
| MT | 6.3 | 4.2 | 5.2 | | 13 | 14.9 | 10.6 |
| NC | 7 | 4.5 | 6.2 | | 10.4 | 13.9 | 8 |
| ND | 5.2 | 4.4 | 3.8 | | 6.1 | 2.5 | 11.8 |
| NE | 4.3 | 4.6 | 4.4 | | 13 | 20.5 | 19.2 |
| NH | 4.1 | 3.5 | 4.7 | | 27 | 37.1 | 18.8 |
| NJ | 5.7 | 4.9 | 4.9 | | 8.8 | 14.2 | 14.2 |
| NM | 7.8 | 5.5 | 5.9 | | 14.3 | 13.2 | 18.5 |
| NV | 9.6 | 9.1 | 10.1 | | 11.4 | 2.3 | 0 |
| **NY** | **5.4** | **5.1** | **5.6** | | **11.8** | **6.8** | **8.5** |
| OH | 6 | 6 | 5.3 | | 13.6 | 10.5 | 12.7 |
| OK | 9.4 | 7.1 | 6.7 | | 3.3 | 7.4 | 15.6 |
| OR | 7.2 | 6.1 | 6.1 | | 15.8 | 11.9 | 17.8 |
| PA | 5.7 | 4 | 4.2 | | 7.8 | 14 | 14.4 |
| RI | 4.4 | 4.7 | 3.5 | | 11.1 | 16.9 | 21.8 |
| SC | 9.2 | 6 | 6 | | 3.6 | 15.3 | 8.7 |
| SD | 6.4 | 5.1 | 5.3 | | 6.5 | 5.9 | 6.6 |
| TN | 8.8 | 8.2 | 6.5 | | 3.9 | 1.3 | 3 |
| TX | 6.7 | 6.7 | 6.5 | | 10.4 | 7.5 | 9.6 |
| UT | 5.8 | 4.8 | 3.7 | | 7.3 | 9 | 15.5 |
| VA | 4.6 | 3.4 | 3.3 | | 21.6 | 25.9 | 33.9 |
| VT | 5.1 | 2.8 | 2.8 | | 17.1 | 18.9 | 27.5 |
| WA | 9.3 | 8.5 | 8.8 | | 5 | 4.2 | 4.8 |
| WI | 3.7 | 3 | 3.4 | | 23 | 24.4 | 21.8 |
| WV | 9.5 | 7.5 | 7.9 | | 2.3 | 4.1 | 6.1 |
| WY | 10.5 | 8.3 | 9.4 | | 2.9 | 2.9 | 5.9 |
| **US** | **6.9** | **6.3** | **6.3** | | **9.5** | **10** | **13.7** |

* Harrington, Charlene, Ph.D., Carrillo, Helen, M.S.& Crawford, Cassandra, M.A., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003, Department of Social and Behavioral Sciences, UCSF, August 2004.

## Percent of Facilities Receiving a Deficiency For Actual Harm or Jeopardy 2001 - 2003*

| State | 2003 | 2002 | 2001 |
|---|---|---|---|
| AK | 0 | 8.3 | 35.7 |
| AL | 14.9 | 12.8 | 15.9 |
| AR | 23.7 | 14.2 | 27.6 |
| AZ | 11.6 | 4.6 | 9.2 |
| CA | 3.8 | 3.1 | 9.7 |
| CO | 23.8 | 23.5 | 25.9 |
| CT | 47.1 | 42.7 | 49.6 |
| DC | 47.1 | 30 | 38.9 |
| DE | 8.1 | 3 | 18.4 |
| FL | 9.6 | 9.9 | 20.9 |
| GA | 22.2 | 18.6 | 18.3 |
| HI | 18.8 | 19.4 | 11.4 |
| IA | 9.8 | 7.9 | 11.6 |
| ID | 26.7 | 36.6 | 28.8 |
| IL | 17.2 | 15.9 | 16.2 |
| IN | 20.1 | 21.9 | 26 |
| KS | 27.2 | 27.8 | 30.8 |
| KY | 24.6 | 22.6 | 27.6 |
| LA | 13.4 | 20.1 | 23.6 |
| MA | 25 | 23.6 | 22.4 |
| MD | 17.7 | 16.6 | 19.4 |
| ME | 14.2 | 8 | 10.7 |
| MI | 24.9 | 29.5 | 24.3 |
| MN | 16.5 | 20.7 | 18.1 |
| MO | 10.3 | 15 | 10.7 |
| MS | 18.3 | 15.2 | 22.2 |
| MT | 18.5 | 13.5 | 23.5 |
| NC | 27.8 | 22.7 | 31.9 |
| ND | 11 | 12.4 | 28.2 |
| NE | 13 | 18 | 19.7 |
| NH | 24.3 | 27.4 | 27.5 |
| NJ | 12.4 | 15.1 | 23 |
| NM | 26 | 14.7 | 20 |
| NV | 9.1 | 9.1 | 6.5 |
| **NY** | **11** | **24.7** | **33.2** |
| OH | 13.8 | 23.9 | 24.5 |
| OK | 23.1 | 21.7 | 22.2 |
| OR | 21.1 | 17.8 | 31 |
| PA | 16.3 | 14.6 | 14.3 |
| RI | 10.3 | 3.6 | 10.3 |
| SC | 28.6 | 25.2 | 16 |
| SD | 32.4 | 17.8 | 31.1 |
| TN | 20.9 | 21 | 16.9 |
| TX | 15.2 | 19.5 | 26.2 |
| UT | 13.4 | 23.6 | 14.3 |
| VA | 13.8 | 13 | 11.6 |
| VT | 9.8 | 16.2 | 17.5 |
| WA | 24.5 | 40 | 39.8 |
| WI | 11.8 | 11.7 | 9.4 |
| WV | 10 | 15.5 | 16.7 |
| WY | 28.6 | 25.7 | 20.6 |
| **US** | **16.6** | **18** | **21.1** |

* Harrington, Charlene, Ph.D., Carrillo, Helen, M.S.& Crawford, Cassandra, M.A., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003, Department of Social and Behavioral Sciences, UCSF, August 2004.

## Total Nursing Staff Hours and Sufficient Staff Deficiencies*

| State | Total Nursing Staff Hours (2003) | Percent of Facilities with F353 Deficiencies** |
|---|---|---|
| AK | 5.3 | 0 |
| AL | 4 | 3.2 |
| AR | 3.8 | 0.9 |
| AZ | 3.5 | 1.8 |
| CA | 3.7 | 5.2 |
| CO | 3.6 | 1 |
| CT | 3.5 | 1.3 |
| DC | 4 | 5.9 |
| DE | 4 | 2.7 |
| FL | 4.2 | 9.3 |
| GA | 3.3 | 3.5 |
| HI | 3.9 | 9.4 |
| IA | 3.2 | 2.9 |
| ID | 4.4 | 8 |
| IL | 3.1 | 2.5 |
| IN | 3.4 | 2.2 |
| KS | 3.4 | 5.3 |
| KY | 4 | 3.9 |
| LA | 3.3 | 5.5 |
| MA | 3.6 | 1.8 |
| MD | 3.7 | 0.5 |
| ME | 4.2 | 2.8 |
| MI | 3.6 | 7.3 |
| MN | 3.5 | 4.5 |
| MO | 3.6 | 6.1 |
| MS | 3.9 | 4.1 |
| MT | 3.8 | 0 |
| NC | 3.6 | 2.5 |
| ND | 3.9 | 0 |
| NE | 3.6 | 0 |
| NH | 3.8 | 0 |
| NJ | 3.6 | 0.6 |
| NM | 3.9 | 7.8 |
| NV | 3.5 | 11.4 |
| **NY** | **3.5** | **0.2** |
| OH | 4 | 1.1 |
| OK | 3.4 | 1.4 |
| OR | 3.7 | 5.3 |
| PA | 3.9 | 0.9 |
| RI | 3.2 | 0 |
| SC | 3.9 | 0 |
| SD | 3.2 | 1.9 |
| TN | 3.5 | 4.9 |
| TX | 3.5 | 1.5 |
| UT | 3.9 | 0 |
| VA | 3.5 | 0.7 |
| VT | 3.8 | 0 |
| WA | 3.8 | 5.4 |
| WI | 3.5 | 0.8 |
| WV | 3.9 | 3.1 |
| WY | 3.8 | 8.6 |
| **US** | **3.6** | **3** |

* Harrington, Charlene, Ph.D., Carrillo, Helen, M.S.& Crawford, Cassandra, M.A., "Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003, Department of Social and Behavioral Sciences, UCSF, August 2004.
** F353: The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

# APPENDIX D

## EVALUATION OF DOH SURVEY FINDINGS

**Legend**: O = Observation; I-S = Interview with Staff; I-R = Interview with Resident; I-F = Interview with Family; R = Record Review

| REGIONAL OFFICE | F-TAG | SCOPE & SEVERITY | O | I-S | I-R | I-F | R | AGREE | DISAGREE | IF DISAGREE, RECOMMENDED SCOPE AND SEVERITY | WHY? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Albany #1 | | | | | | | | | | | |
| | 221 | D | X | X | | | X | X | | | |
| | 246 | D | X | X (2) | X | | X | | X | G | QOL resident was psychologically harmed, "an alert resident could not hear for three months." |
| | 253 | E | X | | | | | | X | F | Three of three nursing units were affected. Likely to affect a large number of residents. |
| | 386 | E | | X | | | X | X | | | |
| Albany #2 | | | | | | | | | | | |
| | 309 | D | | X (3) | | | X | | X | G | If they had acted earlier they could have avoided realized pain. Negative outcome that is more than limited consequence. |
| | 314 | E | X | X | | | X | X | | | |
| | 327 | E | X | X (6) | | | X | X | | | |
| | 441 | D | X | X | | | X | | X | E | Two of three: Isolated or Pattern? |
| Albany #3 | | | | | | | | | | | |
| | 309 | D | | X | | | X | X | | | |
| | 318 | G | X | X | | | X | X | | | |
| | 323 | D | X | X | | | | X | | | |
| Albany #4 | | | | | | | | | | | |
| | 272 | D | | X | | | X | | X | G | Pressure sore was allowed to develop to a stage IV. Negative outcome that has caused more than limited consequence. |
| | 309 | D | X | X | | | X | | X | G | Allowed infection to develop to the point where amputation was considered. Negative outcome that had the potential for more than limited consequence. |
| | 324 | D | X | X (2) | | | X | | X | E | Repeat occurrences of same deficient practice. |
| | 386 | D | | X | | | X | X | | | |
| | 314 | D | X | X | | | X | | X | G | Went from no pressure sores to pressure sores. Negative outcome that has caused more than limited consequence. |
| Buffalo #1 | | | | | | | | | | | |
| | 159 | E | | X (4) | | | X | | X | F or D | 14 of 14 residents is a systematic failure. Could choose D because it was limited to one aspect, but where is the pattern? |
| | 282 | D | X | X (2) | | | X | | X | E | 2 of 3 residents were affected. |
| | 324 | D | X | X | | | X | X | | | |
| Buffalo #2 | | | | | | | | | | | |
| | 157 | D | | X | | | X | X | | | |
| | 309 | D | | | | | X | X | | | |
| Buffalo #3 | | | | | | | | | | | |
| | 309 | D | | X (2) | X | | X | | X | G | No hearing aid for ten months: negative outcome that compromised resident's well-being more than limited consequence |
| | 314 | D | X | X (2) | | | X | X | | | |
| | 322 | D | X | | | | X | X | | | |
| Buffalo #4 | | | | | | | | | | | |
| | 324 | D | X | | | | | X | | | |
| | 325 | D | X | | | | X | X | | | |
| Buffalo #5 | | | | | | | | | | | |
| | 309 | E | | X | | | X | X | | | |
| | 314 | D | X | X (4) | | | X | X | | | |
| | 324 | E | X | X (2) | | | X | X | | | |
| | 329 | D | | X | | | X | | X | G | One resident experienced severe withdrawal for two months. Negative outcome compromised resident's well-being. |
| | 330 | D | X | X | | | X | | X | G | same as F-tag 329 |
| | 386 | B | | X | | | X | | X | E | Potential for more than minimal harm if doctor's orders are not documented and signed. |

| REGIONAL OFFICE | F-TAG | SCOPE & SEVERITY | O | I-S | I-R | I-F | R | AGREE | ISAGREE | IF DISAGREE, RECOMMENDED SCOPE AND SEVERITY | WHY? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rochester #1 | | | | | | | | | | | |
| | 250 | D | | X | | | X | | X | G | For three months no social worker met with a resident who wants to die and has refused to eat and drink: resident's ability to maintain physical, mental, psychological well-being was compromised. |
| | 324 | D | X | X (2) | | | | X | | | |
| Rochester #2 | | | | | | | | | | | |
| | 225 | D | X | X | | | X | X | | | |
| | 241 | D | X | X | | | | X | | | |
| | 250 | D | X | X (2) | X | | X | | X | G | Psychosocial harm. The resident is eligible to leave the nursing home but for two months has not been able to because of the Nursing Home's actions |
| | 312 | D | X | X | | | X | X | | | |
| | 314 | E | X | X (3) | X | | X | | X | G | Negative outcome compromised resident's physical well-being. |
| | 318 | D | X | X (2) | | | X | X | | | |
| | 328 | D | X | | | | X | X | | X | |
| | 333 | D | X | X (2) | | | X | X | | | |
| Rochester #3 (Replacement) | | | | | | | | | | | |
| | 221 | D | X | X (2) | | | X | X | | | |
| | 225 | D | | X | | | X | X | | | |
| | 241 | E | X | X | X (3) | | X | | X | H | Negative outcome compromised resident's psycho-social well-being. |
| | 252 | B | X | | | | | X | | | |
| | 253 | B | X | | | | | X | | | |
| | 281 | D | X | X (2) | | | X | X | | | |
| | 282 | B | X | X | | X (2) | X | | X | E | Non-receipt of required supplements and nourishments is potential for more than minimal harm. |
| | 328 | E | X | X (2) | X | | X | X | | | |
| | 371 | B | X | | | | | | X | C | Potential for minimal harm to many, in not all, residents. |
| | 469 | B | X | X | | | | X | | | |
| Syracuse #1 | | | | | | | | | | | |
| | 246 | B | X | X (2) | | | | X | | | |
| | 309 | D | | X | | | X | X | | | |
| | 323 | E | | | | | | X | | | |
| | 324 | D | | X | | | X | X | | | |
| | 371 | D | X | X | | | | X | | | |
| | 441 | D | X | X (2) | | | X | | X | F | Systematic failure because there were no residence protocols to guide staff. |
| Syracuse #2 | | | | | | | | | | | |
| | 156 | D | | X | | | X | X | | | |
| | 241 | E | X | X | | | | | X | C | No more than potential for minimal harm. |
| | 250 | D | X | X | | | X | X | | | |
| | 309 | D | | X | | | X | X | | | |
| | 315 | D | | X | | | X | X | | | |
| | 322 | E | X | X (3) | | | X | X | | | |
| | 332 | E | X | X (2) | | | X | X | | | |
| | 386 | E | X | X (2) | | | X | X | | | |
| | 388 | D | | | | | X | X | | | |
| | 426 | D | | | | | X | X | | | |
| | 514 | D | | X | | | X | X | | | |
| Syracuse #3 | | | | | | | | | | | |
| | 156 | D | | X | | | X | X | | | |
| | 247 | D | | X (2) | | | X | X | | | |
| | 253 | E | | X (6) | X | X | | X | | | |
| | 279 | D | X | X (4) | X | | X | X | | | |
| | 309 | D | X | X | | | X | X | | | |
| | 363 | C | X | X | | | | X | | | |
| | 368 | C | | X | X (16) | | | X | | | |
| Syracuse #4 | | | | | | | | | | | |
| | 221 | E | X | X | | | X | | X | D | Is 6 of 30 (20%) a pattern? Wasn't in multiple places, multiple times or to the same resident multiple times. |
| | 241 | E | X | | | | X | X | | | |
| | 280 | D | X | | | | X | X | | | |
| | 309 | D | X | X (3) | X | | X | | X | G | Negative outcome was more than limited consequence. |
| | 327 | D | X | X (2) | | | X | X | | | |
| | 492 | E | X | X (2) | | | X | X | | | |
| | 517 | F | | | | | X | X | | | |
| Syracuse #5 | | | | | | | | | | | |
| | 309 | D | | X (2) | | | X | X | | | |
| | 314 | D | | X | | | X | X | | | |
| | 316 | D | X | X (2) | | | X | X | | | |
| | 322 | E | | X (3) | | | X | X | | | |

| REGIONAL OFFICE | F-TAG | SCOPE & SEVERITY | O | I-S | I-R | I-F | R | AGREE | ISAGREE | IF DISAGREE, RECOMMENDED SCOPE AND SEVERITY | WHY? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 324 | D | | X | | | X | X | | | |
| | 333 | E | X | X (2) | | | X | X | | | |
| | 386 | D | | X (2) | | | X | | X | G | Recommendation for surgery was never addressed: negative outcome that was more than limited consequence. |
| New Rochelle #1 | | | | | | | | | | | |
| | 156 | E | X | X (2) | | | X | | X | F | 3 of 3 units, systematic failure with the potential to harm a large number of residents. |
| | 166 | E | X | X (3) | X (8) | | X | | X | I | Negative outcome led to psychosocial harm to many residents. 10 of 13 is not widespread? |
| | 253 | E | X | X (3) | X | | | X | | | |
| | 282 | D | | X | | | X | X | | | |
| | 314 | G | X | X (4) | | | R | | X | H or J | 6 of 11 should be a pattern, or J because 1 developed a stage IV sore in two weeks because there was no policy by the home to relieve the pressure. |
| | 323 | E | X | X | | | | X | | | |
| | 441 | D | X | | | | X | X | | | |
| | 444 | D | X | | | | | X | | | |
| | 464 | E | X | X | X (2) | | | X | | | |
| | 469 | E | X | X | | | | | X | D | |
| | 508 | D | | X (3) | | | X | X | | | |
| New Rochelle #2 (Replacement) | | | | | | | | | | | |
| | 159 | D | | X (2) | | | X | X | | | |
| | 166 | E | X | X (2) | X (13) | | X | X | | | |
| | 241 | E | X | X (6) | X (13) | | X | X | | | |
| | 246 | D | X | X (2) | | | X | X | | | |
| | 252 | E | X | X | X (13) | | X | | X | F | 7 of 7 units. |
| | 279 | D | X | X (2) | | | X | X | | | |
| | 280 | F | X | X | | | X | X | | | |
| | 281 | D | X | X (6) | | | X | X | | | |
| | 313 | D | | X (3) | | | X | X | | | |
| | 324 | D | X | X (3) | | | X | | X | G | |
| | 325 | D | X | X (2) | | | X | X | | | |
| | 363 | E | X | X (4) | X (13) | | X | X | | | |
| | 364 | E | X | X (3) | X (19) | | | | X | F | Large number of residents are affected by the negative outcome. |
| | 371 | D | X | X | | | | X | | | |
| | 441 | E | X | X (2) | | | X | X | | | |
| New Rochelle #3 | | | | | | | | | | | |
| | 282 | D | X | X | | | X | X | | | |
| | 314 | G | X | X (5) | | | X | X | | | |
| | 371 | E | X | X (2) | | | X | X | | | |
| | 372 | D | X | X (1) | | | | X | | | |
| | 386 | D | | X (2) | | | X | X | | | |
| New Rochelle #4 (Replacement) | | | | | | | | | | | |
| | 241 | D | X | X | | | X | X | | | |
| | 250 | D | X | X (2) | | | X | | X | G | Negative outcome that has caused psychosocial harm more than limited consequence. |
| | 252 | E | X | X (5) | X (2) | | | | X | F | 5 of 5 buildings and in multiple locations throughout the buildings. |
| | 280 | D | X | X | | | X | X | | | |
| | 282 | D | | X | | | X | X | | | |
| | 312 | D | X | X (2) | | | X | X | | | |
| | 319 | D | X | X (3) | | | X | | X | G | Negative outcome that has caused psychosocial harm more than limited consequence. |
| | 322 | D | | | | | | X | | | |
| | 371 | C | X | X | | | | X | | | |
| New Rochelle #5 | | | | | | | | | | | |
| | 282 | D | | X (2) | | | X | X | | | |
| | 316 | D | | X (3) | X | | X | X | | | |
| | 367 | D | | X (2) | | | X | | X | E | Same resident has been affected by repeated occurrences of the same deficient practice. |
| | 469 | E | X | | | | | | X | D | Only one location was affected. |

| REGIONAL OFFICE | F-TAG | SCOPE & SEVERITY | O | I-S | I-R | I-F | R | AGREE | ISAGREE | IF DISAGREE, RECOMMENDED SCOPE AND SEVERITY | WHY? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| New Rochelle #6 (Replacement) | | | | | | | | | | | |
| | 221 | D | X | X | | | X | X | | | |
| | 253 | C | X | X | | | | X | | | |
| | 282 | D | X | X (2) | | | X | X | | | |
| | 309 | E | X | X (5) | | | X | X | | | |
| | 327 | D | X | X (3) | X | | X | X | | | |
| | 441 | D | X | X (4) | | | X | X | | | |
| New Rochelle #7 | | | | | | | | | | | |
| | 246 | D | X | X (3) | X | | X | | X | G | Negative outcome compromised resident's psychosocial ability. Call bell was not accessible, thus functioning was harmed. |
| | 250 | E | | X (2) | | | X | X | | | |
| | 309 | D | X | X (2) | | | X | X | | | |
| | 431 | D | X | X (2) | | | X | | X | E | 3 of 7 units. |
| | 441 | D | X | X (3) | X | | X | X | | | |
| New Rochelle #8 | | | | | | | | | | | |
| | 325 | D | | X (4) | | | X | X | | | |
| New York City #1 (Replacement) | | | | | | | | | | | |
| | 281 | D | X | X | | | X | X | | | |
| | 286 | C | X | X (2) | | | X | X | | | |
| | 332 | D | X | X | | | X | X | | | |
| | 441 | E | X | X (6) | | | X | | X | D | Why is 2 of 9 a pattern? There is no multiple occurrences either. |
| New York City #2 | | | | | | | | | | | |
| | 151 | B | | X | X (12) | | X | | X | C | 11 of 12 residents. |
| | 332 | D | X | X | | | X | X | | | |
| | 371 | E | X | X | | | | | X | D or F | Either can say limited to one location or can affect a large number of residents. Why pattern? |
| New York City #3 | | | | | | | | | | | |
| | 241 | D | X | X | X | | | | X | G | Resident felt worthless: negative outcome that compromised mental and psycho-social well-being that is more than limited consequence. |
| New York City #4 | | | | | | | | | | | |
| | 309 | G | X | X (3) | | | X | X | | | |
| | 323 | E | X | X | | | | X | | | |
| | 371 | E | X | | | | | X | | | |
| New York City #5 | | | | | | | | | | | |
| | 253 | D | X | X | | | X | X | | | |
| | 281 | D | X | X | | | X | X | | | |
| | 282 | D | X | X (2) | | | X | X | | | |
| New York City #6 | | | | | | | | | | | |
| | 282 | D | | X (3) | | | X | | X | E | Same resident has been affected by repeated occurrences of the same deficient practice. |
| | 371 | E | X | X (2) | | | X | X | | | |
| | 386 | D | | X (4) | X | | X | X | | | |
| New York City #7 (Replacement) | | | | | | | | | | | |
| | 279 | D | | X (2) | | | X | X | | | |
| | 282 | D | X | X (4) | | | X | X | | | |
| | 314 | G | | X (4) | | | X | | X | J | No documented evidence that the resident's left hip skin integrity was assessed or monitored until it progressed to a stage IV. |
| | 371 | E | X | X | | | X | X | | | |
| | 441 | D | X | X | | | X | X | | | |
| New York City #8 (Replacement) | | | | | | | | | | | |
| | 282 | D | X | X (3) | | | X | X | | | |
| | 323 | D | X | X (2) | | | | X | | | |
| | 386 | D | | X (2) | | | X | X | | | |
| | 441 | D | X | X | | | | X | | | |
| New York City #9 | | | | | | | | | | | |
| | 323 | D | X | X | | | | X | | | |

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LTCCC LONG TERM CARE COMMUNITY COALITION

*Working to improve long term care through research, education & advocacy*

The Long Term Care Community Coalition (LTCCC) is a non-profit organization that works to improve conditions for long term care consumers, such as nursing home residents, assisted living and adult home residents, and people in Managed Long Term Care. We accomplish our goals through policy research and analysis, advocacy and education of the general public, the news media and policy makers.

The Long Term Care Community Coalition:

- Identifies shortcomings in the delivery of long term care;
- Researches issues impacting care delivery to the elderly and disabled;
- Develops recommendations for improvement;
- Advocates for laws and policies to improve care;
- Educates the general public, policy makers and the media on long term care issues; and
- Actively engages government agencies and elected officials in discussion and action on the needed changes.

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